

Cancer Health Disparities

Key Points

- The National Cancer Institute (NCI) defines “cancer health disparities” as adverse differences in cancer incidence (new cases), cancer prevalence (all existing cases), cancer death (mortality), cancer survivorship, and burden of cancer or related health conditions that exist among specific population groups in the United States (see Question 1).
- Complex and interrelated factors contribute to the observed disparities in cancer incidence and death among racial, ethnic, and underserved groups. The most obvious factors are associated with a lack of health care coverage and low socioeconomic status (see Question 2).
- Although cancer deaths have declined for both Whites and African Americans/Blacks living in the United States, African Americans/Blacks continue to suffer the greatest burden for each of the most common types of cancer (see Question 4).
- American White women have the highest incidence rate for breast cancer, although African American/Black women are most likely to die from the disease (see Question 5).
- African American/Black men have the highest incidence rate for prostate cancer in the United States and are more than twice as likely as White men to die of the disease (see Question 9).
- NCI is pursuing a variety of programs and initiatives to address cancer health disparities. In 2001, the Center to Reduce Cancer Health Disparities (CRCHD) was established to serve as the cornerstone of NCI’s efforts to reduce the unequal burden of cancer in our nation (see Questions 15 and 16).

1. How does the National Cancer Institute (NCI) define “cancer health disparities”?

The National Cancer Institute (NCI) defines “cancer health disparities” as *adverse differences in cancer incidence (new cases), cancer prevalence (all existing cases), cancer death (mortality), cancer survivorship, and burden of cancer or related health conditions that exist among specific population groups in the United States*. These population groups may be characterized by age, disability, education, ethnicity, gender, geographic location, income, or race. People who are poor, lack health insurance, and are medically underserved (have limited or no access to effective health care)—regardless of ethnic and racial background—often bear a greater burden of disease than the general population.

A close look at cancer incidence and death statistics reveals that certain groups in this country suffer disproportionately from cancer and its associated effects, including premature death. For example, African Americans/Blacks, Asian Americans, Hispanic/Latinos, American Indians, Alaska Natives, and underserved Whites are more likely than the general population to have higher incidence and death statistics for certain types of cancer.

2. What factors contribute to cancer health disparities?

Complex and interrelated factors contribute to the observed disparities in cancer incidence and death among racial, ethnic, and underserved groups. The most obvious factors are associated with a lack of health care coverage and low socioeconomic status (SES).



SES is most often based on a person's income, education level, occupation, and other factors, such as social status in the community and where he or she lives. Studies have found that SES, more than race or ethnicity, predicts the likelihood of an individual's or a group's access to education, certain occupations, health insurance, and living conditions—including conditions where exposure to environmental toxins is most common—all of which are associated with the risk of developing and surviving cancer. SES, in particular, appears to play a major role in influencing the prevalence of behavioral risk factors for cancer (for example, tobacco smoking, physical inactivity, obesity, and excessive alcohol intake, and health status), as well as in following cancer screening recommendations.

Research also shows that individuals from medically underserved populations are more likely to be diagnosed with late-stage diseases that might have been treated more effectively or cured if diagnosed earlier. Financial, physical, and cultural beliefs are also barriers that prevent individuals or groups from obtaining effective health care.

3. How does NCI gather data on cancer incidence and death for various population groups in the United States?

The Surveillance, Epidemiology, and End Results (SEER) Program is NCI's authoritative source for information about cancer incidence and survival. SEER collects cancer incidence and survival data from cancer registries that cover approximately 26 percent of the U.S. population. Over several decades, SEER has worked diligently to better represent racial, ethnic, and socioeconomic diversity and currently covers 23 percent of African Americans/Blacks, 40 percent of Hispanic/Latinos, 42 percent of American Indians and Alaska Natives, 53 percent of Asian Americans, and 70 percent of Hawaiian/Pacific Islanders living in the United States. In addition, SEER statistics reflect the U.S. population in regard to poverty and education, with both urban and rural groups represented. The *Methods for Measuring Cancer Disparities: A Review Using Data Relevant to Healthy People 2010 Cancer-Related Objectives* report (<http://seer.cancer.gov/publications/disparities/>) describes how data are collected to measure cancer health disparities.

