

South Atlantic Division Cancer Facts & Figures 2008

Includes Appendix
With State &
County Data



***We Are Here.
Making A Difference
In Every Community.***

Delaware

North Carolina

District of Columbia

South Carolina

Georgia

Virginia

Maryland

West Virginia



South Atlantic Division, Inc.

Contents

Introduction.....	1
Demographics	2
Estimated New Cancer Cases & Deaths, 2008.....	4
Incidence and Mortality.....	5
Trends in Cancer Incidence and Mortality	6
Cancer Among Hispanics and Latinos	8
Health Profile among Hispanic Adults	
Health Profile among Hispanic Youth	
Cancer Screening Patterns among Hispanics	
Cancer Incidence and Mortality among Hispanics	
Stage at Cancer Diagnosis and Survival	
Access to Care	
Programs to Promote Healthy Behaviors among Hispanics	
Limitations	
References	
Delaware	18
District of Columbia.....	26
Georgia	34
Maryland	42
North Carolina.....	50
South Carolina.....	58
Virginia	66
West Virginia.....	74
Colorectal Cancer Screening Guidelines.....	82
American Cancer Society Screening Guidelines....	83
Cancer Research	84
Data Sources & Technical Notes.....	88
State Cancer Registries & Vital Statistics.....	91
American Cancer Society South Atlantic Division Offices	92
County Level Data.....	Appendix
County Level Incidence and Mortality Data By State and Cancer Site	



South Atlantic Division, Inc.

American Cancer Society Mission Statement

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

Acknowledgements

With grateful appreciation for their contribution and assistance:

Delaware Cancer Registry

Alison Shevock, PhD

District of Columbia Cancer Registry

Aaron Adade, PhD; Alicia Vargas

Georgia Comprehensive Cancer Registry

Rana Bayakly, MPH

Maryland Cancer Registry

Kimberly Stern, MHA, CTR; Diane Dwyer, MD

Maryland Vital Statistics Administration

Hal Sommers, MA

North Carolina Central Cancer Registry

Karen Knight, MS; Chandrika Rao, PhD

South Carolina Central Cancer Registry

Susan Bolick-Aldrich, MSPH, CTR;
Deborah Hurley, MSPH

Virginia Cancer Registry

Jim Martin, PhD; Carolyn Halbert, MA, MPH

Virginia Center For Health Statistics

Calvin Reynolds; Robert Magnotti

West Virginia Cancer Registry

Patricia Colsher, PhD; Sharon Hill

West Virginia Health Statistics Center

Daniel Christy, MPA; Tom Light

Editor: Judy Walrath, PhD
Planning Manager

© 2008 American Cancer Society, South Atlantic Division, Inc. All rights reserved, including the right to reproduce this publication or portions thereof in any form. However, data provided from the State Cancer Registries/State Centers for Health Statistics may be reproduced without permission. For written permission, address the American Cancer Society, South Atlantic Division, 2200 Lake Boulevard, Atlanta, GA 30319.

Cancer is a group of diseases characterized by uncontrolled growth and spread of abnormal cells. Cancer is caused by both external factors (tobacco, poor diet, physical inactivity, chemicals, radiation and infectious organisms) and internal factors (inherited mutations, hormones, immune conditions and mutations that occur from metabolism). These causal factors may act together or in sequence to initiate or promote carcinogenesis.

Anyone can develop cancer. The risk of being diagnosed with cancer increases with increasing age; about 77% of all cancers are diagnosed in persons 55 and older. In the U.S., men have slightly less than a 1 in 2 lifetime risk of developing cancer and for women, the risk is a little more than 1 in 3.

How to Use *Cancer Facts & Figures* for Planning Cancer Control

South Atlantic Division Cancer Facts & Figures 2008 provides a comprehensive resource for state and community cancer control planning and implementation within the South Atlantic Division, which includes Delaware, District of Columbia, Georgia, Maryland, North Carolina, South Carolina, Virginia and West Virginia.

This resource includes a special section entitled “Cancer among Hispanics/Latinos” (pp. 8-17) that includes demographic data on the Hispanic population and provides a summary of cancer risk factor data as well as cancer incidence and mortality patterns among persons of Hispanic origin. Initiatives currently underway in the South Atlantic Division that are designed to improve the overall healthcare of Hispanics in the Division are highlighted.

Estimates of new cancer cases and deaths (p. 4) for major cancer sites are included for each South Atlantic state as a resource for comprehensive cancer control efforts; particularly in the planning of survivorship programs.

State-specific Cancer Information

Each eight-page state section includes the following cancer information: demographics, cancer trends, cancer incidence and mortality rates, case and death counts, and staging data. We include cancer incidence and mortality data on: all cancers combined, cancers of the female breast, cervix, colon/rectum, lung, prostate, and melanoma of the skin. When sufficient numbers permit, these cancer data are presented by race (white and black) and by gender for cancers that are not sex-specific. Data on stage of cancer at time of diagnosis are shown for cancers of the female breast, cervix, colon/rectum, prostate and malignant melanoma.

Each state section also includes an “At A Glance” report that summarizes state-specific initiatives on tobacco control, cancer screening programs, Comprehensive Cancer Control, access to care measures and other achievements.

County-specific Data – Appendix

For each South Atlantic state and the District of Columbia, cancer incidence and mortality data are provided by county/ward in the Appendix. Five-year counts of cancer cases and cancer deaths are shown, along with five-year average age-adjusted cancer incidence and mortality rates for 2001-2005 unless otherwise noted.

Cancer Prevention & Early Detection

It is estimated that obtaining recommended cancer screening tests and adopting healthy behaviors such as good nutrition, reasonable body weight and regular physical exercise could eliminate at least 50% of cancer deaths.

The prevalence of each of these modifiable risk behaviors among both adults and high school students is reported here by state since these factors can impact each state’s cancer burden. Risk factor data used in this publication are obtained from surveys conducted by the Behavioral Risk Factor Surveillance System (BRFSS) for adults ages 18 and over and by the Youth Risk Behavioral Surveillance System (YRBSS) and Youth Tobacco Survey (YTS) for students in high school.

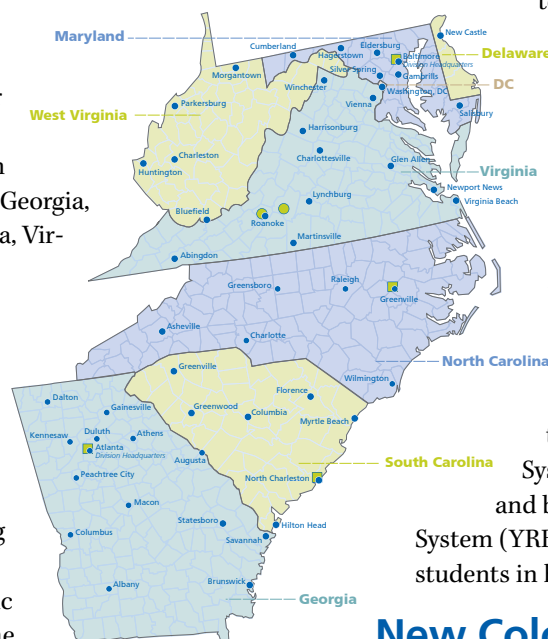
New Colorectal Cancer Screening Guidelines

Information on the new colorectal guidelines, issued in March 2008, is included in “Updated Colorectal Guidelines”. These guidelines, shown in detail on page 82, list colorectal cancer screening recommendations categorized into (1) tests that find polyps and cancer and (2) tests that mainly find cancer.

ACS Supported Research in the South Atlantic Division

The American Cancer Society is the largest source of private, not-for-profit cancer research funds in the United States, second only to the federal government. The 111 grants totaling \$50,557,202 that have been awarded for research in the South Atlantic Division as of January 2008 are listed on pages 84-87.

For additional details and source information, refer to the Technical Notes section on pages 88-90.



Demographics

The South Atlantic (SA) Division, comprised of Delaware, District of Columbia, Georgia, Maryland, North Carolina, South Carolina, Virginia and West Virginia, has a diverse and growing population of 39,196,122 residents (2007 estimate).



- The primary racial and ethnic categories in the SA Division are White, non-Hispanic (64.6%), Black, non-Hispanic (24.3%), Hispanic (6.1%), Asian/Pacific Islander (non-Hispanic) (2.9%) and American Indian, Non-Hispanic (0.5%).
- The size of the Hispanic population varies across the South Atlantic Division, with the District of Columbia having the largest proportion at 8.7% and West Virginia the smallest (0.9%).
- The Hispanic/Latino subgroups in the South Atlantic Division are Mexican (49.3%), Puerto Rican (9.2%), Cuban (2.4%) and other (39.1%).
- The largest subpopulations of Asian Americans are Asian Indian (23.8% of the Asian population), Chinese (17.0%), Korean (16.4%), Vietnamese (12.4%) and Filipino (12.3%).
- Nearly one quarter (24.3%) of residents in the South Atlantic Division are under age eighteen and 11.9% of residents are ages 65 and over.

Estimated South Atlantic Population by Race/Ethnicity and State

	South Atlantic Division	Delaware	District of Columbia	Georgia	Maryland	North Carolina	South Carolina	Virginia	West Virginia
	Count/%	Count/%	Count/%	Count/%	Count/%	Count/%	Count/%	Count/%	Count/%
Total	39,196,122	862,225	580,271	9,339,947	5,675,034	8,875,404	4,332,306	7,708,938	1,821,997
White/Non-Hispanic	25,305,921 (64.6%)	592,324 (68.7%)	181,710 (31.3%)	5,494,797 (58.8%)	3,307,000 (58.3%)	6,000,159 (67.6%)	2,823,716 (65.2%)	5,190,200 (67.3%)	1,716,015 (94.2%)
Black/Non-Hispanic	9,538,836 (24.3%)	174,609 (20.3%)	315,148 (54.3%)	2,735,208 (29.3%)	1,626,374 (28.7%)	1,893,321 (21.3%)	1,248,872 (28.8%)	1,488,118 (19.3%)	57,186 (3.1%)
American Indian/Non-Hispanic	178,243 (0.5%)	2,594 (0.3%)	1,236 (0.2%)	19,460 (0.2%)	13,339 (0.2%)	105,676 (1.2%)	13,857 (0.3%)	18,846 (0.2%)	3,235 (0.2%)
Asian / Pacific Islander/Non-Hispanic	1,154,790 (2.9%)	23,613 (2.7%)	17,796 (3.1%)	257,240 (2.8%)	272,957 (4.8%)	163,189 (1.8%)	48,229 (1.1%)	361,206 (4.7%)	10,560 (0.6%)
Hispanic	2,400,500 (6.1%)	54,319 (6.3%)	50,711 (8.7%)	702,087 (7.5%)	340,026 (6.0%)	598,562 (6.7%)	151,248 (3.5%)	487,057 (6.3%)	16,490 (0.9%)
Other/Multi-Race, Non-Hispanic	617,832 (1.6%)	14,766 (1.7%)	13,670 (2.4%)	131,155 (1.4%)	115,338 (2.0%)	114,497 (1.3%)	46,384 (1.1%)	163,511 (2.1%)	18,511 (1.0%)

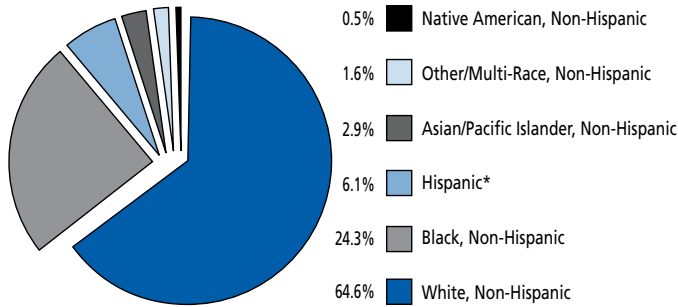
* Hispanic is an ethnicity, not a race.

Percents may not add up to 100 due to rounding.

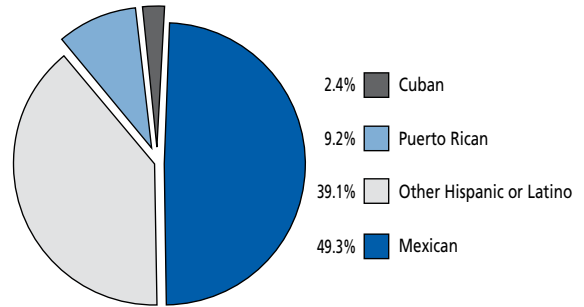
Source: Claritas Inc., Copyright © 2008 Thomson Medstat. ALL RIGHTS RESERVED.

Distribution of South Atlantic Division by Race/Ethnicity

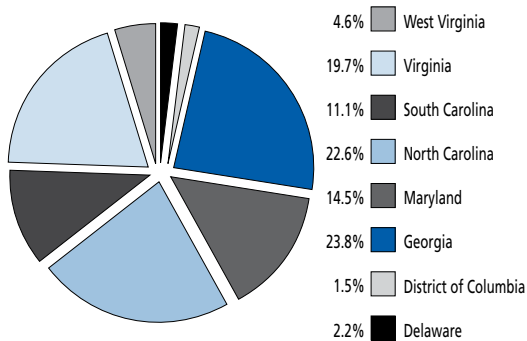
Distribution of the South Atlantic Division by Race & Ethnicity



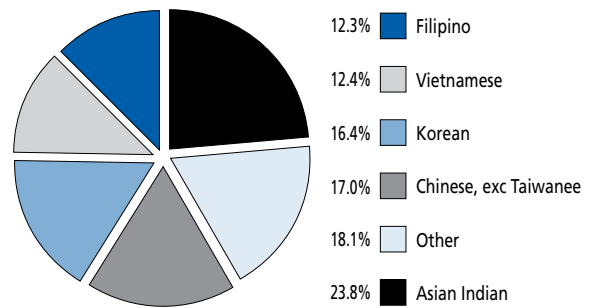
South Atlantic Division's Hispanic/Latino Population by Sub-Ethnicity



South Atlantic Division's Population by State



South Atlantic Division's Asian Population by Sub-Ethnicity

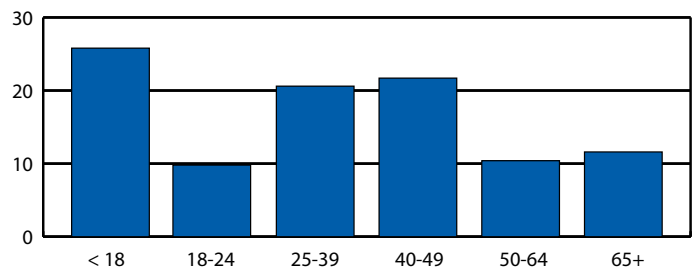


Factors Related to Access to Care in the South Atlantic Division

Percentage with less than high school education	12.9%	Percent rural population	31.8%
Median household income	\$50,717	Percent minority	35.4%
Percent households with income < \$15,000	13.0%	% speak language other than English at home	11.0%
Percent households with income ≥ \$50,000	49.9%	% with no usual source of health care coverage	16.5%
Percent of households with no vehicle	7.7%		

Age Distribution of South Atlantic Division

Age Group	Number	%
< 18	10,111,456	25.8%
18 - 24	3,859,735	9.8%
25 - 39	8,089,987	20.6%
40 - 49	8,512,892	21.7%
50 - 64	4,078,380	10.4%
65 +	4,543,672	11.6%



¹ Total is sum of White, Black, Native American, Asian/Pacific Islander, Other/Multi-Race, and Hispanic.

² Hispanic is an ethnicity, not a race.

³ Department of Labor <http://www.bis.gov/LAU/>, April 2008

Data Sources: Copyright © 2008, Thomson Medstat. ALL RIGHTS RESERVED; US Census Bureau, Population Fact Sheet, 2008, American Community Survey @ <http://factfinder.census.gov>

Estimated New Cancer Cases & Deaths, 2008

Estimated New Cancer Cases by Site and State, 2008*

State	All Cases	Female Breast	Uterine Cervix	Colon & Rectum	Uterine Corpus	Leukemia	Lung & Bronchus	Melanoma of the Skin	Non-Hodgkin Lymphoma	Prostate	Urinary Bladder
DE	4,950	580	†	480	130	110	760	180	190	530	220
DC	2,560	300	†	270	60	50	350	50	100	330	80
GA	36,980	4,910	340	3,760	840	1,030	5,980	1,600	1,550	4,700	1,380
MD	27,380	3,670	210	2,920	810	640	4,100	1,110	1,080	3,420	1,120
NC	40,420	5,000	340	4,380	1,050	1,110	6,510	1,830	1,610	5,050	1,740
SC	20,740	2,510	180	2,170	500	590	3,550	940	780	2,520	850
VA	35,590	4,680	260	3,690	1,000	850	5,340	1,620	1,410	4,430	1,460
WV	10,250	1,150	80	1,200	320	290	2,000	440	410	1,180	530
SA**	178,870	22,800	1,410	18,870	4,710	4,670	28,590	7,770	7,130	22,160	7,380
U.S.	1,437,180	182,460	11,070	148,810	40,100	44,270	215,020	62,480	66,120	186,320	68,810

* Rounded to the nearest 10.

† Estimate is 50 or fewer cases.

** South Atlantic Division

Note: These estimates are offered as a rough guide and should be interpreted with caution.

Data Source: American Cancer Society, Cancer Facts and Figures, 2008

Estimated Cancer Deaths by Site and State, 2008*

State	All Cases	Brain/ Nervous System	Female Breast	Colon & Rectum	Leukemia	Liver	Lung & Bronchus	Non-Hodgkin Lymphoma	Ovary	Pancreas	Prostate
DE	1,870	†	110	150	70	50	590	60	50	110	100
DC	990	†	70	90	†	†	250	†	†	60	70
GA	15,040	300	1,110	1,330	540	400	4,570	480	430	850	730
MD	10,360	220	830	940	390	300	2,920	350	280	660	550
NC	17,450	350	1,300	1,400	600	460	5,470	500	460	1,020	750
SC	8,860	190	620	730	320	260	2,860	270	210	520	420
VA	13,990	310	1,140	1,260	500	390	4,600	420	390	840	630
WV	4,580	100	310	450	150	120	1,450	170	130	210	150
SA**	73,140	1,470	5,490	6,350	2,570	1,980	22,710	2,250	1,950	4,270	3,400
U.S.	565,650	13,070	40,480	49,960	21,710	18,410	161,840	19,160	15,520	34,290	28,660

* Rounded to the nearest 10.

† Estimate is 50 or fewer cases.

** South Atlantic Division

Note: These estimates are offered as a rough guide and should be interpreted with caution.

Data Source: American Cancer Society, Cancer Facts and Figures, 2008

Incidence and Mortality

Cancer Incidence Rates for Selected Sites, 2001-2005, by State and US*, **

	ALL SITES	BREAST	CERVICAL	COLORECTAL			LUNG AND BRONCHUS			MELANOMA	PROSTATE
	Both Genders	Female	Female	Both Genders	Male	Female	Both Genders	Male	Female	Both Genders	Male
DE	507.3	126.4	8.2	53.5	62.6	46.4	79.6	97.8	66.2	20.9	175.5
DC*	538.5	172.4	12.5	62.7	64.5	61.2	66.9	84.7	52.3	12.1	200.9
GA	465.6	120.6	9.0	50.0	60.1	42.6	74.4	104.3	53.4	19.9	163.7
MD**	477.3	130.4	8.1	53.3	62.1	46.7	68.7	86.0	56.2	18.8	182.7
NC	461.6	121.7	7.9	48.6	57.3	41.9	73.8	100.9	54.4	16.6	156.1
SC	483.9	120.3	8.8	53.4	64.2	45.3	74.9	104.9	52.8	19.9	174.1
VA	436.4	120.1	6.9	48.6	56.8	42.5	66.7	86.6	52.2	17.1	156.5
WV	490.1	115.4	10.2	59.8	70.5	51.6	89.5	116.8	69.4	16.9	139.3
US	467.4	126.1	8.4	50.6	59.2	43.8	63.9	79.4	52.6	19.4	163.0

Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.

* - Incidence rates for the District of Columbia are for 2000-2004.

** Incidence rates for Maryland are for 1999-2003.

Source: DE, DC, GA, MD, NC, SC, VA and WV Cancer Registries; US Estimates: http://seer.cancer.gov/csr/1975_2005/, based on November 2007 SEER data submission, posted to the SEER web site, 2008.

Cancer Mortality Rates for Selected Sites, 2001-2005, by State and US*

	ALL SITES	BREAST	CERVICAL	COLORECTAL			LUNG AND BRONCHUS			MELANOMA	PROSTATE
	Both Genders	Female	Female	Both Genders	Male	Female	Both Genders	Male	Female	Both Genders	Male
DE	203.8	25.1	2.9	19.8	23.7	16.8	61.9	80.2	48.5	3.3	29.3
DC*	221.0	32.4	3.7	23.3	24.3	22.5	55.9	71.1	43.3	1.3	37.1
GA	193.0	24.6	2.7	18.4	22.6	15.6	58.5	85.6	39.6	2.5	30.4
MD	194.9	27.2	2.4	19.8	23.8	16.8	55.7	72.3	43.7	2.7	28.6
NC	197.1	25.6	2.6	18.4	22.2	15.6	59.7	85.4	41.5	2.9	30.0
SC	201.4	25.4	2.8	19.2	23.8	15.9	60.8	89.3	40.3	2.5	32.9
VA	192.5	26.4	2.2	18.6	22.8	15.6	56.2	75.7	42.2	2.9	29.5
WV	213.5	25.1	3.4	21.6	26.0	18.2	68.8	93.1	51.1	3.0	24.0
US	189.8	25.0	2.5	18.8	22.7	15.9	54.1	72.0	41.0	2.7	26.7

* - Mortality rates for the District of Columbia are for 2000-2004.

Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.

Data Sources: DC, DE, GA, NC and SC cancer registries; MD Vital Statistics Administration, VA Center for Health Statistics; WV Health Statistics Center; US: http://seer.cancer.gov/csr/1975_2005/, based on November 2007 SEER data submission, posted to the SEER web site, 2008.

Trends in Cancer Incidence and Mortality

In 1996, the American Cancer Society Board of Directors set an ambitious challenge goal of a 50% reduction in age-adjusted cancer mortality rates by the year 2015. As a measure of our progress towards the 2015 goal, U.S. cancer mortality rates have decreased 14.6% since 1990.

In 1998, the Board of Directors set a parallel challenge goal for a 25% reduction in age-adjusted cancer incidence rates by 2015. As of 2005, the cancer incidence for the U.S., based on SEER data, has decreased 5.4% since 1990. Two South Atlantic (SA) Division states, Georgia and Virginia, have a 2005 incidence rate that is lower than the U.S. rate.

The National Cancer Institute ranks five-year average age-adjusted cancer mortality rates from 1 to 51, with 1 being the highest (worst) rate.

- The District of Columbia ranks 6th highest in the Nation for all cancers combined for 2001-2005 (4th among men and 10th among women). The District is also highest in mortality from prostate cancer and cancers of the breast and cervix in women. Colorectal cancer mortality in the District is 3rd highest in the Nation, both among men and women.
- West Virginia ranks 3rd in mortality from all sites combined (2nd among women and 8th among men), with colorectal cancer 2nd, lung cancer 4th (3rd among women and 7th among men) and cervical cancer 4th.
- Seven of the eight South Atlantic states are in the top ten highest for prostate cancer mortality. The District of Columbia ranks highest, South Carolina 4th, Georgia 6th, Virginia 7th, North Carolina 8th, Delaware 9th and Maryland 10th.
- Men in Delaware rank highest in mortality from malignant melanoma. Among Delaware women, lung cancer mortality ranks 4th, mortality from all sites combined ranks 8th and cervical cancer mortality ranks 9th.
- Men in South Carolina are 9th highest in overall mortality and 8th highest in mortality from cancers of the lung and bronchus.
- In Virginia, mortality from malignant melanoma ranks 9th in women and breast cancer mortality is also 9th highest.

State Rankings* of Selected Cancer Mortality Rates 2001-2005 by SA State, Both Sexes Combined

SAD State	All Sites	Colon / Rectum	Lung / Bronchus	Malignant Melanoma
DE	11	16	11	5
DC	6	4	34	51
GA	24	33	17	34
MD	19	14	20	30
NC	20	35	15	22
SC	14	25	13	38
VA	23	27	18	20
WV	3	2	4	9

State Rankings* of Selected Cancer Mortality Rates 2001-2005 by SA State, Males

SAD State	All Sites	Colon / Rectum	Lung / Bronchus	Malignant Melanoma	Prostate
DE	13	18	15	1	9
DC	4	3	18	49	1
GA	17	30	12	36	6
MD	22	16	23	26	10
NC	16	33	13	22	8
SC	9	20	8	34	4
VA	20	23	17	23	7
WV	8	2	7	12	45

State Rankings* of Selected Cancer Mortality Rates by SAD State, Females

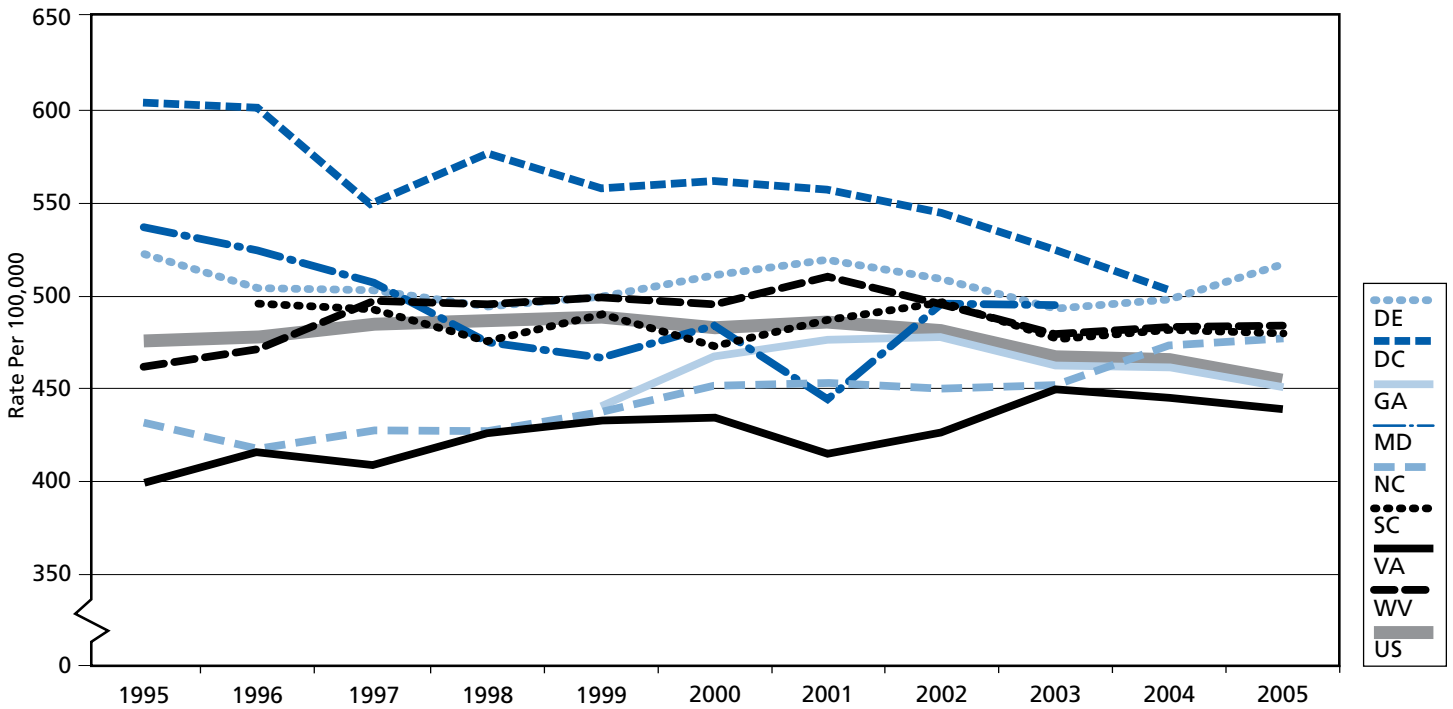
SAD State	All Sites	Colon / Rectum	Lung / Bronchus	Malignant Melanoma	Breast (female)	Cervix
DE	8	18	4	21	20	9
DC	10	3	44	51	1	1
GA	31	33	33	30	25	15
MD	14	15	19	33	5	27
NC	28	34	28	15	15	21
SC	29	30	32	39	19	13
VA	26	32	23	9	9	31
WV	2	2	3	13	21	4

Note: Rankings are of Average Cancer Mortality Rates for all races combined for 2001-2005 that are age-adjusted to the 2000 U.S. standard population.

* A rank of 1 indicates the highest (worst) age-adjusted mortality rate for that cancer among the 50 states and the District of Columbia and 51 is the best (lowest) rate among all 51 states and the District of Columbia

Source: Ries LAG, Melbert D, Krapcho M, Mariotto A, Miller BA, Feuer EJ, Clegg L, Horner MJ, Howlader N, Eisner MP, Reichman M, Edwards BK (eds). SEER Cancer Statistics Review, 1975-2005, National Cancer Institute. Bethesda, MD, http://seer.cancer.gov/csr/1975_2005/, based on November 2007 SEER data submission, posted to the SEER web site, 2008.

Cancer Incidence Rates, All Sites, by State and U.S., 1995-2005*

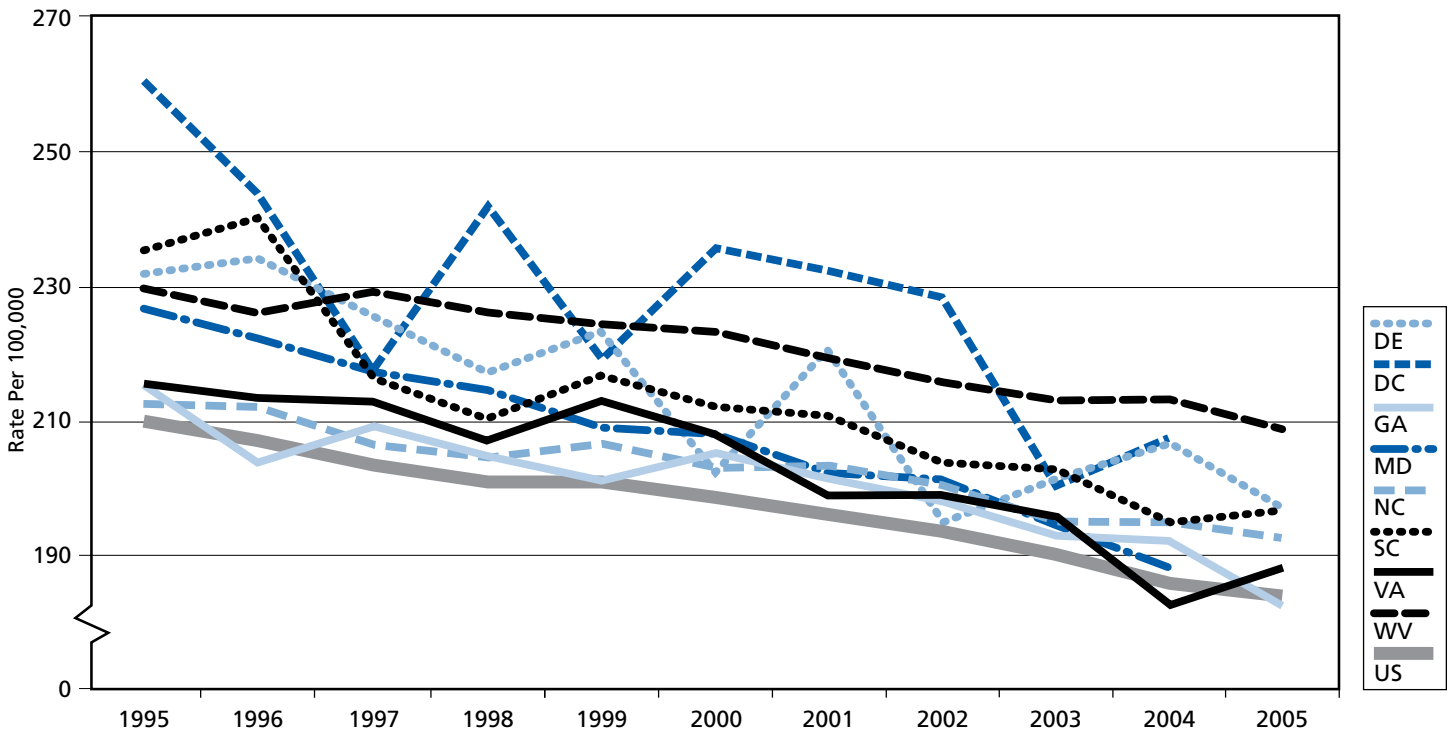


Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.

* District of Columbia data for years 1995-2004, Georgia data years 1999-2005, South Carolina data years 1996-2005, Maryland data years 1995-2003

Data Sources: DC, DE, MD, GA, NC, SC, VA and WV cancer registries; US: http://seer.cancer.gov/csr/1975_2005/, based on November 2007 SEER data submission, posted to the SEER web site, 2008.

Cancer Mortality Rates, All Sites, by State and U.S., 1995-2005*



Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.

* District of Columbia data for years 1995-2004

Data Sources: DC, DE, GA, NC and SC cancer registries; MD Vital Statistics Administration, VA Center for Health Statistics; WV Health Statistics Center; US: http://seer.cancer.gov/csr/1975_2005/, based on November 2007 SEER data submission, posted to the SEER web site, 2008.

Cancer Among Hispanics and Latinos

Introduction

The Hispanic/Latino population is often described as a mosaic of cultures. Moreover, the diversity extends to nationality, customs, heritage, lifestyles and socioeconomic status. The Hispanic heritage can be traced back to Spain. 'Latino/a' refers to persons living in Spanish-speaking Latin America and their heritage can be traced back to the Latin language. The terms 'Hispanic' and 'Latino/a' are used interchangeably in this report.

The Hispanic/Latino population comprises nearly 15% of the U.S. population and is the fastest growing racial/ethnic group. As of 2007, an estimated 2,400,500 Hispanic/Latinos reside in

This report includes the following sections:

- Health profile among Hispanic adults
- Health profile among Hispanic youth
- Cancer screening patterns
- Cancer incidence & mortality among Hispanics
- Stage at diagnosis and survival
- Access to care
- Programs to promote healthy behaviors among Hispanics
- Limitations

the South Atlantic Division (SAD) and they make up 6.1% of the population.⁷ The fastest population growth for Hispanics is in the South; Georgia, North Carolina and South Carolina are among the top states with an increase of more than 300% in the last ten years. Within the Division, the District of Columbia ranks highest in the proportion of Hispanic residents (8.7%), followed by Georgia at 7.5%, and West Virginia has the smallest proportion at 0.9%. (Table 1) Official census counts of the Hispanic/Latino population, however, are believed to be under-represented due to individual identity preference (black/white versus Hispanic/Latino) as well as legal status concerns of the community and recent changes in immigration patterns.

Overall, six out of ten Hispanic/Latino residents in the SAD have reported to be from Mexico, Puerto Rico or Cuba.⁸ In North Carolina, Georgia and South Carolina, Mexicans comprise the majority of Hispanic residents, with 66.6%, 65.4% and 63.0%, respectively. Delaware has the largest proportion of Latinos of Puerto Rican descent (27.3%) and District of Columbia has the highest proportion from Cuba (4.9%). Persons from 'other Hispanic/Latino country' are most common in the District of Columbia (76.5%), Maryland (67.6%) and Virginia (61.3%). (Table 2)

Additional data reveal that the District of Columbia, with more than three-quarters of its population in the "other Hispanic/Latino" category, is home to the largest Bolivian population in the U.S., the second largest concentration of Salvadorans and significant populations from Peru, Colombia, Mexico, Guatemala, Honduras, Ecuador and Nicaragua. The District also includes embassies and consulates from many Latin American countries.

Table 1. Percentage of Hispanic Residents by South Atlantic State (ranked from highest to lowest)

South Atlantic State/District	Number of Hispanic Residents	Percent of Total State Population
District of Columbia	50,711	8.7%
Georgia	702,087	7.5%
North Carolina	598,562	6.7%
Delaware	54,319	6.3%
Virginia	487,057	6.3%
Maryland	340,026	6.0%
South Carolina	151,248	3.5%
West Virginia	16,490	0.9%
South Atlantic Division	2,400,500	6.1%

Source: Claritas

Health Profile among Hispanic Adults

Experts believe that if current knowledge about cancer prevention and early detection were applied, at least half of all cancer deaths could be prevented. The American Cancer Society estimates that in 2008, about 10,000 cancer deaths will be attributed to tobacco use alone. In addition, approximately one-third (188,550) of the 565,650 cancer deaths expected in 2008 are attributable to poor nutrition, overweight/obesity and lack of physical activity. Cancer screening tests can detect pre-cancerous lesions, improve survival or decrease mortality by detecting cancer at an earlier stage when treatment is more effective.³

Table 2. Distribution of Hispanic/Latino Residents by Country of Origin and SA States, 2007 population estimates

Country of Origin	DE	DC	GA	MD	NC	SC	VA	WV	SA*
Mexico	45.8%	12.8%	65.4%	19.1%	66.6%	63.0%	25.1%	40.0%	49.3%
Puerto Rico	27.3%	5.7%	7.4%	10.9%	7.5%	10.1%	10.9%	12.6%	9.2%
Cuba	1.7%	4.9%	2.7%	2.3%	1.8%	1.7%	2.7%	2.9%	2.4%
Other Hispanic/Latino	25.3%	76.5%	24.6%	67.6%	24.1%	25.2%	61.3%	44.5%	39.1%
Total Known Hispanic/Latino Residents	54,319	50,711	702,087	340,026	598,562	151,248	487,057	16,490	2,400,500

Source: Census; *Population - weighted average.



limited, smoking patterns among Latinos in the South Atlantic Division do generally follow the national pattern where 16.7% of Hispanics are current smokers in 2007, compared with 19.4% non-Hispanic (NH) white and 21.7% non-Hispanic (NH) blacks. An exception is noted in South Carolina, where the cigarette smoking rate among Hispanics (24.8%) is higher than among non-Hispanic whites (22.0%) and the same as non-Hispanic blacks (24.7%). (Table 3)

Smoking rates among Hispanic men are about 25% lower than in non-Hispanic white men, and Hispanic women are about half as likely to smoke as non-Hispanic white women.⁶ Cigarette smoking rates among Hispanics born in the U.S. are higher than among those born elsewhere.²

Poor nutrition, lack of physical activity and being obese or overweight are major cancer risk factors, second only to tobacco use. Approximately one-third, or 188,550 of the 565,650 cancer deaths in 2008 will have been associated with these three risk factors. This statistic would mean that 7,772 of the 23,320 U.S. cancer deaths expected among Hispanics in 2006 could have been prevented through a healthy diet, regular physical activity and weight control.

Nutrition and Physical Activity: The ACS Recommendations for Nutrition and Physical Activity, updated in 2006, highlight the importance of having a healthy weight and physical activity in the prevention of cancer.⁵ The recommendations include the following:

Maintain a healthy weight throughout life.

- Balance calorie intake with physical activity.
- Avoid excessive weight gain throughout life.
- Achieve and maintain a healthy weight if currently overweight or obese.

Adopt a physically active lifestyle.

- *Adults:* Engage in at least 30 minutes of moderate to vigorous physical activity, above usual activities, on 5 or more days of the week; 45 to 60 minutes of intentional physical activity are preferable.
- *Children and adolescents:* Engage in at least 60 minutes per day of moderate to vigorous physical activity at least 5 days per week.

Fruits and Vegetables: Eating five or more servings of a variety of vegetables and fruits every day is a recommendation in the American Cancer Society's Nutrition Guidelines, updated in 2006.⁵ Unfortunately, BRFSS estimates show that more than

Continued

Tobacco Use: The National Latino Council on Alcohol and Tobacco Prevention, more commonly known as LCAT, is a non-profit 501(c)(3) national organization established in 1989 in order to combat alcohol and tobacco problems and their underlying causes in Latino communities (www.nlcatp.org). As the only Latino national organization dedicated solely to reducing the harm caused by alcohol and tobacco in the Latino community, their work is conducted through research, advocacy, policy analysis, community education, training and information dissemination.

Results of their research show that:

- Puerto Ricans are more likely than other Latinos to be current smokers.
- For Latinas, there is a positive relationship between level of acculturation and smoking.
- In 2005, 22 percent of Hispanic high school students smoked, a 19 percent increase over the 2003 smoking rate of 18.4 percent.
- In 2004, 9.4 percent of Hispanic middle school students smoked.
- Puerto Rican women are nearly twice as likely to smoke as women of other Hispanic groups.
- Lung cancer is the leading cause of cancer deaths among Latinos living in the United States.

The Behavioral Risk Factor Surveillance System survey (BRFSS) is an annual survey of the Centers for Disease Control and Prevention (CDC) and the U.S. states and territories.⁶ Although the state-specific data on risk behaviors among Hispanics are

Table 3. Estimated Prevalence of Current Cigarette Smoking among Adults (%) by Race/Ethnicity for SAD States and U.S., 2007

	DE	DC	GA	MD	NC	SC	VA	WV	SA*	US
Hispanic	n/a	11.0	15.0	13.9	19.2	24.8	8.2	n/a	15.0	16.7
NH White	19.4	24.1	19.1	17.4	23.1	22.0	13.7	21.9	19.0	19.4
NH Black	14.6	22.0	19.6	19.0	23.0	24.7	15.1	n/a	19.5	21.7

Source: BRFSS; * Population-weighted estimated average of South Atlantic states with available data

three-quarters of adult Americans DO NOT meet the ACS recommendation for minimum fruit and vegetable consumption. In the SAD, consumption is lowest among Hispanics (80.9%), followed by NH blacks (77.9%) and NH whites (75.7%). (Table 4)

Physical Activity: Research indicates that regular physical activity can prevent cancer by helping reduce overweight and obesity. Achieving and/or maintaining an ideal weight can help decrease the risk of cancers of the colon/rectum, breast (premenopausal), uterus and prostate. Regular physical activity is also beneficial in the prevention of chronic diseases, particularly diabetes and heart disease. The BRFSS question “do you have at 30+ minutes of moderate physical activity five or more days per week, or vigorous physical activity for 20+ minutes three or more days per week?” is the measure of adult physical activity that most closely resembles the ACS guideline listed above.

The South Atlantic Division overall has a higher prevalence than the U.S. of persons that DO NOT have regular physical activity in each of the race/ethnicity groups shown in Table 5. The rate of physical inactivity among Hispanics in the SAD is 18% higher than the U.S. Hispanic rate, but data are only available for the District of Columbia, Maryland and North Carolina. In North Carolina and South Carolina, prevalence of physical inactivity is higher than the U.S. among both white and black non-Hispanics.

Obesity/Overweight: Being overweight or obese is associated with increased risk of cancers of the breast, prostate, colon/rectum and uterus, in addition to other chronic diseases such as diabetes, high blood pressure, heart disease and premature death. A common measure to establish whether a person is un-

derweight, normal weight, overweight or obese is the Body Mass Index (BMI) which is determined by the person’s height and weight. Obese is having a BMI of 30 or higher and overweight is defined as having a BMI of 25 to less than 30.

Obesity has been increasing in the U.S. in both Hispanics and non-Hispanics. Data from the BRFSS survey, where overweight and obese are classified based on the individual’s self-reported height and weight, show that in the U.S. nearly 67 percent of Hispanic residents were overweight or obese compared with 62.6% of non-Hispanic whites. Non-Hispanic blacks, however, had an obesity/overweight prevalence of 72.6%. Data from other surveys suggest that the rate of obesity is higher among Puerto Ricans and Mexicans than in other Hispanic subgroups.²

In the South Atlantic Division, the prevalence of overweight/obesity among non-Hispanics is similar to the U.S. rate. An exception is the District of Columbia, where the prevalence of overweight/obesity for NH whites at 39.3% is 37% lower than the U.S. rate for that race/ethnic group. Although data for Hispanics are only available for 2 states and the District of Columbia, the SA combined rate (58.9%) is lower than the U.S. and lower than NH whites and NH blacks in the SA Division; 62.0% and 72.6%, respectively. (Table 6)

Health Profile among Hispanic Youth

The Youth Risk Behavior Surveillances Survey (YRBSS) is an annual survey that is also conducted by the Centers for Disease Prevention and Control.¹³ Although the data on Hispanic youth are limited at the state level, data for the entire U.S. can provide

Table 4. Estimated Prevalence of Not Eating 5 Fruits & Vegetables per Day (%) among Adults by Race/Ethnicity for SAD States and U.S., 2007

	DE	DC	GA	MD	NC	SC	VA	WV	SA*	US
Hispanic	n/a	71.2	78.6	79.1	85.3	81.5	75.6	n/a	80.9	77.4
NH White	79.3	64.7	75.2	72.9	76.9	80.9	73.5	80.9	75.7	75.5
NH Black	77.1	69.5	74.8	74.8	81.5	82.0	72.9	n/a	77.9	76.9

Source: BRFSS; * Population-weighted estimated average of South Atlantic states with available data

Table 5. Estimated Lack of Physical Activity (%) among Adults by Race/Ethnicity for SAD States and U.S., 2007

	DE	DC	GA	MD	NC	SC	VA	WV	SA*	US
Hispanic	n/a	56.2	n/a	60.2	69.0	n/a	n/a	n/a	65.2	55.3
NH White	50.1	33.3	50.9	48.4	53.1	51.7	49.0	54.5	50.6	48.4
NH Black	61.8	54.7	57.3	58.7	62.3	60.0	56.7	n/a	59.0	58.6

Source: BRFSS; * Population-weighted estimated average of South Atlantic states with available data

Table 6. Estimated Prevalence of Overweight/Obesity among Adults (%) by Race/Ethnicity for SAD States and U.S., 2007

	DE	DC	GA	MD	NC	SC	VA	WV	SA*	US
Hispanic	n/a	57.2	n/a	56.5	62.4	n/a	n/a	n/a	58.9	66.9
NH White	64.2	39.3	63.2	60.7	62.5	63.0	60.3	68.6	62.0	62.6
NH Black	73.2	68.8	69.6	74.2	74.7	73.6	72.4	n/a	72.6	72.6

Source: BRFSS; * Population-weighted estimated average of South Atlantic states with available data

Table 7. Estimated Prevalence of Risk Behaviors among High School Students (%) by Race/Ethnicity for the U.S., 2007

Risk Factor	Hispanic		White Non-Hispanic		Black Non-Hispanic	
	Male	Female	Male	Female	Male	Female
Current Cigarette Smoking	18.7	14.6	23.8	22.5	14.9	8.4
Current Smokeless Tobacco Use	6.7	2.7	18.0	2.5	2.0	0.5
Did Not Consume 5 Fruits & Vegetables per Day	74.1	77.9	79.9	82.4	73.4	76.6
Did Not Meet Recommended Level of Physical Activity	18.8	35.2	16.7	28.2	21.8	42.1
Are Overweight or Obese	38.6	30.6	30.3	19.6	35.5	39.2

Source: YRBSS, 2007

an invaluable profile of risk behavior patterns among Hispanic students. (Table 7) Data are shown here for high school students.

