

Cancer

National Challenges and Disparities

Cancer is the 2nd leading cause of death in the United States, exceeded only by heart disease. “Cancer is a group of diseases characterized by uncontrolled growth and spread of abnormal cells”. All cancers involve the malfunctioning genes that control cell growth and division. Cancer can develop in anyone but is most often diagnosed in middle-aged or older adults. In addition, cancer can develop in various places in the body (see Figure 1). Approximately 1.4 million new cancer cases are expected to be diagnosed in 2006. In addition, about 564,830 Americans are expected to die of cancer in 2006. This equates to 1,500 deaths per day.¹ Overall cancer death rates have decreased in both men and women from 1993 to 2004. Notable disparities in death rates in 2000 include lung cancer, with black males having the highest rates, colorectal cancer, showing a higher rate in males, particularly black

men; and cervical cancer with black women having the highest rate.²

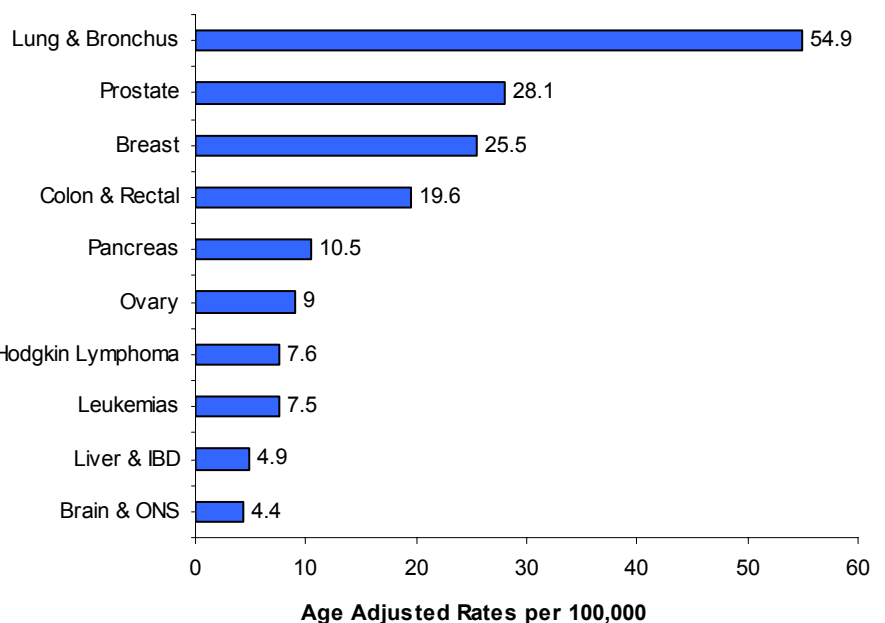
The most common cancers of men among all racial and Hispanic origin populations include prostate (161.2), lung (86.4) and colorectal cancer (61.3). All rates presented are per 100,000 persons. The leading causes of death among men are lung (73.5 for all racial and Hispanic origin populations), prostate (25.8 for white; 63.0 for black, 22.0 for Hispanic and 15.7 for American Indian/Alaskan Native), and colorectal (23.2 for white; 33.4 for black, 17.1 for Hispanic, 16.1 for American Indian/Alaskan Native and 15.9 for Asian/

Pacific Islander). Among all cancers combined, incidence rates for men are highest among blacks (615.1), followed by whites (536.8), Hispanics (422.8), Asian/Pacific Islanders (324.3) and American Indians/Alaska Natives (215.4). Death rates are also highest among blacks (322.9), followed by whites (236.0), Hispanics (163.9) American Indians/Alaska Natives (145.3), and Asian/Pacific Islanders (138.8).³

The most common cancers of women include breast (124.9 for all racial and Hispanic origin populations), lung (54.9 for white, 50.3 for black, 25.2 for Hispanic, 32.9 for American

(continued on page 11)

Figure 1. Top 10 Cancer Mortality Sites, United States, 2002



Source: United States Cancer Statistics Data, Centers for Disease Control and Prevention (CDC)
Re-created by: DCHD, Institute for Health, Policy and Evaluation Research, August, 2006
IBD = Intrahepatic Bile Duct; ONS = Other Nervous System