The incidence and death statistics presented in this fact sheet are from Tables I-23 through I-28 of the *SEER Cancer Statistics Review, 1975-2004* (http://seer.cancer.gov/csr/1975_2004). These statistics are most often reported as the numbers of new cases of invasive cancer and cancer deaths per year per 100,000 persons in the U.S. population. When the statistics focus on cancer incidence and death in a single gender—for example, on female breast cancer or male prostate cancer—the numbers are per 100,000 persons of that gender. In addition, the SEER statistics are age-adjusted to the 2000 U.S. standard population. Age-adjustment is done because different population groups may not be comparable with respect to age. Age-adjustment allows cancer incidence and death statistics (expressed below as cancer incidence and death “rates”) for these population groups to be compared.

4. What are the overall cancer incidence and death rates for different populations living in the United States?

Although cancer deaths have declined for both Whites and African Americans/Blacks living in the United States, African Americans/Blacks continue to suffer the greatest burden for each of the most common types of cancer. For all cancers combined, the death rate is 25 percent higher for African Americans/Blacks than for Whites. Incidence and death rates for all cancers among U.S. racial/ethnic groups are shown in Table 1.

Table 1. Overall Cancer Incidence and Death Rates

Racial/Ethnic Group	All Sites	
	Incidence	Death
All	470.1	192.7
African American/Black	504.1	238.8
Asian/Pacific Islander	314.9	115.5
Hispanic/Latino	356.0	129.1
American Indian/Alaska Native	297.6	160.4
White	477.5	190.7

Statistics are for 2000-2004, age-adjusted to the 2000 U.S. standard million population, and represent the number of new cases of invasive cancer and deaths per year per 100,000 men and women.*

5. How do breast cancer incidence and death rates differ for women from different racial or ethnic groups?

In the United States, White women have the highest incidence rate for breast cancer, although African American/Black women are most likely to die from the disease. Breast cancer incidence and death rates are lower for women from other racial and ethnic groups than for White and African American/Black women. Incidence and death rates for female breast cancer are shown in Table 2.

Table 2. Female Breast Cancer Incidence and Death Rates

Racial/Ethnic Group	Breast	
	Incidence	Death
All	127.8	25.5
African American/Black	118.3	33.8
Asian/Pacific Islander	89.0	12.6
Hispanic/Latino	89.3	16.1
American Indian/Alaska Native	69.8	16.1
White	132.5	25.0

Statistics are for 2000-2004, age-adjusted to the 2000 U.S. standard million population, and represent the number of new cases of invasive cancer and deaths per year per 100,000 women.*

6. What factors might contribute to the higher breast cancer death rate observed in African American/Black women?

Lack of medical coverage, barriers to early detection and screening, and unequal access to improvements in cancer treatment may contribute to observed differences in survival between African American/Black and White women. In addition, recent NCI-supported research indicates that aggressive breast tumors are more common in younger African American/Black and Hispanic/Latino women living in low SES areas. This more aggressive form of breast cancer is less responsive to standard cancer treatments and is associated with poorer survival (1).

7. How do cervical cancer incidence and death rates differ for women from different racial or ethnic groups?

Compared to White women in the general population, African American/Black women are more likely to be diagnosed with cervical cancer. Hispanic/Latino women, however, have the highest cervical cancer incidence rate. Interestingly, White women living in Appalachia suffer a disproportionately higher risk for developing cervical cancer than other White women. The highest death rate from cervical cancer is among African American/Black women. Incidence and death rates for cervical cancer are shown in Table 3.

Table 3. Cervical Cancer Incidence and Death Rates

Racial/Ethnic Group	Cervix	
	Incidence	Death
All	8.7	2.6
African American/Black	11.4	4.9
Asian/Pacific Islander	8.0	2.4
Hispanic/Latino	13.8	3.3
American Indian/Alaska Native	6.6	4.0
White	8.5	2.3

Statistics are for 2000-2004, age-adjusted to the 2000 U.S. standard million population, and represent the number of new cases of invasive cancer and deaths per year per 100,000 women.*

8. What factors might contribute to the greater burden of cervical cancer among Hispanic/Latino and African American/Black women?

The disproportionate burden of cervical cancer in Hispanic/Latino and African American/Black women is primarily due to a lack of screening. In an effort to understand this disparity in cervical cancer screening, NCI conducted a study of regions within the United States where cervical cancer incidence rates are high. They found that cervical cancer rates reflected a larger problem of unequal access to health care. The *Excess Cervical Cancer Mortality: A Marker for Low Access to Health Care in Poor Communities* report (<http://crchd.cancer.gov/attachments/excess-cervcanmort.pdf>) supports reaching these medically underserved groups through culturally sensitive trained care providers; increasing the number of female health providers, particularly those of the same race or ethnicity; and removing cultural and economic barriers to break down resistance to screening for cervical and other cancers.