Cigarette Smoking: Data from the YRBSS 2007 show that the prevalence of cigarette smoking among white NH youth (23.8% male and 22.5% female) is still higher than among Hispanic youth (18.7% male and 14.6% female). (Table 7) Among black non-Hispanic students, 14.9% of male and 8.4% of female students reported current cigarette use (at least one cigarette per day over the past 30 days). Although Hispanic youth in the U.S. tend to smoke less than NH youth, these patterns may change as marketing efforts increase in Latin American countries, particularly among women, and also target Hispanic women and youth in the United States.²

Smokeless Tobacco Use: Smokeless tobacco products, including chewing tobacco and snuff, are not safe substitutes for cigarette smoking. These products can cause oral and pancreatic cancers, noncancerous oral conditions and can lead to nicotine addiction. The tobacco industry continues to market new and existing products as supplemental sources of nicotine in smoke-free settings and misleadingly markets these products as a low-risk option for smokers who are unable to quit.



In Table 7 are usage rates for smokeless tobacco products among high school students. Among Latinos, 6.7% of male and 2.7% of female students used smokeless tobacco products. The highest prevalence rate was 18.0% of white NH youth using smokeless tobacco products and the lowest rate was 0.5% among black non-Latinas. In each race/ethnicity category in Table 7, male students are more likely than female students to be users of smokeless tobacco products,

Fruits and Vegetables: ACS recommendations on fruit and vegetable consumption for children/youth parallel those for adults. Among male students, the prevalence of not eating 5 or more fruits and vegetables was highest among white NH

(72.2%) than Hispanic (76.0%) and black NH (75.1%). In each race/ethnicity category, female students ate more fruits and vegetables daily than male students, although the difference was only about two percentage points in each category. (Table 7)

Physical Activity: The recommended physical activity for children and adolescents is to engage in at least 60 minutes per day of moderate to vigorous physical activity at least 5 days per week. In each race/ethnicity category, the prevalence of students who DO NOT meet the recommended physical activity level is higher among female than male students. Among male students, 18.8% of Hispanics did not meet the physical activity requirements; black non-Hispanics had the highest rate (21.8%) and white non-Hispanics the lowest rate at 16.7%. A similar pattern is seen among female students. (Table 7)

Overweight/Obesity: Since 1990, the prevalence of overweight children has increased sharply in children of all racial and ethnic groups in the U.S. Overweight children often become overweight adults, with increased risks of poor health outcomes such as high blood pressure, high cholesterol and diabetes.³ In Table 7 are prevalence rates for overweight/obese by gender and ethnicity/race category. As in adults, the weight category for children is determined by the Body Mass Index (BMI), but the formulas for the childhood BMI vary by age. Among male youth, the rate of being overweight/obese is highest among Hispanic high school students (38.6%), followed by non-Hispanic black (35.5%) and NH white (30.3%) high school students. Among female high school students, non-Latina blacks have the highest rate of overweight (39.2%), followed by Latinas (30.6%) and non-Latina white high school students (19.6%).

Cancer Screening Patterns among Hispanics

Cancer screening as recommended by the American Cancer Society (ACS) can measurably improve one's chances for a favorable outcome by detecting the cancer at an early stage when treatments are most effective. These guidelines are for people at average risk for cancer (unless otherwise specified) and without any

Continued

specific symptoms. Those that are at increased risk for certain cancers should consult their physician as they may need to follow a different screening schedule, such as starting at an earlier age or being screened more often. Also, persons with symptoms that could be related to cancer should see their doctor right away.⁴

Breast Cancer Screening: The ACS guidelines state that yearly mammograms are recommended starting at age 40 and continuing for as long as a woman is in good health.² A mammogram is a low-dose X-ray procedure that can detect breast cancer at an early stage when treatment would be more effective. In 2006 in the South Atlantic Division, Latinas have a lower rate of mammography screening (60.7%) than non-Latina whites (62.8%) and non-Latina blacks (63.8%). (Table 8) Additional survey data from 2003 show that women from Central and South America, and Cuba have higher mammography screening rates than Mexican women.²

U.S. data show a screening pattern that is similar to the SAD, but the U.S. screening rate in each race/ethnicity group is 1-2 percentage points lower than seen in the SAD. Although the mammography screening rates among Latinas have improved considerably during the past 20 years and are approaching those of non-Latinas, breast cancers diagnosed among Latinas are, on average, diagnosed at a more advanced stage than those diagnosed among non-Latinas.²

Prostate Cancer Screening: The ACS suggests screening for prostate cancer by a combination of the prostate-specific antigen (PSA) test and digital rectal exam (DRE) at ages and time intervals that are dependent upon each man's race, age and

known risk factors.⁵ The BRFSS questionnaire asks men ages 40 and older if they "have had a PSA (prostate-specific antigen) test within the past two years." In the U.S., Hispanic men have the lowest PSA screening rate (43.0%), followed by NH black men (48.1%) and NI white men (55.6%). Non-Hispanic men in the SA Division follow the same pattern as U.S. men. In fact, PSA screening rates are lower for black NH men than white NH men in each state in the South Atlantic Division, most notably in Delaware and South Carolina. (Table 9)

Colorectal Cancer Screening: New screening guidelines for colorectal cancer released in March 2008 include: (1) tests that find polyps and cancer and (2) tests that mainly find cancer and are shown in detail on page 82 of this publication.⁵ The BRFSS questionnaire asks adults ages 50+ if "they have ever had a sigmoidoscopy or colonoscopy" (i.e. an endoscopy) (Table 10). Although the new guidelines recommend a flexible sigmoidoscopy every 5 years or a colonoscopy every 10 years, the BRFSS question can still be used to approximate regional as well as sex- and race/ethnicity-specific screening patterns across the SAD.

The rate of screening by endoscopy among South Atlantic Division residents ages 50+ is higher than that seen for the U.S. in each race/ethnicity category. (Table 10) Although Hispanic adults have the lowest screening rates of the three race/ethnicity groups, their screening rate in the SAD (49.2%) is nearly one-third higher than that among U.S. Hispanics (38.2%). Maryland has the highest screening rate for Hispanics (64.3%), followed by Georgia with 55.2% screened. Among non-Hispanic whites, the District of Columbia and Delaware have the highest screening

Table 8. Estimated Mammography Screening Rates among Women Ages 40+ by Race/Ethnicity for SAD and U.S., 2006

	DE	DC	GA	MD	NC	SC	VA	WV	SA*	US
Hispanic	n/a	n/a	60.7	67.2	52.6	56.3	74.0	n/a	60.7	58.7
NH White	68.9	62.0	63.3	63.1	64.1	56.4	63.3	62.4	62.8	61.6
NH Black	77.8	64.7	67.8	65.3	66.1	61.0	55.1	n/a	63.8	62.7

Source: BRFSS; * Population-weighted estimated average of South Atlantic states with available data

Table 9. Estimated Prostate Cancer Screening (PSA) Rates (%) for Men Ages 40 + by Race/Ethnicity for SAD and U.S., 2006

	DE	DC	GA	MD	NC	SC	VA	WV	SA*	US
Hispanic	n/a	n/a	n/a	n/a	32.1	n/a	n/a	n/a	n/a	43.0
NH White	63.6	57.2	56.7	58.0	57.7	57.3	55.0	54.0	56.9	55.6
NH Black	43.5	50.0	49.9	46.9	50.4	41.2	53.7	n/a	49.2	48.1

Source: BRFSS; * Population-weighted estimated average of South Atlantic states with available data

Table 10. Estimated Colorectal Cancer Screening (endoscopy) Rates (%) for Adults Ages 50 + by Race/Ethnicity for SAD and U.S., 2006

	DE	DC	GA	MD	NC	SC	VA	WV	SA*	US
Hispanic	n/a	n/a	55.2	64.3	41.1	51.8	38.7	n/a	49.2	38.2
NH White	61.7	62.7	50.5	57.7	54.2	51.4	58.4	46.1	54.2	51.5
NH Black	59.3	55.4	47.3	58.4	52.3	43.0	59.3	n/a	52.5	49.3

Source: BRFSS; * Population-weighted estimated average of South Atlantic states with available data

rates at 62.7% and 61.7%, respectively. Non-Hispanic blacks have the highest screening rates in Delaware and Virginia (both at 59.3%).

The BRFSS survey also asks adults ages 50+ if “they have had a blood stool test within the past two years.” (Table 11) The blood stool test, often referred to as the Fecal Occult Blood Test or FOBT, is also one of the tests recommended in the ACS guidelines. Hispanics have the lowest frequency of FOBT screening of the race/ethnic groups in the U.S. (11.3%) and in the SAD (10.9%). The FOBT rate among NH blacks is higher than or equal to the rate for NH whites in each South Atlantic state.

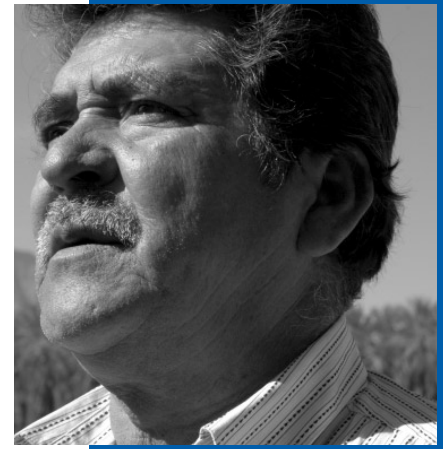
Cervical Cancer Screening: The ACS suggests screening for cervical cancer by Pap tests at time intervals that are dependent upon the woman’s age, risk factors and sexual history.⁵ The BRFSS questionnaire measures cervical cancer screening by the question “have you had a Pap test within the past 2 years?” for women ages 18 and older. Although Latinas have been less likely to participate in cervical cancer screening, their rates have improved in recent decades. Among Latinas, cervical cancer screening rates are lowest among Mexican women and among uninsured women.²

Latinas have the lowest cervical cancer screening rates in the South Atlantic Division (82.8%) as well as the U.S. (82.0%). In Delaware, however, the rate for Latinas is higher than that for non-Latinas, but the opposite is true (higher among non-Latinas than Latinas) in the District of Columbia, Georgia, Maryland and North Carolina. (Table 12)

Cancer Incidence and Mortality among Hispanics

About 39,940 new cancer cases in Hispanic men and 42,140 cases in Hispanic women were expected to be diagnosed in the U.S. in 2006. The most commonly diagnosed cancers among Hispanic men were expected to be prostate (30%), colon/rectum (11%) and lung (8%). Among Latinas, the most common cancers were expected to be breast (34%), colon/rectum (9%) and lung (6%).²

Cancer Incidence: State-specific data on cancer incidence and mortality have not been published by South Atlantic state cancer registries due to the relatively small numbers of Hispanic residents in each state. Data for the United States, however, show that Hispanics have 30% lower incidence rates for all cancers combined when compared to whites, but Latinos generally have higher rates of cancers associated with certain infections, such as cancers of the uterine cervix, liver, gallbladder and stomach.² Hispanic men and women are 1.5 to 2 times more likely to have one of these four cancers than non-Latinos.



Cancer Mortality: The numbers of cancer deaths in 2006 were expected to be 12,320 among Hispanic men and 11,000 in Latinas in the U.S. In Hispanic men, lung cancer would account for 21% of the deaths, followed by colon/rectum (11%) and prostate (9%). Among Latinas, breast cancer is the leading cause of cancer death (21% expected), followed by lung (9%) and colon/rectum (6%). This pattern is in contrast with white non-Hispanic women, among whom lung cancer is the most common cause of cancer death.

Childhood Cancer: Cancer is relatively rare among children (0-14 years) and adolescents (15-19 years), and the types of cancers found in children/adolescents are different from those seen in adults. It was estimated that 1,850 Hispanic children would be diagnosed with cancer in the U.S. in 2006. The prevalence of child/adolescent cancers in Hispanics (2.3% of all cancers) is higher than that seen in the total U.S. population, where only 1%

Continued

Table 11. Estimated Fecal Occult Blood Test Rates (%) for Adults Ages 50 + by Race/Ethnicity for South Atlantic Division and U.S., 2006

	DE	DC	GA	MD	NC	SC	VA	WV	SA*	US
Hispanic	n/a	n/a	11.0	23.3	9.5	12.6	2.4	n/a	10.9	11.3
NH White	14.4	22.5	17.3	18.6	21.1	13.5	14.7	18.4	17.5	16.5
NH Black	16.1	22.5	19.8	21.1	21.1	17.6	15.9	n/a	19.2	16.9

Source: BRFSS; * Population-weighted estimated average of South Atlantic states with available data

Table 12. Estimated Pap Smear Screening Rates by Race/Ethnicity Among Women Ages 18+ for SAD and U.S., 2006

	DE	DC	GA	MD	NC	SC	VA	WV	SA*	US
Hispanic	91.3	86.6	75.3	82.2	83.9	87.2	87.5	n/a	82.8	82.0
NH White	89.4	90.3	87.6	87.7	86.3	85.7	85.3	83.6	86.5	84.2
NH Black	86.8	88.6	90.3	88.5	89.6	90.3	89.2	n/a	89.5	87.2

Source: BRFSS; * Population-weighted estimated average of South Atlantic states with available data

of cancers are childhood cancers. One reason is that the U.S. Hispanic population is younger on average than the rest of the U.S. population; children account for 34% of the Hispanic population compared to 25% of the total U.S. population.² It was estimated that 350 Hispanic children would die from cancer in 2006.

Latinos are affected by many economic and cultural disparities in health care, including a disproportionate lack of participation in federally-funded cancer research. Their lack of inclusion in health research had hindered the development of prevention guidelines and treatments appropriate for this special population group. Among Latinos, inadequate screening and preventive care often lead to late diagnosis, delayed and/or inadequate treatment and, with some cancers, higher mortality. The inequalities seen in cancer incidence and mortality between Latino and non-Latino populations can be reduced by eliminating exposure to infectious agents that cause cancer, preventing Hispanics from adopting traditionally-avoided high risk cancer behaviors, increasing use of effective clinical preventive behaviors and assuring that every person diagnosed with cancer has affordable and timely access to state-of-the-art, affordable cancer care.¹⁰

Stage at Cancer Diagnosis and Survival

Stage at diagnosis indicates whether or not the cancer has spread to other organs and regions of the body and is one of the tumor characteristics that is used to select a treatment for the patient. In general, cancers diagnosed in the later stages (regional and distant) have a poorer prognosis because the tumor has spread beyond the site of origin.

Health care barriers such as lack of health insurance or a usual source of care are experienced by many Hispanic men and women in the U.S., as reflected in their lower rates of cancer screening as well as other preventive behaviors. One example of the effects of lack of access to care can be seen for female breast cancer.

Breast cancer is the leading cancer among women in the United States, representing 32% of all cancer cases among women. It is estimated that 1 in 7 women will develop breast cancer during their lifetime. Although breast cancer incidence rates are lower among Latinas compared to non-Latinas, Latinas are more frequently diagnosed at a later stage of breast cancer than non-Lati-

nas. Data for the U.S. below show that for female breast cancers diagnosed during 2000-2003, only 54% of Latinas compared with 63% of non-Latinas were diagnosed in the local stage. (Chart 1) Latinas are also more likely to be diagnosed with larger breast tumors than non-Hispanic women.

In addition, National data show that Hispanic men diagnosed with prostate cancer are 3.7 times more likely to be diagnosed at a later stage than non-Latinos.²

A cancer survival rate indicates the percentage of patients who are alive for a given time period, usually five years, after a diagnosis of cancer. SEER data show that Hispanic men and women have lower survival rates for most cancers, even after adjusting for difference in age and stage distribution. For example, a Hispanic man diagnosed with stomach cancer is 26% more likely to die from stomach cancer during the five years after diagnosis compared to a non-Hispanic white man of the same age and same stage at diagnosis. SEER data show that five-year survival from breast cancer for Latinas during 1992-2000 was only 83.0% compared to 87.5% for non-Latinas. In addition, when survival is adjusted for stage and age at diagnosis, Latinas were 22% more likely to die from breast cancer than white non-Latinas.² These differences may reflect poorer access to timely, adequate health care.

Access to Care

Health disparities have long been documented among Latinos and other special ethnic and/or racial minority groups in the U.S. Research studies, however, consistently show that when patients from ethnic and racial minority groups receive the same quality of health care as non-Hispanic whites, for example, their health outcomes are very similar.

Although the Spanish language is the second most common language in the U.S. and the Nation has the fifth largest Spanish-speaking population in the world, language barriers prevent many Latinos from understanding information from a doctor's office or instructions for prescription medicine. Lack of culturally-appropriate services adds to barriers for Hispanics to access adequate health care services and for them to be able to navigate successfully through the complex health care system. In addition, Hispanics in the U.S. are less likely to have health insurance coverage than non-Hispanics.²

The Hispanic population comprises 15% of the U.S. population but Hispanics make up 31.3% of the Nation's uninsured.¹¹ Data from the 2007 BRFSS survey show that when asked 'Do you have

Stages At Diagnosis

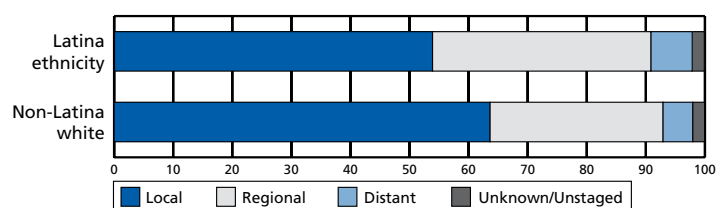
In Situ refers to a neoplasm that is "noninvasive" and confined to a small area within the tissue of origin

Localized is an invasive malignant cancer confined entirely to the organ of origin

Regional is a cancer that 1) extends beyond the limits of the organ of origin into surrounding organs/tissues or 2) involves regional lymph nodes by way of lymphatic system

Distant indicates that the cancer has spread to other parts of the body, such as the lungs, liver, brain or to distant lymph nodes.

Chart 1. Stage at Diagnosis of Female Breast Cancer Cases for Latinas and White Non-Latinas, U.S., 2000-2003



any usual source of health care coverage?, Hispanics are more likely to answer 'no' than non-Hispanics. In the SAD, sparse data from the BRFSS also show that the proportion of adults without any usual source of health care coverage is markedly higher among Hispanic (58.9%) than non-Hispanic whites (12.7%) and blacks (22.8%). (Table 13) Although data are limited to three states, the weighted average of these states estimates that 58.9% of South Atlantic Hispanics do not have access to health care, compared to 43.3% for the U.S. In the South Atlantic Division 12.7% of non-Hispanic whites and 22.8% of non-Hispanic blacks do not have a usual source of health care coverage compared with 13.0% and 22.9%, respectively, for the U.S.

Several measures of disparities among Hispanics are⁹:

Demographics:

- Hispanics/Latinos (H/L) are twice as likely to live in poverty as white non-Hispanics (WN-H).
- H/L have a median income that is 39% lower than WN-H and one-third lower than the national average
- H/L have lower rates of educational attainment than WN-H; only 57% of H/L have completed a high school education compared with 89% of W-NH

Health Status:

- 51% of H/L compared with 65% of WN-H and 51% of BN-H report their health status as fair or poor.

Access to Health Care:

- H/L are 2.5 times more likely to report not having a doctor than WN-H. This disparity holds even when controlling for income and insurance status.
- H/L are more likely (54%) than WN-H (43%) and BN-H (44%) to go without needed care.
- H/L are most likely to use a community health center, as their usual place of care (21% vs. 9% WN-H).

Health Insurance Coverage:

- H/L are three times more likely to lack health insurance coverage than NH-W (35% H/L vs. 12% WN-H). Even at high income levels, Hispanics are more likely to be uninsured.
- Nearly half of Hispanics report being uninsured at some point in the past year.
- H/L are least likely to have continuous insurance coverage even when a family member has full-time employment (53% H/L vs. 82% WN-H).

Quality Care (in addition to cancer screening patterns):

- H/L (140/1,000 discharges with complications), along with Asian/Pacific Islanders (155/1,000), are more likely to die

from complications in hospital care than WN-H and BN-H (both 133/1,000).

- Hispanics (55%) and Asians (54%) are less likely to get a same day or next day appointment than WN-H (66%), and more likely to wait six days or longer to see a doctor (26% H/L and 18% Asian compared with 14% WN-H and 19% BN-H).
- Hispanics and Asians are less likely to understand their doctor and less likely to feel their doctor listened to them than WN-H and BN-H.
- H/L are twice as likely as WN-H to leave the doctor's office with unasked questions.

Programs to Promote Healthy Behaviors among Hispanics

The lack of access to health care among Hispanics as well as other disadvantaged populations can adversely affect cancer incidence and mortality throughout the cancer spectrum, from cancer prevention and early detection to treatment, survivorship and palliative care. Studies have shown, however, that social support offered in local outreach programs and culturally-appropriate interventions will help increase participation in these services. Lay Hispanic health advisors, along with physician encouragement, are an effective strategy to improve participation in cancer screening as well as prevention initiatives.²

Numerous Hispanic outreach programs have been active or are in various phases of development in the South Atlantic Division. Below are just a few examples of such programs designed to improve access to care among Hispanics and help improve the overall health among Latinos in the SAD. Dedicated staff members for Hispanic outreach are strategically placed in regions with the highest Hispanic population. The SAD has hired bilingual and/or bicultural staff employed in key positions, including community outreach to specific populations, patient navigation, and Cancer Resource Network information specialists. In some instances, the South Atlantic Division was able to influence, and in some cases, provide funding for hiring of full time staff dedicated to Hispanic/Latino Outreach: Hispanic Partnerships Project Manager, Hispanic Outreach Project Manager, Bilingual Mission Delivery Manager and Mission Delivery Manager.

I. *Promotores de Salud - Promoters of Health*

Promotores de Salud (Promoters of Health) are often referred to as Community Health Advisors or Community Health Workers. These terms are used interchangeably

Continued

Table 13. Estimated Proportion of Adults With no Usual Source of Health Care Coverage by Race/Ethnicity for South Atlantic Division and U.S., 2007

	DE	DC	GA	MD	NC	SC	VA	WV	SA*	US
Hispanic	n/a	22.2	n/a	53.5	64.7	n/a	n/a	n/a	58.9	43.3
NH White	8.5	2.4	14.1	8.6	15.1	14.2	10.0	20.6	12.7	13.0
NH Black	8.5	12.7	28.2	15.8	25.4	27.8	17.8	n/a	22.8	22.9

Source: BRFSS; * Population-weighted estimated average of South Atlantic states with available data



here with the acknowledgement that cultural nuances exist between Promotores and *Community Health Worker (CHW)* programs. The Promotores are members of a community who provide education and other assistance to fellow community members so that their health needs may be met. They each use their unique strengths of their own experience and cultural background to provide health education, help others navigate through health care systems, provide support as needed so that others may access information and needed care, monitor vital signs and/or advise on self-management of chronic diseases. Although Promotores have traditionally performed their duties in an advocacy role without pay or with a small stipend and perhaps some support services, such as providing a place to keep records and materials, they can also be paid for their work.

- A. Baltimore City, MD:** One example of Promotores in the South Atlantic Division is the Latino Provider Network that works for the rights of Latinos through (1) exchange of information among providers and (2) advocacy and education to Latinas in the City of Baltimore. The primary objective is to promote early detection, prevention and successful treatment of breast and cervical cancer using Promotoras de Salud. These women disseminate breast and cervical cancer education materials and information on where to obtain free or low-cost breast and cervical cancer screening to the Latina community in Baltimore.
- B. South Carolina:** A second Promotores program in the SAD is called the Partnership for Cancer Prevention – Latino/a Initiative in South Carolina. The objectives of the Initiative are to: (1) promote access to cancer prevention and early detection health services among Hispanics in South Carolina who are not proficient in English through the development of resources that can be used by members of the partnership, cancer control agencies and healthcare providers within the South Atlantic Division, (2) to promote partnership activities and increase community awareness of cancer prevention and control resources by developing and

implementing a coordinated health communication campaign targeting the Hispanic community in the greater Columbia area and (3) recruit and train four Promotoras on use of the adapted Spanish Cancer Education Guide and have them deliver cancer educational sessions to groups of ten Spanish-speaking Hispanics. Promotoras will also distribute the *Su Salud* newsletters and promote activities of the Partnership for Cancer Prevention in their communities.

II. *Ventanilla de Salud (VDS) - Health Window*

The Ventanilla de Salud (VDS) or Health Window program is a partnership among local health advocacy and health service organizations and the Mexican consular network. This partnership is led by local United States 501(c)3 service agencies with the appropriate administrative capacity and technical expertise to manage and implement the program. The Institute of Mexicans Abroad (IME), a division of the Secretary of Foreign Affairs of Mexico, has established *VDS* program guidelines and officially promoted the development of this program since 2004.

The American Cancer Society is currently in partnerships with the Mexican consulates in the District of Columbia; Raleigh, North Carolina and Atlanta, Georgia.

The *VDS* Program Objectives are (1) to provide personal and culturally sensitive counseling and referral services onsite to consular clients and their families on how to access available health services in both countries, (2) when necessary and appropriate, provide backup legal advocacy to consular clients on health-related issues such as enrollment in public health insurance programs and establishing medical homes, (3) to educate and inform consular clients on health issues and prevention topics relevant to their community and their specific needs and (4) to build a close, direct partnership linkage of client referral and health education among local Mexican consulates, local health departments, community health organizations and the major health institutions in Mexico.

VDS or *Health Windows* incorporates bilingual, bicultural and highly trained health educators and health advocates into the regular flow of consular services to provide on-site assessment, referral and linkage to available health services. Advocates assess consulate clients for eligibility for government-funded health insurance and for other primary care services, facilitated by a tool called *Guide to Health Programs*. In addition, health educators conduct 15 to 30 minute consumer education sessions for a large number of persons per day. The educational presentations include an array of important public health and health care access topics. Materials such as Public Service Announcements and short health education videos are often used to enhance the presentations.

III. *Estacion de Salud y Servicios de El Consulado de El Salvador - Health and Services Station of the Salvadoran Consulate*

The Hispanic Institute for Blindness Prevention (HIBP) is a non-profit organization (status 501©(3)) whose mission is to contribute to lowering the risk of blindness by focusing on underserved families, minorities and other groups who are more likely to be at risk of eye-related diseases. Since November 2005, HIBP has partnered with the Salvadoran Consulate and other local and federal agencies to create and implement a Program called “*Estacion de Salud y Servicios de El Consulado de El Salvador*” (*Health and Services Station of the Salvadoran Consulate*). HIBP is the leading agency for this program in both the Consulates of El Salvador in Washington, D.C. and Woodbridge, VA. The goal of this partnership is to help overcome barriers such as language, education, opportunity and income that limit access to existing health programs, community health resources and public health insurance programs.

The *Salvadoran Consulate Program* improves cancer awareness among Salvadoran families who attend the consulate for their legal needs. Through an on-site clinic for preventive health care, family members receive health screenings for chronic diseases and culturally-appropriate information through educational sessions, speakers, print and audiovisual materials. For example, patients who receive a screening for diabetes, hypertension or other disease risk factors will also have a one-on-one cancer education session which includes personalized cancer information and referral for cancer screening as appropriate for age and gender of the patient. Topics include cancer prevention, early detection and treatment for the most common types of cancer among Hispanics, as well as information on community programs that offer free or low-cost screenings for the underserved.

Limitations

These data should be interpreted with caution. Although BRFSS and YRBSS data in this report are suppressed if less than 50 persons, the relatively small numbers of responses presented here may result in variations due to small numbers alone. The risk factor data, however, can give a general indication of the cancer risk behaviors among Latinos relative to non-Hispanic whites and non-Hispanic blacks. Also, cancer incidence and mortality data for U.S. Hispanics cannot easily be extrapolated to the experiences of Hispanics within the South Atlantic states because of regional and cultural differences.

Beginning in 1995, cancer rates can now be generated by site and sex for most of the U.S. population stratified by ethnicity and three major race groups. Broad racial and ethnic groupings, however, may mask wide variations in the cancer burden for specific high-risk populations defined by cultural characteristics such as urbanicity, economic deprivation and recent immigration.¹⁰

Identification of ethnic populations is still inconsistent and underreported in medical records and death certificates. In addition to the suspected underrepresentation of the Hispanic/Latino population in U.S. Census data, anecdotal reports are that Hispanic immigrants may return to their native country after a diagnosis of cancer, which would result in underreporting of cancer deaths among Latinos.¹⁰

References

1. ACS-1 – American Cancer Society, Cancer Facts & Figures, 2008,
2. ACS-2 – American Cancer Society, Cancer Facts & Figures for Hispanics, 2006-2008, <http://www.cancer.org/downloads/STT/CAFF2006HisPWSecured.pdf>
3. ACS-3 – American Cancer Society, Cancer Prevention & Early Detection Facts and Figures 2008, http://www.cancer.org/downloads/STT/CPED_2008.pdf
4. ACS-4 – American Cancer Society Guidelines for the Early Detection of Cancer, http://www.cancer.org/docroot/PED/ped_2.asp?sitearea=PED
5. ACS-5 – American Cancer Society Guidelines on Nutrition and Physical Activity for Cancer Prevention, http://www.cancer.org/docroot/PED/ped_3.asp?sitearea=PED
6. BRFSS – Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2007, 2008, <http://www.cdc.gov/brfss/>
7. Claritas Inc., Copyright © 2007 Thomson Healthcare. ALL RIGHTS RESERVED
8. Census – American Fact Finder, U.S. Census Bureau: <http://factfinder.census.gov/>
9. CWF – The Commonwealth Fund: H Mead, L Cartwright-Smith, K Jones, C Ramos, K Woods and B Siegel, Racial and Ethnic Disparities in U.S. Health Care: A Chartbook, March 2008.
10. NAACCR – Annual Report to the Nation on the Status of Cancer, 1975-1993, Featuring Cancer Among U.S. Hispanic/Latino Populations. HL Howe, X Wu, LA Ries, et al. Cancer 2006; (107):1711-42.
11. NCHS – National Center for Health Statistics, Health, United States, 2007, With Chartbook on Trends in the Health of Americans, Hyattsville, MD: 2007.
12. SEER – LAG Ries, D Melbert, M Krapcho, et al (eds). SEER Cancer Statistics Review, 1975-2005, National Cancer Institute. Bethesda, MD, http://seer.cancer.gov/csr/1975_2005/, based on November 2007 SEER data submission, posted to the SEER web site, 2008.
13. YRBSS – Youth Risk Behavior Surveillance System Survey Data, Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2008, <http://www.cdc.gov/HealthyYouth/yrbs/>

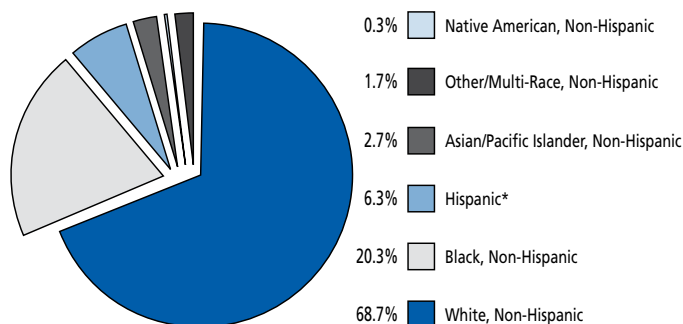
Delaware

DEMOGRAPHICS

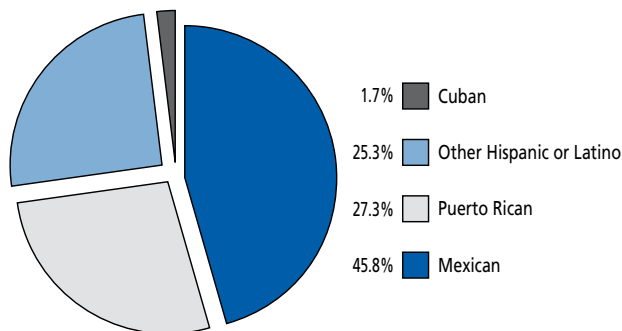
State Level Data, 2007 Estimates

2000 Census Population	736,600
2007 Estimate ¹	862,225
White, Non-Hispanic	592,324
Black, Non-Hispanic	174,609
American Indian, Non-Hispanic	2,594
Asian/Pacific Islander, Non-Hispanic	23,613
Hispanic ²	54,319
Other/Multi-Race, Non-Hispanic	14,766

Distribution of Delaware Population by Race & Ethnicity



Delaware's Hispanic/Latino Population by Sub-Ethnicity

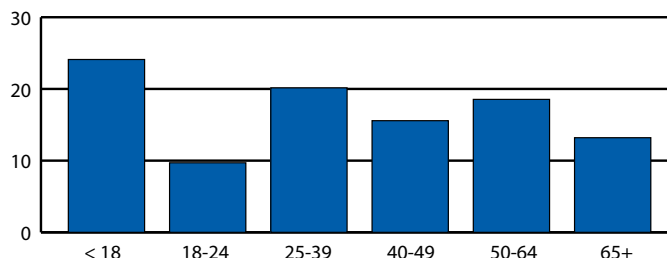


Factors Related to Access to Care

Percent unemployed ³	3.7%
Percentage with less than high school education	12.5%
Median household income	\$55,760
Percent households with income < \$15,000	9.9%
Percent households with income ≥ \$50,000	55.4%
Percent of households with no vehicle	6.7%
Percent rural population	24.0%
Percent minority	31.3%
% speak language other than English at home	12.1%
% with no usual source of health care coverage	11.4%

Age Distribution of Delaware

Age Group	Number	%
< 18	198,368	23.0%
18 - 24	83,925	9.7%
25 - 39	173,402	20.1%
40 - 49	132,450	15.4%
50 - 64	156,593	18.2%
65 +	117,487	13.6%



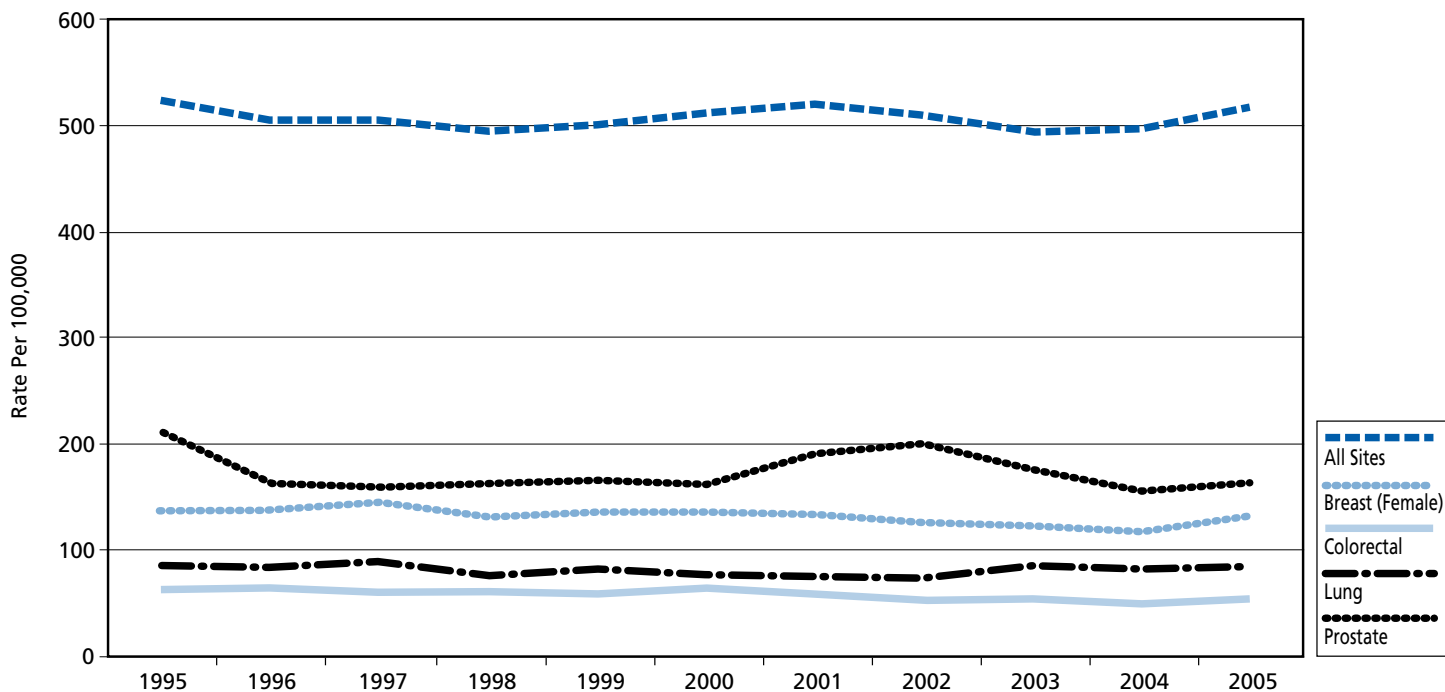
¹ Total is sum of White, Black, Native American, Asian/Pacific Islander, Other/Multi-Race, and Hispanic.

² Hispanic is an ethnicity, not a race.

³ Department of Labor <http://www.bis.gov/LAU/>, April 2008.

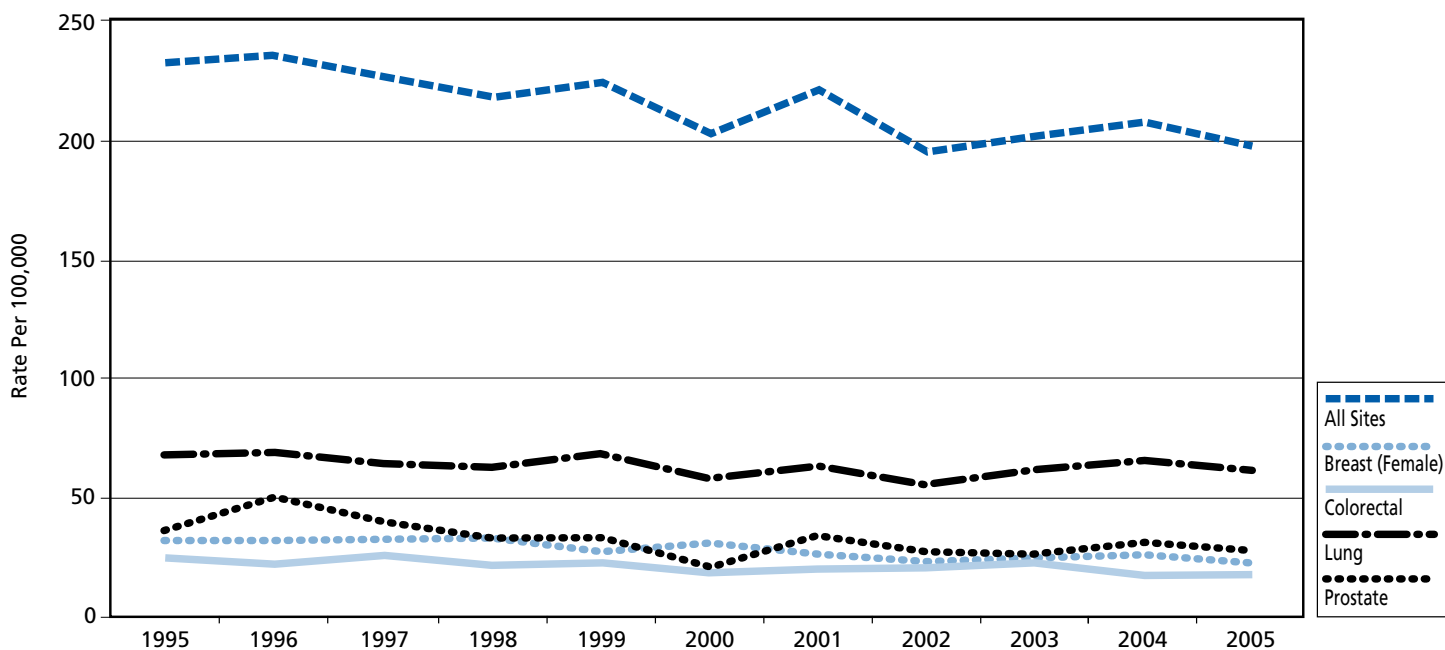
Data Sources: Claritas Inc., Copyright © 2008, Thomson Medstat. ALL RIGHTS RESERVED; US Census Bureau, Population Fact Sheet, 2008, American Community Survey @ <http://factfinder.census.gov>

Delaware Cancer Incidence Rates by Cancer Site (1995-2005)



Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.
Source: Delaware Cancer Registry

Delaware Cancer Mortality Rates by Cancer Site (1995-2005)



Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.
Source: Delaware Cancer Registry

Delaware Cancer Incidence, 2001-2005, by Site, Gender and Race

	All Races ¹		White		Black	
BOTH GENDERS	Cases	Rate	Cases	Rate	Cases	Rate
ALL SITES	21,867	507.3	18,109	501.5	3,264	530.7
COLORECTAL	2,300	53.5	1,911	52.4	328	56.8
LUNG & BRONCHUS	3,454	79.6	2,925	79.4	495	85.4
MELANOMA	894	20.9	821	23.5	^	~
	All Races ¹		White		Black	
MALE	Cases	Rate	Cases	Rate	Cases	Rate
ALL SITES	11,551	601.7	9,536	586.0	1,741	676.8
COLORECTAL	1,176	62.6	982	61.2	162	68.6
LUNG & BRONCHUS	1,863	97.8	1,562	95.8	280	114.8
MELANOMA	542	28.1	504	31.2	^	~
PROSTATE	3,430	175.5	2,652	159.0	677	263.6
	All Races ¹		White		Black	
FEMALE	Cases	Rate	Cases	Rate	Cases	Rate
ALL SITES	10,316	438.6	8,573	440.9	1,523	426.9
BREAST(FEMALE)	2,938	126.4	2,413	126.4	473	125.2
CERVICAL	179	8.2	134	8.0	41	10.0
COLORECTAL	1,124	46.4	929	45.1	166	49.5
LUNG & BRONCHUS	1,591	66.2	1,363	67.3	215	64.9
MELANOMA	352	15.6	317	17.7	^	~

Note: Data exclude basal and squamous cell skin and in situ cancers except urinary bladder. Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.

¹ Includes White, Black and other races

^ Number of cases 5 or less not reported due to confidentiality issues

~ Number of cases too small (25 or less) to calculate reliable rate.

Source: Delaware Cancer Registry

Delaware Cancer Mortality, 2001-2005, by Site, Gender and Race

	All Races ¹		White		Black	
BOTH GENDERS	Deaths	Rate	Deaths	Rate	Deaths	Rate
ALL SITES	8,730	203.8	7,332	200.5	1,334	236.6
COLORECTAL	843	19.8	698	19.1	141	25.9
LUNG & BRONCHUS	2,673	61.9	2,265	61.4	387	68.7
MELANOMA (SKIN)	142	3.3	140	3.8	^	~
	All Races ¹		White		Black	
MALE	Deaths	Rate	Deaths	Rate	Deaths	Rate
ALL SITES	4,585	252.1	3,855	246.7	695	303.2
COLORECTAL	429	23.7	354	22.8	72	32.5
LUNG & BRONCHUS	1,497	80.2	1,262	78.8	224	94.1
MELANOMA (SKIN)	97	5.2	96	6.0	^	~
PROSTATE	477	29.3	373	26.5	99	53.1
	All Races ¹		White		Black	
FEMALE	Deaths	Rate	Deaths	Rate	Deaths	Rate
ALL SITES	4,145	170.7	3,477	168.8	639	193.0
BREAST (FEMALE)	600	25.1	492	24.5	104	28.7
CERVICAL	67	2.9	49	2.7	18	~
COLORECTAL	414	16.8	344	16.2	69	21.1
LUNG & BRONCHUS	1,176	48.5	1,003	48.6	163	50.7
MELANOMA (SKIN)	45	1.9	44	2.3	^	~

Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.

¹ Includes White, Black and other races

^ Number of deaths 5 or less not reported due to confidentiality issues

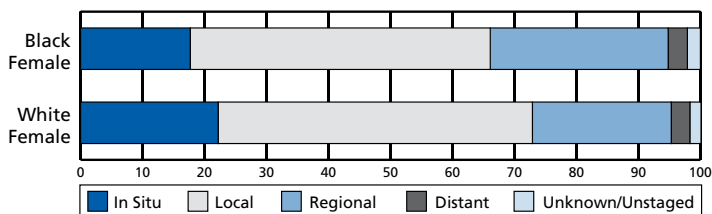
~ Number of deaths too small (25 or less) to calculate reliable rate.