This issue:

- National Challenges and Disparities** **1**
- Jacksonville Cancer Report Card** **2**
- Cancer: Health Disparities at the Local Level** **3**
- Examining the Influence of Culture on Cancer Health Disparities** **4**
- Healthy Jacksonville: Healthy Men** **5**
- Florida Tobacco Control** **7**
- Tomorrow's Rainbow: Breast and Cervical Cancer Program** **9**

Jacksonville Cancer Report Card

Obj #	Objective	U.S. (2003)	FL (2004)	Duval (2004)	2010 Target
3-1	Reduce the overall cancer death rate. (Per 100,000)	190.1 ³	171.6 ¹	207.7 ¹	159.9
3-2	Reduce the lung cancer death rate.* (Per 100,000)	54.1 ³	52.0 ¹	63.7 ¹	44.9
3-3	Reduce the breast cancer death rate. (Per 100,000 Females)	25.3 ³	23.1 ¹	27.2 ¹	22.3
3-4	Reduce the death rate from cancer of the uterine cervix. (Per 100,000 females)	2.5 ³	3.3 ¹	DSU ¹	2.0
3-5	Reduce the colorectal cancer death rate. (Per 100,000)	19.1 ³	15.7 ¹	24.9 ¹	13.9
3-6	Reduce the oropharyngeal cancer death rate. (Per 100,000)	2.6 ³	2.8 ¹	3.1 ¹	2.7
3-7	Reduce the prostate cancer death rate. (Per 100,000 Males)	26.5 ³	20.1 ¹	30.5 ¹	28.8
3-8	Reduce the rate of melanoma cancer deaths. (Per 100,000)	2.7 ³	2.8 ¹	DSU	2.5
3-14	Increase the number of states that have a statewide population-based cancer registry that captures case information on at least 95 percent of the expected number of reportable cancers.	34 ³ States (2005)	Florida has ²	Florida has ²	45 States

¹ Florida Department of Health, Office of Vital Statistics, 2004

² National Program of Cancer Registries (NPCR), CDC, NCI

³ Centers for Disease Control and Prevention, <http://wonder.cdc.gov>

DSU=Data Statistically Unreliable (cases<20)

Data Report Card

Cancer was the second leading cause of death in 2004 for both Duval County and Florida with age-adjusted rates of 207.7 and 171.6 per 100,000 deaths. Duval County was 9% higher than the national rate of 190.1 per 100,000 deaths, while Florida was below by 17%. Both Duval County and Florida were well above the Healthy People 2010 target of 159.9 per 100,000 deaths. Cancer deaths had decreased by 8.6 % for Florida and 8.1 % for Duval since 2000. The leading causes of cancer death overall for Duval County were lung breast, prostate, and colorectal cancer. The same was true for Florida. The Duval County rates for all site specific cancers presented were above the

Florida rates. In addition, Duval County rates for all site specific cancers presented except for colorectal cancer were above national rates. However, rates had decreased since 2000 for all site specific cancers presented in Duval County, except for uterine cancer, which had increased by 12%. The most notable decreases were colorectal cancer with a 30% decrease, Prostate cancer with a 25% decrease, and oral cancer with a 24% decrease. Similarly, all rates for site specific cancers presented had also decreased since 2000 for Florida, except for uterine which had increased by 14%. The most notable decreases were cervical with a 27.3 % decrease and prostate with a 20.2 % decrease. The rates for Florida for lung, breast, colorectal and prostate cancers were

all below the nation. While deaths rates had decreased for most of site specific cancers presented, current data for the nation, state and county indicate a need for more prevention and behavioral initiatives in order to come closer to meeting the Healthy People 2010 objectives. Some of the behavioral risk factors for many types of cancer are tobacco use, heavy alcohol use, screening for various cancers at the appropriate age, access to care, nutritional deficiencies, and lack of physical activity. Data shows that overall cancer incidence had decreased by 3.3 % in Duval County and 5.2 % in Florida since the year 2000. This decrease in incidence may be attributable to changes in behavioral factors that contribute to cancer.