Persistent infection with certain strains of the human papillomavirus (HPV) is the major cause of most cases of cervical cancer. An HPV vaccine is now available that targets two strains of the virus that are associated with development of cervical cancer and account for approximately 70 percent of all cases of cervical cancer worldwide. This vaccine prevents infection by two HPV strains and has the potential to reduce cervical cancer-related health disparities both in the United States and around the world. More information can be found in the NCI fact sheet *Human Papillomavirus (HPV) Vaccines: Questions and Answers* at <http://www.cancer.gov/cancertopics/factsheet/Prevention/HPV-vaccine> on the Internet.

9. How do prostate cancer incidence and death rates differ for men from different racial or ethnic groups?

African American/Black men have the highest incidence rate for prostate cancer in the United States and are more than twice as likely as White men to die of the disease. The lowest death rates for prostate cancer are found in Asian/Pacific Islander men. Incidence and death rates for prostate cancer are shown in Table 4.

Table 4. Prostate Cancer Incidence and Death Rates

Racial/Ethnic Group	Prostate	
	Incidence	Death
All	168.0	27.9
African American/Black	255.5	62.3
Asian/Pacific Islander	96.5	11.3
Hispanic/Latino	140.8	21.2
American Indian/Alaska Native	68.2	21.5
White	161.4	25.6

Statistics are for 2000-2004, age-adjusted to the 2000 U.S. standard million population, and represent the number of new cases of invasive cancer and deaths per year per 100,000 men.*

10. What factors might contribute to the disproportionate burden of prostate cancer among African American/Black men?

The higher incidence of prostate cancer in African American/Black men compared with men from other racial/ethnic groups prompted the hypothesis that genetic factors might account, in part, for the observed differences. Recent findings from NCI's Cancer Genetic Markers of Susceptibility (CGEMS) program (<http://cgems.cancer.gov>) and other investigations support this hypothesis. Researchers have identified changes—called variants—in human DNA that are associated with the risk of developing prostate cancer. Different combinations of these variants have been found in men from different racial/ethnic backgrounds, and each combination is associated with higher or lower risk for prostate cancer. Nearly all of the variants associated with an increased risk of developing prostate cancer were found most often in African American/Black men, and certain combinations of these variants were associated with a five-fold increased risk of prostate cancer in men of this racial/ethnic group (2).

In addition, research has shown that low SES, lack of health insurance coverage, unequal access to health care services, and absence of ties to a primary care physician are barriers to screening for prostate cancer and the timely diagnosis of this disease, making African American/Black men less likely to receive regular physical examinations and screening for prostate cancer (3).

11. Do incidence and death rates differ for colorectal or lung cancer among various racial and ethnic groups?

African American/Black men and women have the highest incidence and death rates for both colorectal and lung cancers, while Hispanic/Latinos have the lowest rates. Colorectal and lung cancer incidence and death rates are shown in Table 5.

Table 5. Colorectal and Lung Cancer Incidence and Death Rates

Racial/Ethnic Group	Colorectal		Lung and Bronchus	
	Incidence	Death	Incidence	Death
All	51.6	19.4	64.5	54.7
African American/Black	62.1	26.7	76.6	62.0
Asian/Pacific Islander	41.6	12.3	39.4	26.9
Hispanic/Latino	39.3	13.6	33.3	23.6
American Indian/Alaska Native	40.8	17.0	44.0	39.9
White	51.2	18.9	65.7	55.0

Statistics are for 2000-2004, age-adjusted to the 2000 U.S. standard million population, and represent the number of new cases of invasive cancer and deaths per year per 100,000 men and women.*

12. Which cancers are diagnosed most often in Asian/Pacific Islander populations?

Asian Americans and Pacific Islanders have the highest incidence rates for both liver and stomach cancer and are twice as likely to die from these cancers as Whites. Incidence and death rates for stomach, liver, and bile duct cancers are shown in Table 6.