Source: Delaware Cancer Registry

Delaware Cancer Stage at Diagnosis, Percent of Total Cases, 2001-2005, by Site and Race

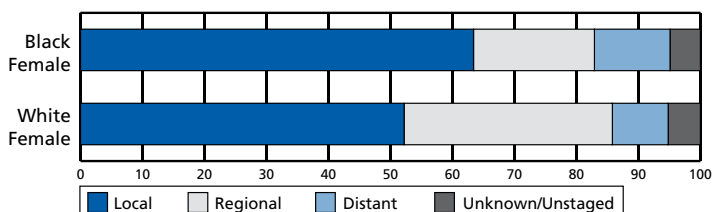
Delaware Female Breast Cancer Stage of Disease at Diagnosis by Race, 2001-2005

	In Situ	Local	Regional	Distant	Unknown
Female, All Races¹	21.7	50.1	23.2	2.9	2.0
White Female	22.2	50.7	22.4	3.0	1.8
Black Female	17.7	48.4	28.7	3.1	2.1



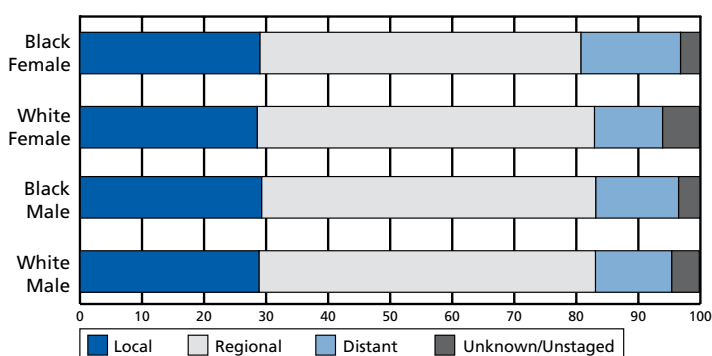
Delaware Cervical Cancer² Stage of Disease at Diagnosis by Race, 2001-2005

	Local	Regional	Distant	Unknown
Female, All Races¹	54.2	29.6	10.1	6.2
White Female	52.2	33.6	9.0	5.2
Black Female	63.4	19.5	12.2	4.9



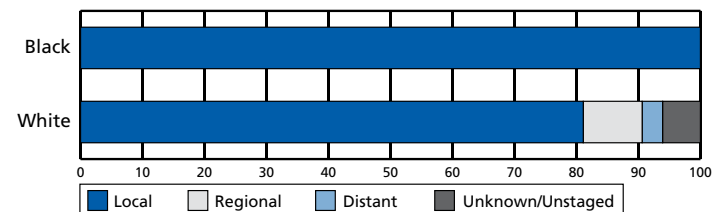
Delaware Colorectal Cancer³ Stage of Disease at Diagnosis by Sex and Race, 2001-2005

	Local	Regional	Distant	Unknown
Male, All Races¹	37.6	70.4	16.0	6.2
White Male	37.1	69.8	15.8	5.9
Black Male	40.5	74.6	18.5	4.6
Female, All Races¹	37.1	69.6	14.8	7.7
White Female	37.1	70.3	14.2	7.7
Black Female	36.1	64.4	20.0	3.9



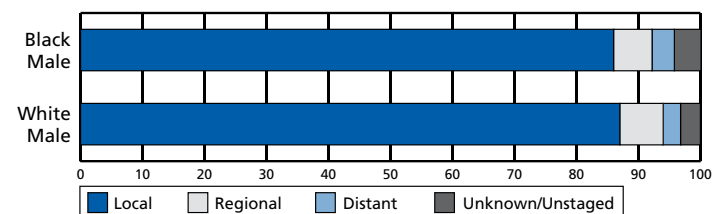
Delaware Malignant Melanoma² Stage of Disease at Diagnosis by Race, 2001-2005

	Local	Regional	Distant	Unknown
All Races¹	81.9	8.7	3.0	6.4
White	81.1	9.5	3.3	6.1
Black	100.0	0.0	0.0	0.0



Delaware Cancer of the Prostate² Stage of Disease at Diagnosis by Race, 2001-2005

	Local	Regional	Distant	Unknown
All Races¹	86.7	6.8	2.9	3.6
White	87.0	7.0	2.8	3.2
Black	86.0	6.2	3.6	3.6



Notes: Stages not reported for lung and bronchus cancer due to unavailability of cost-effective early detection test.

¹Includes White, Black and other races

²Stages reported for invasive cervical, melanoma and prostate cancers only.

³In situ and local stages combined for colorectal cancer

Source: Delaware Cancer Registry

Delaware At a Glance

Tobacco

Tobacco Statistics

Tobacco Use in Delaware (2007)

High school students who smoke	20.2% (10,300)
Male high school students who use smokeless or spit tobacco	8.1% <i>(female use much lower)</i>
Kids (under 18) who become new daily smokers each year	1,300
Kids exposed to secondhand smoke at home	32,000
Packs of cigarettes bought or smoked by kids each year	2.1 million
Adults in Delaware who smoke	18.9% (112,800)

Deaths in Delaware From Smoking

Adults who die each year from their own smoking	1,200
Kids now under 18 and alive in Delaware who will ultimately die prematurely from smoking	18,000
Adult nonsmokers who die each year from exposure to secondhand smoke	70 to 210

Smoking-Caused Monetary Costs in Delaware

Annual health care costs in Delaware directly caused by smoking	\$284 million
- Portion covered by the state Medicaid program	\$79 million
Residents' state & federal tax burden from smoking-caused government expenditures	\$635 / household
Smoking-caused productivity losses in Delaware	\$304 million

Tobacco Industry Influence in Delaware

Estimated portion spent for Delaware marketing each year	\$105.5 million
--	-----------------

Estimated Tobacco Revenue in Delaware - FY2008

Tobacco Settlement Revenues	\$30.4 billion
Tobacco Tax Revenues	\$148.7 billion
Total Annual State Revenues from Tobacco	\$179.1 billion
% of Tobacco Revenue Spent on Tobacco Prevention	6.0%

Spending on Tobacco Prevention - FY2008

CDC Recommended Minimum Spending on Tobacco Prevention	\$8.6 million
% of CDC Recommended Minimum	123.8%
Rank Among States (1-51)	2

Access to Care

Number of Federally Qualified Health Centers and free clinics: 4 main clinics; 2 satellite clinics

State fund for Uninsured Cancer Patients: Delaware Cancer Treatment Program now covers up to two years of cancer treatment for eligible Delawareans.
www.dhss.delaware.gov/dhss/dph/dpc/catreatment.html

Number of ACoS approved hospitals: 7

Uninsured Population (18+): 9.1% (was 9.6% in 2005)



Delaware State Screening Programs

Screenings for cancers of the cervix, breast, colon/rectum and prostate are available through *Screening for Life (SFL)* for persons meeting the following requirements: Delaware resident, don't have health insurance or have health insurance that doesn't cover screening, are in a specific age group (see below for details) or are age 65 and older and do not qualify for Medicare, and meet the income guidelines of SFL (less than 250% of the Federal Poverty Level). www.dhss.delaware.gov/dhss/dph/dpc/sfl.html

Breast and Cervical Cancer Screening: BCCEDP* - Target Populations: Women 18-64 (cervical) Women 40-64 (breast), uninsured or underinsured and under 250% of Federal Poverty Level.

Colorectal cancer screening: There is mandatory coverage for colorectal screening. The Delaware Division of Public Health provides fulltime colorectal care navigators and advocates in each hospital system. Target populations are ages 50-64 (average risk) or ages 18-49 (increased/high risk).

Prostate cancer screening: Prostate cancer screening has been added to *SFL*. Several healthcare systems offer periodic free/low-cost screenings.

The Cancer Screening Nurse Navigation Program provides individuals in need of cancer screening with education, information, resources and support to undergo colorectal, breast, cervical and prostate cancer screening.

*The Breast and Cervical Cancer Early Detection Program (BCCEDP) is a CDC-funded program in every state administered through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

Nutrition and Physical Activity

The Delaware Department of Health and Social Services oversees several programs to promote health and well-being:

- The Council on Lifestyle and Fitness has reported significant progress in two areas: tobacco use and safety belt use. www.dhss.delaware.gov/dph/dpc/gclfreportcard05.html,
- The Lt. Governor's Challenge – Get Up and Do Something! www.getupanddosomething.org/,
- The Delaware Center to Promote Physical Activity and Healthy Nutrition (U.D./Lt. Governor/Healthy Delaware Foundation) - www.behealthydelaware.org,
- The Delaware Division Services for Aging and Adults with Disabilities sponsors health fairs, *Walk Delaware* and the *Senior Olympics*.

Obesity initiatives: www.dhss.delaware.gov/dhss/dsaapd/index.html ;

- Nemours Health and Prevention Services: *5-2-1-Almost None: Our Prescription for Health* - www.nemours.org/internet?url=no/nhps/pubs/521.html
- The Sussex County Child Health Promotion Collaborative - www.nemours.org/internet?url=no/nhps/cyp/collaborative/child_health.html

Delaware Cancer Consortium

www.delawarecancerconsortium.org/

Status of Cancer Control Plan: The Delaware Cancer Consortium has implemented its second four-year plan for 2007-2011.

Accomplishments

- Colorectal cancer screening rates (colonoscopy and/or endoscopy) in Delaware (2006) are 20% higher than the National average for both non-Hispanic blacks and non-Hispanic whites.
- Among the uninsured in Delaware, the colorectal cancer screening rate is 73% higher than the National average of the uninsured in 2006.
- Compared with the U.S. in 2007, the rate of those uninsured in Delaware is 63% lower among non-Hispanic blacks, 35% lower among Delaware non-Hispanic whites and 50% lower among those who have not completed high school.

Delaware Health Information Network (DHIN) - was created in 1997 to advance creation of a state-wide health information and electronic data interchange network for public and private use. The mission of *DHIN*, currently in planning stages, is "To facilitate the design and implementation of an integrated, statewide health data system to support the information needs of consumers, health plans, policymakers, providers, purchasers and research to improve the quality and efficiency of health care services in Delaware." <http://dhcc.delaware.gov/information/dhin.shtml>

Adult Risk Behavior

Early Detection

Recent Mammogram*, Women 40 and Older, Delaware and U.S., 2006

	% Delaware	% U.S.
40 years and older	70.2	61.2
40-64 years old	70.2	59.7
65 years and older	70.2	64.6
White only, non-Hispanic	68.9	61.1
Black only, non-Hispanic	77.8	62.7
Other race only, non-Hispanic	n/a	59.3
Hispanic	n/a	58.7
Low Education**	53.7	51.6
Uninsured***	57.1	34.9

* Mammogram within the past year.

** Women 40 years old and older with less than a high school education

*** Women 40-64 who reported that they did not have coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare.

Source: Behavioral Risk Factor Surveillance System, 2006

Recent Pap Test*, Women 18 and Older, Delaware and U.S., 2006

	% Delaware	% U.S.
18 years and older	88.7	83.7
18-44 years	91.3	85.1
45-64 years old	91.2	86.6
65 years and older	74.1	70.8

* A pap test within the preceding 3 years for women with intact uteri.

Source: Behavioral Risk Factor Surveillance System, 2006

Recent Sigmoidoscopy/Colonoscopy*, Adults 50 and Older, Delaware and U.S., 2006

	% Delaware	% U.S.
50 years and older	60.9	50.0
50-64 years old	55.8	44.9
65 years and older	67.8	57.1
Male, 50 years or older	62.1	50.5
Male, 50-64 years old	56.6	45.1
Male, 65 years and older	70.2	59.5
Female, 50 years and older	59.9	49.5
Female, 50-64 years old	55.2	44.8
Female, 65 years and older	65.9	55.4
White only, non-Hispanic	61.7	51.5
Black only, non-Hispanic	59.3	49.3
Other races only, non-Hispanic	n/a	43.9
Hispanic	n/a	38.2
Low Education**	44.3	38.8
Uninsured***	36.2	20.9

* Sigmoidoscopy/Colonoscopy within the past 5 years

** Adults 50 years old and older with less than a high school education

*** Adults 50-64 who reported that they did not have coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare.

Source: Behavioral Risk Factor Surveillance System, 2006

Recent Prostate-Specific Antigen Test*, Men 50 and Older Delaware and U.S., 2006

	% Delaware	% U.S.
50 years and older	62.4	53.8
50-64 years old	54.8	48.5
65 years and older	74.7	63.4
White only, non-Hispanic	63.6	55.6
Black only, non-Hispanic (45+)	43.5	48.1
Other races only, non-Hispanic	n/a	44.9
Hispanic	n/a	43.0
Low Education**	55.5	40.3

* Prostate-specific antigen test within the past year for men who reported they were not told by a doctor, nurse, or other health professional that they had prostate cancer

** Adults 50 years old and older with less than a high school education

Source: Behavioral Risk Factor Surveillance System, 2006

Prevention

Current Cigarette Smoking*, Adults 18 and Older, Delaware and U.S., 2007

	% Delaware	% U.S.
Total	18.9	19.7
18-24 years old	22.4	24.0
25-34 years old	22.9	23.9
35-44 years old	20.2	20.4
45-54 years old	21.7	22.3
55-64 years old	17.1	18.0
65 years and older	9.9	9.0
Male	23.3	21.2
Female	20.2	18.4
White only, non-Hispanic	19.4	19.4
Black only, non-Hispanic	14.6	21.7
Other race only, non-Hispanic	n/a	18.3
Hispanic	n/a	16.7
Low Education**	28.2	33.2
Female 18-44 (2006)	24.5	20.6

* Ever smoked 100 cigarettes in lifetime and are current smokers (regular and irregular).

** Adults 25 years old and older with less than a high school education

Source: Behavioral Risk Factor Surveillance System, 2007

Physical Activity, Adults 18 and Older, Delaware and U.S., 2007

No Leisure Time Physical Activity*	% Delaware	% U.S.
Total	52.1	50.5
Male	47.8	48.5
Female	55.9	52.5
White only, non-Hispanic	50.1	48.4
Black only, non-Hispanic	61.8	58.6
Other race only, non-Hispanic	n/a	51.0
Hispanic	n/a	55.3
Low Education**	59.6	59.8

* Adults with 30+ minutes of moderate physical activity five or more days per week, or vigorous physical activity for 20+ minutes three or more days per week.

** Adults 25 years old and older with less than a high school education

Source: Behavioral Risk Factor Surveillance System, 2007

Nutrition, Adults 18 and Older, Delaware and U.S., 2007

Eating 5 or More Fruits and Vegetables per Day	% Delaware	% U.S.
Total	21.4	24.4
Male	19.4	19.4
Female	23.2	28.8
White only, non-Hispanic	20.7	24.5
Black only, non-Hispanic	22.9	23.1
Other race only, non-Hispanic	n/a	26.6
Hispanic	n/a	22.6
Low Education*	14.0	18.4

* Adults 25 years old and older with less than a high school education
Source: Behavioral Risk Factor Surveillance System, 2007

Overweight*, Adults 18 and Older, Delaware and U.S., 2007

	% Delaware	% U.S.
Total	65.1	63.0
Male	73.4	70.8
Female	57.0	55.4
White only, non-Hispanic	64.2	62.6
Black only, non-Hispanic	73.2	72.6
Other race only, non-Hispanic	n/a	51.2
Hispanic	n/a	66.9
Low Education**	68.5	65.7

*Overweight is defined as having body mass index of 25 kg/m² or greater
**Adults 25 years old and older with less than a high school education
Source: Behavioral Risk Factor Surveillance System, 2007

Youth Risk Behavior

Tobacco Use, High School Students, Delaware and U.S., 2007

Current Cigarette Smoking*	% Delaware	% U.S.
Total	20.2	20.0
Male	20.7	21.3
Female	19.1	18.7
Current Smokeless Tobacco Use**		
Total	5.2	7.9
Male	8.1	13.4
Female	1.9	2.3

* Smoked cigarettes on 1 or more of the 30 days preceding the survey
** Used chewing tobacco, snuff or dip on 1 or more of the 30 days preceding the survey
Source: Youth Risk Behavior Surveillance System, 2007

Nutrition, High School Students, Delaware and U.S., 2005

Eating 5 or More Fruits and Vegetables per Day	% Delaware	% U.S.
Total	16.3	20.1
Male	18.6	21.4
Female	13.7	18.7

Source: Youth Risk Behavior Surveillance System, 2005

Physical Activity, High School Students, Delaware and U.S., 2007

Met Current Physical Activity Level*	% Delaware	% U.S.
Total	40.4	34.7
Male	49.2	43.7
Female	32.1	25.6

* Were physically active during any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes/day on 5 or more days during the 7 days before the survey
Source: Youth Risk Behavior Surveillance System, 2007

Overweight/Obese High School Students, Delaware and U.S., 2007

Obese*	% Delaware	% U.S.
Total	13.3	13.0
Male	15.6	16.3
Female	10.9	9.6
Overweight**		
Total	17.5	15.8
Male	16.0	16.4
Female	10.2	15.1

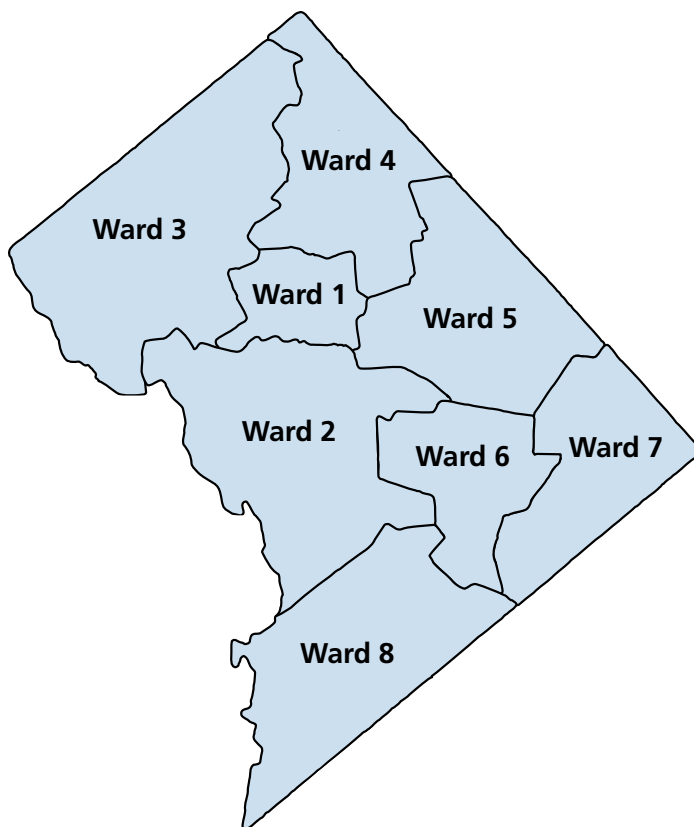
* Obese - At or above the 95th percentile for body mass index, by age and sex, based on reference data from the National Health and Nutrition Examination Survey
** - Overweight - At or above the 85th percentile but below the 95th percentile for body mass index, by age and sex, based on reference data from the National Health and Nutrition Examination Survey.
Source: Youth Risk Behavior Surveillance System, 2007

District of Columbia

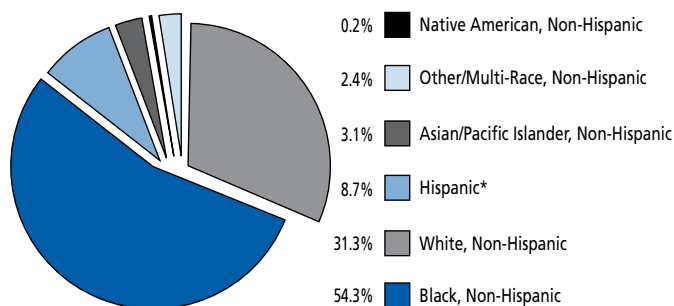
DEMOGRAPHICS

State Level Data, 2007 Estimates

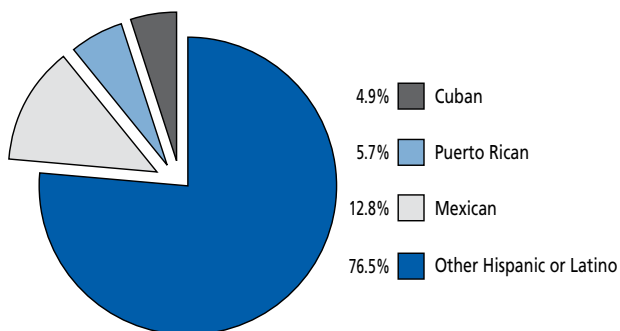
2000 Census Population	572,059
2007 Estimate ¹	580,271
White, Non-Hispanic	181,710
Black, Non-Hispanic	315,148
Native American, Non-Hispanic	1,236
Asian/Pacific Islander, Non-Hispanic	17,796
Hispanic ²	50,711
Other/Multi-Race, Non-Hispanic	13,670



Distribution of District of Columbia's Population by Race & Ethnicity



District of Columbia's Hispanic/Latino Population by Sub-Ethnicity

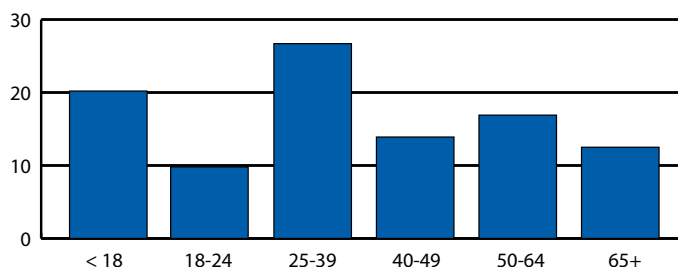


Factors Related to Access to Care

Percent unemployed ³	6.0%
Percentage with less than high school education	14.5%
Median household income	\$49,508
Percent households with income < \$15,000	17.4%
Percent households with income ≥ \$50,000	49.6%
Percent of households with no vehicle	36.0%
Percent rural population	0.0%
Percent minority	68.7%
% speak language other than English at home	15.3%
% with no usual source of health care coverage	9.8%

Age Distribution of District of Columbia

Age Group	Number	%
< 18	117,358	20.2%
18 - 24	56,649	9.8%
25 - 39	154,950	26.7%
40 - 49	80,816	13.9%
50 - 64	98,174	16.9%
65 +	72,324	12.5%



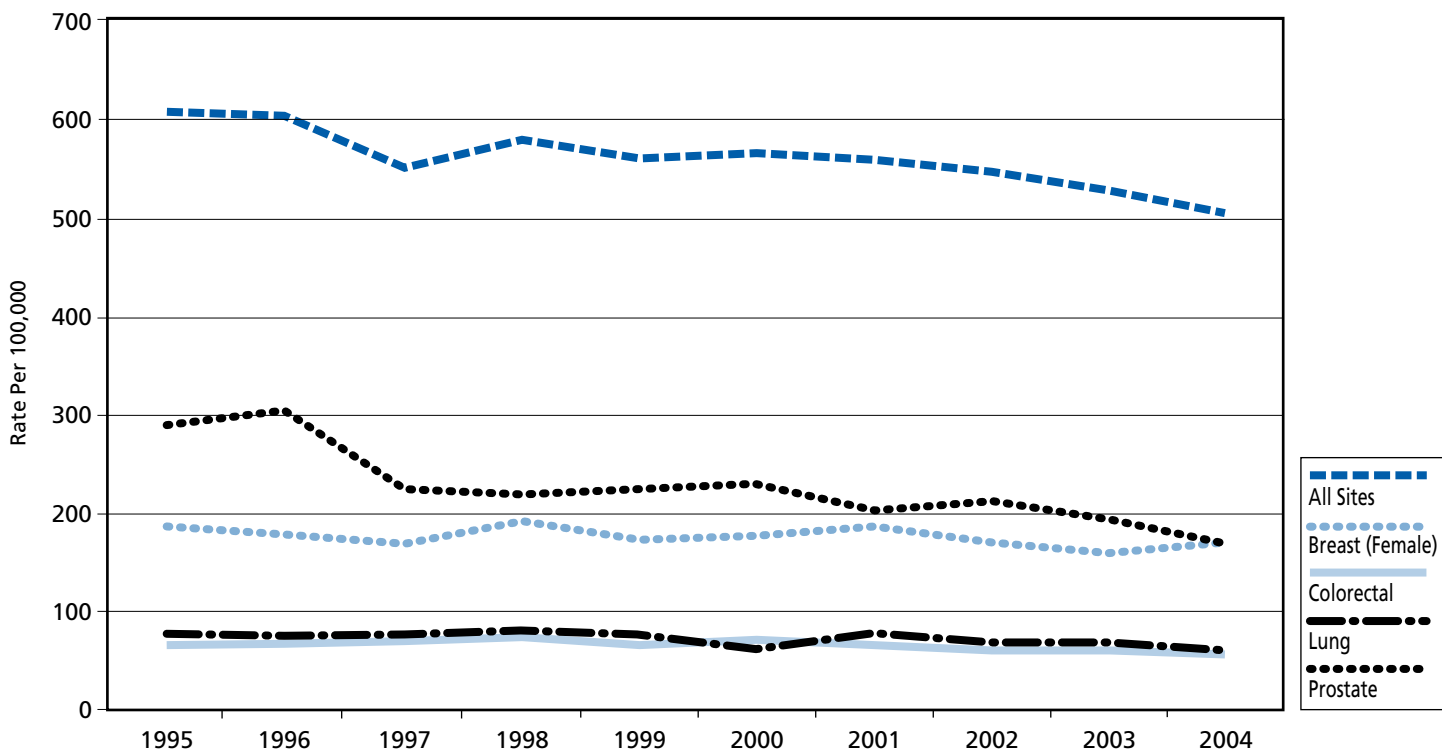
¹ Total is sum of White, Black, Native American, Asian/Pacific Islander, Other/Multi-Race, and Hispanic.

² Hispanic is an ethnicity, not a race.

³ Department of Labor <http://www.bis.gov/LAU/>, April 2008

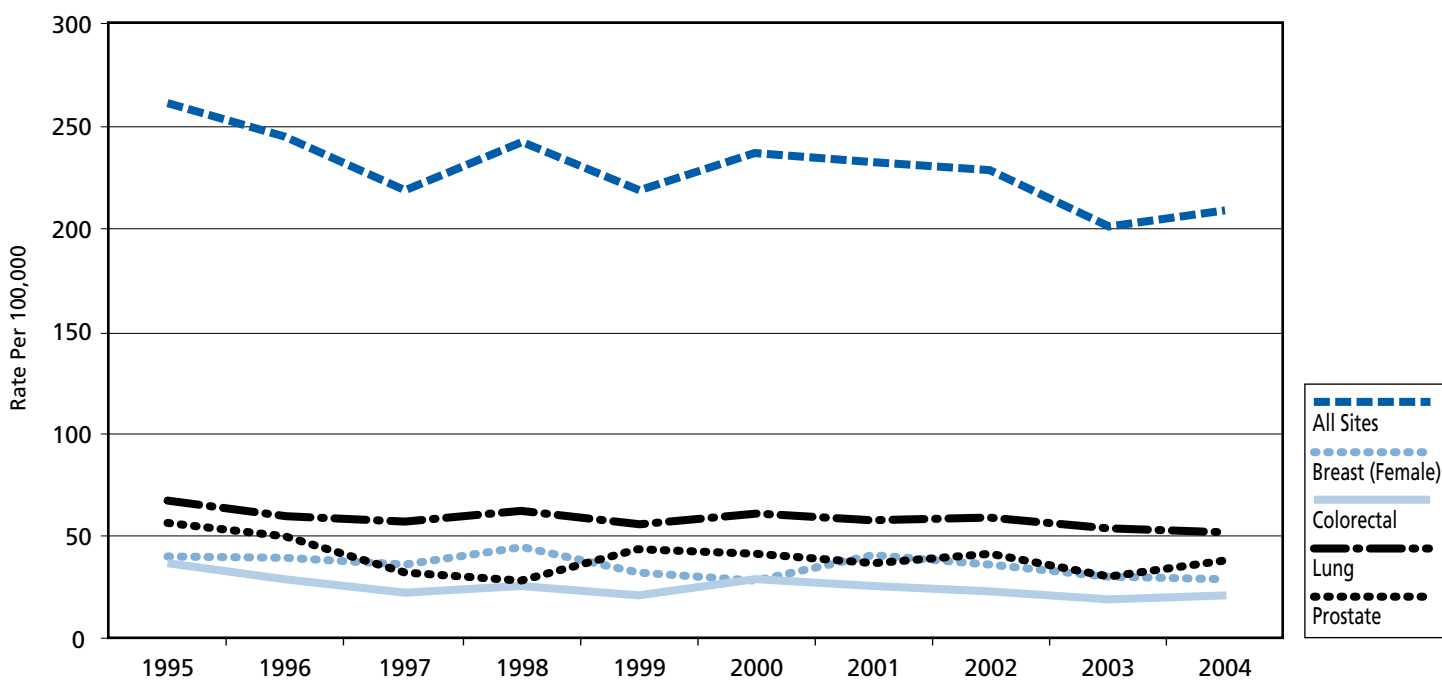
Data Sources: Copyright © 2008, Thomson Medstat. ALL RIGHTS RESERVED; US Census Bureau, Population Fact Sheet, 2008, American Community Survey @ <http://factfinder.census.gov>

District of Columbia Cancer Incidence Rates by Cancer Site 1995-2004



Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.
Data Source: District of Columbia Cancer Registry

District of Columbia Cancer Mortality Rates by Cancer Site 1995-2004



Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.
Data Source: District of Columbia Cancer Registry

District of Columbia Cancer Incidence, 2000-2004, By Site, Gender and Race

	All Races ¹		White		Black	
BOTH GENDERS	Cases	Rate	Cases	Rate	Cases	Rate
ALL SITES	14,901	538.5	4,209	498.5	9,941	592.3
COLORECTAL	1,733	62.7	381	45.4	1,284	76.2
LUNG & BRONCHUS	1,839	66.9	398	48.0	1,396	83.3
MELANOMA	347	12.1	239	27.0	18	~
	All Races ¹		White		Black	
MALE	Cases	Rate	Cases	Rate	Cases	Rate
ALL SITES	7,430	595.8	2,005	539.1	5,052	661
COLORECTAL	803	64.5	190	51.4	576	75.1
LUNG & BRONCHUS	1,050	84.7	208	56.9	815	106.8
MELANOMA	193	15.0	134	34.7	11	~
PROSTATE	2,491	200.9	612	166.2	1,761	230.2
	All Races ¹		White		Black	
FEMALE	Cases	Rate	Cases	Rate	Cases	Rate
ALL SITES	7,471	491.5	2,204	466.9	4,889	534.9
BREAST(FEMALE)	2,610	172.4	920	194.9	1,552	170.7
CERVICAL	194	12.5	36	7.5	135	14.7
COLORECTAL	930	61.2	191	40.7	708	77.1
LUNG & BRONCHUS	789	52.3	190	40.9	581	63.7
MELANOMA	154	9.7	105	20.9	7	~

Note: Data exclude basal and squamous cell skin cancers and in situ cancers except urinary bladder. Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.

¹ Includes White, Black and other races

~ Number of cases too small (25 or less) to calculate reliable rate.

Source: District of Columbia Cancer Registry

District of Columbia Cancer Mortality, 2000-2004, by Site, Gender and Race

	All Races ¹		White		Black	
BOTH GENDERS	Deaths	Rate	Deaths	Rate	Deaths	Rate
ALL SITES	6,099	221.0	1,352	162.6	4,670	277.1
COLORECTAL	645	23.3	135	16.2	502	29.7
LUNG & BRONCHUS	1,537	55.9	320	38.5	1,204	71.7
MELANOMA (SKIN)	36	1.3	25	~	11	~
	All Races ¹		White		Black	
MALE	Deaths	Rate	Deaths	Rate	Deaths	Rate
ALL SITES	3,121	250.7	672	183.9	2,411	314.1
COLORECTAL	303	24.3	71	19.4	228	29.6
LUNG & BRONCHUS	883	71.1	180	49.3	695	90.9
MELANOMA (SKIN)	23	~	18	~	^	~
PROSTATE	463	37.1	75	20.7	382	49.1
	All Races ¹		White		Black	
FEMALE	Deaths	Rate	Deaths	Rate	Deaths	Rate
ALL SITES	2,978	196.5	680	145.9	2,259	246.2
BREAST (FEMALE)	492	32.4	120	25.6	367	40.1
CERVICAL	56	3.7	7	~	46	5.0
COLORECTAL	342	22.5	64	13.6	274	29.8
LUNG & BRONCHUS	654	43.3	140	30	509	55.7
MELANOMA (SKIN)	13	~	7	~	6	~

Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.

¹ Includes White, Black and other races

^ Number of deaths 5 or less not reported due to confidentiality issues

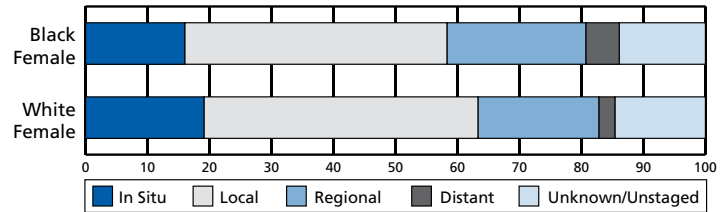
~ Number of deaths too small (25 or less) to calculate reliable rate.

Source: District of Columbia Cancer Registry

District of Columbia Cancer Stage at Diagnosis, Percent of Total Cases, 2000-2004, by Site and Race

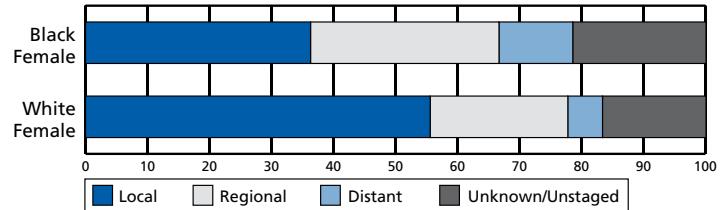
District of Columbia Female Breast Cancer Stage of Disease at Diagnosis by Race, 2000-2004

	In Situ	Local	Regional	Distant	Unknown
Female, All Races¹	17.5	42.6	21.1	4.2	14.6
White Female	19.1	44.2	19.5	2.6	14.6
Black Female	16.0	42.3	22.4	5.4	13.9



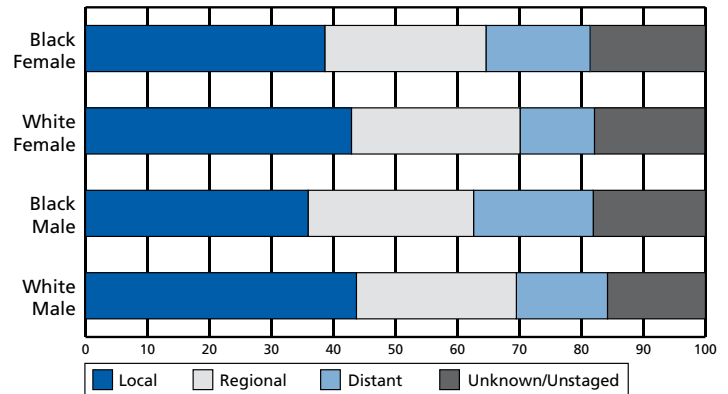
District of Columbia Cervical Cancer² Stage of Disease at Diagnosis by Race, 2000-2004

	Local	Regional	Distant	Unknown
Female, All Races¹	39.2	26.3	9.8	24.7
White Female	55.6	22.2	5.6	16.7
Black Female	36.3	30.4	11.9	21.5



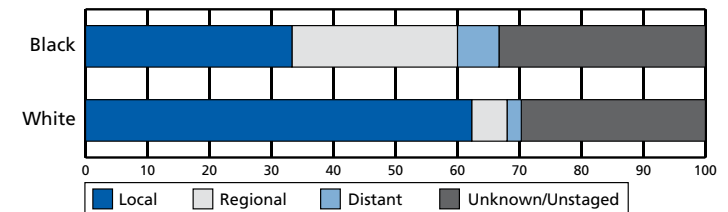
District of Columbia Colorectal Cancer³ Stage of Disease at Diagnosis by Sex and Race, 2000-2004

	Local	Regional	Distant	Unknown
Male, All Races¹	37.9	26.3	18.2	17.7
White Male	43.7	25.8	14.7	15.8
Black Male	35.9	26.7	19.3	18.1
Female, All Races¹	39.9	25.6	15.6	18.9
White Female	42.9	27.2	12.0	17.8
Black Female	38.6	26.0	16.8	18.6



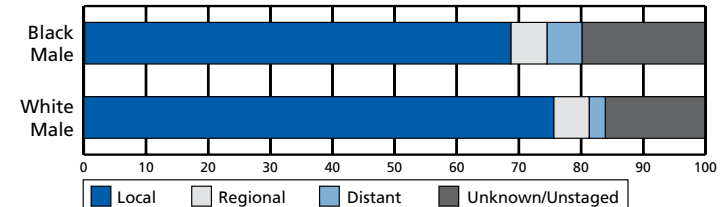
District of Columbia Malignant Melanoma² Stage of Disease at Diagnosis by Race, 2000-2004

	Local	Regional	Distant	Unknown
All Races¹	57.9	6.5	2.3	33.3
White	62.3	5.7	2.3	29.7
Black	33.3	26.7	6.7	33.3



District of Columbia Cancer of the Prostate² Stage of Disease at Diagnosis by Race, 2000-2004

	Local	Regional	Distant	Unknown
Male, All Races¹	69.0	5.7	4.8	20.5
White Male	75.6	5.7	2.6	16.0
Black Male	69.4	5.9	5.7	18.9



Notes: Stages not reported for lung and bronchus cancer due to unavailability of cost-effective early detection test.

¹ Includes White, Black and other races

² Stages reported for invasive cervical, melanoma and prostate cancers only.

³ In situ and local stages combined for colorectal cancer

Source: District of Columbia Cancer Registry

District of Columbia At a Glance

Tobacco

Tobacco Statistics	
Tobacco Use in Washington, DC (2007)	
High school students who smoke	10.6% (2,800)
Male high school students who use smokeless or spit tobacco	8.1% <i>(female use much lower)</i>
Kids (under 18) who become new daily smokers each year	500
Kids exposed to secondhand smoke at home	40,000
Packs of cigarettes bought or smoked by kids each year	0.6 million
Adults in Washington, DC who smoke	17.2% (80,200)
Deaths in Washington, DC From Smoking	
Adults who die each year from their own smoking	700
Kids now under 18 and alive in Washington, DC who will ultimately die prematurely from smoking	8,000
Adult nonsmokers who die each year from exposure to secondhand smoke	40 to 120
Smoking-Caused Monetary Costs in Washington, DC	
Annual health care costs in Washington, DC directly caused by smoking	\$243 million
- Portion covered by the state Medicaid program	\$78 million
Residents' state & federal tax burden from smoking-caused government expenditures	\$609 / household
Smoking-caused productivity losses in Washington, DC	\$233 million
Tobacco Industry Influence in Washington, DC	
Estimated portion spent for Washington, DC marketing each year	\$14.7 million
Estimated Tobacco Revenue in Washington, DC - FY2008	
Tobacco Settlement Revenues	\$43.3 million
Tobacco Tax Revenues	\$22.5 million
Total Annual District Revenues from Tobacco	\$65.8 million
% of Tobacco Revenue Spent on Tobacco Prevention	5.5%
Spending on Tobacco Prevention (FY2008)	
% of CDC Recommended Minimum	48.1%
Rank Among States (1-51)	22

District of Columbia Screening Programs

Breast cancer screening: *BCCEDP**—*Project WISH*, Target Population: women 40-64, uninsured or underinsured

Colorectal cancer screening: There is mandatory coverage for colorectal screening but no city screening programs are available.

Prostate cancer screening: There is a city prostate screening program.

*The Breast and Cervical Cancer Early Detection Program (BCCEDP) is a CDC-funded program in every state administered through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

Nutrition and Physical Activity

State coalition: DC Cancer Consortium addresses nutrition and physical activity in the DC Cancer Plan.

Obesity initiatives: Are being addressed through a DC Department of Health Initiative under Maternal Health.

Access to Care

Number of Federally Qualified Health Centers and free clinics: 4 main clinics; 49 satellite clinics

State fund for Uninsured Cancer Patients: DC HealthCare Alliance

Number of ACoS approved hospitals: 7

Number of NCI Cancer Centers: 1 Comprehensive Cancer Center

Uninsured Population (18+): 9.5% (was 11.2% in 2005)



District of Columbia Cancer Consortium

www.dccancerconsortium.org/

The District of Columbia Cancer Consortium was formed by a group of over 60 concerned health care professionals, advocates and community leaders in the District. The District of Columbia's Cancer Plan, *Facing the Challenge: The DC Cancer Control Plan 2005-2010*, completed in April, 2006, is firmly focused on District-wide efforts in cancer prevention, screening, public education and outreach.

Accomplishments

- An interactive website keeps stakeholders informed about Consortium activities, resources and opportunities.
- A Community Resource Guide, prepared for survivors, caregivers and healthcare professionals, provides useful information covering the Greater Washington area on many topics. www.dccancerconsortium.org/resource/DCCCResourceGuide.pdf
- A colorectal summit of key medical and lay stakeholders has outlined action steps to increase colorectal cancer screening among the underserved.
- A pediatric hospice program and a coordinated patient navigation system are being developed.
- Requests for Proposals have been released to increase early detection of breast, colorectal, prostate and cervical cancers, to increase access to care, and to increase awareness and education about ovarian and endometrial cancers.

Adult Risk Behavior

Early Detection

Recent Mammogram*, Women 40 and Older, District of Columbia and U.S., 2006

	% District of Columbia	% U.S.
40 years and older	64.2	61.2
40-64 years old	63.0	59.7
65 years and older	66.8	64.6
White only, non-Hispanic	62.0	61.6
Black only, non-Hispanic	64.7	62.7
Other race only, non-Hispanic	n/a	59.3
Hispanic	n/a	58.7
Low Education**	64.9	51.6
Uninsured***	36.6	34.9

* Mammogram within the past year.

** Women 40 years old and older with less than a high school education

*** Women 40-64 who reported that they did not have coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare.

Source: Behavioral Risk Factor Surveillance System, 2006

Recent Pap Test*, Women 18 and Older, District of Columbia and U.S., 2006

	% District of Columbia	% U.S.
18 years and older	89.0	83.7
18-44 years	89.2	85.1
45-64 years old	92.4	86.6
65 years and older	80.4	70.8

* A pap test within the preceding 3 years for women with intact uteri.

Source: Behavioral Risk Factor Surveillance System, 2006

Recent Sigmoidoscopy/Colonoscopy*, Adults 50 and Older, District of Columbia and U.S., 2006

	% District of Columbia	% U.S.
50 years and older	57.2	50.0
50-64 years old	49.9	44.9
65 years and older	67.4	57.1
Male, 50 years or older	53.8	50.5
Male, 50-64 years old	46.2	45.1
Male, 65 years and older	66.8	59.5
Female, 50 years and older	59.8	49.5
Female, 50-64 years old	53.2	44.8
Female, 65 years and older	67.7	55.4
White only, non-Hispanic	62.7	51.5
Black only, non-Hispanic	55.4	49.3
Other races only, non-Hispanic	n/a	43.9
Hispanic	n/a	38.2
Low Education**	50.5	38.8
Uninsured***	26.7	20.9

* Sigmoidoscopy/Colonoscopy within the past 5 years.

** Adults 50 years old and older with less than a high school education

*** Adults 50-64 who reported that they did not have coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare.

Source: Behavioral Risk Factor Surveillance System, 2006

Recent Prostate-Specific Antigen Test*, Men 50 and Older District of Columbia and U.S., 2006

	% District of Columbia	% U.S.
50 years and older	55.2	53.8
50-64 years old	49.9	48.5
65 years and older	65.2	63.4
White only, non-Hispanic	57.2	55.6
Black only, non-Hispanic (45+)	50.0	48.1
Other races only, non-Hispanic	n/a	44.9
Hispanic	n/a	43.0
Low Education**	n/a	40.3

* Prostate-specific antigen test within the past year for men who reported they were not told by a doctor, nurse, or other health professional that they had prostate cancer

** Adults 50 years old and older with less than a high school education

Source: Behavioral Risk Factor Surveillance System, 2006

Prevention

Current Cigarette Smoking*, Adults 18 and Older, District of Columbia and U.S., 2007

	% District of Columbia	% U.S.
Total	17.2	19.7
18-24 years old	18.1	14.0
25-34 years old	19.5	23.9
35-44 years old	15.5	20.4
45-54 years old	20.6	22.3
55-64 years old	20.1	18.0
65 years and older	10.5	9.0
Male	17.5	21.2
Female	20.3	18.4
White only, non-Hispanic	8.5	19.4
Black only, non-Hispanic	24.1	21.7
Other race only, non-Hispanic	22.2	18.3
Hispanic	11.0	16.7
Low Education**	26.2	33.2
Female 18-44 (2006)	14.8	20.6

* Ever smoked 100 cigarettes in lifetime and are current smokers (regular and irregular).

** Adults 25 years old and older with less than a high school education

Source: Behavioral Risk Factor Surveillance System, 2007

Physical Activity, Adults 18 and Older, District of Columbia and U.S., 2007

No Leisure Time Physical Activity*	% District of Columbia	% U.S.
Total	46.1	50.5
Male	41.9	48.5
Female	49.8	52.5
White only, non-Hispanic	33.3	48.4
Black only, non-Hispanic	54.7	58.6
Other race only, non-Hispanic	42.8	51.0
Hispanic	56.2	55.3
Low Education**	66.7	59.8

* Adults with 30+ minutes of moderate physical activity five or more days per week, or vigorous physical activity for 20+ minutes three or more days per week.