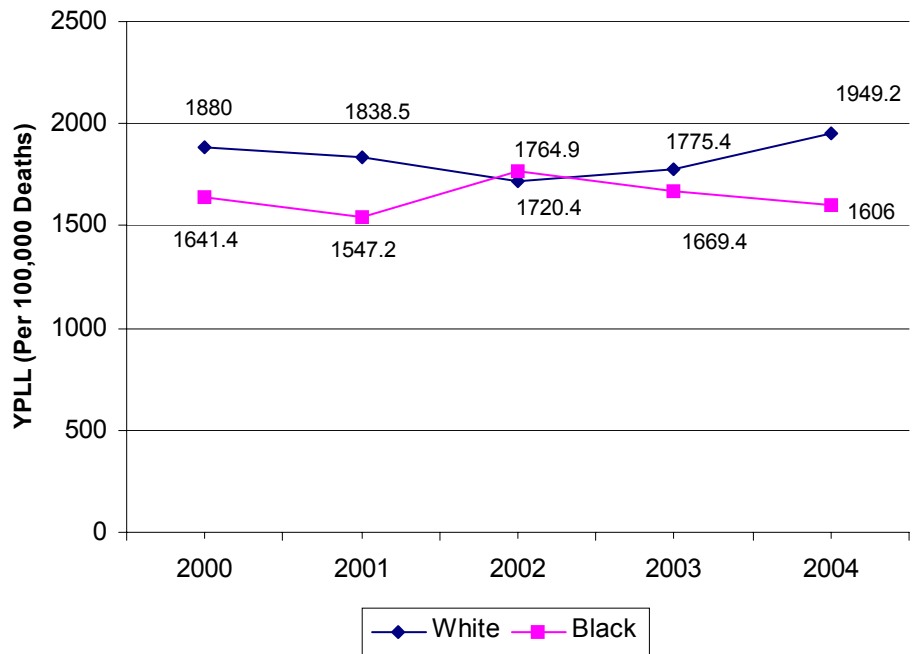
Cancer: Health Disparities at the Local Level

Disparities in health can be seen across many disease areas. Cancer disparities in Duval County are numerous and should be at the forefront of chronic disease initiatives. Overall, there were racial disparities for cancer shown in Years of Potential Life Lost (YPLL). YPLL is an estimate of premature mortality that has been defined as the number of years of life lost among persons who die before a predetermined age, which is 75 in the state of Florida. YPLL is a particularly useful gauge of health disparities because it is especially sensitive to premature death, (deaths that are not primarily attributable to the aging process). The YPLL for the white population for all cancer was 1949.2 in 2004. This was 21.4% higher than for the black population with a YPLL of 1606.0 (See Figure 2). The black population had shown a 2.2% decrease in cancer deaths since 2000 while the white population had shown a 3.7% decrease. Gender disparities were also shown with males having an age-adjusted cancer rate of 244.9 per 100,000 (95% CI=227.9-263.0) in 2004 which is statistically significantly higher than for females with a rate of 180.5 per 100,000 (95% CI=167.9-193.9, see Figure 3).

Lung cancer also showed a similar racial disparity. The white population has a YPLL of 540.22 per 100,000 in 2004 while blacks have a YPLL of 388.2. Smoking tobacco is the number one cause of lung cancer. Smoking related cancer deaths were also higher in the white population with a rate of 87.6 per 100,000 deaths and 44.0 per 100,000 for the black population. According to the Behavioral Risk Factor Surveillance System (BRFSS), 21.5% of white adults smoked in 2002 compared to 15.7% of black adult smokers. As with all cancers, in 2004 men had a statistically