Table 6. Liver and Stomach Cancer Incidence and Death Rates

Racial/Ethnic Group	Liver and Bile Duct		Stomach	
	Incidence	Death	Incidence	Death
All	6.2	4.9	8.1	4.2
African American/Black	7.6	6.5	12.5	8.2
Asian/Pacific Islander	13.9	10.6	14.3	8.0
Hispanic/Latino	9.7	7.6	12.3	6.8
American Indian/Alaska Native	9.7	8.4	11.5	7.2
White	5.2	4.5	7.1	3.7

Statistics are for 2000-2004, age-adjusted to the 2000 U.S. standard million population, and represent the number of new cases of invasive cancer and deaths per year per 100,000 men and women.*

13. Why is stomach cancer more commonly diagnosed in Asian/Pacific Islander populations?

Asian/Pacific Islanders, similar to Hispanic/Latinos, have lower incidence rates than Whites for most common cancers. However, they suffer more often from cancers that are related to infections. One risk factor for stomach cancer is infection with a bacterium called *Helicobacter pylori*, or *H. pylori*. Although additional study is needed, infection with *H. pylori* may explain, in part, why Asian/Pacific Islander populations have higher rates for this type of cancer.

14. Which cancer is more commonly diagnosed in American Indian and Alaska Native populations?

American Indians and Alaska Natives have higher incidence and death rates for kidney cancer than other racial/ethnic groups. However, these rates should be viewed with caution because the data currently available for American Indian/Alaska Native populations are not representative. An analysis of cancer incidence and mortality data within Native American populations is the focus of the *Annual Report to the Nation on the Status of Cancer 1975-2004, Featuring Cancer in American Indians and Alaska Natives* (<http://www.interscience.wiley.com/cancer/report2007>), a yearly publication that summarizes the latest cancer statistics. Incidence and death rates for kidney and renal pelvis cancers are shown in Table 7.

Table 7. Kidney Cancer Incidence and Death Rates

Racial/Ethnic Group	Kidney and Renal Pelvis	
	Incidence	Death
All	12.8	4.2
African American/Black	14.3	4.1
Asian/Pacific Islander	6.3	1.7
Hispanic/Latino	12.4	3.6
American Indian/Alaska Native	14.7	6.5
White	13.3	4.3

Statistics are for 2000-2004, age-adjusted to the 2000 U.S. standard million population, and represent the number of new cases of invasive cancer and deaths per year per 100,000 men and women.*

15. How is NCI working in a coordinated way to reduce cancer health disparities?

NCI has a longstanding history of pursuing research aimed at understanding and addressing cancer health disparities. As many as 20 years ago, NCI established the Special Populations Studies Branch to study groups of people within the United States who suffer a greater burden of cancer. NCI's commitment to underserved populations continued to grow and mature over the years, and, in 2001, the institute established the Center to Reduce Cancer Health Disparities (CRCHD) to serve as the cornerstone of NCI's efforts to reduce the unequal burden of cancer in our nation.

Today, CRCHD is working to strengthen and integrate NCI's studies in basic, clinical, translational, and community-based research that offer opportunities to advance our understanding of cancer-related health disparities and ways to effectively address them. CRCHD manages specific programs and grants aimed at examining the diverse aspects of cancer-related disparities. These programs are addressing the cultural barriers and biases that racial and ethnic minorities encounter in obtaining appropriate and timely treatment, as well as financial and physical restraints that prevent underserved populations from obtaining quality health care. CRCHD is also leading NCI's efforts to train students and investigators from diverse populations to pursue research in cancer, as well as research examining factors that contribute to cancer health disparities.

CRCHD also cosponsors an annual Cancer Health Disparities Summit. During this 3-day meeting, NCI-funded researchers from training, education, and outreach programs gather to discuss both disparities issues that are present in their communities and possible solutions for these issues.

16. What are some of NCI's programs and projects aimed at addressing cancer health disparities and increasing access to quality cancer care for medically underserved communities?

NCI and its divisions support diverse research programs that address the behavioral, biological, treatment, prevention, and economic issues that all contribute to cancer health disparities. The programs listed below highlight NCI's commitment to addressing the needs of the medically underserved.