** Adults 25 years old and older with less than a high school education

Source: Behavioral Risk Factor Surveillance System, 2007

Nutrition, Adults 18 and Older, District of Columbia and U.S., 2007

Eating 5 or More Fruits and Vegetables per Day	% District of Columbia	% U.S.
Total	32.5	24.4
Male	28.8	19.4
Female	35.8	28.8
White only, non-Hispanic	35.3	24.5
Black only, non-Hispanic	30.5	23.1
Other race only, non-Hispanic	38.6	26.6
Hispanic	28.8	22.6
Low Education*	28.7	18.4

* Adults 25 years old and older with less than a high school education
Source: Behavioral Risk Factor Surveillance System, 2007

Overweight*, Adults 18 and Older, District of Columbia and U.S., 2007

	% District of Columbia	% U.S.
Total	55.3	63.0
Male	57.0	70.8
Female	53.7	55.4
White only, non-Hispanic	39.3	62.6
Black only, non-Hispanic	68.8	72.6
Other race only, non-Hispanic	44.8	51.2
Hispanic	57.2	66.9
Low Education**	69.3	65.7

* Overweight is defined as having body mass index of 25 kg/m² or greater
**Adults 25 years old and older with less than a high school education
Source: Behavioral Risk Factor Surveillance System, 2007

Youth Risk Behavior

Tobacco Use, High School Students, District of Columbia and U.S., 2007

Current Cigarette Smoking*	% District of Columbia	% U.S.
Total	10.6	20.0
Male	13.5	21.3
Female	7.5	18.7
Current Smokeless Tobacco Use**		
Total	5.6	7.9
Male	8.1	13.4
Female	2.6	2.3

* Smoked cigarettes on 1 or more of the 30 days preceding the survey
** Used chewing tobacco, snuff or dip on 1 or more of the 30 days preceding the survey
Source: Youth Risk Behavior Surveillance System, 2007

Physical Activity, High School Students, District of Columbia and U.S., 2007

Met Current Physical Activity Level*	% District of Columbia	% U.S.
Total	30.2	34.7
Male	33.9	43.7
Female	26.0	25.6

* Were physically active during any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes/day on 5 or more days during the 7 days before the survey
Source: Youth Risk Behavior Surveillance System, 2007

Nutrition, High School Students, District of Columbia and U.S., 2007

Eating 5 or More Fruits and Vegetables per Day	% District of Columbia	% U.S.
Total	19.3	21.4
Male	20.9	22.9
Female	17.3	19.9

Source: Youth Risk Behavior Surveillance System, 2007

Overweight/Obese High School Students, District of Columbia and U.S., 2007

Obese*	% District of Columbia	% U.S.
Total	17.7	13.0
Male	19.6	16.3
Female	15.8	9.6
Overweight**		
Total	17.8	15.8
Male	15.8	16.4
Female	19.9	15.1

* Obese - At or above the 95th percentile for body mass index, by age and sex, based on reference data from the National Health and Nutrition Examination Survey

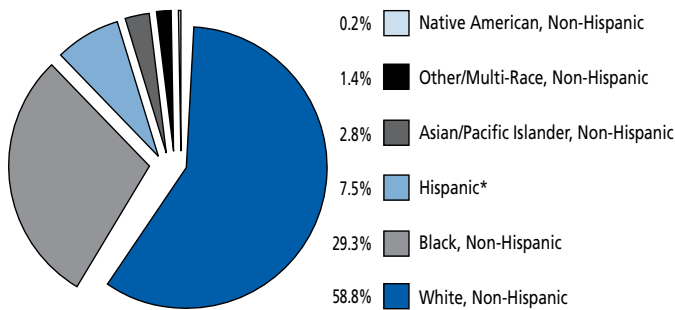
** - Overweight - At or above the 85th percentile but below the 95th percentile for body mass index, by age and sex, based on reference data from the National Health and Nutrition Examination Survey.
Source: Youth Risk Behavior Surveillance System, 2007

DEMOGRAPHICS

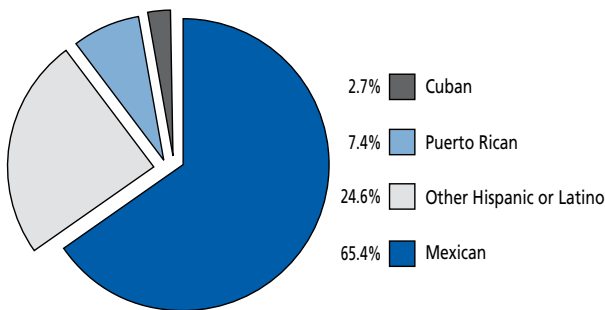
State Level Data, 2007 Estimates

2000 Census Population	8,186,453
2007 Estimate ¹	9,339,947
White, Non-Hispanic	5,494,797
Black, Non-Hispanic	2,735,208
Native American, Non-Hispanic	19,460
Asian/Pacific Islander, Non-Hispanic	257,240
Hispanic ²	702,087
Other/Multi-Race, Non-Hispanic	131,155

Distribution of Georgia's Population by Race & Ethnicity



Georgia's Hispanic/Latino Population by Sub-Ethnicity

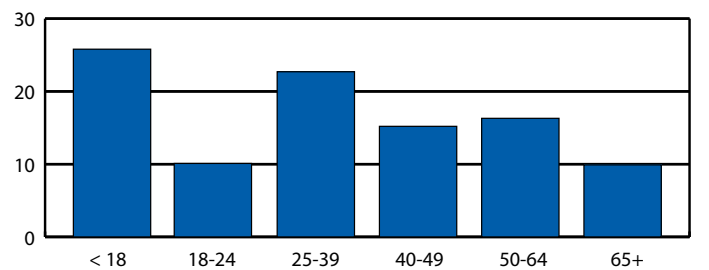


Factors Related to Access to Care

Percent unemployed ³	5.3%
Percentage with less than high school education	13.7%
Median household income	\$49,495
Percent households with income < \$15,000	13.4%
Percent households with income ≥ \$50,000	49.5%
Percent of households with no vehicle	6.1%
Percent rural population	30.4%
Percent minority	41.2%
% speak language other than English at home	12.2%
% with no usual source of health care coverage	17.9%

Age Distribution of Georgia

Age Group	Number	%
< 18	2,411,585	25.8%
18 - 24	945,171	10.1%
25 - 39	2,116,112	22.7%
40 - 49	1,416,668	15.2%
50 - 64	1,524,368	16.3%
65 +	926,043	9.9%



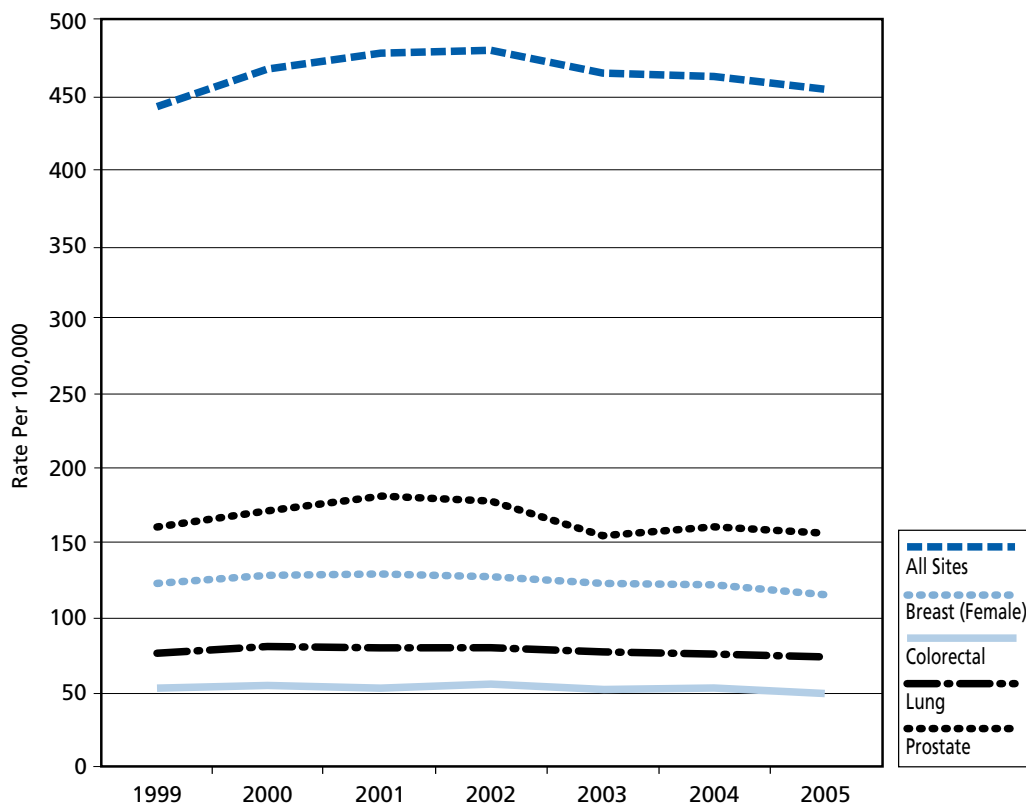
¹ Total is sum of White, Black, Native American, Asian/Pacific Islander, Other/Multi-Race, and Hispanic.

² Hispanic is an ethnicity, not a race.

³ Department of Labor <http://www.bis.gov/LAU>, April 2008

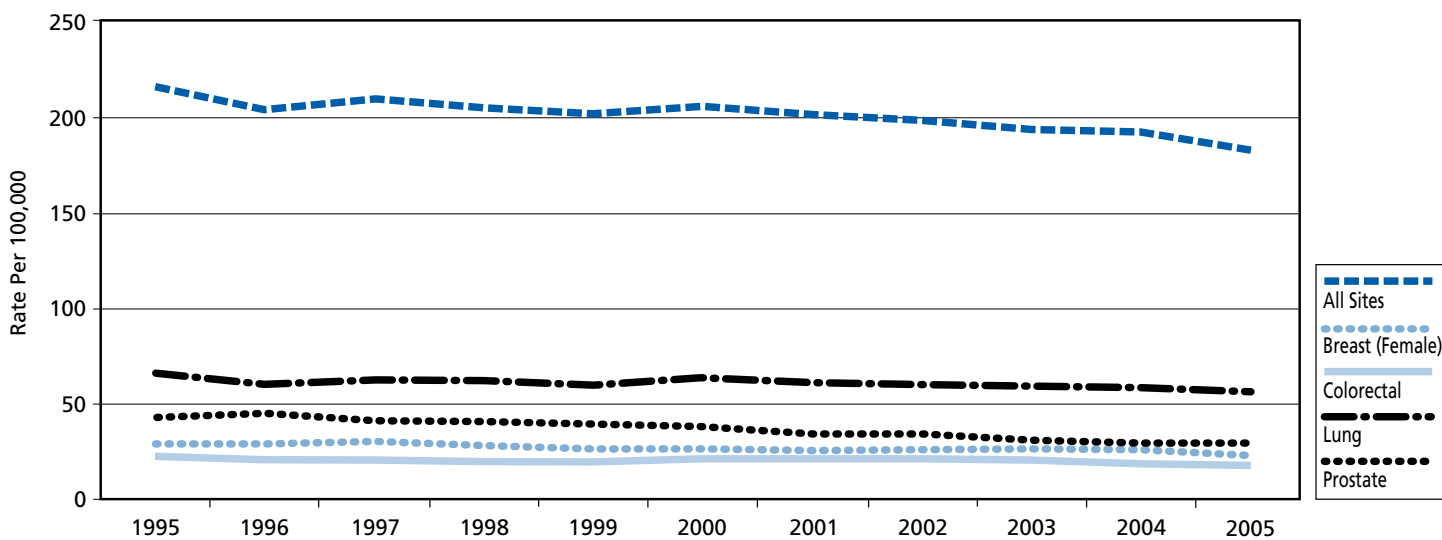
Data Sources: Copyright © 2008, Thomson Medstat. ALL RIGHTS RESERVED; US Census Bureau, Population Fact Sheet, 2008, American Community Survey @ <http://factfinder.census.gov>

Georgia Cancer Incidence Rates by Cancer Site (1999-2005)



Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.
Source: Georgia Comprehensive Cancer Registry

Georgia Cancer Mortality Rates by Cancer Site (1995-2005)



Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.
Source: Georgia Comprehensive Cancer Registry

Georgia Cancer Incidence, 2001-2005, by Site, Gender and Race

	All Races ¹		White		Black	
BOTH GENDERS	Cases	Rate	Cases	Rate	Cases	Rate
ALL SITES	177,686	465.6	131,623	473.5	41,390	480.7
COLORECTAL	18,586	50.0	13,264	48.2	4,874	59.0
LUNG & BRONCHUS	27,409	74.4	21,563	78.3	5,491	67.9
MELANOMA	7,967	19.9	7,663	27.2	97	1.1
	All Races ¹		White		Black	
MALE	Cases	Rate	Cases	Rate	Cases	Rate
ALL SITES	93,008	571.7	68,910	567.2	21,825	652.7
COLORECTAL	9,576	60.1	7,065	59.0	2,270	70.0
LUNG & BRONCHUS	16,293	104.3	12,604	105.9	3,476	110.0
MELANOMA	4,539	26.3	4,392	34.6	48	1.4
PROSTATE	26,503	163.7	17,747	144.0	8,218	257.7
	All Races ¹		White		Black	
FEMALE	Cases	Rate	Cases	Rate	Cases	Rate
ALL SITES	84,675	395.1	62,711	410.9	19,564	375.4
BREAST(FEMALE)	26,168	120.6	19,257	125.7	6,230	113.8
CERVICAL	1,986	9.0	1,185	8.2	657	11.5
COLORECTAL	9,010	42.6	6,199	40.0	2,604	52.7
LUNG & BRONCHUS	11,115	53.4	8,959	58.4	2,014	41.8
MELANOMA	3,428	15.6	3,271	22.2	49	0.9

Note: Data exclude basal and squamous cell skin and in situ cancers except urinary bladder. Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.

¹ Includes White, Black and other races

Source: Georgia Comprehensive Cancer Registry

Georgia Cancer Mortality, 2001-2005, by Site, Gender and Race

	All Races ¹		White		Black	
BOTH GENDERS	Deaths	Rate	Deaths	Rate	Deaths	Rate
ALL SITES	70,074	193.0	51,547	186.1	17,892	223.4
COLORECTAL	6,603	18.4	4,582	16.7	1,957	25.1
LUNG & BRONCHUS	21,212	58.5	16,763	60.2	4,327	54.4
MELANOMA	966	2.5	938	3.3	27	0.3
	All Races ¹		White		Black	
MALE	Deaths	Rate	Deaths	Rate	Deaths	Rate
ALL SITES	36,904	249.4	27,254	236.4	9,337	313.8
COLORECTAL	3,303	22.6	2,391	21.0	872	29.8
LUNG & BRONCHUS	13,005	85.6	10,088	84.9	2,850	92.7
MELANOMA	599	3.6	585	4.6	13	~
PROSTATE	3,625	30.4	2,155	22.9	1,455	65.1
	All Races ¹		White		Black	
FEMALE	Deaths	Rate	Deaths	Rate	Deaths	Rate
ALL SITES	33,170	157.4	24,293	153.2	8,555	173.2
BREAST(FEMALE)	5,312	24.6	3,641	22.8	1,629	30.4
CERVICAL	601	2.7	352	2.3	238	4.5
COLORECTAL	3,300	15.6	2,191	13.6	1,085	22.5
LUNG & BRONCHUS	8,207	39.6	6,675	42.6	1,477	30.9
MELANOMA	367	1.7	353	2.2	14	~

Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.

¹ Includes White, Black and other races

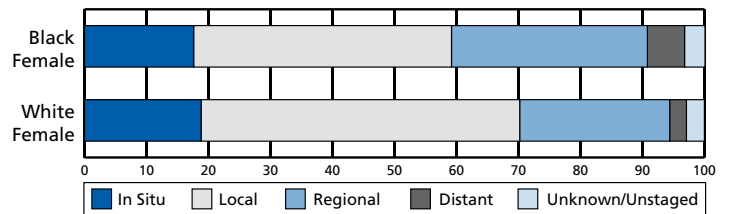
~ Number of deaths too small (25 or less) to calculate reliable rate.

Source: Georgia Comprehensive Cancer Registry

Georgia Cancer Stage at Diagnosis, Percent of Total Cases, 2001-2005, by Site and Race

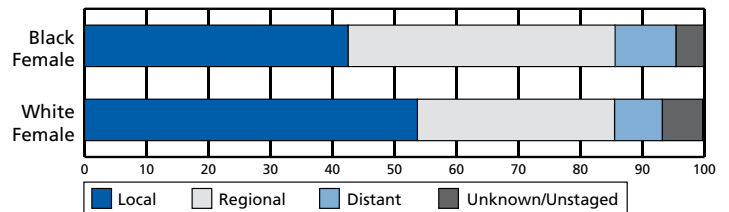
Georgia Female Breast Cancer Stage of Disease at Diagnosis by Race, 2001-2005

	In Situ	Local	Regional	Distant	Unknown
Female, All Races¹	18.5	49.0	26.1	3.5	3.0
White Female	18.8	51.4	24.2	2.7	2.9
Black Female	17.6	41.6	31.6	6.0	3.3



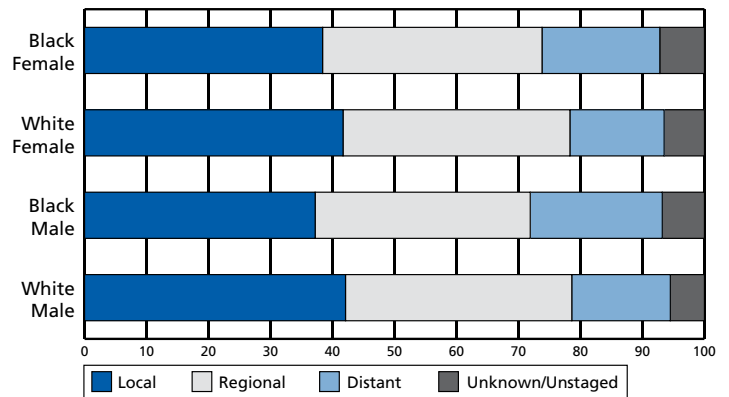
Georgia Cervical Cancer² Stage of Disease at Diagnosis by Race, 2001-2005

	Local	Regional	Distant	Unknown
Female, All Races¹	50.1	35.5	8.3	5.9
White Female	53.7	31.8	7.7	6.5
Black Female	42.5	43.1	9.8	4.5



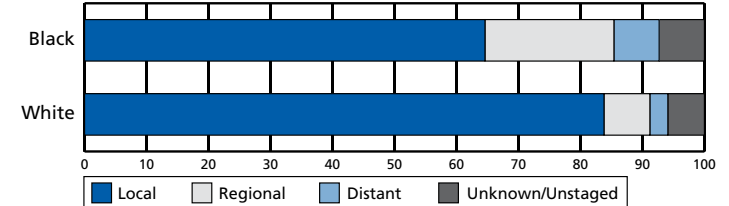
Georgia Colorectal Cancer³ Stage of Disease at Diagnosis by Sex and Race, 2001-2005

	Local	Regional	Distant	Unknown
Male, All Races¹	40.8	36.2	17.2	5.8
White Male	42.1	36.5	15.9	5.5
Black Male	37.2	34.7	21.3	6.8
Female, All Races¹	40.5	36.3	16.3	6.8
White Female	41.7	36.6	15.2	6.5
Black Female	38.4	35.4	19.0	7.2



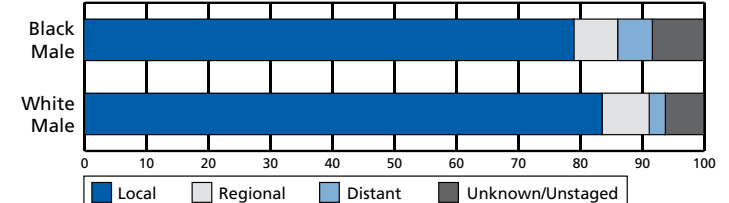
Georgia Malignant Melanoma² Stage of Disease at Diagnosis by Race, 2001-2005

	Local	Regional	Distant	Unknown
All Races¹	83.6	7.5	3.0	5.9
White	83.8	7.4	2.9	5.9
Black	64.6	20.8	7.3	7.3



Georgia Cancer of the Prostate² Stage of Disease at Diagnosis by Race, 2001-2005

	Local	Regional	Distant	Unknown
Male, All Races¹	82.1	7.5	3.6	6.8
White Male	83.5	7.6	2.6	6.3
Black Male	79.1	7.2	5.6	8.1



Notes: Stages not reported for lung and bronchus cancer due to unavailability of cost-effective early detection test.

¹Includes White, Black and other races

²Stages reported for invasive cervical, melanoma and prostate cancers only.

³In situ and local stages combined for colorectal cancer

Source: Georgia Comprehensive Cancer Registry

Georgia At a Glance

Tobacco

Tobacco Statistics	
Tobacco Use in Georgia (2007)	
High school students who smoke	18.6%
Male high school students who use smokeless or spit tobacco	14.8%
	<i>(female use much lower)</i>
Kids (under 18) who become new daily smokers each year	13,100
Kids exposed to secondhand smoke at home	423,000
Packs of cigarettes bought or smoked by kids each year	18.7 million
Adults in Georgia who smoke	19.4% (1,340,300)
Deaths in Georgia From Smoking	
Adults who die each year from their own smoking	10,300
Kids now under 18 and alive in Georgia who will ultimately die prematurely from smoking	184,000
Adult nonsmokers who die each year from exposure to secondhand smoke	750 to 2,120
Smoking-Caused Monetary Costs in Georgia	
Annual health care costs in Georgia directly caused by smoking	2.25 billion
- Portion covered by the state Medicaid program	\$537 million
Residents' state & federal tax burden from smoking-caused government expenditures	\$569 / household
Smoking-caused productivity losses in Georgia	\$3.08 billion
Tobacco Industry Influence in Georgia	
Estimated portion spent for Georgia marketing each year	\$444.8 million
Estimated Tobacco Revenue in Georgia - FY2008	
Tobacco Settlement Revenues	\$157.8 million
Tobacco Tax Revenues	\$247.4 million
Total Annual State Revenues from Tobacco	\$405.2 million
% of Tobacco Revenue Spent on Tobacco Prevention	0.6%
Spending on Tobacco Prevention - FY2008	
CDC Recommended Minimum Spending on Tobacco Prevention	\$42.6 million
% of CDC Recommended Minimum	5.3%
Rank Among States (1-51)	48

Georgia State Screening Programs

Breast cancer screening program: *BCCEDP**—*Breast and Cervical Cancer Program (BCCP)*: Target population: Women 40-64, uninsured, under 200% of Federal Poverty Level - www.georgiacancer.org/treat-screening.php BCCP employs Client Navigators in some health districts to assist with client recruitment and navigation. Also contracts with the American Cancer Society to manage recruitment.

Colorectal cancer screening program: There is mandatory coverage for colorectal screening, but no state screening program. A state work group was formed in 2005 to address colorectal cancer screening for the uninsured or underinsured in the state.

Prostate cancer screening program: None.

*The Breast and Cervical Cancer Early Detection Program (BCCEDP) is a CDC-funded program in every state administered through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).



Nutrition and Physical Activity

State coalition: *Policy Leadership for Active Youth (PLAY)* Leadership Council

Obesity initiatives: None

Access to Care

Number of Federally Qualified Health Centers and free clinics: 24 main clinics; 122 satellite clinics

State screening program: Cancer State Aid

Number of ACoS approved hospitals: 43

Number of NCI Cancer Centers: 0

Uninsured Population (18+): 19.5% (was 18.7% in 2005)

Georgia Cancer Coalition

www.georgiacancer.org

Status of Cancer Control Plan: The Georgia Cancer Coalition, in its seventh year, has a new *Comprehensive Cancer Control Plan* that covers 2008-2012. Over 100 stakeholders from across the state were engaged in a facilitated work group process to design the state plan. www.georgiacancer.org/gcccp/index.html The Plan's goals fall into five categories across the spectrum of cancer care: prevention; early detection and screening; cancer diagnosis and staging; treatment and palliation; and data and metrics. Implementation of a new *Comprehensive Cancer Control Plan* has begun with the formation of a state-wide steering committee to begin assessment of current initiatives, identification of gaps and determination of resources to fulfill the *Comprehensive Cancer Control Plan*.

Accomplishments

The 2008 Georgia Cancer Summit, held in January, 2008, drew cancer caregivers, educators, researchers, administrators, business and civic leaders from across the state. Its purpose was to showcase and refine Georgia's 5-Year *Comprehensive Cancer Control Plan*.

The Georgia Tobacco Quit Line fielded more than 35,000 calls since its inception in 2001. *The Breast Cancer License Plate Initiative* contributes to the Indigent Care Trust Fund that supports breast cancer screenings and treatment for underserved women.

Additional Initiatives: Pain and Palliation initiatives were included in the new *State Cancer Plan* and Georgia has developed a State Cancer Pain Coalition as a result.

Adult Risk Behavior

Early Detection

Recent Mammogram*, Women 40 and Older, Georgia and U.S., 2006

	% Georgia	% U.S.
40 years and older	64.0	61.2
40-64 years old	62.2	59.7
65 years and older	69.1	64.6
White only, non-Hispanic	63.3	61.6
Black only, non-Hispanic	67.8	62.7
Other race only, non-Hispanic	57.1	59.3
Hispanic	60.7	58.7
Low Education**	56.9	51.6
Uninsured***	42.5	34.9

* Mammogram within the past year

** Women 40 years old and older with less than a high school education

*** Women 40-64 who reported that they did not have coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare.

Source: Behavioral Risk Factor Surveillance System, 2006

Recent Pap Test*, Women 18 and Older, Georgia and U.S., 2006

	% Georgia	% U.S.
18 years and older	87.2	83.7
18-44 years	87.8	85.1
45-64 years old	88.5	86.6
65 years and older	78.7	70.8

* A pap test within the preceding 3 years for women with intact uteri.

Source: Behavioral Risk Factor Surveillance System, 2006

Recent Sigmoidoscopy/Colonoscopy*, Adults 50 and Older, Georgia and U.S., 2006

	% Georgia	% U.S.
50 years and older	49.2	50.0
50-64 years old	43.6	44.9
65 years and older	58.5	57.1
Male, 50 years or older	48.8	50.5
Male, 50-64 years old	43.9	45.1
Male, 65 years and older	58.2	59.5
Female, 50 years and older	49.5	49.5
Female, 50-64 years old	43.4	44.8
Female, 65 years and older	58.6	55.4
White only, non-Hispanic	50.5	51.5
Black only, non-Hispanic	47.3	49.3
Other races only, non-Hispanic	31.7	43.9
Hispanic	55.2	38.2
Low Education**	38.2	38.8
Uninsured***	25.1	20.9

* Sigmoidoscopy/Colonoscopy within the past 5 years

** Adults 50 years old and older with less than a high school education

*** Adults 50-64 who reported that they did not have coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare.

Source: Behavioral Risk Factor Surveillance System, 2006

Recent Prostate-Specific Antigen Test*, Men 50 and Older Georgia and U.S., 2006

	% Georgia	% U.S.
50 years and older	57.4	53.8
50-64 years old	52.7	48.5
65 years and older	67.7	63.4
White only, non-Hispanic	56.7	55.6
Black only, non-Hispanic (45+)	49.9	48.1
Other races only, non-Hispanic	n/a	44.9
Hispanic	n/a	43.0
Low Education**	38.2	40.3

* Prostate-specific antigen test within the past year for men who reported they were not told by a doctor, nurse, or other health professional that they had prostate cancer

** Adults 50 years old and older with less than a high school education

Source: Behavioral Risk Factor Surveillance System, 2006

Prevention

Current Cigarette Smoking*, Adults 18 and Older, Georgia and U.S., 2007

	% Georgia	% U.S.
Total	19.4	19.7
18-24 years old	23.4	24.0
25-34 years old	22.0	23.9
35-44 years old	18.8	20.4
45-54 years old	23.2	22.3
55-64 years old	18.3	18.0
65 years and older	9.9	9.0
Male	21.2	21.2
Female	17.6	18.4
White only, non-Hispanic	19.1	19.4
Black only, non-Hispanic	19.6	21.7
Other race only, non-Hispanic	n/a	21.7
Hispanic	15.0	16.7
Low Education**	35.1	33.2
Female 18-44 (2006)	19.5	20.6

* Ever smoked 100 cigarettes in lifetime and are current smokers (regular and irregular).

** Adults 25 years old and older with less than a high school education

Source: Behavioral Risk Factor Surveillance System, 2007

Physical Activity, Adults 18 and Older, Georgia and U.S., 2007

No Leisure Time Physical Activity*	% Georgia	% U.S.
Total	51.8	50.5
Male	48.8	48.5
Female	54.7	52.5
White only, non-Hispanic	50.9	48.4
Black only, non-Hispanic	57.3	58.6
Other race only, non-Hispanic	46.6	51.0
Hispanic	n/a	55.3
Low Education**	57.9	59.8

* Adults with 30+ minutes of moderate physical activity five or more days per week, or vigorous physical activity for 20+ minutes three or more days per week.

** Adults 25 years old and older with less than a high school education

Source: Behavioral Risk Factor Surveillance System, 2007

Nutrition, Adults 18 and Older, Georgia and U.S., 2007

Eating 5 or More Fruits and Vegetables per Day	% Georgia	% U.S.
Total	25.0	24.4
Male	21.1	19.4
Female	28.8	28.8
White only, non-Hispanic	24.8	24.5
Black only, non-Hispanic	25.2	23.1
Other race only, non-Hispanic	28.7	26.6
Hispanic	21.4	22.6
Low Education*	16.2	18.4

* Adults 25 years old and older with less than a high school education
Source: Behavioral Risk Factor Surveillance System, 2007

Overweight*, Adults 18 and Older, Georgia and U.S., 2007

	% Georgia	% U.S.
Total	65.0	63.0
Male	71.5	70.8
Female	58.6	55.4
White only, non-Hispanic	63.2	62.6
Black only, non-Hispanic	69.6	72.6
Other race only, non-Hispanic	60.8	51.2
Hispanic	n/a	66.9
Low Education**	69.2	65.7

*Overweight is defined as having body mass index of 25 kg/m² or greater
**Adults 25 years old and older with less than a high school education
Source: Behavioral Risk Factor Surveillance System, 2007

Youth Risk Behavior

Tobacco Use, High School Students, Georgia and U.S., 2007

Current Cigarette Smoking*	% Georgia	% U.S.
Total	18.6	20.0
Male	20.7	21.3
Female	16.5	18.7
Current Smokeless Tobacco Use**		
Total	8.4	7.9
Male	14.8	13.4
Female	1.8	2.3

* Smoked cigarettes on 1 or more of the 30 days preceding the survey
** Used chewing tobacco, snuff or dip on 1 or more of the 30 days preceding the survey
Source: Youth Risk Behavior Surveillance System, 2007

Nutrition, High School Students, Georgia and U.S., 2007

Eating 5 or More Fruits and Vegetables per Day	% Georgia	% U.S.
Total	19.0	21.4
Male	21.4	22.9
Female	16.7	19.9

Source: Youth Risk Behavior Surveillance System, 2007

Physical Activity, High School Students, Georgia and U.S., 2007

Met Current Physical Activity Level*	% Georgia	% U.S.
Total	43.8	34.7
Male	57.2	43.7
Female	30.5	25.6

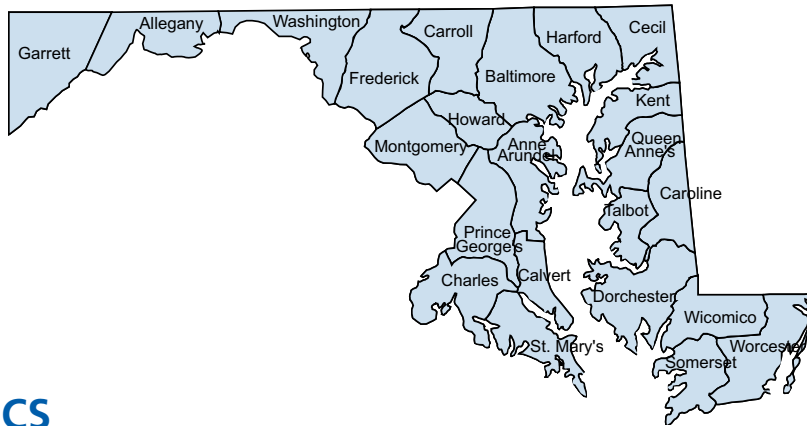
* Were physically active during any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes/day on 5 or more days during the 7 days before the survey
Source: Youth Risk Behavior Surveillance System, 2007

Overweight/Obese High School Students, Georgia and U.S., 2007

Obese*	% Georgia	% U.S.
Total	13.8	13.0
Male	16.6	16.3
Female	11.1	9.6
Overweight**		
Total	18.2	15.8
Male	17.5	16.4
Female	18.9	15.1

* Obese - At or above the 95th percentile for body mass index, by age and sex, based on reference data from the National Health and Nutrition Examination Survey
** - Overweight - At or above the 85th percentile but below the 95th percentile for body mass index, by age and sex, based on reference data from the National Health and Nutrition Examination Survey.
Source: Youth Risk Behavior Surveillance System, 2007

Maryland



DEMOGRAPHICS

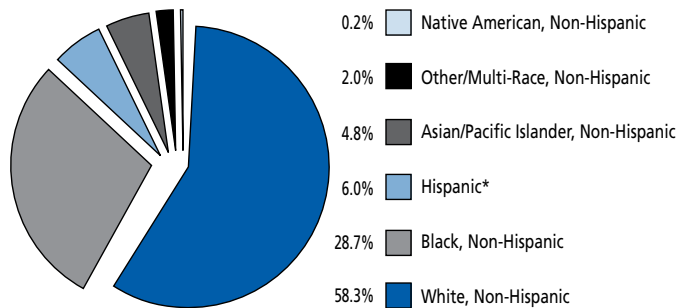
State Level Data, 2007 Estimates

2000 Census Population	5,296,486
2007 Estimate ¹	5,675,034
White, Non-Hispanic	3,307,000
Black, Non-Hispanic	1,626,374
Native American, Non-Hispanic	13,339
Asian/Pacific Islander, Non-Hispanic	272,957
Hispanic ²	340,026
Other/Multi-Race, Non-Hispanic	115,338

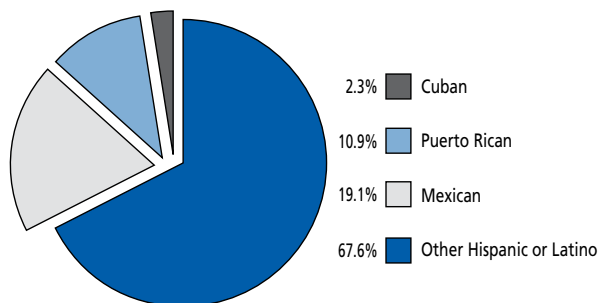
Factors Related to Access to Care

Percent unemployed ³	3.7%
Percentage with less than high school education	10.8%
Median household income	\$64,357
Percent households with income < \$15,000	8.9%
Percent households with income ≥ \$50,000	61.7%
Percent of households with no vehicle	9.4%
Percent rural population	15.4%
Percent minority	41.7%
% speak language other than English at home	14.9%
% with no usual source of health care coverage	11.8%

Distribution of Maryland's Population by Race & Ethnicity

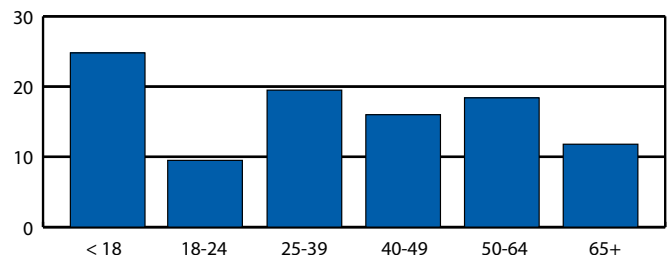


Maryland's Hispanic/Latino Population by Sub-Ethnicity



Age Distribution of Maryland

Age Group	Number	%
< 18	1,409,242	24.8%
18 - 24	539,364	9.5%
25 - 39	1,104,942	19.5%
40 - 49	908,114	16.0%
50 - 64	1,042,028	18.4%
65 +	671,344	11.8%



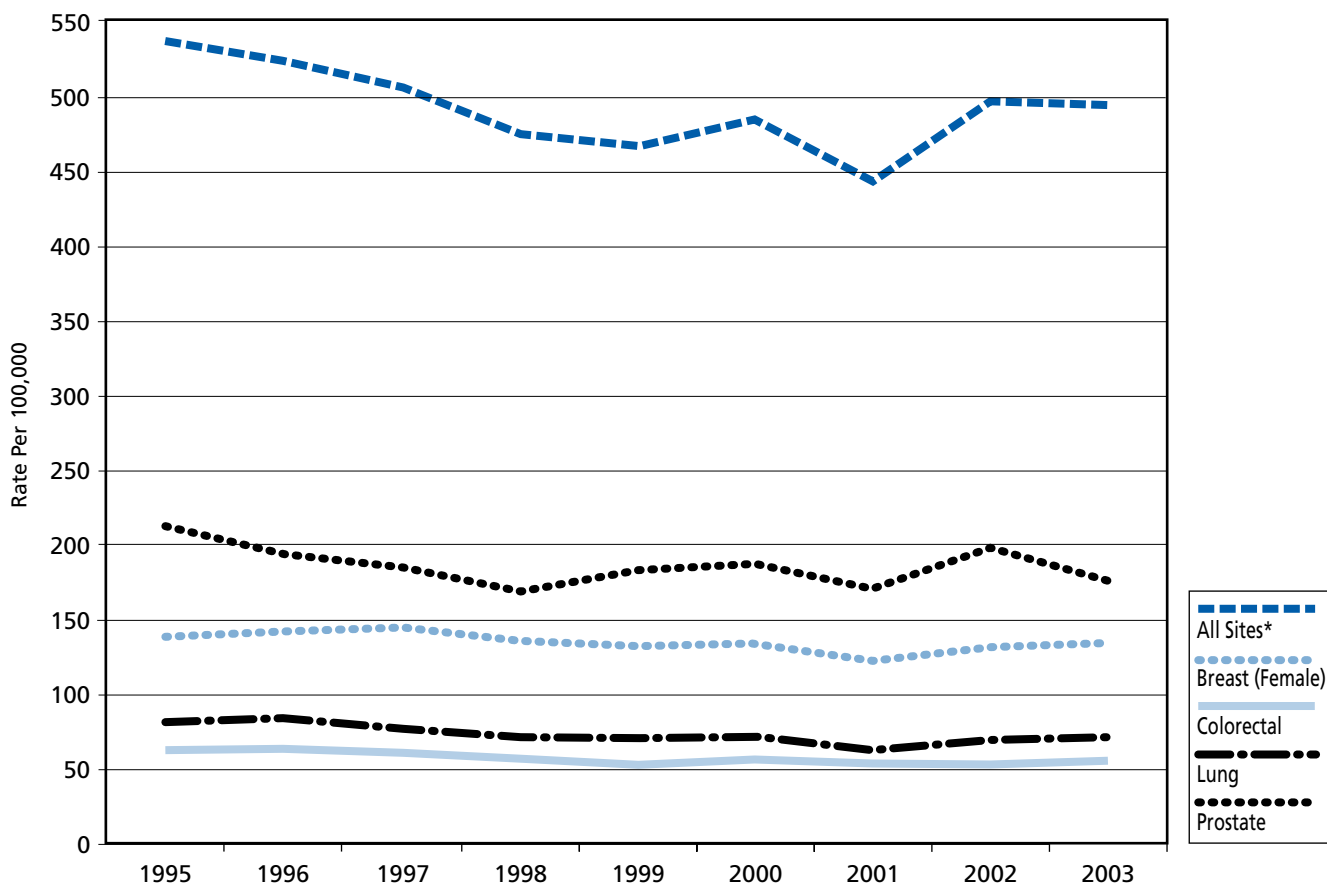
¹ Total is sum of White, Black, Native American, Asian/Pacific Islander, Other/Multi-Race, and Hispanic.

² Hispanic is an ethnicity, not a race.

³ Department of Labor <http://www.bis.gov/LAU/>, April 2008

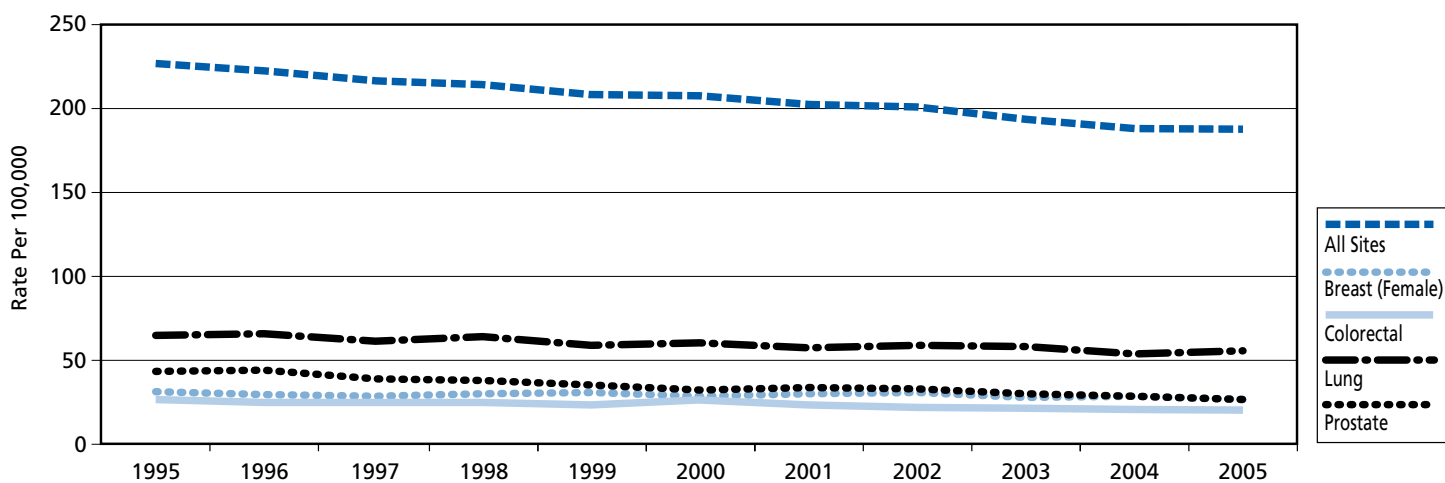
Data Sources: Copyright © 2008, Thomson Medstat. ALL RIGHTS RESERVED; US Census Bureau, Population Fact Sheet, 2008, American Community Survey @ <http://factfinder.census.gov>

Maryland Cancer Incidence Rates by Cancer Site (1995-2003)



Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.
Source: Maryland Cancer Registry

Maryland Cancer Mortality Rates by Cancer Site (1995-2005)



Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.
Source: Maryland Vital Statistics Administration

Maryland Cancer Incidence, 1999-2003, By Site, Gender and Race

	All Races ¹		White		Black	
BOTH GENDERS	Cases	Rate	Cases	Rate	Cases	Rate
ALL SITES	123,951	477.4	90,530	470.6	26,634	462.4
COLORECTAL	13,602	53.3	9,851	51.0	3,058	56.7
LUNG & BRONCHUS	17,513	68.7	13,290	69.0	3,881	70.9
MELANOMA	5,030	18.8	4,344	22.8	66	1.2
	All Races ¹		White		Black	
MALE	Cases	Rate	Cases	Rate	Cases	Rate
ALL SITES	63,566	567.8	46,095	544.5	13,612	586.7
COLORECTAL	6,761	62.1	5,010	60.3	1,383	63.8
LUNG & BRONCHUS	9,420	86.0	7,030	84.0	2,193	98.8
MELANOMA	2,823	24.0	2,452	28.1	33	1.5
PROSTATE	20,540	182.7	13,501	157.6	5,261	229.8
	All Races ¹		White		Black	
FEMALE	Cases	Rate	Cases	Rate	Cases	Rate
ALL SITES	60,370	415.1	44,429	420.6	13,018	381.0
BREAST(FEMALE)	19,055	130.4	13,945	133.5	4,251	117.0
CERVICAL	1,181	8.1	659	6.7	379	10.1
COLORECTAL	6,838	46.7	4,839	43.7	1,672	52.1
LUNG & BRONCHUS	8,091	56.2	6,258	58.1	1,688	52.5
MELANOMA	2,207	15.2	1,892	19.0	33	0.9

Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.

¹ Includes White, Black and other races

Data Source: Maryland Cancer Registry

Maryland Cancer Mortality, 2001-2005, By Site, Gender and Race

	All Races ¹		White		Black	
BOTH GENDERS	Deaths	Rate	Deaths	Rate	Deaths	Rate
ALL SITES	51,426	194.9	37,680	188.2	12,779	233.2
COLORECTAL	5,199	19.8	3,704	18.4	1,406	26.8
LUNG & BRONCHUS	14,681	55.7	11,025	55.1	3,447	62.5
MELANOMA (SKIN)	716	2.7				
	All Races ¹		White		Black	
MALE	Deaths	Rate	Deaths	Rate	Deaths	Rate
ALL SITES	26,081	238.0	19,125	226.9	6,456	306.9
COLORECTAL	2,606	23.8	1,890	22.4	670	32.8
LUNG & BRONCHUS	8,092	72.3	5,949	69.5	2,018	91.3
MELANOMA (SKIN)						
PROSTATE	2,732	28.6	1,753	23.0	939	59.2
	All Races ¹		White		Black	
FEMALE	Deaths	Rate	Deaths	Rate	Deaths	Rate
ALL SITES	25,345	166.4	18,555	162.0	6,323	190.4
BREAST (FEMALE)	4,168	27.2	2,871	25.3	1,222	33.7
CERVICAL	356	2.4	193	1.8	151	4.1
COLORECTAL	2,593	16.8	1,814	15.3	736	23.1
LUNG & BRONCHUS	6,589	43.7	5,076	44.8	1,429	43.8
MELANOMA (SKIN)						

Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.