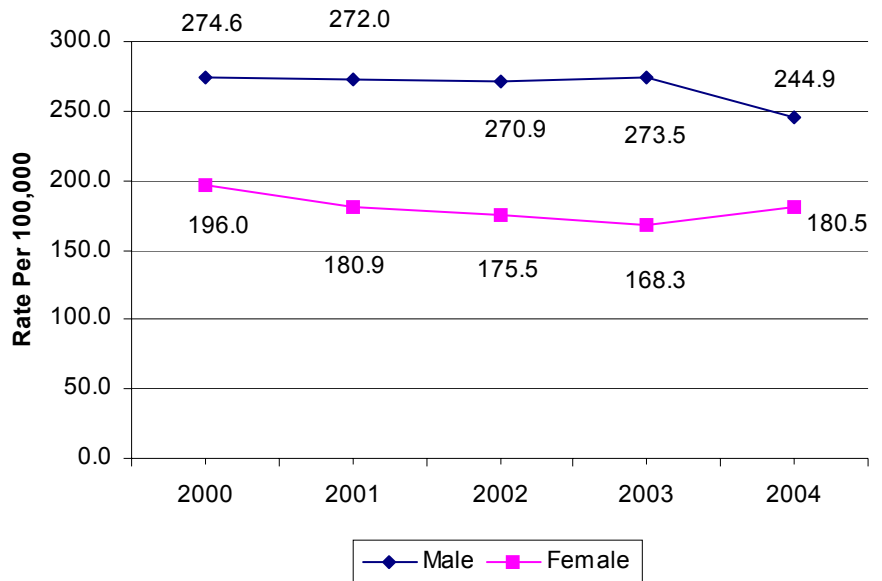
(continued on page 8)

Figure 2. Years of Potential Life Lost (YPLL) Before Age 75 from Cancer by Race, Duval County, 2000-2004



Source: Florida Department of Health, Office of Vital Statistics, 2000-2004
 Prepared by: DCHD, Institute for Health, Policy and Evaluation Research, May, 2006

Figure 3. Mortality Rate from Cancer by Gender Duval County, 2000-2004



Source: Florida Department of Health, Office of Vital Statistics, 2000-2004
 Prepared by: DCHD, Institute for Health, Policy and Evaluation Research, August, 2006

Examining the Influence of Culture on Cancer Health Disparities

By: Dana Fields-Johnson, M.P.A.

Cancer affects people of all racial, ethnic and socioeconomic backgrounds. Cancer is the second leading cause of death in the United States, Florida and Duval County. However, when addressing the burden of cancer a closer examination is needed. There are significant differences in cancer rates for racial and ethnic groups that surface, with certain racial and ethnic groups experiencing higher incidence, prevalence, mortality and burden of cancer.

Cancer health disparities exist in almost all primary cancers, including breast, prostate, lung and colorectal cancers. According to Florida CHARTS, African American females (29 per 100,000) have a 52% higher colorectal cancer death rate than white females (19 per 100,000). For 2003, in Duval County, the incidence of breast cancer in women 45-49 was 206 per 100,000 African American females versus 180 per 100,000 white

females. In addition, African-American females have a 13% greater chance of dying of breast cancer than white females in Jacksonville. There are also concerns related to Latina women. Breast cancer is the most commonly diagnosed cancer among Hispanic women. African American males are more likely to develop and die from prostate cancer than are their white counterparts. The death rate from cancer for non-white men is 36% higher than that for whites (254 versus 186 per 100,000). See Figure 4 for additional data supporting cancer health disparities.

According to the National Cancer Institute, individuals from racial and ethnic populations are more likely to:

- be diagnosed with and die from preventable cancers
- be diagnosed with late stage disease from cancers that are detectable at an early stage through screening

- receive either no treatment or treatment that does not meet currently accepted standards
- die of cancers that are generally curable
- suffer from terminal cancers in the absence of adequate pain control and other palliative care.