- NCI Community Cancer Centers Program (NCCCP)
(<http://ncccp.cancer.gov/index.htm>)
In 2007, NCI launched the pilot phase of the NCCCP, an initiative that aims to bring the latest advances in cancer care to patients in their own communities. Over the next three years, 16 community hospitals and health care systems will work with NCI to identify the best strategies for delivering state-of-the-art cancer care to the greatest number of Americans in the communities in which they live. The program seeks to bring more Americans into a system of high-quality cancer care, increase participation in clinical trials, reduce cancer health care disparities, and improve information sharing among community cancer centers. The NCCCP will focus on underserved communities and groups that are disproportionately affected by cancer.
- The Centers for Population Health and Health Disparities (CPHHD)
(<http://cancercontrol.cancer.gov/populationhealthcenters/>)
Initiated in 2003, the CPHHD supports a transdisciplinary approach to overcoming health disparities. The eight centers of the CPHHD initiative are supported by a collaboration of NCI and other National Institutes of Health institutes and offices. NCI supports five of the eight centers that address cancer health disparities through innovative research to understand the complex interaction of the social and physical environment, in combination with behavioral and biological factors that determine health and disease in diverse populations.
- The Community Networks Program (CNP)
(<http://crchd.cancer.gov/cnp/background.html>)
The CNP aims to reduce cancer health disparities through community-based education, training, and research among racial and ethnic minorities and medically underserved populations. The overall goal of this program is to significantly improve access to—and use of—beneficial cancer interventions and treatments in communities experiencing cancer health disparities.
- Minority-Based Community Clinical Oncology Program (MB-CCOP)
(<http://prevention.cancer.gov/programs-resources/programs/ccop>)
Initiated in 1990, the MB-CCOP provides underserved cancer patients with access to state-of-the-art cancer treatment and prevention in their own communities. In addition, as part of NCI's effort to reduce cancer health disparities in minority populations, the program encourages physicians who are practicing in these communities to become involved in NCI-approved clinical trials. Over the past decade, more than 5,500 minority patients have enrolled in both treatment and prevention clinical trials sponsored by NCI through the MB-CCOP network.
- The Cancer Disparities Research Partnership (CDRP) Program
(<http://www3.cancer.gov/rp/CDRP/index.html>)
The CDRP is a unique research program that supports the planning, development, and conduct of radiation oncology clinical trials in institutions that care for a disproportionate number of medically underserved, low-income, ethnic and minority populations that have not been traditionally involved in NCI-sponsored research. The CDRP works to establish partnerships between large comprehensive centers and smaller community centers so that the smaller centers can build and sustain an effective radiation oncology clinical trial program.
- Patient Navigation Program (PNP)
(<http://crchd.cancer.gov/pnp/background.html>)
The PNP was developed to help guide cancer patients from underserved populations through the complex journey of seeking treatment and overcoming language, financial, and cultural barriers that often undermine their care. The PNP places patients in contact with trained, culturally sensitive health care workers, or “navigators,” from local communities. Navigators help minority cancer patients obtain accurate information about their diagnosis and treatment procedures, assist in gaining access to hospitals and clinics, provide guidance on financial assistance, and help with tracking their medical records and obtaining prescriptions.
- Southern Community Cohort Study
(<http://epi.grants.cancer.gov/ResPort/Southern.html>)
This NCI-funded study will follow about 100,000 residents from six southeastern states—two-thirds of whom are African American/Black—to determine what roles diet, lifestyle, occupation, and environmental factors play in the development of common types of cancer, such as prostate, lung, breast, and colon cancers.

- NCI Spanish-language Web Site (<http://www.cancer.gov/espanol>)
NCI launched its Spanish-language Web site in April 2007 to address the language and cultural barriers that many Hispanic/Latinos face when seeking cancer-related information. NCI's Spanish Web site is not simply a translation of information available on the English-language Web site; the content is tailored to meet the needs and concerns of the Hispanic community. The Spanish Web site is a complement to existing Spanish-language resources from NCI, such as those available through the Cancer Information Service (CIS) and the NCI Publications Locator (<http://www.cancer.gov/publications>). NCI established the CIS in 1975 to educate people about cancer prevention, risk factors, early detection, symptoms, diagnosis, treatment, and research. CIS information specialists provide the latest, most-accurate information about cancer by telephone (1-800-4-CANCER), instant messaging, and e-mail.
- Continuing Umbrella of Research Experiences (CURE) and Minority Institutions/Cancer Center Partnership (MI/CCP) Programs (<http://crchd.cancer.gov/research/cure-overview.html> and <http://crchd.cancer.gov/research/miccp-overview.html>)
NCI supports training programs for students and investigators from diverse populations. The CURE program provides long-term funding to qualified minority students interested in pursuing scientific and cancer-related careers. The MI/CCP program provides funding to support NCI Cancer Centers and other institutions in recruiting minorities to pursue cancer research.
- The Network for Cancer Control Research Among American Indian/Alaska Native Populations (AI/AN) (<http://crchd.cancer.gov/spn/aian-spcn-pilot.html>)
The network is an NCI program that fosters collaborations between American Indian/Alaska Native researchers and other researchers and educators. The program's goals are to facilitate the exchange of cancer control information among researchers and to encourage American Indian researchers and medical students to become involved in their community health care programs. The network established the Native Cancer Information Resource Center (Native C.I.R.C.L.E.) in 1998, which serves as a clearinghouse for cancer educational materials that are specific to American Indian and Alaska Native communities.
- NCI's *Atlas of Cancer Mortality in the United States, 1950-94* (<http://www3.cancer.gov/atlasplus/new.html>)
NCI's *Atlas of Cancer Mortality in the United States, 1950-94* is a book of maps, text, tables, and figures showing the geographic patterns of cancer death rates throughout the United States from 1950-1994 for more than 40 types of cancer. Included are maps of cancer mortality specific to African Americans/Blacks. These maps can be used to pinpoint areas of high cancer mortality in the United States and provide avenues to focus future cancer health disparities research.
- Tobacco Research Network on Disparities (TReND) Program (<http://dccps.nci.nih.gov/tcrb/trend/index.html>)
To address the high rates of lung cancer in minority populations, NCI, in collaboration with the American Legacy Foundation, initiated the TReND program. This program supports collaborations among researchers to develop new solutions that address tobacco use in underserved communities and to better understand tobacco-related health disparities.