¹ Includes White, Black and other races

Source: Maryland Vital Statistics Administration

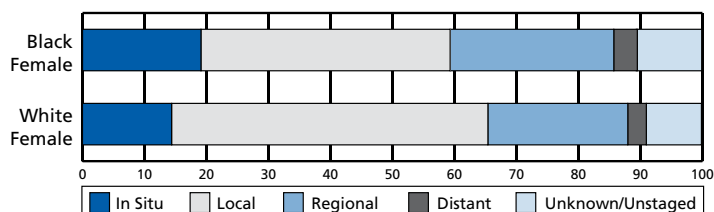
Notes on Maryland Cancer Registry Data

Incidence data for 2004 and 2005 from the Maryland Cancer Registry have been suppressed since these data are undergoing a data quality review and were unavailable at time of publication. Maryland state and county incidence data are included up to 2003, or for multiple years 1999-2003. Stage at diagnosis data are available for 1999-2003.

Maryland Cancer Stage at Diagnosis, Percent of Total Cases, 1999-2003, by Site and Race

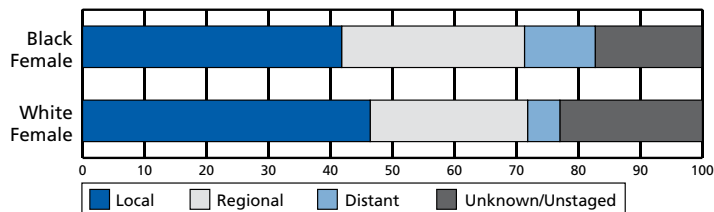
Maryland Female Breast Cancer Stage of Disease at Diagnosis by Race, 1999-2003

	In Situ	Local	Regional	Distant	Unknown
Female, All Races¹	19.0	46.1	22.4	3.0	9.5
White Female	14.4	51.1	22.6	3.0	8.9
Black Female	19.1	40.2	26.4	3.8	10.4



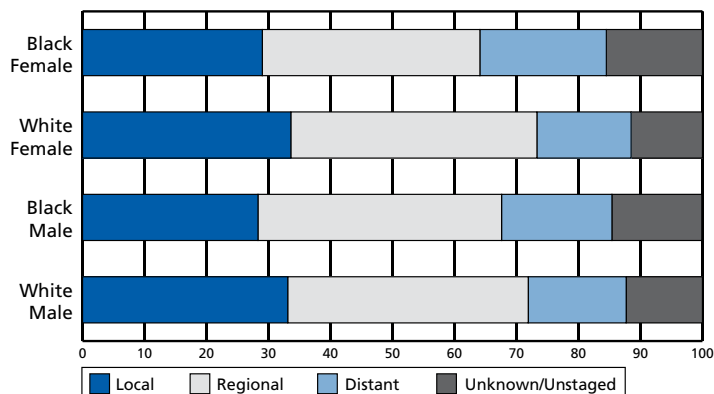
Maryland Cervical Cancer² Stage of Disease at Diagnosis by Race, 1999-2003

	Local	Regional	Distant	Unknown
Female, All Races¹	42.4	25.1	6.9	25.6
White Female	46.4	25.4	5.2	23.0
Black Female	41.8	29.5	11.4	17.2



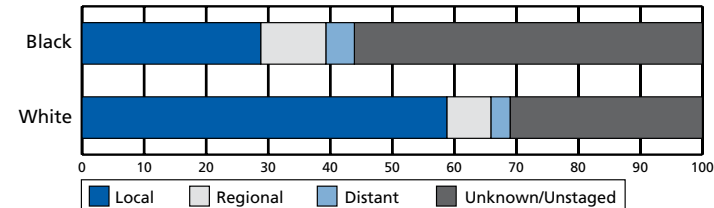
Maryland Colorectal Cancer³ Stage of Disease at Diagnosis by Sex and Race, 1999-2003

	Local	Regional	Distant	Unknown
Male, All Races¹	31.4	38.2	15.7	14.7
White Male	33.1	38.8	15.8	12.3
Black Male	28.3	39.3	17.8	14.5
Female, All Races¹	31.7	37.8	16.6	14.3
White Female	33.6	39.7	15.2	11.5
Black Female	29.0	35.1	20.4	15.5



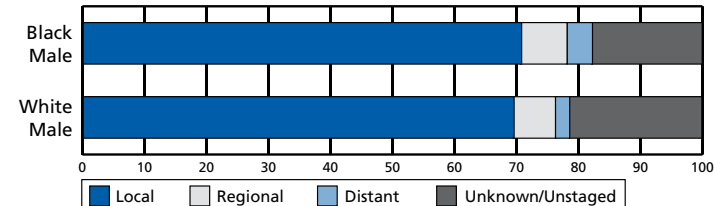
Maryland Malignant Melanoma² Stage of Disease at Diagnosis by Race, 1999-2003

	Local	Regional	Distant	Unknown
All Races¹	52.6	6.3	2.8	38.2
White	58.8	7.1	3.1	31.0
Black	28.8	10.6	4.6	56.1



Maryland Cancer of the Prostate² Stage of Disease at Diagnosis by Race, 1999-2003

	Local	Regional	Distant	Unknown
Male, All Races¹	65.9	6.6	2.7	24.8
White Male	69.5	6.8	2.3	21.3
Black Male	70.7	7.5	4.1	17.8



Notes: Stages not reported for lung and bronchus cancer due to unavailability of cost-effective early detection test.

¹Includes White, Black and other races

²Stages reported for invasive cervical, melanoma and prostate cancers only.

³In situ and local stages combined for colorectal cancer

Source: Maryland Cancer Registry

Maryland At a Glance

Tobacco

Tobacco Statistics	
Tobacco Use in Maryland (2007)	
High school students who smoke	16.8%
Male high school students who use smokeless or spit tobacco	6.7% <i>(female use much lower)</i>
Kids (under 18) who become new daily smokers each year	7,700
Kids exposed to secondhand smoke at home	270,000
Packs of cigarettes bought or smoked by kids each year	10.8 million
Adults in Maryland who smoke	17.1% (727,600)
Deaths in Maryland From Smoking	
Adults who die each year from their own smoking	6,800
Kids now under 18 and alive in Maryland who will ultimately die prematurely from smoking	108,000
Adult nonsmokers who die each year from exposure to secondhand smoke	410 to 1,160
Smoking-Caused Monetary Costs in Maryland	
Annual health care costs in Maryland directly caused by smoking	\$1.96 billion
- Portion covered by the state Medicaid program	\$476 million
Residents' state & federal tax burden from smoking-caused government expenditures	\$627 / household
Smoking-caused productivity losses in Maryland	\$1.78 billion
Tobacco Industry Influence in Maryland	
Estimated portion spent for Maryland marketing each year	\$192.7 million
Estimated Tobacco Revenue in Maryland – FY2008	
Tobacco Settlement Revenues	\$165.2 million
Tobacco Tax Revenues	\$375.6 million
Total Annual State Revenues from Tobacco	\$540.8 million
% of Tobacco Revenue Spent on Tobacco Prevention	3.4%
Spending on Tobacco Prevention – FY2008	
CDC Recommended Minimum Spending on Tobacco Prevention	\$38.9 million
% of CDC Recommended Minimum	60.7%
Rank Among States (1-51)	19

Maryland State Screening Programs

Breast cancer screening: *BCCEDP**—*Breast and Cervical Cancer Screening Program (BCCP)*, target population: women 40-64, uninsured, under 250% of Federal Poverty Level. BCCP employs Lay Health Outreach Workers to educate, motivate and recruit women from priority populations.

Colorectal cancer screening: There is mandatory coverage for colorectal screening. Cigarette Restitution Funds are distributed to local County health departments and 22 of 24 departments run CRC screening programs with these monies.

Prostate cancer screening: Cigarette Restitution Funds are distributed to local County health departments and several run screening programs with these monies.

*The Breast and Cervical Cancer Early Detection Program (BCCEDP) is a CDC-funded program in every state administered through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

Nutrition and Physical Activity

State coalition: *Maryland Healthy Eating and Active Lifestyle (HEAL) Coalition*, www.healthyactivemaryland.org/

Maryland State Nutrition Action Plan (SNAP) focuses educational efforts on parents and teachers.
www.fns.usda.gov/oane/SNAP/Accomplishments/Maryland.htm

Maryland Nutrition and Physical Activity Plan - www.kentonthemove.org/pdf/NPA_Summary.pdf

Access to Care

Number of Federally Qualified Health Centers and free clinics: 15 main clinics; 92 satellite clinics

State fund for Uninsured Cancer Patients: State-funded program pays for breast and cervical cancer diagnosis and treatment.

Number of ACoS approved hospitals: 37

Number of NCI Cancer Centers: 1 Comprehensive Cancer Center

Uninsured Population (18+): 14.9% (was 12.7% in 2005)

Maryland Comprehensive Cancer Control Plan

www.marylandcancerplan.org

Status of Cancer Control Plan: Maryland Comprehensive Cancer Control Plan is currently implementing the 2004-2008 Plan: Our Call to Action, *"A Plan By Marylanders, For Marylanders"*.
www.fha.state.md.us/cancer/cancerplan/

In collaboration with the Maryland State Council on Cancer Control, hosted the 14th Annual State Conference *"Cancer Issues and Challenge"* on Cancer Control in November 2007 with over 400 attendees.

This Year's Activities: To continue establishing priorities for implementation and working to bring the messages contained in the Maryland cancer plan to the citizens of Maryland through programs and partnerships.



Adult Risk Behavior

Early Detection

Recent Mammogram*, Women 40 and Older, Maryland and U.S., 2006

	% Maryland	% U.S.
40 years and older	63.9	61.2
40-64 years old	62.7	59.7
65 years and older	67.0	64.6
White only, non-Hispanic	63.1	61.6
Black only, non-Hispanic	65.3	62.7
Other race only, non-Hispanic	61.6	59.3
Hispanic	67.2	58.7
Low Education**	58.4	51.6
Uninsured***	39.6	34.9

* Mammogram within the past year

** Women 40 years old and older with less than a high school education

*** Women 40-64 who reported that they did not have coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare.

Source: Behavioral Risk Factor Surveillance System, 2006

Recent Pap Test*, Women 18 and Older, Maryland and U.S., 2006

	% Maryland	% U.S.
18 years and older	87.7	83.7
18-44 years	87.7	85.1
45-64 years old	91.6	86.6
65 years and older	76.9	70.8

* A pap test within the preceding 3 years for women with intact uteri.

Source: Behavioral Risk Factor Surveillance System, 2006

Recent Sigmoidoscopy/Colonoscopy*, Adults 50 and Older, Maryland and U.S., 2006

	% Maryland	% U.S.
50 years and older	57.4	50.0
50-64 years old	53.1	44.9
65 years and older	64.0	57.1
Male, 50 years or older	59.9	50.5
Male, 50-64 years old	54.0	45.1
Male, 65 years and older	70.4	59.5
Female, 50 years and older	55.3	49.5
Female, 50-64 years old	52.3	44.8
Female, 65 years and older	59.4	55.4
White only, non-Hispanic	57.7	51.5
Black only, non-Hispanic	58.4	49.3
Other races only, non-Hispanic	47.3	43.9
Hispanic	64.3	38.2
Low Education**	45.8	38.8
Uninsured***	28.3	20.9

* Sigmoidoscopy/Colonoscopy within the past 5 years

** Adults 50 years old and older with less than a high school education

*** Adults 50-64 who reported that they did not have coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare.

Source: Behavioral Risk Factor Surveillance System, 2006

Recent Prostate-Specific Antigen Test*, Men 50 and Older Maryland and U.S., 2006

	% Maryland	% U.S.
50 years and older	57.1	53.8
50-64 years old	51.3	48.5
65 years and older	67.9	63.4
White only, non-Hispanic	58.0	55.6
Black only, non-Hispanic (45+)	46.9	48.1
Other races only, non-Hispanic	n/a	44.9
Hispanic	n/a	43.0
Low Education**	31.8	40.3

* Prostate-specific antigen test within the past year for men who reported they were not told by a doctor, nurse, or other health professional that they had prostate cancer

** Adults 50 years old and older with less than a high school education

Source: Behavioral Risk Factor Surveillance System, 2006

Prevention

Current Cigarette Smoking*, Adults 18 and Older, Maryland and U.S., 2007

	% Maryland	% U.S.
Total	17.1	19.7
18-24 years old	24.0	24.0
25-34 years old	20.5	23.9
35-44 years old	19.3	20.4
45-54 years old	17.2	22.3
55-64 years old	15.1	18.0
65 years and older	7.5	9.0
Male	18.3	21.2
Female	15.9	18.4
White only, non-Hispanic	17.4	19.4
Black only, non-Hispanic	19.0	21.7
Other race only, non-Hispanic	n/a	18.3
Hispanic	13.9	16.7
Low Education**	30.6	33.2
Female 18-44 (2006)	17.0	20.6

* Ever smoked 100 cigarettes in lifetime and are current smokers (regular and irregular).

** Adults 25 years old and older with less than a high school education

Source: Behavioral Risk Factor Surveillance System, 2007

Physical Activity, Adults 18 and Older, Maryland and U.S., 2007

No Leisure Time Physical Activity*	% Maryland	% U.S.
Total	51.8	50.5
Male	49.9	48.5
Female	53.5	52.5
White only, non-Hispanic	48.4	48.4
Black only, non-Hispanic	58.7	58.6
Other race only, non-Hispanic	50.9	51.0
Hispanic	60.2	55.3
Low Education**	62.9	59.8

* Adults with 30+ minutes of moderate physical activity five or more days per week, or vigorous physical activity for 20+ minutes three or more days per week.

** Adults 25 years old and older with less than a high school education

Source: Behavioral Risk Factor Surveillance System, 2007

Nutrition, Adults 18 and Older, Maryland and U.S., 2007

Eating 5 or More Fruits and Vegetables per Day	% Maryland	% U.S.
Total	26.6	24.4
Male	22.3	19.4
Female	30.5	28.8
White only, non-Hispanic	27.1	24.5
Black only, non-Hispanic	25.2	23.1
Other race only, non-Hispanic	31.0	26.6
Hispanic	20.9	22.6
Low Education*	19.3	18.4

* Adults 25 years old and older with less than a high school education
 Source: Behavioral Risk Factor Surveillance System, 2007

Overweight*, Adults 18 and Older, Maryland and U.S., 2007

	% Maryland	% U.S.
Total	62.7	63.0
Male	68.6	70.8
Female	56.9	55.4
White only, non-Hispanic	60.7	62.6
Black only, non-Hispanic	74.2	72.6
Other race only, non-Hispanic	40.2	51.2
Hispanic	56.5	66.9
Low Education**	62.8	65.7

*Overweight is defined as having body mass index of 25 kg/m² or greater
 **Adults 25 years old and older with less than a high school education
 Source: Behavioral Risk Factor Surveillance System, 2007

Youth Risk Behavior

Tobacco Use, High School Students, Maryland and U.S., 2007

Current Cigarette Smoking*	% Maryland	% U.S.
Total	16.8	20.0
Male	17.4	21.3
Female	15.8	18.7
Current Smokeless Tobacco Use**		
Total	4.2	7.9
Male	6.7	13.4
Female	1.8	2.3

* Smoked cigarettes on 1 or more of the 30 days preceding the survey
 ** Used chewing tobacco, snuff or dip on 1 or more of the 30 days preceding the survey
 Source: Youth Risk Behavior Surveillance System, 2007

Nutrition, High School Students, Maryland and U.S., 2007

Eating 5 or More Fruits and Vegetables per Day	% Maryland	% U.S.
Total	19.0	21.4
Male	20.3	22.9
Female	17.6	19.9

Source: Youth Risk Behavior Surveillance System, 2007

Physical Activity, High School Students, Maryland and U.S., 2005

Met Current Physical Activity Level*	% Maryland	% U.S.
Total	30.6	34.7
Male	36.4	43.7
Female	25.0	25.6

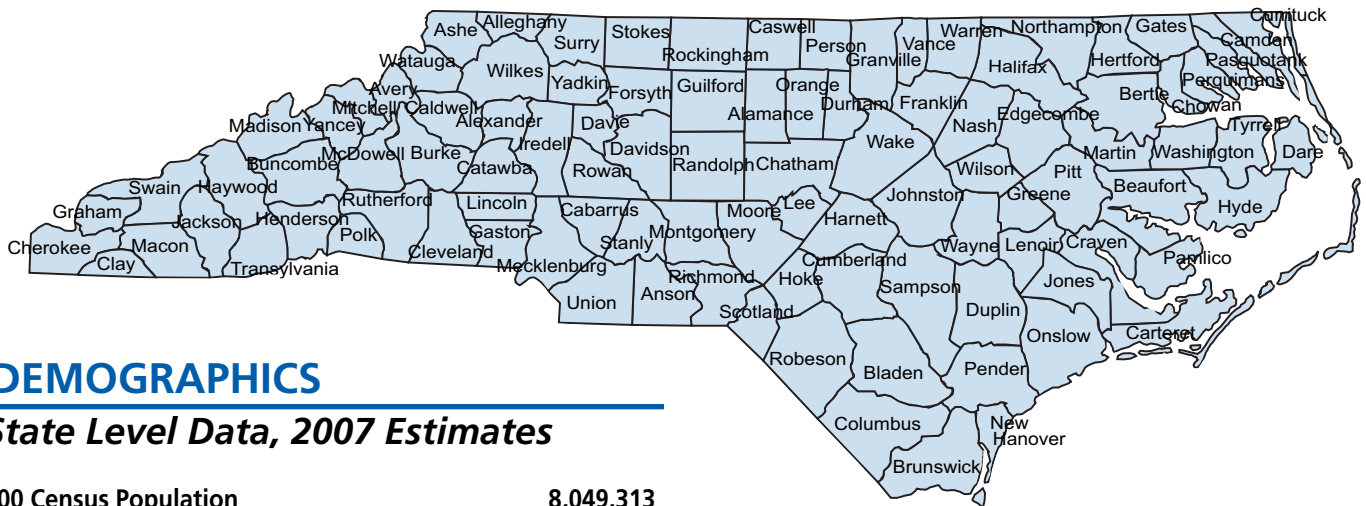
* Were physically active during any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes/day on 5 or more days during the 7 days before the survey
 ** At least 20 minutes of vigorous physical activity that made them sweat and breathe hard on 3 or more of the 7 days preceding the survey
 Source: Youth Risk Behavior Surveillance System, 2007

Overweight/Obese High School Students, Maryland and U.S., 2007

Obese*	% Maryland	% U.S.
Total	13.1	13.0
Male	16.7	16.3
Female	9.2	9.6
Overweight**		
Total	15.2	15.8
Male	15.1	16.4
Female	15.4	15.1

* Obese - At or above the 95th percentile for body mass index, by age and sex, based on reference data from the National Health and Nutrition Examination Survey
 ** - Overweight - At or above the 85th percentile but below the 95th percentile for body mass index, by age and sex, based on reference data from the National Health and Nutrition Examination Survey.
 Source: Youth Risk Behavior Surveillance System, 2007

North Carolina

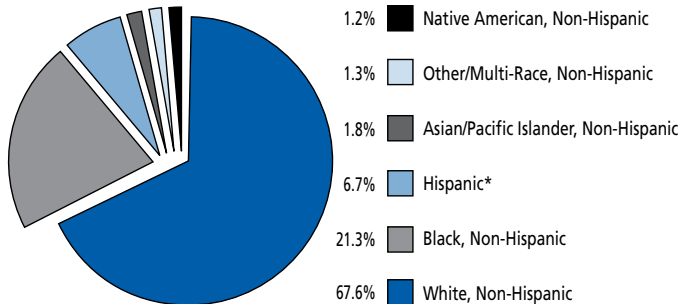


DEMOGRAPHICS

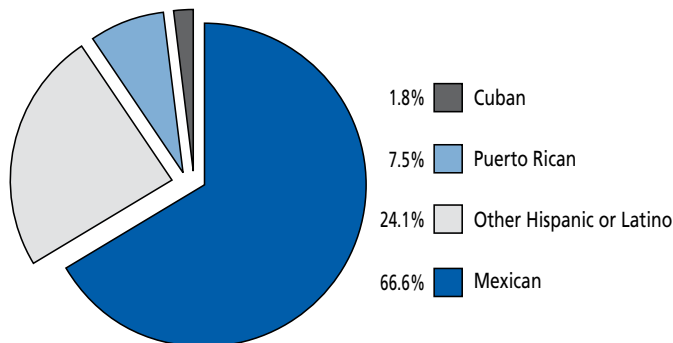
State Level Data, 2007 Estimates

2000 Census Population	8,049,313
2007 Estimate ¹	8,875,404
White, Non-Hispanic	6,000,159
Black, Non-Hispanic	1,893,321
Native American, Non-Hispanic	105,676
Asian/Pacific Islander, Non-Hispanic	163,189
Hispanic ²	598,562
Other/Multi-Race, Non-Hispanic	114,497

Distribution of North Carolina's Population by Race & Ethnicity



North Carolina's Hispanic/Latino Population by Sub-Ethnicity

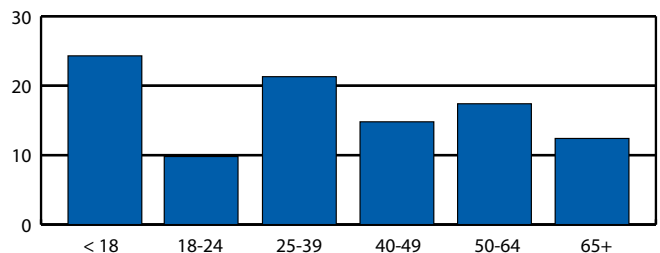


Factors Related to Access to Care

Percent unemployed ³	5.4%
Percentage with less than high school education	13.7%
Median household income	\$44,988
Percent households with income < \$15,000	14.4%
Percent households with income ≥ \$50,000	44.6%
Percent of households with no vehicle	6.5%
Percent rural population	41.0%
Percent minority	32.4%
% speak language other than English at home	9.6%
% with no usual source of health care coverage	20.9%

Age Distribution of North Carolina

Age Group	Number	%
< 18	2,157,416	24.3%
18 - 24	867,970	9.8%
25 - 39	1,886,342	21.3%
40 - 49	1,316,418	14.8%
50 - 64	1,544,451	17.4%
65 +	1,102,807	12.4%



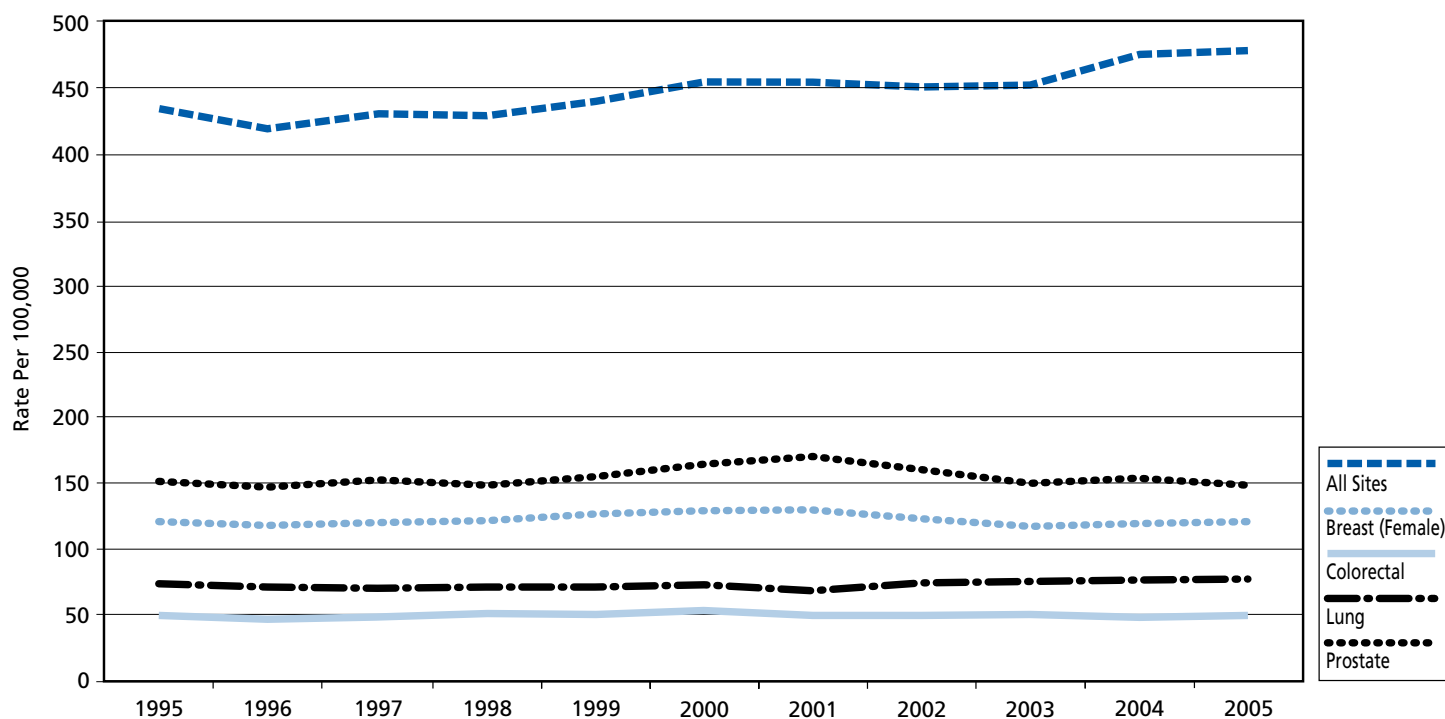
¹ Total is sum of White, Black, Native American, Asian/Pacific Islander, Other/Multi-Race, and Hispanic.

² Hispanic is an ethnicity, not a race.

³ Department of Labor <http://www.bis.gov/LAU/>, April 2008

Data Sources: Copyright © 2008, Thomson Medstat. ALL RIGHTS RESERVED; US Census Bureau, Population Fact Sheet, 2008, American Community Survey @ <http://factfinder.census.gov>

North Carolina Cancer Incidence Rates by Cancer Site (1995-2005)

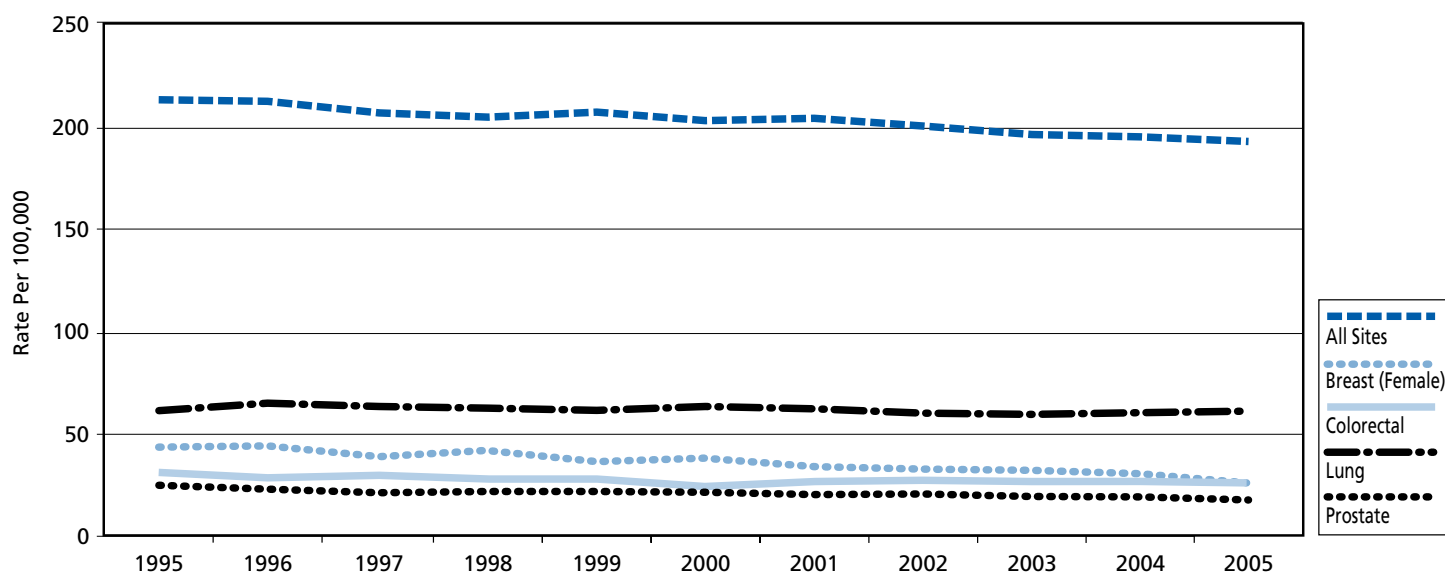


Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.

Note: Data exclude in situ cancers except urinary bladder.

Source: North Carolina Central Cancer Registry

North Carolina Cancer Mortality Rates by Cancer Site (1995-2005)



Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.

Source: North Carolina Central Cancer Registry

North Carolina Cancer Incidence, 2001-2005, by Site, Gender and Race

	All Races ¹		White		Black	
BOTH GENDERS	Cases	Rate	Cases	Rate	Cases	Rate
ALL SITES	194,014	461.6	155,021	458.0	35,246	478.9
COLORECTAL	20,240	48.6	15,847	46.9	4,053	56.3
LUNG & BRONCHUS	30,914	73.8	25,545	74.9	4,957	69.0
MELANOMA	6,998	16.6	6,843	20.5	56	0.8
MALE	All Races ¹		White		Black	
	Cases	Rate	Cases	Rate	Cases	Rate
ALL SITES	101,237	555.4	80,486	538.7	18,861	641.3
COLORECTAL	10,281	57.3	8,215	55.8	1,916	66.1
LUNG & BRONCHUS	18,082	100.9	14,689	99.3	3,164	110.3
MELANOMA	3,975	21.3	3,903	25.7	21	~
PROSTATE	28,757	156.1	21,051	138.2	7,080	248.2
FEMALE	All Races ¹		White		Black	
	Cases	Rate	Cases	Rate	Cases	Rate
ALL SITES	92,766	398.4	74,528	404.2	16,384	376.0
BREAST(FEMALE)	28,057	121.7	22,411	123.2	5,138	116.1
CERVICAL	1,746	7.9	1,205	7.2	453	10.1
COLORECTAL	9,957	41.9	7,631	39.9	2,136	49.9
LUNG & BRONCHUS	12,832	54.4	10,856	57.2	1,793	42.2
MELANOMA	3,022	13.4	2,939	17.0	35	0.8

Note: Data exclude basal and squamous cell skin and in situ cancers except urinary bladder. Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.

¹ Includes White, Black and other races

Source: North Carolina Central Cancer Registry

North Carolina Cancer Mortality, 2001-2005, by Site, Gender and Race

	All Races ¹		White		Black	
BOTH GENDERS	Deaths	Rate	Deaths	Rate	Deaths	Rate
ALL SITES	81,428	197.1	64,091	190.4	16,412	233.3
COLORECTAL	7,553	18.4	5,753	17.2	1,711	24.5
LUNG & BRONCHUS	24,856	59.7	20,408	60.1	4,183	59.2
MELANOMA (SKIN)	1,203	2.9	1,159	3.5	41	0.6
MALE	All Races ¹		White		Black	
	Deaths	Rate	Deaths	Rate	Deaths	Rate
ALL SITES	42,952	252.7	33,777	240.3	8,710	327.8
COLORECTAL	3,759	22.2	2,915	20.9	806	30.1
LUNG & BRONCHUS	15,010	85.4	12,107	83.3	2,741	98.7
MELANOMA (SKIN)	740	4.1	719	4.9	^	~
PROSTATE	4,341	30.0	2,854	23.8	1,444	67.3
FEMALE	All Races ¹		White		Black	
	Deaths	Rate	Deaths	Rate	Deaths	Rate
ALL SITES	38,475	161.1	30,313	157.3	7,702	179.9
BREAST (FEMALE)	6,026	25.6	4,458	23.6	1,490	34.0
CERVICAL	591	2.6	394	2.2	186	4.1
COLORECTAL	3,793	15.6	2,837	14.4	905	21.3
LUNG & BRONCHUS	9,846	41.5	8,301	43.4	1,442	34.1
MELANOMA (SKIN)	463	2.0	440	2.4	^	~

Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.

¹ Includes White, Black and other races

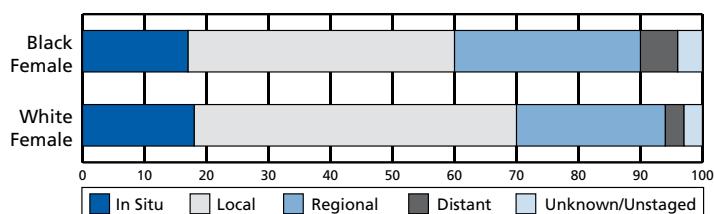
~ Number of deaths too small (25 or less) to calculate reliable rate.

Source: North Carolina Central Cancer Registry

North Carolina Cancer Stage at Diagnosis, Percent of Total Cases, 2001-2005, by Site and Race

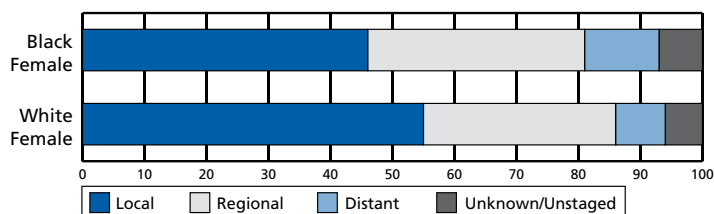
North Carolina Female Breast Cancer Stage of Disease at Diagnosis by Race, 2001-2005

	In Situ	Local	Regional	Distant	Unknown
Female, All Races¹	18.0	50.0	25.0	4.0	3.0
White Female	18.0	52.0	24.0	3.0	3.0
Black Female	17.0	43.0	30.0	6.0	4.0



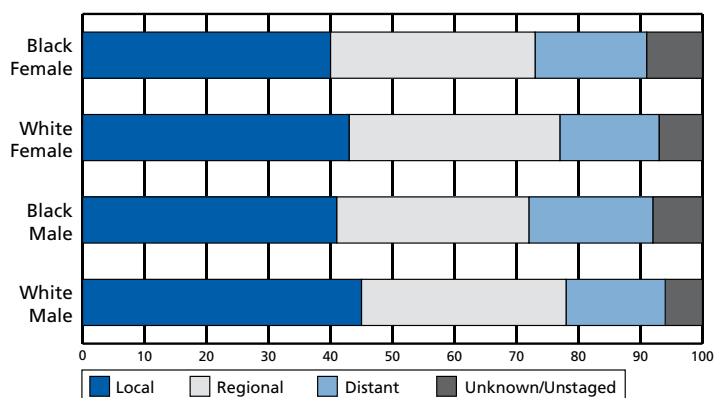
North Carolina Cervical Cancer² Stage of Disease at Diagnosis by Race, 2001-2005

	Local	Regional	Distant	Unknown
Female, All Races¹	52.0	33.0	9.0	6.0
White Female	55.0	31.0	8.0	6.0
Black Female	46.0	35.0	12.0	7.0



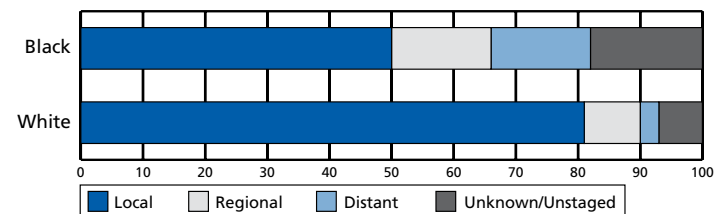
North Carolina Colorectal Cancer³ Stage of Disease at Diagnosis by Sex and Race, 2001-2005

	Local	Regional	Distant	Unknown
Male, All Races¹	44.0	33.0	17.0	6.0
White Male	45.0	33.0	16.0	6.0
Black Male	41.0	31.0	20.0	8.0
Female, All Races¹	43.0	34.0	16.0	7.0
White Female	43.0	34.0	16.0	7.0
Black Female	40.0	33.0	18.0	9.0



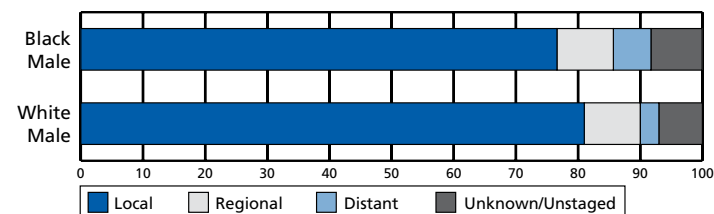
North Carolina Malignant Melanoma² Stage of Disease at Diagnosis by Race, 2001-2005

	Local	Regional	Distant	Unknown
All Races¹	81.0	9.0	3.0	7.0
White	81.0	9.0	3.0	7.0
Black	50.0	16.0	16.0	18.0



North Carolina Cancer of the Prostate² Stage of Disease at Diagnosis by Race, 2001-2005

	Local	Regional	Distant	Unknown
Male, All Races¹	79.0	9.0	4.0	8.0
White Male	81.0	9.0	3.0	7.0
Black Male	76.0	9.0	6.0	8.0



Notes: Stages not reported for lung and bronchus cancer due to unavailability of cost-effective early detection test.

¹Includes White, Black and other races

²Stages reported for invasive cervical, melanoma and prostate cancers only.

³In situ and local stages combined for colorectal cancer

Source: North Carolina Central Cancer Registry

North Carolina At a Glance

Tobacco

Tobacco Statistics	
Tobacco Use in North Carolina (2007)	
High school students who smoke	22.5%
Male high school students who use smokeless or spit tobacco	14.5%
	<i>(female use much lower)</i>
Kids (under 18) who become new daily smokers each year	13,800
Kids exposed to secondhand smoke at home	416,000
Packs of cigarettes bought or smoked by kids each year	18.6 million
Adults in North Carolina who smoke	22.9% (1,534,500)
Deaths in North Carolina From Smoking	
Adults who die each year from their own smoking	11,900
Kids now under 18 and alive in North Carolina who will ultimately die prematurely from smoking	193,000
Adult nonsmokers who die each year from exposure to secondhand smoke	810 to 2,270
Smoking-Caused Monetary Costs in North Carolina	
Annual health care costs in North Carolina directly caused by smoking	\$2.46 billion
- Portion covered by the state Medicaid program	\$769 million
Residents' state & federal tax burden from smoking-caused government expenditures	\$589 / household
Smoking-caused productivity losses in North Carolina	\$3.30 billion
Tobacco Industry Influence in North Carolina	
Estimated portion spent for North Carolina marketing each year	\$569.3 million
Estimated Tobacco Revenue in North Carolina – FY2008	
Tobacco Settlement Revenues	\$158.6 million
Tobacco Tax Revenues	\$267.3 million
Total Annual State Revenues from Tobacco	\$425.9 million
% of Tobacco Revenue Spent on Tobacco Prevention	4.0%
Spending on Tobacco Prevention - FY2008	
CDC Recommended Minimum Spending on Tobacco Prevention	\$42.6 million
% of CDC Recommended Minimum	40.2%
Rank Among States (1-51)	28

North Carolina State Screening Programs

Breast cancer screening: *BCCEDP**—*Breast and Cervical Cancer Control Program (NC BCCCP)*, target population: women 50-64, uninsured or underinsured, under 200% of Federal Poverty Level.
www.communityhealth.dhhs.state.nc.us/cancer.htm

BCCCP has CDC funding for the *WISEWOMAN* program enhancement that provides integrated cardiovascular screening and education on nutrition, physical activity, and tobacco use for *BCCCP* clients.

Colorectal cancer screening: There is mandatory coverage for colorectal screening. Colorectal cancer screening is promoted but there is no formal state screening activity.

Prostate cancer screening: There is no state screening program but prostate health and informed decision making are promoted per CDC guidelines and based on USPSTF recommendations.

*The *Breast and Cervical Cancer Early Detection Program (BCCEDP)* is a CDC-funded program in every state administered through the *National Breast and Cervical Cancer Early Detection Program (NBCCEDP)*.

Nutrition and Physical Activity

State coalition: *Eat Smart, Move More...* North Carolina Leadership Team

www.ncpanbranch.com

www.eatsmartmovemorenc.com/index.html

Obesity initiatives: In addition to *Eat Smart, Move More*; the North Carolina Health and Wellness Trust Fund provides support for several adolescent-specific projects.

www.healthwellnc.com/hwtfc/htmfiles/fundprty_obesity.htm

Access to Care

Number of Federally Qualified Health Centers and free clinics: 28 main clinics; 111 satellite clinics

State fund for Uninsured Cancer Patients: The NC Cancer Assistance Unit provides limited funding for diagnosis and treatment for eligible patients.

www.communityhealth.dhhs.state.nc.us/cancer/ccp.htm

Number of ACoS approved hospitals: 43

Number of NCI Cancer Centers: 3 Comprehensive Cancer Centers

Uninsured Population (18+): 22.1% (was 22.5% in 2005)



North Carolina Advisory Committee on Cancer Coordination and Control

www.nccancer.com

Status of Cancer Control Plan: The North Carolina Advisory Committee on Cancer Coordination and Control (NCAC), established in 1993, includes representatives from public and private organizations and institutions, cancer survivors, and legislators who are committed to reducing the burden of cancer in North Carolina.

The third 5-year plan is underway and in December, 2007, the ACCCC implemented the “*Living Plan for the People of North Carolina*” that is web-based so that it can be continuously updated and tracked.

Accomplishments

- The North Carolina (NC) Oncology Navigation Association (NCONA) held its inaugural meeting in April, 2008. Patient Navigators from across the state met to discuss how to better address quality of care through patient navigation. Goals of the NCONA are to embrace the vision and mission of the NC State Cancer plan; increase awareness of the Oncology Navigator role; ensure that all newly-diagnosed patients and their caregivers will be provided with patient navigation resources; and promote collegiality for best practice.
- The second North Carolina Cancer Survivorship Summit was held in June, 2008.
- An evaluation of the North Carolina Cancer Plan is underway using data collected by staff at the NC Comprehensive Cancer Program and the NCAC in order to measure processes employed in the implementation of the Plan. Measurement data on impact and outcome are obtained through the NC Central Cancer Registry, the NC Behavioral Risk Factor Surveillance System, North Carolina Cancer Survey as well as the National Cancer Institute and the Commission on Cancer of the American College of Surgeons.

Adult Risk Behavior

Early Detection

Recent Mammogram*, Women 40 and Older, North Carolina and U.S., 2006

	% North Carolina	% U.S.
40 years and older	63.9	61.2
40-64 years old	63.5	59.7
65 years and older	64.9	64.6
White only, non-Hispanic	64.1	61.6
Black only, non-Hispanic	66.1	62.7
Other race only, non-Hispanic	62.4	59.3
Hispanic	52.6	58.7
Low Education**	48.8	51.6
Uninsured	35.9	34.9

* Mammogram within the past year

** Women 40 years old and older with less than a high school education

*** Women 40-64 who reported that they did not have coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare.

Source: Behavioral Risk Factor Surveillance System, 2006

Recent Pap Test*, Women 18 and Older, North Carolina and U.S., 2006

	% North Carolina	% U.S.
18 years and older	86.5	83.7
18-44 years	87.5	85.1
45-64 years old	89.6	86.6
65 years and older	74.6	70.8

* A pap test within the preceding 3 years for women with intact uteri.

Source: Behavioral Risk Factor Surveillance System, 2006

Recent Sigmoidoscopy/Colonoscopy*, Adults 50 and Older, North Carolina and U.S., 2006

	% North Carolina	% U.S.
50 years and older	53.3	50.0
50-64 years old	49.1	44.9
65 years and older	59.4	57.1
Male, 50 years or older	53.0	50.5
Male, 50-64 years old	47.5	45.1
Male, 65 years and older	62.4	59.5
Female, 50 years and older	53.6	49.5
Female, 50-64 years old	50.6	44.8
Female, 65 years and older	57.3	55.4
White only, non-Hispanic	54.2	51.5
Black only, non-Hispanic	52.3	49.3
Other races only, non-Hispanic	47.5	43.9
Hispanic	41.1	38.2
Low Education**	42.1	38.8
Uninsured***	26.0	20.9

* Sigmoidoscopy/Colonoscopy within the past 5 years

** Adults 50 years old and older with less than a high school education

*** Adults 50-64 who reported that they did not have coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare.

Source: Behavioral Risk Factor Surveillance System, 2006

Recent Prostate-Specific Antigen Test*, Men 50 and Older North Carolina and U.S., 2006

	% North Carolina	% U.S.
50 years and older	56.1	53.8
50-64 years old	50.5	48.5
65 years and older	66.8	63.4
White only, non-Hispanic	57.7	55.6
Black only, non-Hispanic (45+)	50.4	48.1
Other races only, non-Hispanic	51.1	44.9
Hispanic	32.1	43.0
Low Education**	46.4	40.3

* Prostate-specific antigen test within the past year for men who reported they were not told by a doctor, nurse, or other health professional that they had prostate cancer

** Adults 50 years old and older with less than a high school education

Source: Behavioral Risk Factor Surveillance System, 2006

Prevention

Current Cigarette Smoking*, Adults 18 and Older, North Carolina and U.S., 2007

	% North Carolina	% U.S.
Total	22.9	19.7
18-24 years old	31.3	24.0
25-34 years old	25.6	23.9
35-44 years old	24.4	20.4
45-54 years old	26.7	22.3
55-64 years old	19.7	18.0
65 years and older	9.9	9.0
Male	25.2	21.2
Female	20.7	18.4
White only, non-Hispanic	23.1	19.4
Black only, non-Hispanic	23.0	21.7
Other race only, non-Hispanic	23.5	18.3
Hispanic	19.2	16.7
Low Education**	32.0	33.2
Female 18-44 (2006)	22.6	20.6

* Ever smoked 100 cigarettes in lifetime and are current smokers (regular and irregular).