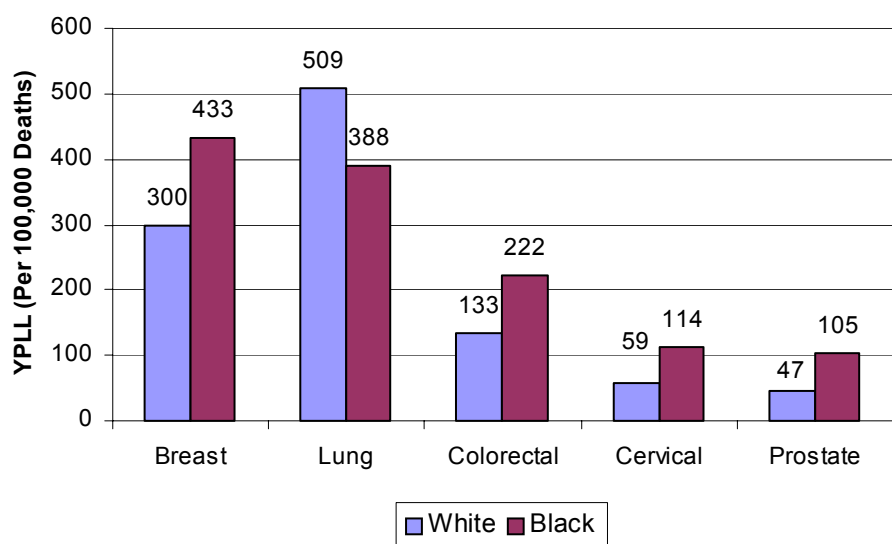
Research documenting contributors to these disparate outcomes has considered multiple factors such as socioeconomic status, access to diagnostic testing and healthcare, access to health insurance, environmental factors, education, biological features of the disease, and physician attitudes. However, increasingly cultural differences and views in racial and ethnic populations, which may affect all facets of the cancer continuum, including screening, stage of diagnosis, and treatment, are being discussed as factors attributing to cancer health disparities. Cultural norms, views and influences that may impact cancer outcomes for racial and ethnic groups are varied among groups. They include:

“Fear and Fatalism”—Cancer may be seen as a death sentence for some racial and ethnic groups, making the fear of cancer a strong determinant in seeking care. Fear of a cancer diagnosis and fatalistic views may negatively impact cancer screening and early detection rates for minorities.

“Faith and Spirituality”—Faith in God and/or spirituality may be a strong influence in how some racial and ethnic populations deal with and address a cancer diagnosis. For example, religious beliefs are very important in the African-American

(continued on page 10)

Figure 4. Years of Potential Life Lost (YPLL) Under Age 75 by Cancer Site and Race, Duval County, 2002-2004



Healthy Jacksonville: Healthy Men

Anthony Grissett, M.B.A., Program Director

It is commonly stated that “Men just don’t go to the doctor!” Though many believe it, this statement is none the less, false. Men do visit the doctor; unfortunately, it is usually after an illness or condition which could have been easily treated, and in many cases prevented, has progressed from an “acute” to a “chronic” stage. So, a more accurate statement would be “men don’t go to the doctor until it is too late!”

The Duval County Health Department was awarded a three year federally funded grant aimed at reducing disparities surrounding prostate cancer incidence and death. This faith-based initiative focused on increasing awareness among underserved minority residents in Health Zone 1 (zip codes 32202, 32204, 32206, 32208, 32209, and 32254) of the importance of early screening and detection in improving prostate cancer outcomes. Over the course of this initiative, many learning opportunities that can be beneficial to other programs targeting African American males in Jacksonville’s urban core were encountered. Participant interaction, community forums, screening data, case management records and leadership team feedback was extremely beneficial in efforts to continuously improve the program so that our goals and objectives could be achieved most efficiently.

Lessons Learned

Make sure that marketing materials are culturally appropriate and representative of the target population.

An immediate concern for our program was to address and ensuring that marketing materials represented the target

population. On most prostate cancer literature, pamphlets and marketing materials we reviewed, the images presented were often Caucasian males in their late 60’s as with African Americans, which is counterproductive as data from the Center for Disease Control (CDC) shows the average life expectancy for black males to be 69 years. To educe the behavioral changes required to reduce prostate cancer disparities, there was an immediate focus on modifying the images and messages on outreach materials. To encourage African American males 40 – 55 years of age to participate in cancer related screenings, members of that age group were utilized to review marketing materials.