For information about other NCI programs that address cancer health disparities, go to <http://www.cancer.gov/cancertopics/types/disparities> on the Internet.

Selected References

1. Carey LA, Perou CM, Livasy CA, et al. Race, breast cancer subtypes, and survival in the Carolina Breast Cancer Study. *JAMA*, 2006; 295(21); 2492-2502.
2. Haiman CA, Patterson N, Freedman ML, et al. Multiple regions within 8q24 independently affect risk for prostate cancer. *Nature Genetics*, 2007; 39(5); 638-644.
3. Talcott TA, Spain P, Clark JA, et al. Hidden barriers between knowledge and behavior: The North Carolina Prostate Cancer Screening and Treatment Experience. *Cancer*, 2007; 109(8); 1899-1606.

***The data sources for all tables in this fact sheet are the following:**

Source for incidence statistics:

Surveillance, Epidemiology, and End Results (SEER) Program (<http://seer.cancer.gov>) SEER*Stat Database: Incidence—SEER 17 Regs Limited-Use, Nov 2006 Sub (2000-2004)—Linked To County Attributes—Total U.S., 1969-2004 Counties, National Cancer Institute, DCCPS, Surveillance Research Program, Cancer Statistics Branch, released April 2007, based on the November 2006 submission.

Source for mortality statistics:

Surveillance, Epidemiology, and End Results (SEER) Program (<http://seer.cancer.gov>) SEER*Stat Database: Mortality—All COD, Total U.S. (1990-2004)—Linked To County Attributes—Total U.S., 1969-2004 Counties, National Cancer Institute, DCCPS, Surveillance Research Program, Cancer Statistics Branch, released November 2006. Underlying mortality data provided by the National Center for Health Statistics (<http://www.cdc.gov/nchs>).

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Related NCI materials and Web pages:

- National Cancer Institute Fact Sheet 4.21, *Human Papillomavirus (HPV) Vaccines: Questions and Answers* (<http://www.cancer.gov/cancertopics/factsheet/Prevention/HPV-vaccine>)
- *Atlas of Cancer Mortality in the United States, 1950-94* (<http://www3.cancer.gov/atlasplus/new.html>)
- *Methods for Measuring Cancer Disparities: A Review Using Data Relevant to Healthy People 2010 Cancer-Related Objectives* (<http://seer.cancer.gov/publications/disparities/>)
- Cancer Health Disparities Home Page (<http://www.cancer.gov/cancertopics/types/disparities>)
- Center to Reduce Cancer Health Disparities Home Page (<http://crchd.cancer.gov/>)

How can we help?

We offer comprehensive research-based information for patients and their families, health professionals, cancer researchers, advocates, and the public.

- **Call** NCI's Cancer Information Service at 1-800-4-CANCER (1-800-422-6237)
- **Visit** us at <http://www.cancer.gov> or <http://www.cancer.gov/espanol>
- **Chat** using LiveHelp, NCI's instant messaging service, at <http://www.cancer.gov/livehelp>
- **E-mail** us at cancergovstaff@mail.nih.gov
- **Order** publications at <http://www.cancer.gov/publications> or by calling 1-800-4-CANCER
- **Get help** with quitting smoking at 1-877-44U-QUIT (1-877-448-7848)

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