** Adults 25 years old and older with less than a high school education

Source: Behavioral Risk Factor Surveillance System, 2007

Physical Activity, Adults 18 and Older, North Carolina and U.S., 2007

No Leisure Time Physical Activity*	% North Carolina	% U.S.
Total	56.0	50.5
Male	53.4	48.5
Female	58.4	52.5
White only, non-Hispanic	53.1	48.4
Black only, non-Hispanic	62.3	58.6
Other race only, non-Hispanic	52.9	51.0
Hispanic	69.0	55.3
Low Education**	67.7	59.8

* Adults with 30+ minutes of moderate physical activity five or more days per week, or vigorous physical activity for 20+ minutes three or more days per week.

** Adults 25 years old and older with less than a high school education

Source: Behavioral Risk Factor Surveillance System, 2007

Nutrition, Adults 18 and Older, North Carolina and U.S., 2007

Eating 5 or More Fruits and Vegetables per Day	% North Carolina	% U.S.
Total	21.6	24.4
Male	18.2	19.4
Female	24.8	28.8
White only, non-Hispanic	23.1	24.5
Black only, non-Hispanic	18.5	23.1
Other race only, non-Hispanic	25.2	26.6
Hispanic	14.7	22.6
Low Education*	12.9	18.4

* Adults 25 years old and older with less than a high school education
Source: Behavioral Risk Factor Surveillance System, 2007

Overweight*, Adults 18 and Older, North Carolina and U.S., 2007

	% North Carolina	% U.S.
Total	64.6	63.0
Male	70.5	70.8
Female	58.8	55.4
White only, non-Hispanic	62.5	62.6
Black only, non-Hispanic	74.7	72.6
Other race only, non-Hispanic	57.3	51.2
Hispanic	62.4	66.9
Low Education**	66.9	65.7

*Overweight is defined as having body mass index of 25 kg/m² or greater
**Adults 25 years old and older with less than a high school education
Source: Behavioral Risk Factor Surveillance System, 2007

Youth Risk Behavior

Tobacco Use, High School Students, North Carolina and U.S., 2007

Current Cigarette Smoking*	% North Carolina	% U.S.
Total	22.5	20.0
Male	22.5	21.3
Female	22.2	18.7

Current Smokeless Tobacco Use - not available

* Smoked cigarettes on 1 or more of the 30 days preceding the survey
Source: Youth Risk Behavior Surveillance System, 2007

Physical Activity, High School Students, North Carolina and U.S., 2007

Met Current Physical Activity Level*	% North Carolina	% U.S.
Total	44.3	34.7
Male	54.0	43.7
Female	34.8	25.6

* Were physically active during any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes/day on 5 or more days during the 7 days before the survey
Source: Youth Risk Behavior Surveillance System, 2007

Nutrition, High School Students, North Carolina and U.S., 2007

Eating 5 or More Fruits and Vegetables per Day - data not available	% North Carolina	% U.S.
Total	14.8	21.4
Male	15.1	22.9
Female	14.3	19.9

Source: Youth Risk Behavior Surveillance System, 2007

Overweight/Obese High School Students, North Carolina and U.S., 2007

Obese*	% North Carolina	% U.S.
Total	12.8	13.0
Male	15.9	16.3
Female	9.5	9.6
Overweight**		
Total	17.1	15.8
Male	17.0	16.4
Female	17.2	15.1

* Obese - At or above the 95th percentile for body mass index, by age and sex, based on reference data from the National Health and Nutrition Examination Survey

** - Overweight - At or above the 85th percentile but below the 95th percentile for body mass index, by age and sex, based on reference data from the National Health and Nutrition Examination Survey.
Source: Youth Risk Behavior Surveillance System, 2007

South Carolina

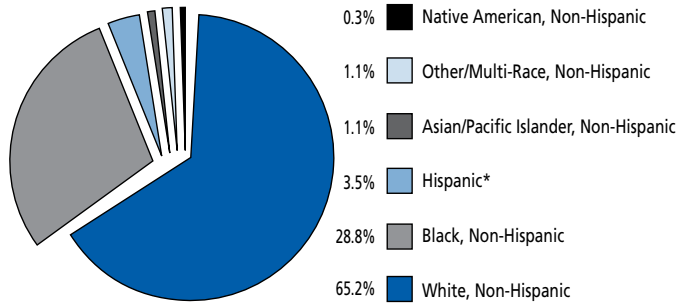
DEMOGRAPHICS

State Level Data, 2007 Estimates

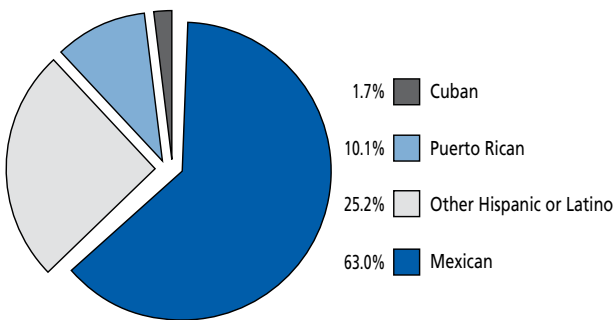
2000 Census Population	4,012,012
2007 Estimate ¹	4,332,306
White, Non-Hispanic	2,823,716
Black, Non-Hispanic	1,248,872
Native American, Non-Hispanic	13,857
Asian/Pacific Islander, Non-Hispanic	48,229
Hispanic ²	151,248
Other/Multi-Race, Non-Hispanic	46,384



Distribution of South Carolina's Population by Race & Ethnicity



South Carolina's Hispanic/Latino Population by Sub-Ethnicity

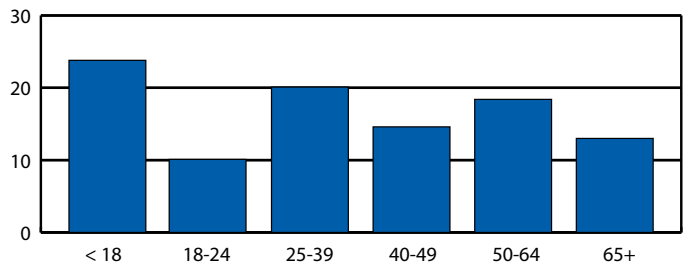


Factors Related to Access to Care

Percent unemployed ³	5.9%
Percentage with less than high school education	15.0%
Median household income	\$43,023
Percent households with income < \$15,000	15.9%
Percent households with income ≥ \$50,000	42.5%
Percent of households with no vehicle	5.9%
Percent rural population	40.8%
Percent minority	34.8%
% speak language other than English at home	6.0%
% with no usual source of health care coverage	19.6%

Age Distribution of South Carolina

Age Group	Number	%
< 18	1,029,257	23.8%
18 - 24	437,783	10.1%
25 - 39	872,906	20.1%
40 - 49	633,506	14.6%
50 - 64	797,000	18.4%
65 +	561,854	13.0%



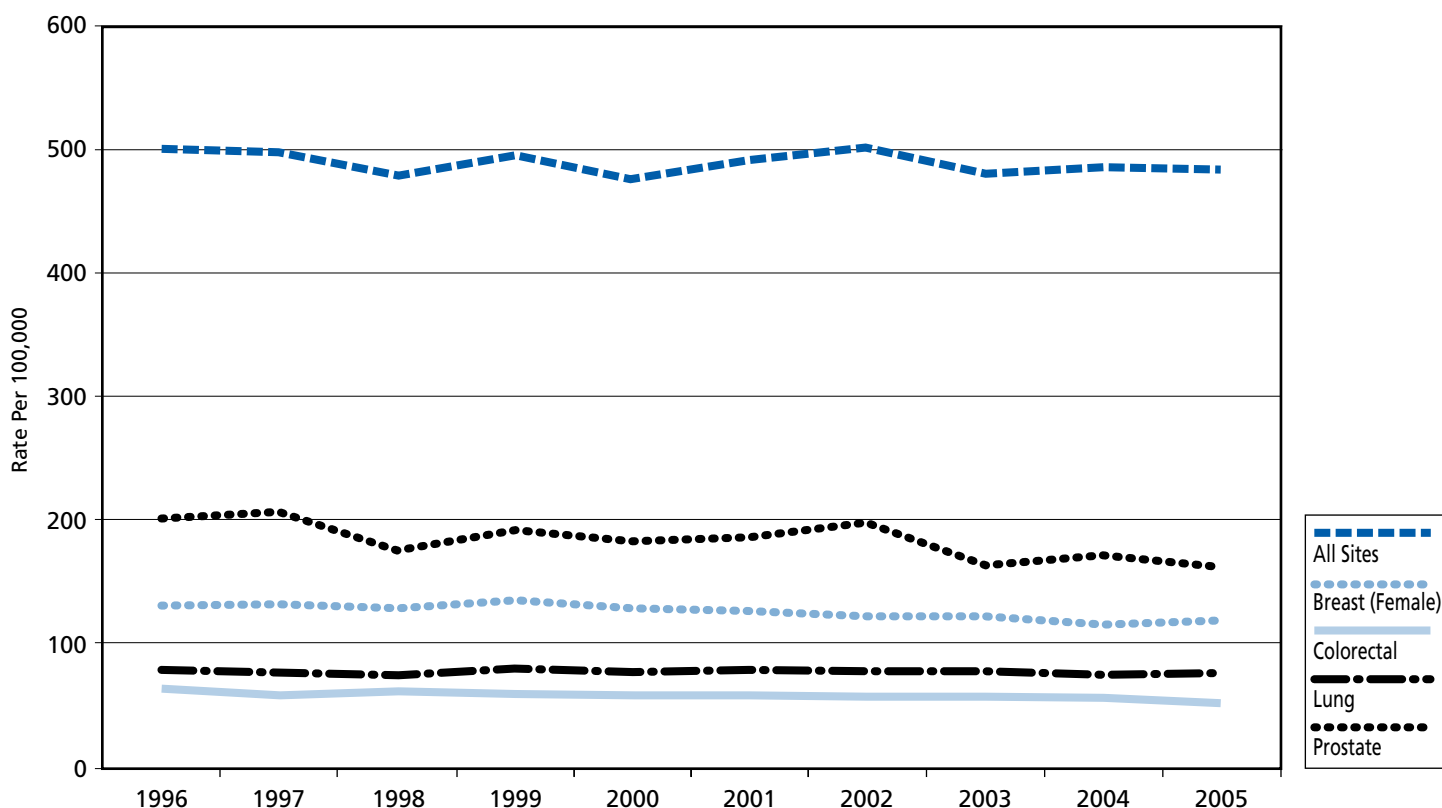
¹ Total is sum of White, Black, Native American, Asian/Pacific Islander, Other/Multi-Race, and Hispanic.

² Hispanic is an ethnicity, not a race.

³ Department of Labor <http://www.bis.gov/LAU/>, April 2008

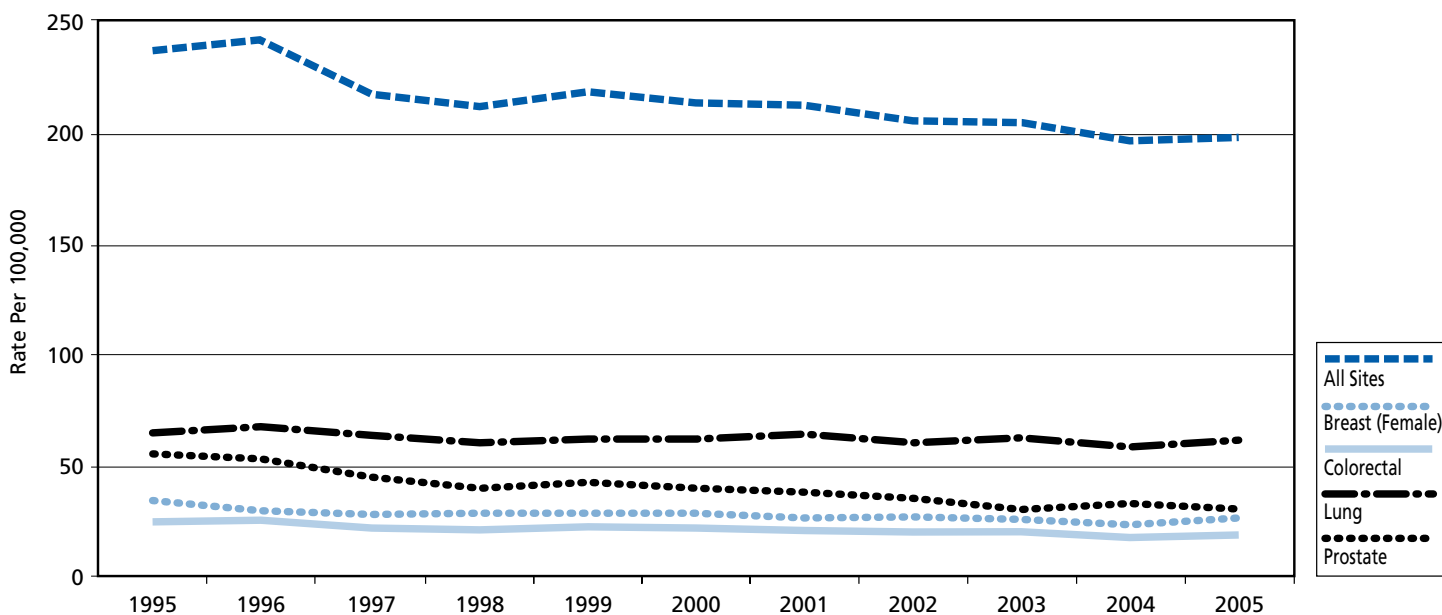
Data Sources: Copyright © 2008, Thomson Medstat. ALL RIGHTS RESERVED; US Census Bureau, Population Fact Sheet, 2008, American Community Survey @ <http://factfinder.census.gov>

South Carolina Cancer Incidence Rates by Cancer Site (1996-2005)



Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.
Source: South Carolina Central Cancer Registry

South Carolina Cancer Mortality Rates by Cancer Site (1995-2005)



Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.
Source: South Carolina Central Cancer Registry

South Carolina Cancer Incidence, 2001-2005, by Site, Gender and Race

	All Races ¹		White		Black	
BOTH GENDERS	Cases	Rate	Cases	Rate	Cases	Rate
ALL SITES	102,813	483.9	76,730	478.6	24,621	492.7
COLORECTAL	11,243	53.4	8,097	50.5	3,021	61.7
LUNG & BRONCHUS	15,946	74.9	12,548	77.0	3,274	66.8
MELANOMA	4,201	19.9	4,052	26.0	48	1.0
MALE	Cases	Rate	Cases	Rate	Cases	Rate
ALL SITES	55,393	599.3	41,004	574.2	13,568	676.7
COLORECTAL	5,842	64.2	4,288	61.0	1,482	75.4
LUNG & BRONCHUS	9,642	104.9	7,422	103.6	2,150	108.4
MELANOMA	2,405	25.7	2,327	32.4	16	~
PROSTATE	16,348	174.1	10,856	147.6	5,158	263.9
FEMALE	Cases	Rate	Cases	Rate	Cases	Rate
ALL SITES	47,420	403.7	35,726	412.4	11,053	373.6
BREAST(FEMALE)	14,065	120.3	10,598	123.1	3,294	109.4
CERVICAL	973	8.8	582	7.6	363	11.9
COLORECTAL	5,401	45.3	3,809	42.6	1,539	52.7
LUNG & BRONCHUS	6,304	52.8	5,126	57.1	1,124	39.0
MELANOMA	1,796	15.8	1,725	21.5	32	1.1

Note: Data exclude basal and squamous cell skin and in situ cancers except urinary bladder. Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.

~ Number of cases too small (25 or less) to calculate reliable rate

¹ Includes White, Black and other races

Source: South Carolina Central Cancer Registry

South Carolina Cancer Mortality, 2001-2005, by Site, Gender and Race

	All Races ¹		White		Black	
BOTH GENDERS	Deaths	Rate	Deaths	Rate	Deaths	Rate
ALL SITES	41,991	201.4	30,467	191.4	11,309	235.8
COLORECTAL	3,979	19.3	2,746	17.4	1,224	25.8
LUNG & BRONCHUS	12,836	60.8	10,067	62.2	2,710	56.0
MELANOMA (SKIN)	527	2.5	503	3.2	23	~
MALE	Deaths	Rate	Deaths	Rate	Deaths	Rate
ALL SITES	22,863	265.3	16,566	247.0	6,207	337.7
COLORECTAL	2,053	23.8	1,431	21.5	619	33.3
LUNG & BRONCHUS	8,010	89.3	6,141	87.8	1,841	95.3
MELANOMA (SKIN)	331	3.7	326	4.8	^	~
PROSTATE	2,366	32.9	1,353	24.2	1,007	68.2
FEMALE	Deaths	Rate	Deaths	Rate	Deaths	Rate
ALL SITES	19,128	159.4	13,901	153.9	5,102	175.4
BREAST (FEMALE)	3,016	25.4	2,052	23.1	950	32.0
CERVICAL	325	2.8	173	2.1	145	4.9
COLORECTAL	1,926	15.9	1,315	14.4	605	20.8
LUNG & BRONCHUS	4,826	40.3	3,926	43.4	869	30.2
MELANOMA (SKIN)	196	1.7	177	2.0	19	~

Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.

¹ Includes White, Black and other races

^ Number of deaths less than 5 not reported due to confidentiality issues

Cells with 5-10 observations are rounded to 10

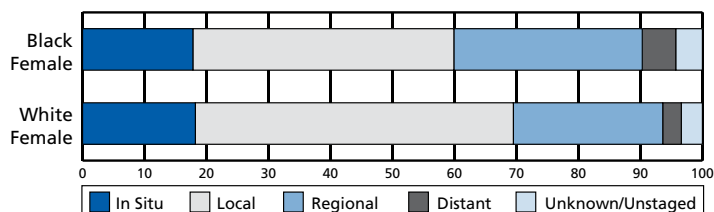
~ Number of deaths too small (25 or less) to calculate reliable rate.

Source: South Carolina Central Cancer Registry

South Carolina Cancer Stage at Diagnosis, Percent of Total Cases, 2001-2005, by Site and Race

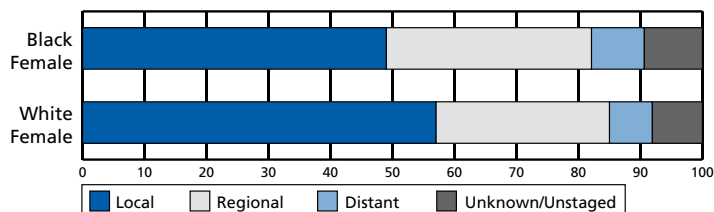
South Carolina Female Breast Cancer Stage of Disease at Diagnosis by Race, 2001-2005

	In Situ	Local	Regional	Distant	Unknown
Female, All Races¹	18.1	49.1	25.6	3.6	3.7
White Female	18.2	51.3	24.1	3.0	3.4
Black Female	17.8	42.1	30.4	5.4	4.3



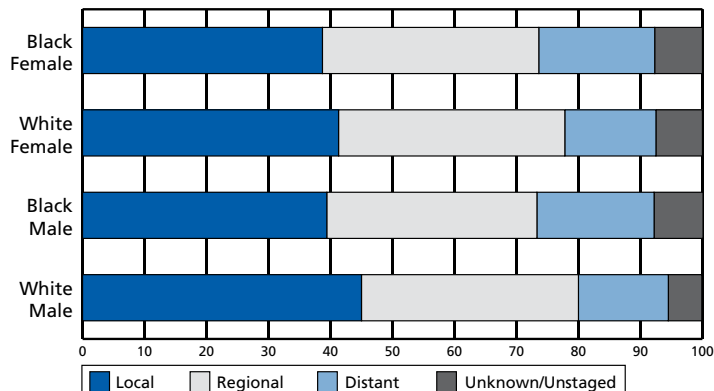
South Carolina Cervical Cancer² Stage of Disease at Diagnosis by Race, 2001-2005

	Local	Regional	Distant	Unknown
Female, All Races¹	54.3	29.7	7.3	8.7
White Female	57.0	28.0	6.9	8.1
Black Female	49.0	33.1	8.5	9.4



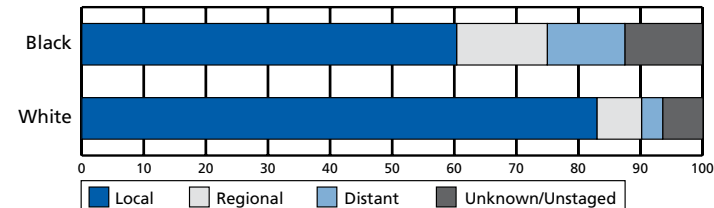
South Carolina Colorectal Cancer³ Stage of Disease at Diagnosis by Sex and Race, 2001-2005

	Local	Regional	Distant	Unknown
Male, All Races¹	43.7	34.7	15.5	6.1
White Male	45.0	35.0	14.5	5.4
Black Male	39.4	33.9	18.9	7.9
Female, All Races¹	40.7	36.0	15.8	7.6
White Female	41.3	36.5	24.7	7.5
Black Female	38.7	34.9	18.7	7.7



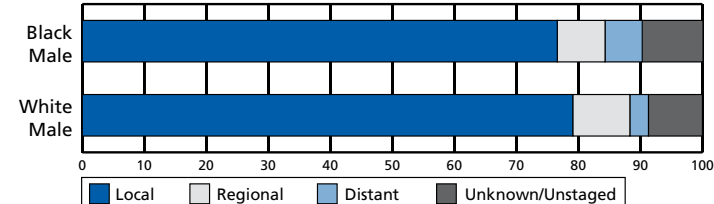
South Carolina Malignant Melanoma² Stage of Disease at Diagnosis by Race, 2001-2005

	Local	Regional	Distant	Unknown
All Races¹	82.4	7.1	3.4	7.1
White	83.0	7.2	3.4	6.5
Black	60.4	14.6	12.5	12.5



South Cancer of the Prostate² Stage of Disease at Diagnosis by Race, 2001-2005

	Local	Regional	Distant	Unknown
Male, All Races¹	78.0	8.6	3.9	9.4
White Male	79.1	9.2	3.0	8.7
Black Male	76.6	7.7	6.0	9.8



Notes: Stages not reported for lung and bronchus cancer due to unavailability of cost-effective early detection test.

¹Includes White, Black and other races

²Stages reported for invasive cervical, melanoma and prostate cancers only.

³In situ and local stages combined for colorectal cancer

Source: South Carolina Central Cancer Registry

South Carolina At a Glance

Tobacco

Tobacco Statistics

Tobacco Use in South Carolina (2007)

High school students who smoke	17.8%
Male high school students who use smokeless or spit tobacco	13.4%
	<i>(female use much lower)</i>
Kids (under 18) who become new daily smokers each year	7,300
Kids exposed to secondhand smoke at home	240,000
Packs of cigarettes bought or smoked by kids each year	9.7 million
Adults in South Carolina who smoke	21.9% (718,600)

Deaths in South Carolina From Smoking

Adults who die each year from their own smoking	5,900
Kids now under 18 and alive in South Carolina who will ultimately die prematurely from smoking	103,000
Adult nonsmokers who die each year from exposure to secondhand smoke	400 to 1,120

Smoking-Caused Monetary Costs in South Carolina

Annual health care costs in South Carolina directly caused by smoking	\$1.09 billion
- Portion covered by the state Medicaid program	\$393 million
Residents' state & federal tax burden from smoking-caused government expenditures	\$578 / household
Smoking-caused productivity losses in South Carolina	\$1.83 billion

Tobacco Industry Influence in South Carolina

Estimated portion spent for South Carolina marketing each year	\$280.3 million
--	-----------------

Estimated Tobacco Revenue in South Carolina – FY2008

Tobacco Settlement Revenues	\$82.9 million
Tobacco Tax Revenues	\$32.4 million
Total Annual State Revenues from Tobacco	\$115.3 million
% of Tobacco Revenue Spent on Tobacco Prevention	1.7%

Spending on Tobacco Prevention - FY2008

CDC Recommended Minimum Spending on Tobacco Prevention	\$23.9 million
% of CDC Recommended Minimum	8.4%
Rank Among States (1-51)	45

Access to Care

Number of Federally Qualified Health Centers and free clinics: 19 main clinics; 95 satellite clinics

State fund for Uninsured Cancer Patients: None

Number of ACoS Approved Hospitals: 19

Number of NCI Cancer Centers: 0

Uninsured Population (18+): 19.3% (was 22.3% in 2005)



South Carolina State Screening Programs

Breast cancer screening: *BCCEDP* *—*The Best Chance Network (BCN)* Target Population: Women 47-64 (will be lowered to 40-64 in September, 2008), uninsured or underinsured, under 200% of Federal Poverty Level. www.scdhec.net/health/chcdp/cancer/bcn.htm

Unique aspect of *BCN* is that they contract with the American Cancer Society to provide recruitment and service delivery coordination services. *Best Chance Network* screened 8,858 women during the 2006-2007 fiscal year. Of that number, 1,222 were identified as having breast follow-ups with 74% having normal clinical breast exams but abnormal mammograms. This year, the first-ever state allocation of \$2 million will provide an additional 9,000 women with access to life-saving cancer screening.

In addition, the CDC has awarded SC a five-year grant of \$650,000 annually to implement the *Wisewoman* program. *Wisewoman* adds cardiovascular and diabetes screening for *BCN* clients, plus client education on risk factors

Colorectal cancer screening: The state has awarded one million dollars for a statewide colorectal cancer screening program. The South Carolina Cancer Alliance Colorectal Cancer Work Group Screening Subcommittee is in the process of developing the plan for the statewide colorectal cancer screening program entitled *SCOPE SC*.

Prostate cancer screening: There are no state prostate screening programs.

*The Breast and Cervical Cancer Early Detection Program (BCCEDP) is a CDC-funded program in every state administered through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

Nutrition and Physical Activity

State coalition: Healthy Schools and Healthy South Carolina

Obesity initiatives: Governor's Healthy Challenge, Weight Loss Matters for Kids; Wizdom Kit, South Carolina Coalition for Obesity Prevention Efforts (SCCOPE) www.scdhec.gov/health/chcdp/obesity/coalition.htm

South Carolina Cancer Alliance

www.sccanceralliance.org

Status of Cancer Control Plan: The *Comprehensive Cancer Plan* is in its third year of implementation. The South Carolina Cancer Alliance has five task forces (Advocacy/Policy, Early Detection, Patient Care, Prevention, and Research) to coordinate and promote partnerships and collaborations to address cancer prevention and control strategies that will reduce the impact of cancer on all South Carolinians.

The goals of the *South Carolina Plan* are to:

- Reduce the number of new cases of cancer.
- Reduce deaths attributable to cancer.
- Improve the quality of life of those living with cancer and their families/caregivers.
- Eliminate and/or reduce health disparities attributable to cancer.
- Improve access to and provision of quality cancer care.

Accomplishments

Moving To Action: *Addressing Cervical Cancer in SC* was held in June, 2008.

Adult Risk Behavior

Early Detection

Recent Mammogram*, Women 40 and Older, South Carolina and U.S., 2006

	% South Carolina	% U.S.
40 years and older	57.4	61.2
40-64 years old	55.7	59.7
65 years and older	61.2	64.6
White only, non-Hispanic	56.4	61.6
Black only, non-Hispanic	61.0	62.7
Other race only, non-Hispanic	56.0	59.3
Hispanic	56.3	58.7
Low Education**	48.7	51.6
Uninsured***	34.0	34.9

* Mammogram within the past year

** Women 40 years old and older with less than a high school education

*** Women 40-64 who reported that they did not have coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare.

Source: Behavioral Risk Factor Surveillance System, 2006

Recent Pap Test*, Women 18 and Older, South Carolina and U.S., 2006

	% South Carolina	% U.S.
18 years and older	86.3	83.7
18-44 years	88.3	85.1
45-64 years old	86.0	86.6
65 years and older	77.6	70.8

* A pap test within the preceding 3 years for women with intact uteri.

Source: Behavioral Risk Factor Surveillance System, 2006

Recent Sigmoidoscopy/Colonoscopy*, Adults 50 and Older, South Carolina and U.S., 2006

	% South Carolina	% U.S.
50 years and older	49.4	50.0
50-64 years old	44.5	44.9
65 years and older	56.2	57.1
Male, 50 years or older	47.7	50.5
Male, 50-64 years old	43.0	45.1
Male, 65 years and older	55.1	59.5
Female, 50 years and older	50.7	49.5
Female, 50-64 years old	45.8	44.8
Female, 65 years and older	57.0	55.4
White only, non-Hispanic	51.4	51.5
Black only, non-Hispanic	43.0	49.3
Other races only, non-Hispanic	43.2	43.9
Hispanic	51.8	38.2
Low Education**	41.0	38.8
Uninsured***	27.1	20.9

* Sigmoidoscopy/Colonoscopy within the past 5 years

** Adults 50 years old and older with less than a high school education

*** Adults 50-64 who reported that they did not have coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare.

Source: Behavioral Risk Factor Surveillance System, 2006

Recent Prostate-Specific Antigen Test*, Men 50 and Older South Carolina and U.S., 2006

	% South Carolina	% U.S.
50 years and older	54.4	53.8
50-64 years old	49.0	48.5
65 years and older	64.0	63.4
White only, non-Hispanic	57.3	55.6
Black only, non-Hispanic (45+)	41.2	48.1
Other races only, non-Hispanic	n/a	44.9
Hispanic	n/a	43.0
Low Education**	41.6	40.3

* Prostate-specific antigen test within the past year for men who reported they were not told by a doctor, nurse, or other health professional that they had prostate cancer

** Adults 50 years old and older with less than a high school education

Source: Behavioral Risk Factor Surveillance System, 2006

Prevention

Current Cigarette Smoking*, Adults 18 and Older, South Carolina and U.S., 2007

	% South Carolina	% U.S.
Total	21.9	19.7
18-24 years old	24.0	24.0
25-34 years old	28.4	23.9
35-44 years old	23.7	20.4
45-54 years old	25.0	22.3
55-64 years old	19.9	18.0
65 years and older	9.3	9.0
Male	25.3	21.2
Female	18.7	18.4
White only, non-Hispanic	22.0	19.4
Black only, non-Hispanic	20.7	21.7
Other race only, non-Hispanic	19.5	18.3
Hispanic	24.8	16.7
Low Education**	33.8	33.2
Female 18-44 (2006)	22.3	20.6

* Ever smoked 100 cigarettes in lifetime and are current smokers (regular and irregular).

** Adults 25 years old and older with less than a high school education

Source: Behavioral Risk Factor Surveillance System, 2007

Physical Activity, Adults 18 and Older, South Carolina and U.S., 2007

No Leisure Time Physical Activity*	% South Carolina	% U.S.
Total	53.5	50.5
Male	48.5	48.5
Female	58.0	52.5
White only, non-Hispanic	51.7	48.4
Black only, non-Hispanic	60.0	58.6
Other race only, non-Hispanic	n/a	51.0
Hispanic	n/a	55.3
Low Education**	62.6	59.8

* Adults with 30+ minutes of moderate physical activity five or more days per week, or vigorous physical activity for 20+ minutes three or more days per week.

** Adults 25 years old and older with less than a high school education

Source: Behavioral Risk Factor Surveillance System, 2007

Nutrition, Adults 18 and Older, South Carolina and U.S., 2007

Eating 5 or More Fruits and Vegetables per Day	% South Carolina	% U.S.
Total	18.7	24.4
Male	16.2	19.4
Female	21.1	28.8
White only, non-Hispanic	19.1	24.5
Black only, non-Hispanic	18.0	23.1
Other race only, non-Hispanic	19.1	26.6
Hispanic	18.5	22.6
Low Education*	14.8	18.4

* Adults 25 years old and older with less than a high school education
Source: Behavioral Risk Factor Surveillance System, 2007

Overweight*, Adults 18 and Older, South Carolina and U.S., 2007

	% South Carolina	% U.S.
Total	65.3	63.0
Male	71.5	70.8
Female	59.4	55.4
White only, non-Hispanic	63.0	62.6
Black only, non-Hispanic	73.6	72.6
Other race only, non-Hispanic	n/a	51.2
Hispanic	n/a	66.9
Low Education**	64.4	65.7

*Overweight is defined as having body mass index of 25 kg/m² or greater

**Adults 25 years old and older with less than a high school education
Source: Behavioral Risk Factor Surveillance System, 2007

Youth Risk Behavior

Tobacco Use, High School Students, South Carolina and U.S., 2007

Current Cigarette Smoking*	% South Carolina	% U.S.
Total	17.8	20.0
Male	18.1	21.3
Female	17.4	18.7
Current Smokeless Tobacco Use**		
Total	7.9	7.9
Male	13.4	13.4
Female	2.2	2.3

* Smoked cigarettes on 1 or more of the 30 days preceding the survey

** Used chewing tobacco, snuff or dip on 1 or more of the 30 days preceding the survey

Source: Youth Risk Behavior Surveillance System, 2007

Nutrition, High School Students, South Carolina and U.S., 2007

Eating 5 or More Fruits and Vegetables per Day	% South Carolina	% U.S.
Total	17.1	21.4
Male	17.0	22.9
Female	17.0	19.9

Source: Youth Risk Behavior Surveillance System, 2007

Physical Activity, High School Students, South Carolina and U.S., 2007

Met Current Physical Activity Level*	% South Carolina	% U.S.
Total	38.0	34.7
Male	45.1	43.7
Female	30.7	25.6

* Were physically active during any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes/day on 5 or more days during the 7 days before the survey

Source: Youth Risk Behavior Surveillance System, 2007

Overweight/Obese High School Students, South Carolina and U.S., 2007

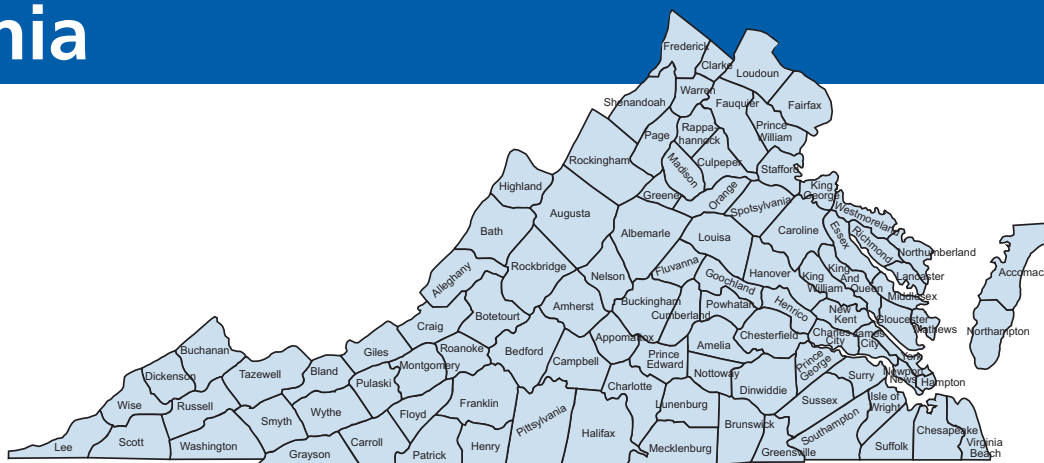
Obese*	% South Carolina	% U.S.
Total	14.4	13.0
Male	16.6	16.3
Female	12.2	9.6
Overweight**		
Total	17.1	15.8
Male	15.3	16.4
Female	18.9	15.1

* Obese - At or above the 95th percentile for body mass index, by age and sex, based on reference data from the National Health and Nutrition Examination Survey

** - Overweight - At or above the 85th percentile but below the 95th percentile for body mass index, by age and sex, based on reference data from the National Health and Nutrition Examination Survey.

Source: Youth Risk Behavior Surveillance System, 2007

Virginia



VIRGINIA DEMOGRAPHICS

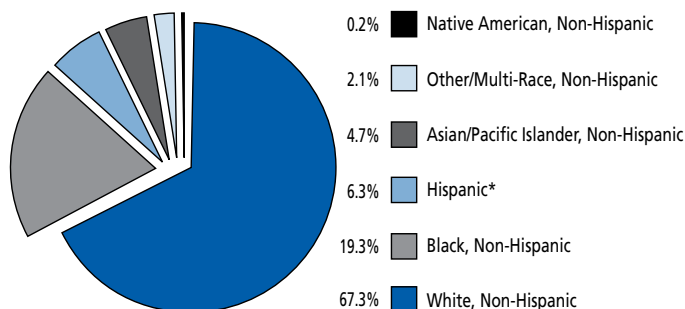
State Level Data, 2007 Estimates

2000 Census Population	7,078,515
2007 Estimate ¹	7,708,938
White, Non-Hispanic	5,190,200
Black, Non-Hispanic	1,488,118
Native American, Non-Hispanic	18,846
Asian/Pacific Islander, Non-Hispanic	361,206
Hispanic ²	487,057
Other/Multi-Race, Non-Hispanic	163,511

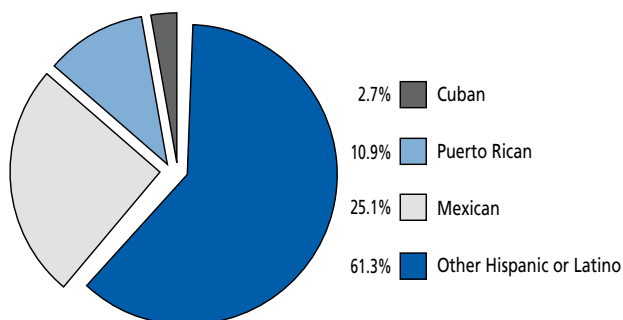
Factors Related to Access to Care

Percent unemployed ³	3.5%
Percentage with less than high school education	11.0%
Median household income	\$56,827
Percent households with income < \$15,000	10.4%
Percent households with income ≥ \$50,000	55.9%
Percent of households with no vehicle	6.3%
Percent rural population	28.1%
Percent minority	32.7%
% speak language other than English at home	13.1%
% with no usual source of health care coverage	12.0%

Distribution of Virginia's Population by Race & Ethnicity

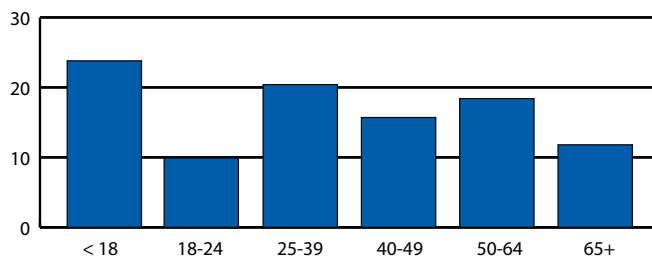


Virginia's Hispanic/Latino Population by Sub-Ethnicity



Age Distribution of Virginia

Age Group	Number	%
< 18	1,836,310	23.8%
18 - 24	764,967	9.9%
25 - 39	1,570,607	20.4%
40 - 49	1,207,192	15.7%
50 - 64	1,421,731	18.4%
65 +	908,131	11.8%



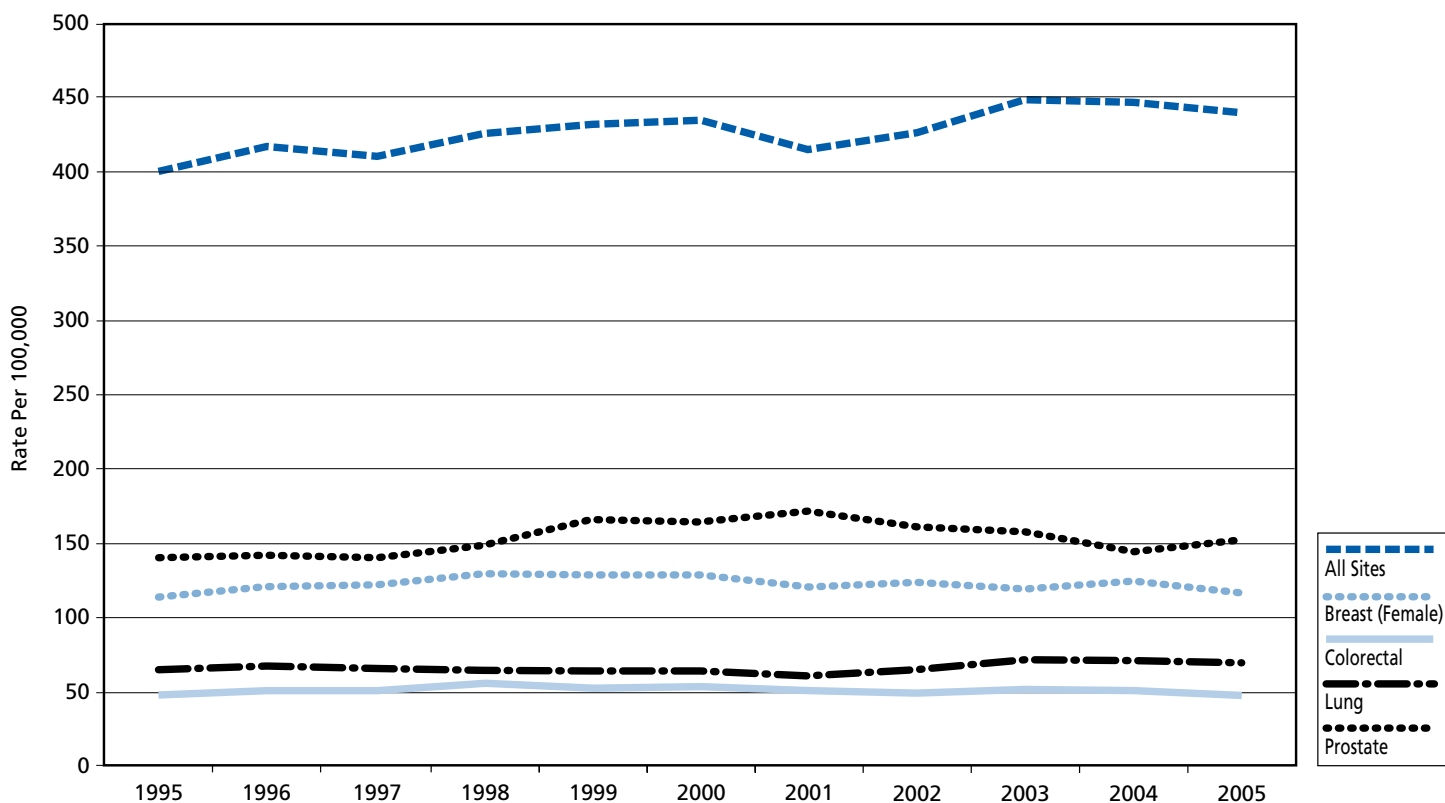
¹ Total is sum of White, Black, Native American, Asian/Pacific Islander, Other/Multi-Race, and Hispanic.

² Hispanic is an ethnicity, not a race.

³ Department of Labor <http://www.bis.gov/LAU/>, April 2008

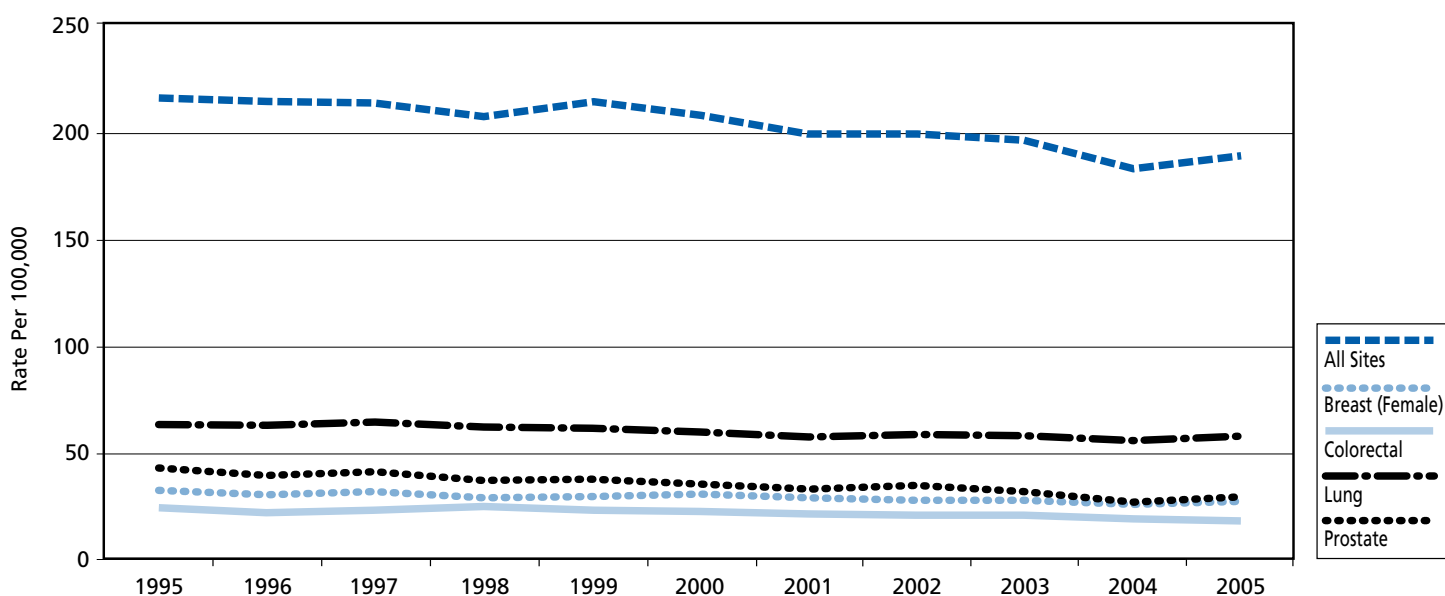
Data Sources: Copyright © 2008, Thomson Medstat. ALL RIGHTS RESERVED; US Census Bureau, Population Fact Sheet, 2008, American Community Survey @ <http://factfinder.census.gov>

Virginia Cancer Incidence Rates by Cancer Site (1995-2005)



Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.
Source: Virginia Division of Health Statistics

Virginia Cancer Mortality Rates by Cancer Site (1995-2005)



Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.
Source: Virginia Division of Health Statistics

Virginia Cancer Incidence, 2001-2005, by Site, Gender and Race

	All Races ¹		White		Black	
BOTH GENDERS	Cases	Rate	Cases	Rate	Cases	Rate
ALL SITES	157,362	436.4	127,474	431.5	27,290	461.0
COLORECTAL	17,255	48.6	13,348	46.7	3,401	59.2
LUNG & BRONCHUS	23,570	66.7	19,113	66.9	4,012	70.4
MELANOMA	6,319	17.1	5,952	20.5	64	1.1
	All Races ¹		White		Black	
MALE	Cases	Rate	Cases	Rate	Cases	Rate
ALL SITES	81,790	520.5	64,226	504.0	14,712	606.4
COLORECTAL	8,738	56.8	6,819	54.5	1,663	70.1
LUNG & BRONCHUS	13,238	86.6	10,587	84.8	2,412	103.3
MELANOMA	3,653	22.3	3,442	26.2	31	1.3
PROSTATE	24,891	156.5	18,203	140.2	5,620	233.6
	All Races ¹		White		Black	
FEMALE	Cases	Rate	Cases	Rate	Cases	Rate
ALL SITES	75,566	378.6	60,244	382.3	12,576	364.3
BREAST(FEMALE)	24,113	120.1	19,078	121.0	4,161	117.4
CERVICAL	1,357	6.9	973	6.6	290	8.0
COLORECTAL	8,514	42.5	6,527	40.6	1,737	51.8
LUNG & BRONCHUS	10,332	52.5	8,526	53.8	1,600	48.3
MELANOMA	2,666	13.5	2,510	16.6	33	1.0

Note: Data exclude basal and squamous cell skin and in situ cancers except urinary bladder. Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.

¹ Includes White, Black and other races

Source: Virginia Cancer Registry

See "Notes on Virginia Cancer Registry Data" for more information.

Virginia Cancer Mortality, 2001-2005, by Site, Gender and Race

	All Races ¹		White		Black	
BOTH GENDERS	Deaths	Rate	Deaths	Rate	Deaths	Rate
ALL SITES	67,315	192.5	52,577	185.8	13,563	241.2
COLORECTAL	6,477	18.6	4,890	17.3	1,472	26.5
LUNG & BRONCHUS	19,690	56.2	15,897	56.0	3,550	63.3
MELANOMA (SKIN)	1,023	2.9				
	All Races ¹		White		Black	
MALE	Deaths	Rate	Deaths	Rate	Deaths	Rate
ALL SITES	34,971	240.6	27,143	228.4	7,275	329.9
COLORECTAL	3,319	22.8	2,537	21.4	729	32.8
LUNG & BRONCHUS	11,295	75.7	8,932	73.2	2,233	98.6
MELANOMA (SKIN)						
PROSTATE	3,671	29.5	2,496	24.4	1,145	62.1
	All Races ¹		White		Black	
FEMALE	Deaths	Rate	Deaths	Rate	Deaths	Rate
ALL SITES	32,344	161.2	25,434	157.8	6,288	187.4
BREAST (FEMALE)	5,323	26.4	3,972	24.7	1,244	35.7
CERVICAL	437	2.2	302	1.9	120	3.5
COLORECTAL	3,158	15.6	2,353	14.3	743	22.3
LUNG & BRONCHUS	8,395	42.2	6,965	43.6	1,317	39.9
MELANOMA (SKIN)						

Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.

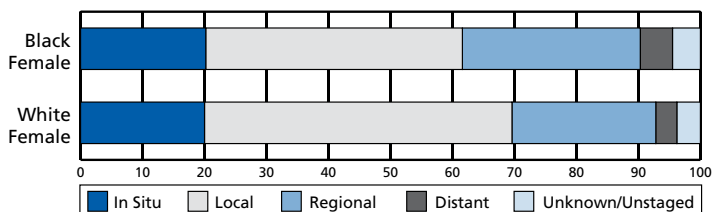
¹ Includes White, Black and other races

Source: Virginia Center for Health Statistics

Virginia Cancer Stage at Diagnosis, Percent of Total Cases, 2001-2005, by Site and Race

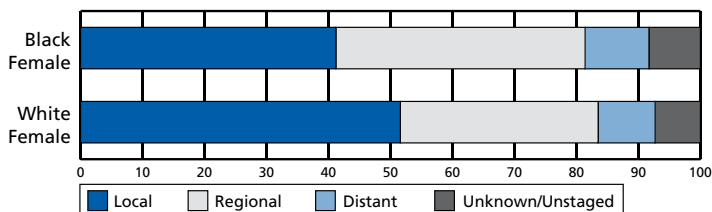
Virginia Female Breast Cancer Stage of Disease at Diagnosis by Race, 2001-2005

	In Situ	Local	Regional	Distant	Unknown
Female, All Races¹	20.1	47.9	24.2	3.7	4.1
White Female	20.0	49.6	23.2	3.4	3.8
Black Female	20.2	41.4	28.7	5.2	4.5



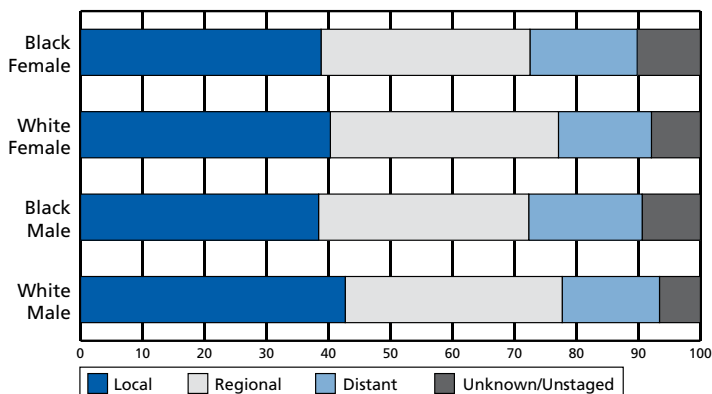
Virginia Cervical Cancer² Stage of Disease at Diagnosis by Race, 2001-2005

	Local	Regional	Distant	Unknown
Female, All Races¹	49.3	33.3	9.2	8.3
White Female	51.6	31.9	9.2	7.3
Black Female	41.2	40.2	10.3	8.3



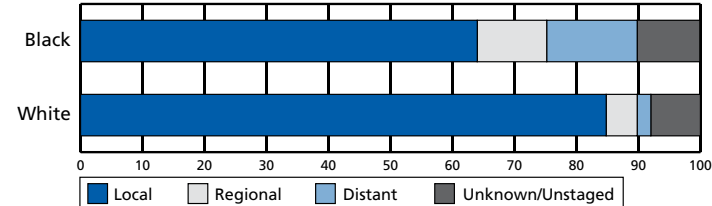
Virginia Colorectal Cancer³ Stage of Disease at Diagnosis by Sex and Race, 2001-2005

	Local	Regional	Distant	Unknown
Male, All Races¹	41.8	34.7	16.1	7.4
White Male	42.7	35.0	15.7	6.6
Black Male	38.4	33.9	18.3	9.4
Female, All Races¹	40.0	36.0	15.5	8.5
White Female	40.3	36.8	15.0	7.9
Black Female	38.8	33.7	17.3	10.2



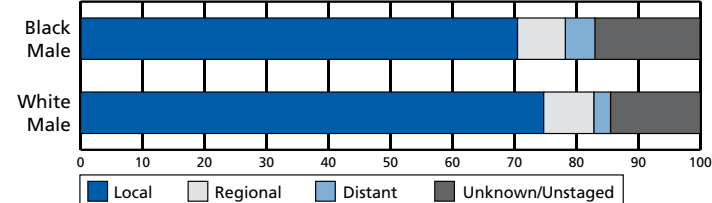
Virginia Malignant Melanoma² Stage of Disease at Diagnosis by Race, 2001-2005

	Local	Regional	Distant	Unknown
All Races¹	83.8	4.8	2.2	9.2
White	84.8	5.0	2.2	8.0
Black	64.0	11.2	14.6	10.1



Virginia Cancer of the Prostate² Stage of Disease at Diagnosis by Race, 2001-2005

	Local	Regional	Distant	Unknown
Male, All Races¹	72.2	7.9	3.1	16.7
White Male	74.7	8.1	2.7	14.5
Black Male	70.3	7.7	4.7	16.7



Notes: Stages not reported for lung and bronchus cancer due to unavailability of cost-effective early detection test.

¹Includes White, Black and other races

²Stages reported for invasive cervical, melanoma and prostate cancers only.

³In situ and local stages combined for colorectal cancer

Source: Virginia Division of Health Statistics

Virginia at a Glance

Tobacco

Tobacco Statistics	
Tobacco Use in Virginia (2007)	
High school students who smoke (2005)	22.0%
Male high school students who use smokeless or spit tobacco	13.3%
	<i>(female use much lower)</i>
Kids (under 18) who become new daily smokers each year	10,800
Kids exposed to secondhand smoke at home	336,000
Packs of cigarettes bought or smoked by kids each year	18.4 million
Adults in Virginia who smoke	18.5% (1,079,600)
Deaths in Virginia From Smoking	
Adults who die each year from their own smoking	9,300
Kids now under 18 and alive in Virginia who will ultimately die prematurely from smoking	152,000
Adult nonsmokers who die each year from exposure to secondhand smoke	610 to 1,720
Smoking-Caused Monetary Costs in Virginia	
Annual health care costs in Virginia directly caused by smoking	\$2.08 billion
- Portion covered by the state Medicaid program	\$401 million
Residents' state & federal tax burden from smoking-caused government expenditures	\$576 / household
Smoking-caused productivity losses in Virginia	\$2.42 billion
Tobacco Industry Influence in Virginia	
Estimated portion spent for Virginia marketing each year	\$438.5 million
Estimated Tobacco Revenue in Virginia – FY2008	
Tobacco Settlement Revenues	\$131.2 million
Tobacco Tax Revenues	\$188.5 million
Total Annual State Revenues from Tobacco	\$319.7 million
% of Tobacco Revenue Spent on Tobacco Prevention	4.5%
Spending on Tobacco Prevention - FY2008	
CDC Recommended Minimum Spending on Tobacco Prevention	\$38.9 million
% of CDC Recommended Minimum	37.3%
Rank Among States (1-51)	32

Virginia Screening Programs

Breast cancer screening: *BCCEDP**—*Every Woman's Life (EWL)*. The target population is women 50-64, uninsured or underinsured and under 200% of Federal Poverty Level. A unique aspect of *EWL* is that it involves several coalitions around the state that assist with local recruitment and program coordination.

Colorectal cancer screening: There is currently no statewide program for colon cancer screening.

Prostate cancer screening: There is no statewide screening program. The Virginia Prostate Cancer Coalition (VPCC), however, focuses on increasing awareness and screening of prostate cancer. The VPCC's website has information on prostate cancer screenings, local support groups and events. www.vapcacoalition.org

*The Breast and Cervical Cancer Early Detection Program (BCCEDP) is a CDC-funded program in every state administered through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

Nutrition and Physical Activity

Virginia received funding from CDC in June to implement the *WISEWOMAN* program through the infrastructure of the *BCCEDP*. *WISEWOMAN* provides integrated cardiovascular screening and education on nutrition, physical activity and tobacco use.

Access to Care

Number of Federally Qualified Health Centers and free clinics: 21 main clinics; 132 satellite clinics

State fund for Uninsured Cancer Patients: Uninsured Medical Catastrophe Fund

Number of ACoS approved hospitals: 42

Number of NCI Cancer Centers: 2

Uninsured Population (18+): 14.7% (was 12.8% in 2005)



Virginia Cancer Plan Action Coalition (CPAC)

www.vahealth.org/cdpc/cancerprevention/VCP.htm

- The C-PAC Cancer Plan for 2008-2012 will be unveiled at Virginia's First Comprehensive Statewide Cancer Conference "*JOINING THE RACE TO CONQUER CANCER*", to be held in November, 2008.
- Virginia Cancer Plan Action Coalition (CPAC) contracted with Division of Community Health and Research at Eastern Virginia Medical School to conduct an evaluation of the coalition. Report was released in July 2008 and will serve to make improvements in the Coalition effectiveness.

Additional Initiatives

- ACS sponsored two African American Men's Health Forums in 2008 with presentations on cardiovascular health, diabetes, and cancers of the colon, lung and prostate. Locations were Richmond and Norfolk with an average attendance of 500 men.
- Virginia has hosted 14 Clergy Conferences this past year, educating the faith-based community leaders of the many programs and services available to their constituents. The model continues to be used in other states around South Atlantic Division.
- Virginia awarded one summer fellowship to a second year medical student for their cancer research study.

Adult Risk Behavior

Early Detection

Recent Mammogram*, Women 40 and Older, Virginia and U.S., 2006

	% Virginia	% U.S.
40 years and older	62.2	61.2
40-64 years old	60.6	59.7
65 years and older	66.5	64.6
White only, non-Hispanic	63.3	61.6
Black only, non-Hispanic	55.1	62.7
Other race only, non-Hispanic	n/a	59.3
Hispanic	74.0	58.7
Low Education**	52.4	51.6
Uninsured***	25.2	34.9

* Mammogram within the past year

** Women 40 years old and older with less than a high school education

***Women 40-64 who reported that they did not have coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare.

Source: Behavioral Risk Factor Surveillance System, 2006

Recent Pap Test*, Women 18 and Older, Virginia and U.S., 2006

	% Virginia	% U.S.
18 years and older	85.4	83.7
18-44 years	87.9	85.1
45-64 years old	87.1	86.6
65 years and older	67.6	70.8

* A pap test within the preceding 3 years for women with intact uteri.

Source: Behavioral Risk Factor Surveillance System, 2006

Recent Sigmoidoscopy/Colonoscopy*, Adults 50 and Older, Virginia and U.S., 2006

	% Virginia	% U.S.
50 years and older	57.1	50.0
50-64 years old	53.8	44.9
65 years and older	62.6	57.1
Male, 50 years or older	58.1	50.5
Male, 50-64 years old	53.9	45.1
Male, 65 years and older	65.7	59.5
Female, 50 years and older	56.3	49.5
Female, 50-64 years old	53.7	44.8
Female, 65 years and older	60.3	55.4
White only, non-Hispanic	58.4	51.5
Black only, non-Hispanic	59.3	49.3
Other races only, non-Hispanic	45.3	43.9
Hispanic	38.7	38.2
Low Education**	42.7	38.8
Uninsured***	32.5	20.9

* Sigmoidoscopy/Colonoscopy within the past 5 years

** Adults 50 years old and older with less than a high school education

***Adults 50-64 who reported that they did not have coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare.

Source: Behavioral Risk Factor Surveillance System, 2006

Recent Prostate-Specific Antigen Test*, Men 50 and Older Virginia and U.S., 2006

	% Virginia	% U.S.
50 years and older	53.9	53.8
50-64 years old	47.0	48.5
65 years and older	67.4	63.4
White only, non-Hispanic	55.0	55.6
Black only, non-Hispanic (45+)	53.7	48.1
Other races only, non-Hispanic	n/a	44.9
Hispanic	n/a	43.0
Low Education**	43.6	40.3

* Prostate-specific antigen test within the past year for men who reported they were not told by a doctor, nurse, or other health professional that they had prostate cancer

** Adults 50 years old and older with less than a high school education

Source: Behavioral Risk Factor Surveillance System, 2006

Prevention

Current Cigarette Smoking*, Adults 18 and Older, Virginia and U.S., 2007

	% Virginia	% U.S.
Total	18.5	19.7
18-24 years old	23.0	24.0
25-34 years old	23.9	23.9
35-44 years old	17.6	20.4
45-54 years old	20.5	22.3
55-64 years old	17.2	18.0
65 years and older	8.1	9.0
Male	15.4	21.2
Female	12.8	18.4
White only, non-Hispanic	13.7	19.4
Black only, non-Hispanic	15.1	21.7
Other race only, non-Hispanic	n/a	18.3
Hispanic	8.2	16.7
Low Education**	31.4	33.2
Female 18-44 (2006)	23.6	20.6

* Ever smoked 100 cigarettes in lifetime and are current smokers (regular and irregular).

** Adults 25 years old and older with less than a high school education
Source: Behavioral Risk Factor Surveillance System, 2007

Physical Activity, Adults 18 and Older, Virginia and U.S., 2007

No Leisure Time Physical Activity*	% Virginia	% U.S.
Total	50.5	50.5
Male	50.1	48.5
Female	50.8	52.5
White only, non-Hispanic	49.0	48.4
Black only, non-Hispanic	56.7	58.6
Other race only, non-Hispanic	0.0	51.0
Hispanic	n/a	55.3
Low Education**	62.7	59.8

* Adults with 30+ minutes of moderate physical activity five or more days per week, or vigorous physical activity for 20+ minutes three or more days per week.

** Adults 25 years old and older with less than a high school education
Source: Behavioral Risk Factor Surveillance System, 2007

Tobacco Use, High School Students, Virginia 2005

Current Cigarette Smoking*	% Virginia	% U.S.
Total	21.7	20.0
Male	25.7	21.3
Female	17.8	18.7
Current Smokeless Tobacco Use**		
Total	7.4	7.9
Male	13.3	13.4
Female	1.8	13.4

* Smoked cigarettes on 1 or more of the 30 days preceding the survey

** Used chewing tobacco, snuff or dip on 1 or more of the 30 days preceding the survey

Source: Youth Tobacco Survey, 2005

Nutrition, Adults 18 and Older, Virginia and U.S., 2007

Eating 5 or More Fruits and Vegetables per Day	% Virginia	% U.S.
Total	26.3	24.4
Male	20.3	19.4
Female	32.0	28.8
White only, non-Hispanic	23.1	24.5
Black only, non-Hispanic	18.5	23.1
Other race only, non-Hispanic	25.2	26.6
Hispanic	14.7	22.6
Low Education*	24.9	18.4

* Adults 25 years old and older with less than a high school education
Source: Behavioral Risk Factor Surveillance System, 2007

Overweight*, Adults 18 and Older, Virginia and U.S., 2007

	% Virginia	% U.S.
Total	61.8	63.0
Male	69.9	70.8
Female	54.0	55.4
White only, non-Hispanic	60.3	62.6
Black only, non-Hispanic	72.4	72.6
Other race only, non-Hispanic	n/a	51.2
Hispanic	n/a	66.9
Low Education**	61.4	65.7

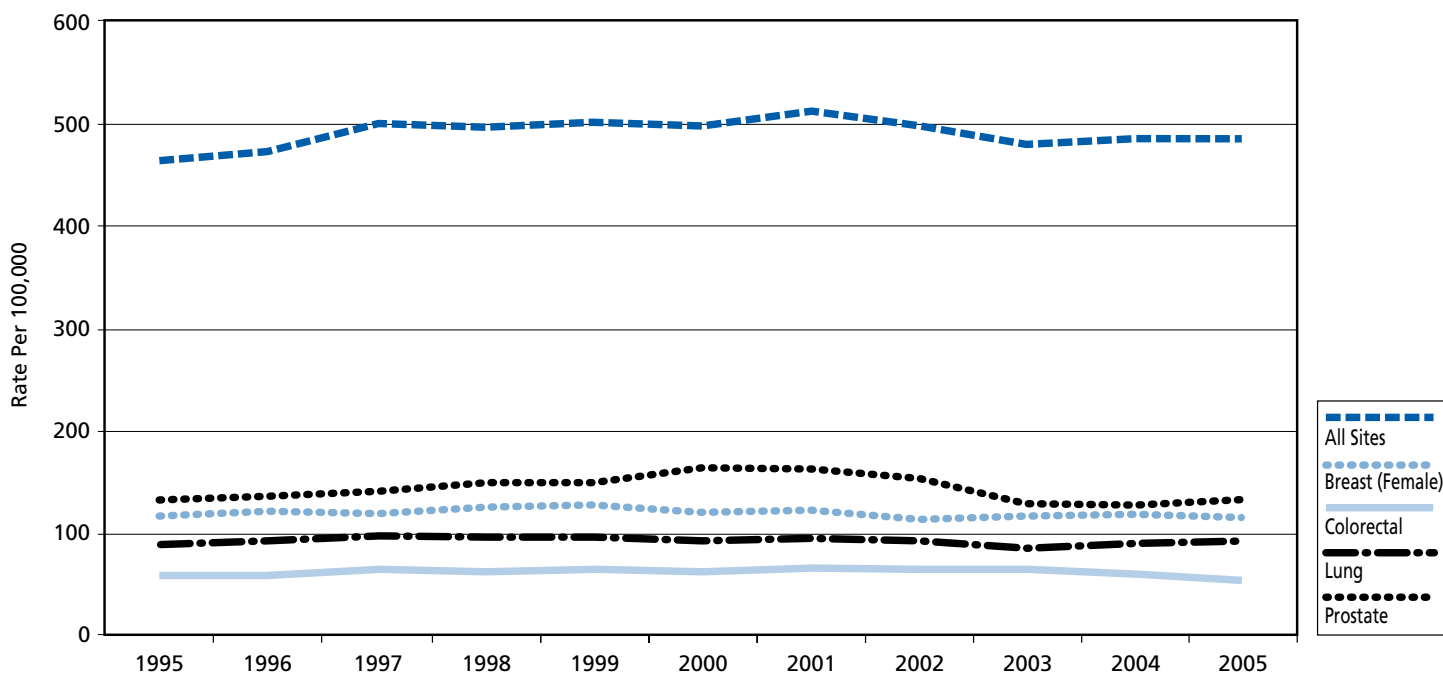
* Overweight is defined as having body mass index of 25 kg/m² or greater

** Adults 25 years old and older with less than a high school education
Source: Behavioral Risk Factor Surveillance System, 2007

Youth Risk Behavior

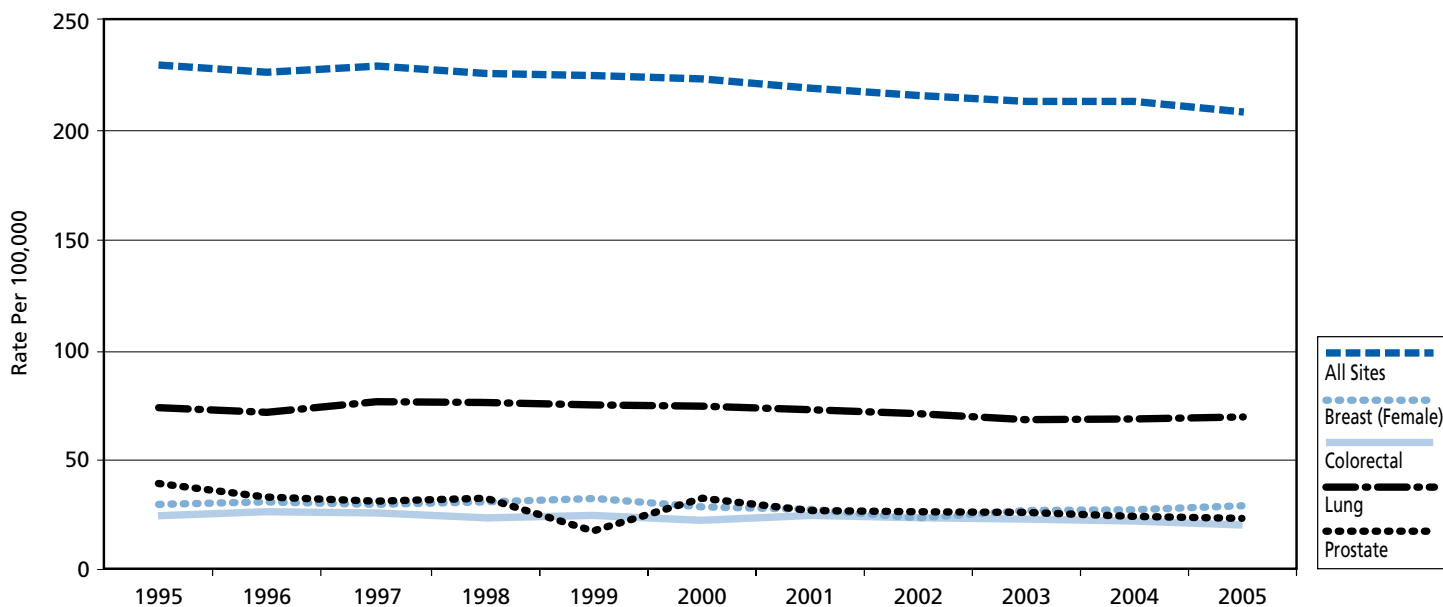
Additional data are not available since Virginia did not participate in the Youth Risk Behavior Surveillance System, a voluntary collaboration between the state's departments of health and education and the Centers for Disease Control and Prevention.

West Virginia Cancer Incidence Rates by Cancer Site (1995-2005)



Note: Data exclude basal and squamous cell skin and in situ cancers except urinary bladder.
 Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.
 Source: West Virginia Cancer Registry

West Virginia Cancer Mortality Rates by Cancer Site (1995-2004)



Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.
 Data Source: West Virginia Health Statistics Center

West Virginia Cancer Incidence, 2001-2005, by Site, Gender and Race

	All Races ¹		White		Black	
BOTH GENDERS	Cases	Rate	Cases	Rate	Cases	Rate
ALL SITES	52,803	490.1	51,322	494.5	1,268	460.8
COLORECTAL	6,513	59.8	6,311	60.0	181	64.2
LUNG & BRONCHUS	9,836	89.4	9,628	90.7	185	67.9
MELANOMA	1,730	16.8	1,722	17.5	^	~
	All Races ¹		White		Black	
MALE	Cases	Rate	Cases	Rate	Cases	Rate
ALL SITES	27,363	575.4	26,601	579.3	659	589
COLORECTAL	3,313	70.5	3,237	71.2	66	60.2
LUNG & BRONCHUS	5,597	116.8	5,463	117.9	116	105.2
MELANOMA	988	21.0	985	21.7	^	~
PROSTATE	6,713	139.2	6,455	138.4	228	210.5
	All Races ¹		White		Black	
FEMALE	Cases	Rate	Cases	Rate	Cases	Rate
ALL SITES	25,440	433.6	24,721	438	609	383.9
BREAST(FEMALE)	6,608	115.3	6,423	116.5	153	99.4
CERVICAL	512	10.2	490	10.2	^	~
COLORECTAL	3,200	51.6	3,074	51.4	115	69.5
LUNG & BRONCHUS	4,239	69.4	4,165	70.7	69	43.3
MELANOMA	742	14.0	737	14.5	^	~

Note: Data exclude basal and squamous cell skin and in situ cancers except urinary bladder. Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.

¹ Includes White, Black and other races

^ Number of cases 5 or less not reported due to confidentiality issues

~ Number of cases too small (25 or less) to calculate reliable rate.

Source: West Virginia Cancer Registry

West Virginia Cancer Mortality, 2001-2005, by Site, Gender and Race

	All Races ¹		White		Black	
BOTH GENDERS	Deaths	Rate	Deaths	Rate	Deaths	Rate
ALL SITES	23,274	213.0	22,577	214.8	673	241.4
COLORECTAL	2,362	21.6	2,275	21.6	85	29.7
LUNG & BRONCHUS	7,566	68.5	7,401	69.7	160	58.1
MELANOMA (SKIN)	314	3.0	314	3.1	0	0.0
	All Races ¹		White		Black	
MALE	Deaths	Rate	Deaths	Rate	Deaths	Rate
ALL SITES	12,170	262.5	11,832	265.8	325	303.4
COLORECTAL	1,188	25.9	1,150	26.1	36	32.8
LUNG & BRONCHUS	4,404	92.3	4,322	94.5	81	74.7
MELANOMA (SKIN)	201	4.3	201	4.4	0	0.0
PROSTATE	993	24.1	929	23.2	64	67.0
	All Races ¹		White		Black	
FEMALE	Deaths	Rate	Deaths	Rate	Deaths	Rate
ALL SITES	11,104	179.5	10,745	180.1	348	207.4
BREAST (FEMALE)	1,516	25.1	1,455	25.1	58	36.4
CERVICAL	185	3.4	180	3.5	^	~
COLORECTAL	1,174	18.3	1,125	18.2	49	27.5
LUNG & BRONCHUS	3,162	51.1	3,079	51.6	79	47.2
MELANOMA (SKIN)	113	1.9	113	2.0	0	0.0

Note: Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.

¹ Includes White, Black and other races

^ Number of deaths 5 or less not reported due to confidentiality issues

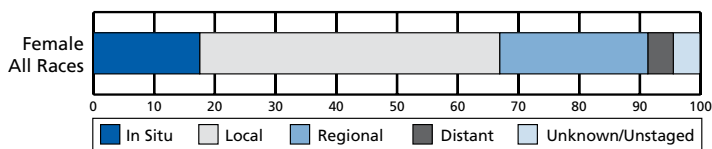
~ Number of deaths too small (25 or less) to calculate reliable rate.

Source: West Virginia Health Statistics Center

West Virginia Cancer Stage at Diagnosis, Percent of Total Cases, 2001-2005, by Site

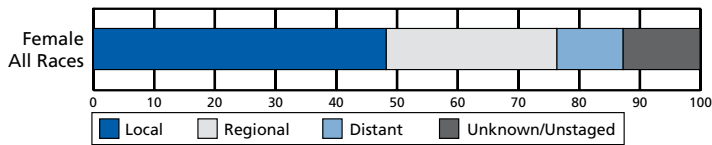
West Virginia Female Breast Cancer Stage of Disease at Diagnosis, 2001-2005

	In Situ	Local	Regional	Distant	Unknown
Female, All Races¹	17.5	49.4	24.4	4.2	4.4



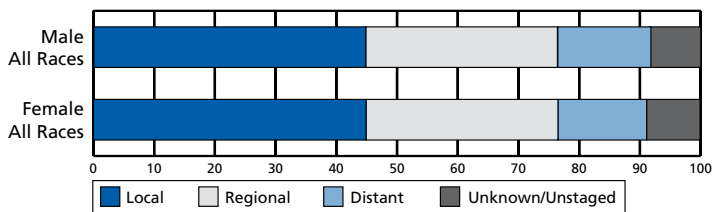
West Virginia Cervical Cancer² Stage of Disease at Diagnosis, 2001-2005

	Local	Regional	Distant	Unknown
Female, All Races¹	48.2	28.1	10.9	12.7



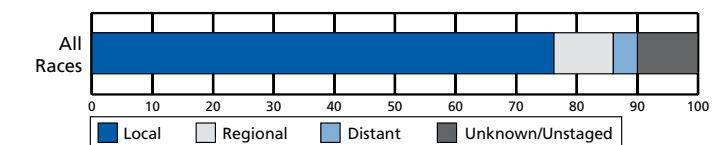
West Virginia Colorectal Cancer³ Stage of Disease at Diagnosis by Sex, 2001-2005

	Local	Regional	Distant	Unknown
Male, All Races¹	44.7	31.5	15.3	8.5
Female, All Races¹	44.9	31.6	14.6	8.8



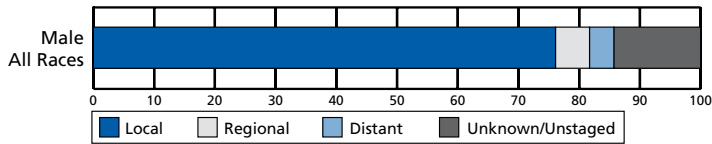
West Virginia Malignant Melanoma² Stage of Disease at Diagnosis, 2001-2005

	Local	Regional	Distant	Unknown
All Races¹	76.2	9.8	4.0	10.0



West Virginia Cancer of the Prostate² Stage of Disease at Diagnosis, 2001-2005

	Local	Regional	Distant	Unknown
Male, All Races¹	76.1	5.6	4.0	14.3



Notes: Stages not reported for lung and bronchus cancer due to unavailability of cost-effective early detection test.
¹Includes White, Black and other races
²Stages reported for invasive cervical, melanoma and prostate cancers only.
³In situ and local stages combined for colorectal cancer
 Source: West Virginia Cancer Registry

West Virginia At a Glance

Tobacco

Tobacco Statistics

Tobacco Use in West Virginia (2007)

High school students who smoke	27.6%
Male high school students who use smokeless or spit tobacco	27.0%
	<i>(female use much lower)</i>
Kids (under 18) who become new daily smokers each year	3,200
Kids exposed to secondhand smoke at home	128,000
Packs of cigarettes bought or smoked by kids each year	4.8 million
Adults in West Virginia who smoke	26.9% (384,500)

Deaths in West Virginia From Smoking

Adults who die each year from their own smoking	3,900
Kids now under 18 and alive in West Virginia who will ultimately die prematurely from smoking	46,000
Adult nonsmokers who die each year from exposure to secondhand smoke	200 to 560

Smoking-Caused Monetary Costs in West Virginia

Annual health care costs in West Virginia directly caused by smoking	\$690 million
- Portion covered by the state Medicaid program	\$229 million
Residents' state & federal tax burden from smoking-caused government expenditures	\$591 / household
Smoking-caused productivity losses in West Virginia	\$994 million

Tobacco Industry Influence in West Virginia

Estimated portion spent for West Virginia marketing each year	\$132.0 million
---	-----------------

Estimated Tobacco Revenue in West Virginia – FY2008

Tobacco Settlement Revenues	\$72.9 million
Tobacco Tax Revenues	\$113.5 million
Total Annual State Revenues from Tobacco	\$186.4 million
% of Tobacco Revenue Spent on Tobacco Prevention	3.0%

Spending on Tobacco Prevention - FY2008

CDC Recommended Minimum Spending on Tobacco Prevention	\$38.9 million
% of CDC Recommended Minimum	40.0%
Rank Among States (1-51)	29



Access to Care

Number of Federally Qualified Health Centers and free clinics: 34 main clinics; 153 satellite clinics

State fund for Uninsured Cancer Patients: The WV Legislature set up a Catastrophic Illness Commission in 1999 to provide funds when other avenues are exhausted.

Uninsured Population (18+): 20.6% (was 22.2% in 2005)

Number of ACoS Approved Hospitals: 11

Number of NCI Cancer Centers: 0

West Virginia State Screening Programs

Breast and Cervical Cancer Screening: *BCCEDP** - *Breast and Cervical Cancer Screening Program (BCCSP)*; target population: women 50-64 (women 40-49 if high risk), uninsured or underinsured, under 200% of Federal Poverty Level.

Unique Aspect of BCCSP: Employs regional Cancer Information Specialists who manage client recruitment and navigation in their assignment areas. *BCCSP* has CDC funding for the *WISEWOMAN* program enhancement, which provides integrated cardiovascular screening and education on nutrition, physical activity, and tobacco use for *BCCSP* clients.

Colorectal cancer screening: There is mandatory coverage for colorectal cancer screening, however, there is no statewide screening program. The Mountains of Hope (MOH) Cancer Coalition state comprehensive cancer program has an initiative in conjunction with Mary Babb Randolph Cancer Center that addresses screening needs of the underserved. The WVCCI (West Virginia Colorectal Cancer Initiative) seeks to raise awareness and knowledge among the public and health professionals about the critical role screening plays in prevention and early detection of colon cancer. The WVCCI recently conducted an assessment of colorectal cancer screening capacity in West Virginia in anticipation of a statewide screening program.

Prostate cancer screening: There is no statewide screening program, but the Mountains of Hope Cancer Coalition has an initiative in conjunction with Mary Babb Randolph Cancer Center that addresses screening needs of underserved men.

*The Breast and Cervical Cancer Early Detection Program (BCCEDP) is a CDC-funded program in every state administered through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

Nutrition and Physical Activity

Physical Activity Initiatives: Begun as a pilot in 2005, “*Dance, Dance Revolution*” is now in 160 middle schools in West Virginia. The video game is an interactive dance game that burns more calories in 15 minutes than walking on a treadmill. Over 25 weeks in 2008, 35 overweight children between ages 7-12 were tracked to gauge a sampling of results. Weight loss was seen in those who also had diet modifications, and there was “weight stall” in those who only used the game but did not change their diet habits. “*Dance*” will continue in the schools next year. Gov. Joe Manchin asked the legislature to provide \$350,000 in the 08-09 school budget for games for a health project in state schools.

West Virginia Comprehensive Cancer Program

www.wvhpcd.org/ccp

West Virginia has a *Comprehensive Cancer Program (WVCCP)* at the Bureau for Public Health and an ovarian cancer initiative called *Reaching Out* at the Edwards Comprehensive Cancer Center. These programs are funded by a cooperative agreement with CDC. The *WVCCP* coordinates all cancer control efforts in West Virginia, oversees the Mountains of Hope Cancer Coalition, tracks implementation of the *WV Cancer Plan* and educates the public about the early detection of ovarian cancer.

Status of Cancer Control Plan: *The West Virginia Cancer Plan* is in its second year of implementation by the Mountains of Hope Coalition.

This Year’s Activities: As implementation of the *WV Cancer Plan* is just beginning its second year of implementation, results from year one are not yet compiled. This past year’s activities consisted of (1) identification of two key priorities from each section of the *Plan* and (2) securing several sources of funding for implementation of the cancer plan, including \$100,000 from the West Virginia Legislature.

Accomplishments:

- The West Virginia Oncology Society was formed in May 2008 Mountains of Hope after a meeting with 26 West Virginia oncologists and several other interested individuals. Plans are in progress for a West Virginia Clinical Trials Network. Both of these new efforts will help in meeting the objectives of the cancer plan.
- Three mini-grants were awarded to community organizations for education and awareness of ovarian cancer among health professionals and older women. Another mini-grant was awarded to a prostate cancer awareness program called “*Prime Rib, Prizes and Your Prostate*”.

Adult Risk Behavior

Early Detection

Recent Mammogram*, Women 40 and Older, West Virginia and U.S., 2006

	% West Virginia	% U.S.
40 years and older	61.9	61.2
40-64 years old	61.5	59.7
65 years and older	62.7	64.6
White only, non-Hispanic	62.4	61.6
Black only, non-Hispanic	n/a	62.7
Other race only, non-Hispanic	n/a	59.3
Hispanic	n/a	58.7
Low Education**	52.2	51.6
Uninsured***	28.3	34.9

* Mammogram within the past year

** Women 40 years old and older with less than a high school education

*** Women 40-64 who reported that they did not have coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare.

Source: Behavioral Risk Factor Surveillance System, 2006

Recent Pap Test*, Women 18 and Older, West Virginia and U.S., 2006

	% West Virginia	% U.S.
18 years and older	83.3	83.7
18-44 years	86.5	85.1
45-64 years old	85.2	86.6
65 years and older	68.0	70.8

* A pap test within the preceding 3 years for women with intact uteri.

Source: Behavioral Risk Factor Surveillance System, 2006

Recent Sigmoidoscopy/Colonoscopy*, Adults 50 and Older, West Virginia and U.S., 2006

	% West Virginia	% U.S.
50 years and older	45.8	50.0
50-64 years old	41.5	44.9
65 years and older	51.4	57.1
Male, 50 years or older	43.8	50.5
Male, 50-64 years old	39.8	45.1
Male, 65 years and older	49.7	59.5
Female, 50 years and older	47.6	49.5
Female, 50-64 years old	43.2	44.8
Female, 65 years and older	52.7	55.4
White only, non-Hispanic	46.1	51.5
Black only, non-Hispanic	0.0	49.3
Other races only, non-Hispanic	0.0	43.9
Hispanic	0.0	38.2
Low Education**	40.7	38.8
Uninsured***	20.2	20.9

** Adults 50 years old and older with less than a high school education

*** Adults 50-64 who reported that they did not have coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare.

Source: Behavioral Risk Factor Surveillance System, 2006

Recent Prostate-Specific Antigen Test*, Men 50 and Older West Virginia and U.S., 2006

	% West Virginia	% U.S.
50 years and older	53.9	53.8
50-64 years old	49.2	48.5
65 years and older	61.6	63.4
White only, non-Hispanic	54.0	55.6
Black only, non-Hispanic (45+)	n/a	48.1
Other races only, non-Hispanic	n/a	44.9
Hispanic	n/a	43.0
Low Education**	38.2	40.3

* Prostate-specific antigen test within the past year for men who reported they were not told by a doctor, nurse, or other health professional that they had prostate cancer

** Adults 50 years old and older with less than a high school education

Source: Behavioral Risk Factor Surveillance System, 2006

Prevention

Current Cigarette Smoking*, Adults 18 and Older, West Virginia and U.S., 2007

	% West Virginia	% U.S.
Total	26.9	19.7
18-24 years old	34.9	24.0
25-34 years old	36.2	23.9
35-44 years old	33.1	20.4
45-54 years old	28.8	22.3
55-64 years old	22.2	18.0
65 years and older	11.5	9.0
Male	22.0	21.2
Female	21.3	18.4
White only, non-Hispanic	21.9	19.4
Black only, non-Hispanic	n/a	21.7
Other race only, non-Hispanic	n/a	18.3
Hispanic	n/a	16.7
Low Education**	35.6	33.2
Female 18-44	34.0	20.6

* Ever smoked 100 cigarettes in lifetime and are current smokers (regular and irregular).

** Adults 25 years old and older with less than a high school education

Source: Behavioral Risk Factor Surveillance System, 2007

Physical Activity, Adults 18 and Older, West Virginia and U.S., 2007

No Leisure Time Physical Activity*	% West Virginia	% U.S.
Total	54.1	50.5
Male	50.0	48.5
Female	57.9	52.5
White only, non-Hispanic	54.5	48.4
Black only, non-Hispanic	n/a	58.6
Other race only, non-Hispanic	n/a	51.0
Hispanic	n/a	55.3
Low Education**	66.3	59.8

* Adults with 30+ minutes of moderate physical activity five or more days per week, or vigorous physical activity for 20+ minutes three or more days per week.

** Adults 25 years old and older with less than a high school education

Source: Behavioral Risk Factor Surveillance System, 2007

Nutrition, Adults 18 and Older, West Virginia and U.S., 2007

Eating 5 or More Fruits and Vegetables per Day	% West Virginia	% U.S.
Total	19.7	24.4
Male	15.1	19.4
Female	24.1	28.8
White only, non-Hispanic	19.1	24.5
Black only, non-Hispanic	n/a	23.1
Other race only, non-Hispanic	n/a	26.6
Hispanic	n/a	22.6
Low Education*	12.2	18.4

* Adults 25 years old and older with less than a high school education
Source: Behavioral Risk Factor Surveillance System, 2007

Overweight*, Adults 18 and Older, West Virginia and U.S., 2007

	% West Virginia	% U.S.
Total	68.0	63.0
Male	75.1	70.8
Female	61.1	55.4
White only, non-Hispanic	68.6	62.6
Black only, non-Hispanic	n/a	72.6
Other race only, non-Hispanic	n/a	51.2
Hispanic	n/a	66.9
Low Education**	68.7	65.7

*Overweight is defined as having body mass index of 25 kg/m² or greater

**Adults 25 years old and older with less than a high school education
Source: Behavioral Risk Factor Surveillance System, 2007

Youth Risk Behavior

Tobacco Use, High School Students, West Virginia and U.S., 2007

Current Cigarette Smoking*	% West Virginia	% U.S.
Total	27.6	20.0
Male	26.7	21.3
Female	28.4	18.7
Current Smokeless Tobacco Use**		
Total	14.8	7.9
Male	27.0	13.4
Female	2.2	2.3

* Smoked cigarettes on 1 or more of the 30 days preceding the survey

** Used chewing tobacco, snuff or dip on 1 or more of the 30 days preceding the survey

Source: Youth Risk Behavior Surveillance System, 2007

Nutrition, High School Students, West Virginia and U.S., 2007

Eating 5 or More Fruits and Vegetables per Day	% West Virginia	% U.S.
Total	19.8	21.4
Male	21.7	22.9
Female	17.5	19.9

Source: Youth Risk Behavior Surveillance System, 2007

Physical Activity, High School Students, West Virginia and U.S., 2007

Met Current Physical Activity Level*	% West Virginia	% U.S.
Total	42.8	34.7
Male	53.1	43.7
Female	31.8	25.6

* Were physically active during any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes/day on 5 or more days during the 7 days before the survey

Source: Youth Risk Behavior Surveillance System, 2007

Overweight/Obese High School Students, West Virginia and U.S., 2007

Obese*	% West Virginia	% U.S.
Total	14.7	13.0
Male	17.6	16.3
Female	11.7	9.6
Overweight**		
Total	17.0	15.8
Male	15.0	16.4
Female	19.0	15.1

* Obese - At or above the 95th percentile for body mass index, by age and sex, based on reference data from the National Health and Nutrition Examination Survey

** - Overweight - At or above the 85th percentile but below the 95th percentile for body mass index, by age and sex, based on reference data from the National Health and Nutrition Examination Survey.

Source: Youth Risk Behavior Surveillance System, 2007

Colorectal Cancer Screening Guidelines

The American Cancer Society, the American College of Radiology, and the U.S. Multi-Society Task Force on Colorectal Cancer (a group that comprises representatives from the American College of Gastroenterology, American Gastroenterological Association, and American Society for Gastrointestinal Endoscopy) have released the first-ever joint consensus guidelines for colorectal cancer screening.

The guidelines, which represent the most current scientific evidence and expert opinion available, also outline quality elements essential to each of the recommended testing methods.

Of significance in the new guidelines:

- two new tests are added to the list of recommended options: stool DNA (sDNA) and CT colonography (CTC), also known as virtual colonoscopy
- a preference is stated for screening tests that not only detect cancer early but also detect precancerous polyps, as those tests provide a greater potential for cancer prevention through polyp removal.
- any proposed colorectal screening test that has not been shown in the medical literature to detect the majority of cancers present at the time of testing should not be offered to patients for colorectal cancer screening. That includes some types of previously endorsed guaiac-based stool tests.

Based on a review of the historic and recent evidence, the new recommendations are:

Beginning at age 50, both men and women at average risk for developing colorectal cancer should use one of the screening tests below. The tests that are designed to find both early cancer and polyps are preferred if these tests are available to you and you are willing to have one of these more invasive tests. Talk to your doctor about which test is best for you.

Tests That Detect Adenomatous Polyps and Cancer

- flexible sigmoidoscopy every 5 years*
- colonoscopy every 10 years
- double contrast barium enema every 5 years*
- CT colonography (virtual colonoscopy) every 5 years*

Tests That Primarily Detect Cancer

- fecal occult blood test (FOBT) every year*,**
- fecal immunochemical test (FIT) every year*,**
- stool DNA test (sDNA), interval uncertain*

*Colonoscopy should be done if test results are positive.

**For FOBT or FIT used as a screening test, the take-home multiple sample method should be used. A FOBT or FIT done during a digital rectal exam in the doctor's office is not adequate for screening.



In addition, people should talk to their doctor about starting colorectal cancer screening earlier and/or being screened more often if they have any of the following colorectal cancer risk factors:

- a personal history of colorectal cancer or adenomatous polyps
- a personal history of chronic inflammatory bowel disease (Crohn's disease or ulcerative colitis)
- a strong family history of colorectal cancer or polyps (cancer or polyps in a first-degree relative [parent, sibling, or child] younger than 60 or in 2 or more first-degree relatives of any age)
- a known family history of hereditary colorectal cancer syndromes such as familial adenomatous polyposis (FAP) or hereditary non-polyposis colon cancer (HNPCC)

It was the strong opinion of the expert panel that colon cancer prevention should be the primary goal of colorectal cancer screening, so the guidelines state a preference for tests designed to detect both early cancer and adenomatous polyps, as long as resources are available and patients are willing to undergo an invasive test.

The panel recognized that some patients will not want to undergo an invasive test that requires a bowel prep, may prefer to have screening in the privacy of their home, or may not have access to the invasive tests due to lack of coverage or local resources, so will opt for stool occult blood or DNA testing, which can be performed at home, without bowel prep. But the panel said providers and patients should understand that those tests are less likely to prevent cancer compared with the invasive tests; they must be repeated at regular intervals to be effective; and if the test is abnormal, an invasive test (colonoscopy) will still be needed.

The full guideline can be viewed at
<http://caonline.amcancersoc.org/>

American Cancer Society Screening Guidelines

For the Early Detection of Cancer in Asymptomatic People

Site	Recommendation
Breast	<ul style="list-style-type: none"> Yearly mammograms are recommended starting at age 40. The age at which screening should be stopped should be individualized by considering the potential risks and benefits of screening in the context of overall health status and longevity. Clinical breast exam should be part of a periodic health exam about every 3 years for women in their 20s and 30s and every year for women 40 and older. Women should know how their breasts normally feel and report any breast change promptly to their health care providers. Breast self-exam is an option for women starting in their 20s. Screening MRI is recommended for women with an approximately 20%-50% or greater lifetime risk of breast cancer, including women with a strong family history of breast or ovarian cancer and women who were treated for Hodgkin disease.
Colon & rectum	<p>Beginning at age 50, men and women at average risk should begin screening with one of the examination schedules below.</p> <p>Tests that detect adenomatous polyps and cancer:</p> <ul style="list-style-type: none"> A flexible sigmoidoscopy every 5 years A colonoscopy every 10 years A double-contrast barium enema every 5 years Computed Tomographic (CT) colonography every 5 years <p>Tests that primarily detect cancer:</p> <ul style="list-style-type: none"> A guaiac-based fecal occult blood test (gFOBT) or fecal immunochemical test (FIT), with high test sensitivity for cancer every year Stool DNA test (interval uncertain) Individuals with a personal or family history of colorectal cancer or adenomas, inflammatory bowel disease, or high-risk genetic syndromes should continue to follow the most recent recommendations for individuals at increased or high risk.
Prostate	<p>The PSA test and the digital rectal examination should be offered annually, beginning at age 50, to men who have a life expectancy of at least 10 years. Men at high risk (African American men and men with a strong family history of 1 or more first-degree relatives diagnosed with prostate cancer at an early age) should begin testing at age 45. For both men at average risk and high risk, information should be provided about what is known and what is uncertain about the benefits and limitations of early detection and treatment of prostate cancer so that they can make an informed decision about testing.</p>
Uterus	<p>Cervix: Screening should begin approximately 3 years after a woman begins having vaginal intercourse, but no later than 21 years of age. Screening should be done every year with regular Pap tests or every 2 years using liquid-based tests. At or after age 30, women who have had 3 normal test results in a row may get screened every 2 to 3 years. Alternatively, cervical cancer screening with HPV DNA testing and conventional or liquid-based cytology could be performed every 3 years. However, doctors may suggest a woman get screened more often if she has certain risk factors, such as HIV infection or a weak immune system. Women aged 70 and older who have had 3 or more consecutive normal Pap tests in the last 10 years may choose to stop cervical cancer screening. Screening after total hysterectomy (with removal of the cervix) is not necessary unless the surgery was done as a treatment for cervical cancer.</p> <p>Endometrium: The American Cancer Society recommends that at the time of menopause all women should be informed about risks and symptoms of endometrial cancer and strongly encouraged to report any unexpected bleeding or spotting to their physicians. Annual screening for endometrial cancer with endometrial biopsy beginning at age 35 should be offered to women with or at risk for hereditary nonpolyposis colon cancer (HNPCC).</p>
Cancer-related checkup	<p>For individuals undergoing periodic health examinations, a cancer-related checkup should include health counseling about tobacco, sun exposure, diet and nutrition, sexual practices, environmental and occupational exposures and depending on a person's age and gender, might include examinations for cancers of the thyroid, oral cavity, skin, lymph nodes, testes, and ovaries, as well as for some nonmalignant diseases.</p>

American Cancer Society guidelines for early cancer detection are assessed annually in order to identify whether there is new scientific evidence sufficient to warrant a re-evaluation of current recommendations. If evidence is sufficiently compelling to consider a change or clarification in a current guideline or the development of a new guideline, a formal procedure is initiated. Guidelines are formally evaluated every 5 years regardless of whether new evidence suggests a change in the existing recommendations. There are 9 steps in this procedure, and these "guidelines for guideline development" were formally established to provide a specific methodology for science and expert judgment to form the underpinnings of specific statements and recommendations from the Society. These procedures constitute a deliberate process to ensure that all Society recommendations have the same methodological and evidence-based process at their core. This process also employs a system for rating strength and consistency of evidence that is similar to that employed by the Agency for Health Care Research and Quality (AHCRO) and the US Preventive Services Task Force (USPSTF). ©2008, American Cancer Society, Inc.

Cancer Research



The American Cancer Society pursues its goal of eliminating cancer as a major health problem by funding the work of qualified researchers at scientific and medical institutions across the country. The ACS is the largest source of private, not-for-profit cancer research funds in the United States, second only to the

federal government. Since the ACS Research Program began in 1946, the Society has devoted over \$3.2 billion to cancer research. By funding groundbreaking research, the American Cancer Society has contributed to many important discoveries that have led to a better understanding of cancer and cancer treatment.

The research program is composed of two main umbrellas: Extramural Grants and the Intramural components of Epidemiology and Surveillance Research, the Behavioral Research Center (BRC) and the Statistics and Evaluation Center (SEC).

The extramural program supports investigator-initiated projects taking place in leading centers across the country and as well as health professional training grants (HPTGs) awarded to nurses, physicians and oncology social work professionals. Applications for grants are subjected to a rigorous external peer review which ensures that only the highest quality applications receive funding.

The Society is justly proud of the 42 investigators who were supported before they went on to win the Nobel Prize, considered the highest accolade any scientist can receive. This is a tribute to the ACS's Research Program and the strength of its peer-review process. As important as any medal, however, is the contribution each of these scientists has made toward understanding more about cancer and translating that knowledge into prevention and treatment measures that help patients and their families. For more details on the impact that the ACS research program has had: http://www.cancer.org/docroot/RES/RES_7.asp?sitearea=RES

As of January, 2008, 111 grants totaling \$4,299,500 have been awarded for research in the South Atlantic Division.

American Cancer Society Research in the South Atlantic Division

1/1/2008 Current Grants: 111 Totaling: \$50,557,202

CURRENT ACS RESEARCH AND TRAINING GRANTS IN DISTRICT OF COLUMBIA		10 GRANTS	TOTAL \$4,299,500
Children's National Medical Center		1	\$12,000
Hardesty, Lynn L, MSS, LICSW	Master's Training Grant in Clinical Oncology Social Work (\$12,000)		
George Washington University		2	\$879,000
Leitenberg, David, MD, PhD	CD45 Regulation of T Lymphocyte Activation (\$699,000)		
Patierno, Steven, PhD	Institutional Research Grant* (\$180,000)		
Georgetown University		6	\$3,368,500
Maric, Maja, PhD	Disulfide Bond Processing and the Immune Response (\$543,000)		
Shields, Peter G, MD	Institutional Research Grant* (\$247,500)		
Sheppard, Vanessa B, PhD	Narrowing the Gap in Breast Adjuvant Therapy for African American Women (\$729,000)		
Taylor, Kathryn L, PhD	Quality of Life of Long-Term Prostate Cancer Survivors in the PLCO Trial (400,000)		
Wladman, Todd, MD, PhD	Initiation and Effector Mechanisms of a PTEN-Dependent Size Checkpoint (\$720,000)		
Wang, Judy H, PhD	Promoting Adherence to Mammography Use in Chinese Women (\$729,000)		
The Catholic University of America		1	\$40,000
Domingue, Philip M, MSW	Clinical Trial of Adapted Emotionally Focused Therapy for Bereaved Parents (\$40,000)		
CURRENT ACS RESEARCH AND TRAINING GRANTS IN GEORGIA		16 GRANTS	TOTAL \$9,369,000
Emory University		9	\$5,204,000
Elrod, Heath Acuff, PhD	The Role of COX-2 in Perifosine-induced Apoptosis (\$138,000)		
Howard, David H, PhD	The Impact of Prognosis on the Treatment of Patients with Localized Tumors (\$608,000)		
Jacob, Joshy, PhD	B Cell Memory (\$720,000)		

* Institutional Research Grant is a block grant awarded to an institution. The institution establishes its own review board to award smaller grants to its junior investigators.

CURRENT ACS RESEARCH AND TRAINING GRANTS IN GEORGIA, CONTINUED

Kersh, Gilbert J, PhD	Regulation of T Cell Fate (\$720,000)		
Ly, Hinh, PhD	Telomerase Dysfunction in Aplastic Anemia and Myelodysplastic Syndromes (\$720,000)		
Marcus, Adam, PhD	Investigating the Role of LKB1 in Cancer Cell Polarity (\$720,000)		
McCabe, Michael T, PhD	Local Features Affecting DeNovo Methylation of CpG Islands in Cancer (\$138,000)		
Wei Zhou, PhD	Disease Progression in Patients with 8p Allelic Imbalance Prostate Tumors (\$720,000)		
Ye, Keqiang, PhD	Dissection of the Nuclear GTPase PIKE Signaling (\$720,000)		
Georgia State University		1	\$780,000
King, Tricia, PhD	Childhood Brain Tumor Survivors: Predictors of Adult Functional Outcomes (\$780,000)		
Medical College of Georgia		2	\$1,440,00
Browning, Darren D, PhD	The Role of G-Kinase in Tumor Progression (\$720,000)		
Du, Quansheng, PhD	Interaction between Astra Microtubules and the Cell Cortex (\$720,000)		
University of Georgia		3	\$1,645,000
Abbott, Karen L, PhD	Identification of Glycoprotein Biomarkers of Breast Carcinoma (\$138,000)		
Dougan, Scott T, PhD	The Role of Nodal-Related Genes in Embryonic Development (\$707,000)		
Zhao, Shaying, PhD	Identification of Bona Fide Colorectal Tumorigenesis Events and Genes (\$800,000)		
Morehouse School of Medicine		1	\$300,000
Taylor, Beverly D, MD	Physician Training Award in Preventive Medicine (\$300,000)		
CURRENT ACS RESEARCH AND TRAINING GRANTS IN MARYLAND		33 GRANTS	TOTAL \$12,745,000
Johns Hopkins Hospital		1	\$717,000
Xing, Michael M, PhD	Clinical Use of Gene Mutation and Methylation Markers in Thyroid Cancer (\$717,000)		
Johns Hopkins University		18	\$9,475,000
Brovitz-Palmer, Sallie, BSN	Masters Degree Scholarship in Cancer Nursing (\$20,000)		
Casero, Robert A, PhD	Institutional Research Grant* (\$240,000)		
Clegg Smith, Catherine M, PhD	The Relationship Between Media Advocacy and Tobacco Attitudes and Use (\$434,000)		
Dinkova-Kostova, Albena T, PhD	Protection against Skin Cancer by Phase 2 Enzyme Induction (\$720,000)		
Emens, Leisha, MD, PhD	Manipulating Immunoregulatory Pathways to Maximize Breast Cancer Immunity (\$720,000)		
Grote, Eric, PhD	Cell Fusion of Mating Yeast (\$720,000)		
Hendrickson, Tamara, PhD	GPI Membrane Anchoring: Substrate Specificity and Tumorigenicity (\$720,000)		
Hristova, Kalina , PhD	Role of FGFR3 Transmembrane Domain in Cancer (\$645,000)		
Hung, Chien-fu, PhD	Control of Ovarian Cancer by Immunotherapy (\$720,000)		
Kirk, Gregory D, MD, MPH, PhD	Novel Approaches for Identifying Hepatitis C Progression to Liver Cancer (\$729,000)		
Mohammad, Helai P, PhD	The Role of CBX7 in Tumor Suppressor Gene Silencing (\$138,000)		
Pomerantz, Joel L, PhD	Function of CARD11 in T Cell Receptor Signaling (\$720,000)		
Powell, Jonathan D, MD, PhD	De Novo Methylation as a Means of Promoting Tumor-induced T cell Tolerance (\$720,000)		
Robinson, Douglas N, PhD	Investigation into Mechanical Feedback Regulation of Cytokinesis (\$720,000)		
Ruble, Kathy J, BSN, MSN, PNP	Musculoskeletal Outcomes after Childhood Bone Marrow Transplant (\$30,000)		
Shang, Jingjing, MSN	Fatigue-Reducing Strategies and Influencing Factors in Cancer Survivors (\$30,000)		
Snyder, Claire, PhD	Using Patient-Reported Outcomes Assessment to Improve the Quality of Care (\$729,000)		
Umbricht, Christopher B, MD, PhD	Genetic and Epigenetic Analysis of Thyroid Cancer (\$720,000)		
Maryland Biotechnology Institute		1	\$538,000
Wuyuan Lu, PhD	Mirror Image Phage Display Targeting Survivin (538,000)		

Continued

* Institutional Research Grant is a block grant awarded to an institution. The institution establishes its own review board to award smaller grants to its junior investigators.

CURRENT ACS RESEARCH AND TRAINING GRANTS IN MARYLAND, CONTINUED

NIH/National Cancer Institute		1	\$138,000
Yatrik M Shah, PhD	Mechanisms for Species Difference to Fibrate-Induced Liver Tumors (\$138,000)		
University of Maryland, Baltimore		12	\$1,877,000
Beckman, Tammy, BSN	Masters Degree Scholarship in Cancer Nursing (\$20,000)		
Broge, Kristine M, BSN	Masters Degree Scholarship in Cancer Nursing (\$10,000)		
Frankenhauser, Ted R, BSN	Masters Degree Scholarship in Cancer Nursing (\$20,000)		
Haisfield-Wolfe, Mary Ellen, BSN, MS, RN, OCN	Uncertainty and First Line Treatment for Head and Neck Cancer Patients (\$30,000)		
Mai, Volker, PhD, MPH	Diet, Microflora and Colorectal Carcinogenesis in African Americans (\$727,000)		
Nguyen, Phuong, BSN, BA	Masters Degree Scholarship in Cancer Nursing (\$20,000)		
Parker, Karen L, MSW	Social Workers and Smoking Cessation Counseling (\$40,000)		
Staines, Carrie A., BSN	Masters' Degree Scholarship in Cancer Nursing (\$20,000)		
Tanner, Alicia, BSN	Masters' Degree Scholarship in Cancer Nursing (\$20,000)		
Tomkinson, Alan, PhD	Institutional Research Grant* (\$220,000)		
Wilson, Gerald M, PhD	The Role of Tristetraprolin in Tumor Cell Progression (\$720,000)		
Woolery, Myra, MN	Constipation in the Pediatric Oncology Patient (\$30,000)		

CURRENT ACS RESEARCH AND TRAINING GRANTS IN NORTH CAROLINA

		39 GRANTS	TOTAL \$17,530,702
Duke University		3	\$296,000
Brinegar, Angela M, BSN	Masters Degree Scholarship in Cancer Nursing (\$20,000)		
Cushman, Ian, PhD	Role of Icm1-Catalyzed Methylation in Rho Signaling and Cancer (\$138,000)		
Thomenius, Michael J, PhD	Scythe Regulation of Apoptosis in Vertebrates and Invertebrates (\$138,000)		
Duke University Medical Center		5	\$3,065,000
Berchuck, Andrew, MD	Barbara Thomason Ovarian Cancer Professorship (\$500,000)		
Koh, James, PhD	Chromatin Immunoprecipitation Through the Retinoblastoma Tumor Suppressor (\$756,000)		
Lyerly, Herbert K, MD	Institutional Research Grant* (\$360,000)		
Potti, Anil, MD	A Genomic Approach to Targeted Therapy in Lung Carcinoma (\$729,000)		
York, Sally, MD, PhD	The Role of DNA Mismatch Repair in Response to 5-Fluorouracil (\$720,000)		
Research Triangle Institute		1	\$156,000
Subramanian, Sujha, PhD	Impact of Medicaid Copayment Policies on Access to Quality Cancer Treatment (\$156,000)		
University of North Carolina, Chapel Hill		24	\$10,818,702
Brewer, Noel T, PhD	Genomic Testing to Select an Optimal Breast Cancer Treatment (\$684,000)		
Cheever, Matthew L, PhD	R7-RGS Proteins: Essential Components in Heterotrimeric G Protein Signaling (\$138,000)		
Cook, Jeanette G, PhD	Control of Prereplication Complexes in Mammalian Cells (\$688,000)		
Cykert, Samuel, MD	Lung Cancer Surgery: Anatomy of Decisions against Life Saving Care (\$1,733,000)		
Doughman, Renee PhD	Characterization of Slit-Robo GTPase Activating Protein 2 in Tumorigenesis (\$138,000)		
Duronio, Robert J, PhD	Genetic Analysis of SCF E3 Ubiquitin Ligase Function in Drosophila (\$720,000)		
Healy, Kevin D, PhD	DLC-1 Tumor Suppression, Aberrant Rho GTPase Activation, and Lung Cancer (\$138,000)		
Huggins, Bruce W, PhD	HTLV-1 Genomic RNA Dimer Structure and Function (\$138,000)		
Karpnich, Natalie, PhD	Role of PTEN in Astrocytoma Suppression (\$138,000)		
Liu, Rihe, PhD	Novel Calmodulin-binding Proteins in Regulating Ubiquitin-Proteasome System (\$720,000)		
Maresca, Thomas J, PhD	Identifying Novel Spindle Assembly Checkpoint Components and Mechanisms (\$138,000)		
Porterfield, Deborah S, MD, MPH-TRAINEE: Arroyave, Ana Maria, MD, MPH	Physician Training Award in Preventive Medicine PTAPM-01-085-05 (\$300,000)		
Porterfield, Deborah S, MD, MPH	Physician Training Award in Preventive Medicine PTAPM-01-085-09 (\$300,000)		

* Institutional Research Grant is a block grant awarded to an institution. The institution establishes its own review board to award smaller grants to its junior investigators.

CURRENT ACS RESEARCH AND TRAINING GRANTS IN NORTH CAROLINA, CONTINUED

Rusan, Nasser M, PhD	Neural Stem Cells: Mitotic-spindle and Contractile Ring Positioning (\$138,000)		
Satia, Jessie, PhD, MPH	Longitudinal Study of White and African American Colon Cancer Survivors (\$1,465,000)		
Schroeder, Jane C, DVM, PhD	Health Care Access and Prostate Cancer Treatment in North Carolina: HCaP-NC (\$926,000)		
Sekelsky, Jeff, PhD	Drosophila Blm in Double-strand Break Repair (\$720,000)		
Spector, Denise J, BSN, MSN, MPH	Breast Cancer Risk Perception and Lifestyle Factors in Women at High Risk (\$30,000)		
Thomson, John Michael, PhD	The Role of MicroRNAs in Tumorigenesis (\$138,000)		
Vigil, Dominico, PhD	Role of the Ral Guanine Nucleotide Exchange Factors in Pancreatic Cancer (\$138,000)		
Yankaskas, Bonnie C, PhD	Assessing and Improving Radiologists' Mammography Interpretive Skills (\$143,902)		
Yankaskas, Bonnie C, PhD	Evaluation of False Positive Mammography in Community Practice (\$208,800)		
Zawistowski, Jon, PhD	Spatio-Temporal Control of MAP Kinase Activation by Scaffold Proteins (\$138,000)		
Zhang, Yanping, PhD	Cellular Functions and Biochemical Mechanisms of ARF (\$800,000)		
Wake Forest University		6	\$3,195,000

Dubey, Purnima, PhD	Effector T Cell Function in Androgen-independent Prostate Cancer (\$720,000)		
Foley, Kristie L, PhD	Colon Cancer Treatment, Surveillance, and Survival among the Poor (\$274,000)		
Hollis, Thomas, PhD	Structural Biology of DNA Repair Proteins (\$720,000)		
Inoue, Kazushi, MD, PhD	Roles of Dmp1 in the Prevention of HER2/neu-induced Breast Cancer (\$850,000)		
Miller, David P, MD	Overcoming Literacy Barriers in Colorectal Cancer Screening (\$195,000)		
Petty, W Jeffrey, MD	Retinoic Acid Receptor Beta 1': B99A Target for Lung Cancer Chemoprevention (\$436,000)		
CURRENT ACS RESEARCH AND TRAINING GRANTS IN SOUTH CAROLINA		4 GRANTS	TOTAL \$2,124,000

Medical University of South Carolina		2	\$693,000
---	--	----------	------------------

Chavin, Kenneth D, MD, PhD	Effects of Obesity on Musculocutaneous Flaps Used for Breast Reconstruction (\$333,000)		
Reed, Carolyn E, MD	Institutional Research Grant* (\$360,000)		
University of South Carolina		2	\$1,431,000

Dixon, Dan A, PhD	Post-Transcriptional Targeting COX-2 Gene Expression in Colorectal Cancer (\$711,000)		
Pittman, Douglas L, A168 PhD	Understanding the Roles of RAD51-Related Genes in Cancer Initiation (\$720,000)		

CURRENT ACS RESEARCH AND TRAINING GRANTS IN VIRGINIA

		7 GRANTS	\$3,049,000
--	--	-----------------	--------------------

University of Virginia		4	\$2,001,000
-------------------------------	--	----------	--------------------

Bauer, Todd W, MD	Role of uPAR Signaling in Pancreatic Cancer Growth, Invasion and Metastasis (\$729,000)		
Bender, Timothy P, PhD	Institutional Research Grant* (\$360,000)		
Erickson, Loren D, PhD	Targeting Plasma Cell Precursors as the Multiple Myeloma Stem Cell (\$717,000)		
Strayer, Scott M, MD, MPH	An Intervention to Improve Smoking Cessation Counseling by Medical Students (\$195,000)		

University of Virginia Health System		1	\$138,000
---	--	----------	------------------

Elliott, Michael R, PhD	The Role of ELMO1 in Apoptotic Cell Engulfment In Vivo (\$138,000)		
-------------------------	--	--	--

Virginia Commonwealth University		2	\$910,000
---	--	----------	------------------

Gewitz, David A, PhD	Institutional Research Grant* (\$270,000)		
Hart, Alton, MD, MPH	A Decision Making Tool for Prostate Cancer Screening (\$640,000)		

CURRENT ACS RESEARCH AND TRAINING GRANTS IN WEST VIRGINIA

		2 GRANT	TOTAL \$1,440,000
--	--	----------------	--------------------------

West Virginia University		2	\$1,440,000
---------------------------------	--	----------	--------------------

Jiang, Bing-Hua, PhD	Role of P13K Signaling in Ovarian Tumorigenesis (\$720,000)		
Liu, Jun, MD, PhD	The Role of Caveolin in Endothelial Cell Migration (\$720,000)		

* Institutional Research Grant is a block grant awarded to an institution. The institution establishes its own review board to award smaller grants to its junior investigators.

Data Sources & Technical Notes

Demographic Data

Demographic data describe the population distribution within a community. These data include age, race, income, education, as well as a host of other variables that describe the socioeconomic and cultural composition of a community. Demographic data are helpful in identifying populations most at risk for cancer in order to better target cancer control efforts. We must, however, ensure that interventions utilize messages and human resources reflective of the racial and cultural make-up of the community. Population data are obtained from the U.S. Census Bureau and Claritas.⁹

Cancer Incidence and Mortality Data

Cancer incidence data are cases that are newly-diagnosed during a specific time period; 2001-2005 in this issue, unless otherwise noted. Data on annual cancer incidence counts can be helpful, for example, in planning a particular survivorship program. Deaths due to cancer during a specific time period are referred to as **cancer mortality**. Counts of cancer deaths can also be used to describe the cancer burden in a community.

Comparing the number of new cancer cases/deaths from year to year is not recommended because population demographics change over time. Further, it is difficult to compare cancer patterns across two or more regions in the same year because of potential differences in population characteristics. Therefore, **age-adjusted rates**, which account for population differences, are used to track year-to-year changes in the cancer burden. Both incidence and mortality rates are age-adjusted to the 2000 U.S. standard population to allow for comparisons across populations with different age distributions.

Age-adjusted cancer incidence rates are the number of people per 100,000 who are diagnosed with cancer during a given time period, 2001-2005 unless otherwise noted. Age-adjusted cancer incidence rates are adjusted as noted above for the age distribution of the population. Cancer mortality rates are defined as the number of people per 100,000 who die and have cancer listed as the underlying cause of death on their death certificate. **Age-adjusted cancer mortality rates**, like age-adjusted incidence rates, account for population differences and should be used when comparing cancer mortality patterns from different populations. These mortality data also cover 2001-2005 unless otherwise noted. **Counts of cancer cases and deaths** are presented as total counts for the 5-year period 2001-2005 unless otherwise noted. For an average annual count, divide the 5-year count by five.

For the **county- and ward-specific cancer data**, certain restrictions apply to the presentation of the cancer case/death counts and rates. In order to maintain privacy of individuals, the number of cases/deaths is not included for categories in which the count is less than six. Also, to avoid variation in data due to small numbers, incidence and mortality rates are only presented

if the case/death count exceeds 25. Exceptions to these restrictions are noted where applicable.

Statistical significance is tested on the individual county/ward age-adjusted incidence and mortality rates to determine whether or not the rate is statistically significantly different from the overall state rate. If an incidence or mortality rate is **statistically** significantly lower than the state rate, this is indicated by a '<' placed next to the rate and if a rate is significantly higher than the state rate, a '>' is next to that rate. Statistical significance is only tested in case/death categories when the count exceeds 25. A statistically significantly higher or lower rate does not necessarily mean that the difference is biologically or clinically important or **of special note**. These differences could have occurred by chance alone since we are making multiple comparisons.



Stage at Time

of Cancer Diagnosis indicates whether or not the cancer has spread to other organs and regions of the body. Also, stage at diagnosis is one of the tumor characteristics that the oncologist uses to select a treatment for the patient. Summary categories for stage at diagnosis are as follows:

In Situ refers to a neoplasm that is “noninvasive” and confined to a small area within the tissue of origin;

Localized is an invasive malignant cancer confined entirely to the organ of origin;

Regional is a malignant cancer that 1) extends beyond the limits of the organ of origin into surrounding organs/tissues or 2) involves regional lymph nodes by way of lymphatic system; and

Distant indicates that the cancer has spread to other parts of the body, such as the lungs, liver, brain or to distant lymph nodes.

Estimates of New Cancer Cases and Deaths for 2008 are provided by the American Cancer Society’s Surveillance Research Department.² Beginning in 2007, estimated new cancer cases were computed using a new, more accurate method developed by re-

searchers at the National Cancer Institute and the American Cancer Society. Improvements in the new model include use of data from a much larger percentage of the US population, allowance for geographical variation in cancer incidence, adjustment for delays in reporting and the inclusion of many socio-demographic, medical facility, lifestyle and cancer screening behavior variables. For more detail, visit www.cancer.org/docroot/stt/stt_0.asp

State and county cancer incidence and mortality data are provided by the State Cancer Registries in the South Atlantic (SA) Division. In most SA states, mortality data are also provided by the State Cancer Registry, but in Maryland, Virginia and West Virginia, these data are provided by the State Vital Statistics Departments. Contact information for these state registries and vital statistics offices is on page 87.

Data on U.S. cancer incidence, mortality and survival are from the Surveillance, Epidemiology and End Results (SEER) Program.⁷

Prevention and Early Detection - Risk Factor Data

Thirty percent of cancer deaths, including nearly 90% of lung cancer deaths, are the result of tobacco use.³ Although tobacco use, primarily cigarette smoking, has been associated most strongly with cancers of the lung, bronchus and other respiratory organs, it also increases risks of cancers of the pancreas, cervix, kidney, bladder and stomach, and acute myeloid leukemia. Utilizing tobacco prevalence data to identify differences between gender, race/ethnicity, age and educational status will help focus comprehensive efforts to decrease consumption of tobacco products in specific populations. Identification of populations with high smoking rates will also help target areas where policies and ordinances regarding clean indoor air are still needed.

Eating a healthy diet, engaging in physical activity and maintaining a healthy weight are additional lifestyle factors that help reduce the risk of developing cancer. The prevalence of each of these modifiable risk behaviors among both adults and youth is reported here as an important measure of each state's cancer burden. It is estimated that obtaining recommended cancer screening tests and adopting healthy behaviors such as good nutrition, reasonable body weight and regular physical exercise could eliminate at least 50% of cancer deaths.²

Risk factor data used in the South Atlantic Division Cancer Facts & Figures 2008 were obtained from surveys conducted by the **Behavioral Risk Factor Surveillance System (BRFSS)**, the **Youth Risk Behavior Surveillance System (YRBSS)** and the **Youth Tobacco Survey (YTS)** for students in high school. A description of the data sources as well as a summary of the risk factor determinants is provided below.

Adult Risk Factor Data: The BRFSS is a survey of the Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) and the US states and territories. Data are gathered through computer-assisted telephone interviews with adults ages 18 and older who live in a household in a state or US territory. BRFSS data are reported on an annual basis although not all questions are asked annually. Screening data are from the 2006 BRFSS Survey and risk factor data are from the 2007 survey.⁵

Youth Risk Factor Data: The YRBSS is a state-based survey of the CDC and NCCDPHP in voluntary collaboration with states. The survey is designed to provide state and local prevalence estimates on health risk behaviors, such as tobacco use, unhealthy dietary behaviors and physical inactivity, among youth who attend public high schools. The YRBSS is a biennial survey conducted in odd-numbered years and data presented here are from the 2007 survey. Not all states participate in the YRBSS.¹¹

Youth Tobacco Data (Virginia): The Youth Tobacco Survey (YTS), also developed by the CDC, includes international, national and state school-based surveys of middle school and high school students. The YTS and YRBSS use identical sampling methods and the same wording for questions about tobacco use to enable states to use the high school data on tobacco use collected by both surveys. Not all states participate in the YTS.¹¹

Risk factor data selected for this publication are related to specific recommendations in the Society's guidelines on Nutrition and Physical Activity for Cancer Prevention as follows:²

Tobacco Use:

- **ACS Recommendation:** Do not use any tobacco products.
- **BRFSS Question:** Adults who are current smokers.
- **YRBSS Questions:** High school students who (1) have smoked cigarettes at least one day during the last 30 days, (2) have used chewing tobacco, snuff or dip on at least 1 day during the 30 days before the survey.

Physical activity:

- **ACS Recommendation:** Engage in at least 30 minutes of moderate to vigorous physical activity, above usual activities, on 5 or more days of the week; 45 to 60 minutes of intentional physical activity are preferable.
- **BRFSS Question:** Adults with 30+ minutes of moderate physical activity five or more days per week, or vigorous physical activity for 20+ minutes three or more days per week.
- **YRBSS Question:** High school students who were physically active during any kind of physical activity that increased their heart rate and made them breathe hard some of the time, for a total of at least 60 minutes/day on 5 or more days during the 7 days before the survey.

Continued

Nutrition:

- **ACS Recommendation:** Eat 5 or more servings of a variety of vegetables and fruits every day.
- **BRFSS Question:** Adults who have consumed fruits and vegetables 5 or more times per day.
- **YRBSS Question:** High school students who have consumed 5 or more fruits and vegetables per day.

Overweight:

- **ACS Recommendations:** (1) Avoid excessive weight gain throughout life, (2) Achieve and maintain a healthy weight if currently overweight or obese.
- **BRFSS Question:** Weight classification by Body Mass Index (BMI) that is overweight (BMI = 25 -< 30) or obese (BMI >= 30.0).
- **YRBSS Question:** High school students who were at or above the 85th percentile but below the 95th percentile for body mass index (overweight) or above the 95th percentile (obese), by age and sex, based on reference data from the National Health and Nutrition Examination Survey.

Each state section also includes a two-page **At A Glance** report that summarizes state-specific initiatives on tobacco control¹⁰, cancer screening⁶, comprehensive cancer control efforts⁸, improved access to care³ and other achievements⁴.

Special State Notes

Notes on Maryland Cancer Registry Data

Incidence data for 2004 and 2005 from the Maryland Cancer Registry have been suppressed since these data are undergoing a data quality review and were unavailable at time of publication. Maryland state and county incidence data are included up to 2003, or for multiple years 1999-2003. Stage at diagnosis data are also available for 1999-2003.

Notes on Virginia Cancer Registry Data

Data in the Virginia Cancer Registry (VCR) reflect a conservative account of the disease. Not all outpatient facilities and private pathology laboratories report cases to the registry yet. Virginia residents sometimes travel out-of-state for diagnosis and treatment and may not be reported to the VCR. While the registry does maintain exchange agreements with cancer registries in neighboring states, there is some lag time in posting those cases. Cancer data for areas primarily in Southwest Virginia may be under-reported; interpret these data carefully. Because the completeness of reporting varies in different areas of the state, some observed differences in case counts or rates are most likely reporting artifacts. For instance, rates may be higher in more urbanized areas because case ascertainment is

more complete. Similarly, case reporting may be more complete for certain racial groups, cancer sites, or diagnosis stages. Cancer registry staff have not been able to assess the extent to which these biases exist, so interpret the data with caution.

Data Sources

1. American Cancer Society, Cancer Facts & Figures 2008. Atlanta, GA 2008
2. American Cancer Society, Cancer Prevention & Early Detection Facts and Figures 2008. Atlanta, GA 2008
3. Access to Care: Health Resources and Services Administration's Bureau of Health Professionals, 2005
Unite for Sight, Inc., 2008 (Federally Qualified Health Center and free clinic Information) <http://uniteforsight.org/freclinics.php>
4. ACoS Approved Hospitals: <http://web.facs.org/cpm/default.htm>
5. Adult Risk Factor Data: Behavioral Risk Factor Surveillance System Survey Data (BRFSS). Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2007, 2008, www.cdc.gov/brfss
6. BCCEDP, 2004 Insurance Coverage Data: National Cancer Institute: State Cancer Legislative Database, 2008
7. Cancer Data (U.S.): SEER Cancer Statistics Review, 1975-2005, Ries LAG, Melbert D, Krapcho M, Stinchcomb DG, Howlander N, Horner MJ, Mariotto A, Miller BA, Feuer EJ, Altekruse SF, Lewis DR, Clegg L, Eisner MP, Reichman M, Edwards BK (eds). National Cancer Institute. Bethesda, MD, http://seer.cancer.gov/csr/1975_2005/, based on November 2007 SEER data submission, posted to the SEER web site, 2008, www.seer.cancer.gov
8. Comprehensive Cancer Control: National Comprehensive Cancer Control Program (NCCCP), Division of Cancer Protection and Control, Centers for Disease Control and Prevention, www.cdc.gov/cancer/ncccp/
9. Demographic Data: Claritas Inc., Copyright © 2007 Thomson Healthcare. ALL RIGHTS RESERVED
American Fact Finder, U.S. Census Bureau: <http://factfinder.census.gov/>
10. Tobacco: Americans For Nonsmokers' Rights Foundation, 2008 (www.no-smoke.org)
State Medicaid Tobacco Dependence Treatment Survey 2005, (MMWR (2006) 55(44):1194-1197)
Cigarette Excise Tax as of 7/01/2008: www.tobaccofreekids.org/research/factsheets/pdf/0097.pdf
Centers for Disease Control and Prevention (CDC). Reducing the Health Consequences of Smoking: 25 Years of Progress, Atlanta, GA. U.S. Department of Health and Human Services, 1989.
State Tobacco Prevention Spending vs. State Tobacco Revenues (April 2008): www.tobaccofreekids.org/reports/settlements/2008/spendingrevenues.pdf.
11. Youth Risk Data: Youth Tobacco Survey (YTS), 2005 VA and Youth Risk Behavior Surveillance System (YRBSS), 2007 for DE, DC, GA, MD, NC, SC, WV, Centers for Disease Control and Prevention 2008, www.cdc.gov/yrbss.

State Cancer Registries & Vital Statistics

DELAWARE

Alison Shevock, PhD, Cancer Epidemiologist
Delaware Chronic Disease Bureau
540 South DuPont Highway, Suite 10
Dover, DE 19901
Phone: (302) 744-1036
<http://www.dhss.delaware.gov/dhss/dph/dpc/registry.html>

DISTRICT OF COLUMBIA

Aaron Adade, PhD, Director
District of Columbia Cancer Registry
825 N. Capitol, NE
Washington, DC 20002
Phone: (202) 442-5910
<http://doh.dc.gov/doh/>
under Special Programs/Cancer Control Registry

GEORGIA

Rana Bayakly, MPH, Director
Georgia Comprehensive Cancer Registry
2 Peachtree St, NW, Suite 14.283
Atlanta, GA 30303
Phone: (404) 657-1943
<http://health.state.ga.us/programs/gccr/>

MARYLAND

Kimberly Stern, MHA, CTR, Director
Maryland Cancer Registry
Maryland Dept of Health & Mental Hygiene
201 West Preston Street
Baltimore, MD 21201
Phone: (410) 767-5521
<http://www.fha.state.md.us/cancer/registry/>

Hal Sommers, MA, Research Statistician
Maryland Vital Statistics Administration
Maryland Dept of Health & Mental Hygiene
201 West Preston Street, Room 425
Baltimore, MD 21201
Phone: (410) 767-5937
<http://www.vsa.state.md.us/>

NORTH CAROLINA

Karen Knight, MS, Director
North Carolina Central Cancer Registry
1908 Mail Service Center
Raleigh, NC 27699-1908
Phone: (919) 715-4556
<http://www.schs.state.nc.us/SCHS/CCR/>

SOUTH CAROLINA

Susan Bolick-Aldrich, MSPH, CTR, Director
South Carolina Central Cancer Registry
SC Dept of Health & Environmental Control
810 Dutch Square Blvd, Suite 220
Columbia, SC 29210
Phone: (803) 731-1419, x107
<http://www.scdhec.gov/co/phis/biostatistics/SCCCR/sc-crmmain.htm>

VIRGINIA

Jim Martin, PhD, Director
Virginia Cancer Registry
Virginia Department of Health
109 Governor Street, 10th Floor
Richmond, VA 23219
Phone: (804) 864-7865
<http://www.vahealth.org/cdpc/cancer/index.asp>

Calvin Reynolds, Director
Division of Health Statistics
Virginia Department of Health
1601 Willow Lawn Drive, Ste 237
Richmond, VA 23230
Phone: (804) 662-6276
<http://www.vdh.virginia.gov/healthstats/>

WEST VIRGINIA

Patricia Colsher, PhD, Director
West Virginia Cancer Registry
WV Dept of Health & Human Resources
350 Capitol Street, Room 125
Charleston, WV 25301
Phone: (304) 558-6421
<http://www.wvdhhr.org/IDEP/cancer.htm>

Daniel Christy, MPA, Director
WV Health Statistics Center
350 Capitol Street, Room 165
Charleston, WV 25301
Phone: (304) 558-9100
<http://www.wvdhhr.org/bph/oehp/vital04/>

American Cancer Society South Atlantic Division Offices

Atlanta Headquarters

PO Box 56567
250 Williams Street
Atlanta, GA 30343
404-816-7800

Region 1

PO Box 56566
250 Williams Street
Atlanta, GA 30343
404-315-1123

Region 2

323 Pine Avenue, Suite 100
Albany, GA 31701
229-446-1073

Region 3

5900 Core Road, Suite 504
North Charleston, SC 29406
843-744-1922

Region 4

8300 Health Park, Suite 10
Raleigh, NC 27615
919-334-5218

Region 5

6000 Fairview Road, Suite 200
Charlotte, NC 28210
704-552-6147

Region 6

4240 Park Place Court
Glen Allen, VA 23060
804-527-3700

Region 7

4416 Expressway Drive
Virginia Beach, VA 23452
757-493-7940

Region 8

301 RHL Blvd, Suite 6 & 7
Charleston, WV 25309
304-746-9950

Region 9

2840 Electric Road, Suite 106A
Roanoke, VA 24018
540-774-2716

Region 10

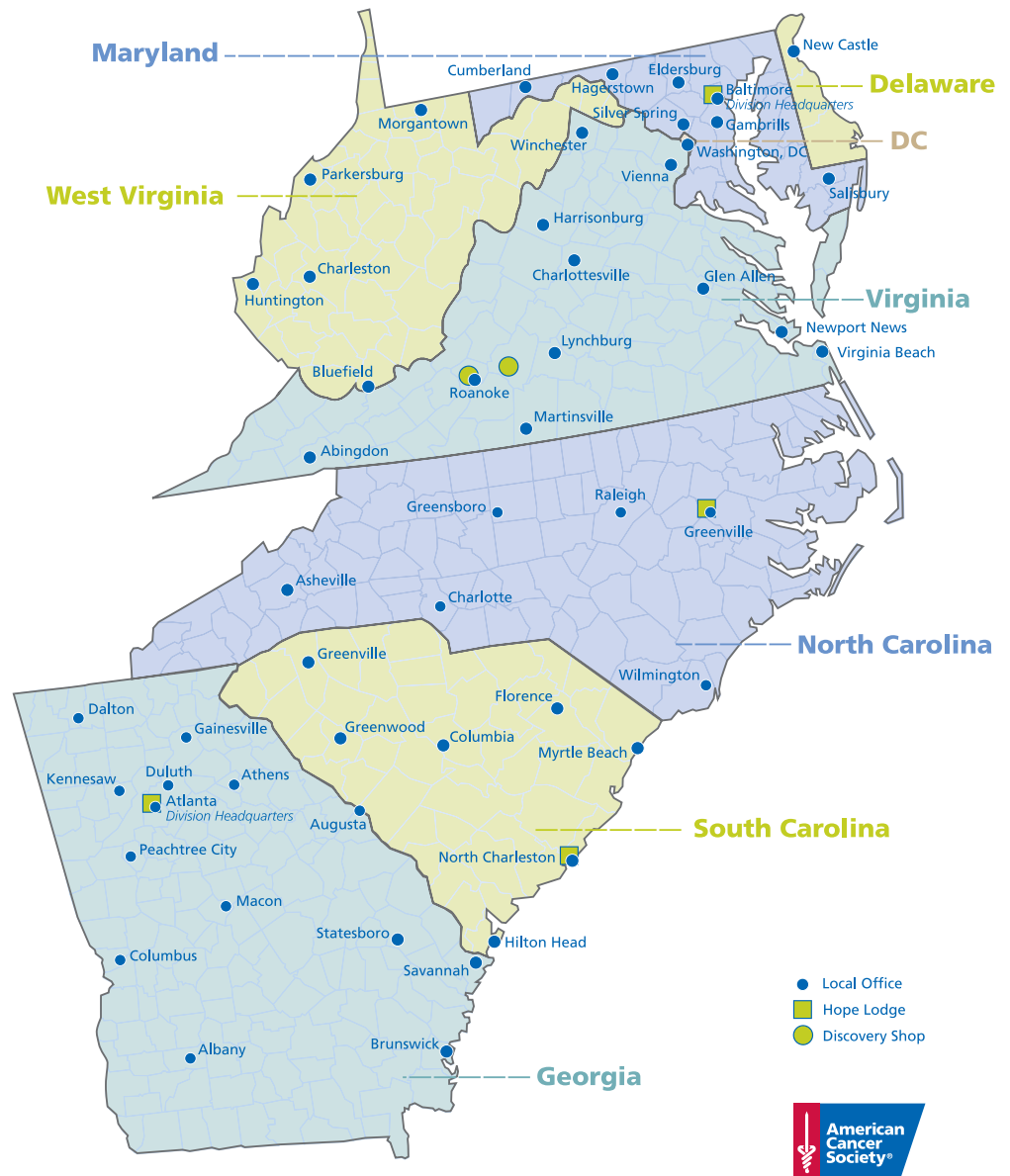
1875 Connecticut Ave, NW, Suite 730
Washington, DC 20009
202-483-2600

Region 11

White Marsh Headquarters
8219 Town Center Drive
Baltimore, MD 21236
410-931-6850

Region 12

92 Read's Way, Suite 205
New Castle, DE 19720
302-324-4227



Place CD Sleeve Here

**Having cancer is hard.
Finding help shouldn't be.
The American Cancer Society can help.**

1.800.ACS.2345
1-800-227-2345
www.cancer.org

Hope.Progress.Answers.®



South Atlantic Division, Inc.