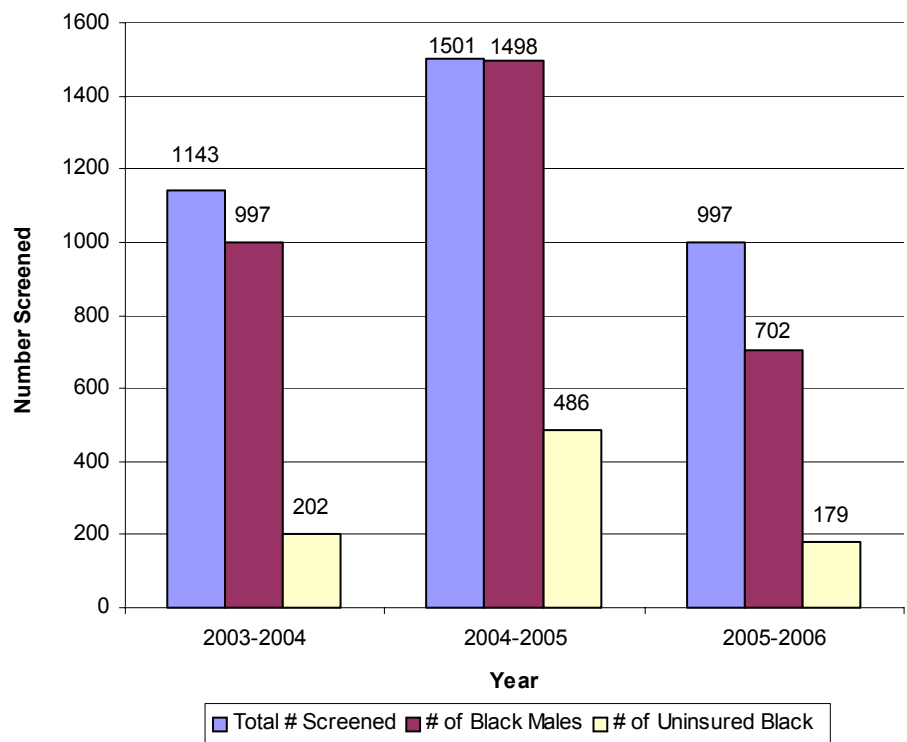
Pictures of Caucasian or black males over the age of sixty were avoided and instead elected to use images of active black men in their early to mid 40’s. By presenting a younger image, the program hoped to encourage men to begin considering prostate cancer screenings at a younger age so that prostate changes could be monitored closely and any issues identified could be addressed in the acute rather than chronic stage.

Identify the best mechanisms for gaining access to the target population.

In the first year screening data showed that approximately 70% of the men screened in faith based settings had health care coverage. It was also observed that African American men ages 18-60 were absent from

(continued on page 6)

Figure 5. Healthy Jacksonville: Healthy Men Screenings 2003-2006



Source: Healthy Jacksonville: Health Men Project, 2003-2006
 Prepared by: Healthy Jacksonville, Healthy Men, DCHD

Healthy Jacksonville: Healthy Men

(continued from page 5)

inner city churches, and that women composed 70-80% of most congregations. These facts made it necessary for the program to look into other avenues and methods to identify and reach the target population. Following a national trend, the program reached out to barbers and shop owners to assist in educating the target population. The barbershop is considered the most easily accessible avenue for reaching black men. The barbershop is perhaps the only public venue wherein African American men can freely exchange in a free flow of ideas and thoughts without the fear of criticism or castigation.

Through partnerships with Healthy Jacksonville 2010, the Jacksonville Urban League and Shands Department of Urology, local barbers on prostate cancer risk factors and the importance of early screening were educated; then employed them as “lay health educators” to relay this information to their customers. In conjunction with this grass roots education, Duval County Health Department’s mobile health units were utilized to provide free prostate cancer screenings and case management services at selected shops throughout the city. Through these venues there was more effective outreach to underserved African American men in Health Zone 1. In the process the program was successful at creating a unique point of entry into the health care system for men who may not have sought medical interventions through conventional methods.

Identify and acknowledge cultural and social barriers that impede

The outreach workers and lay educators consistently reported that men who

elected not to participate in the screening program declined, most commonly out of fear. The idea that someone may infer from their participation that they were impotent or sexually dysfunctional was more of a concern than knowing their prostate health status. One technique used to overcome this barrier was to change marketing tools from advertising “Prostate Cancer Screenings” to promoting “Men’s Health Screenings”. This afforded men an opportunity to freely access services without there being a specific “disease” or “illness” immediately associated with their visit. Prostate cancer screenings then became one of a bundle of services available on the mobile outreach unit removing any immediate association between program and any perceived affront to masculinity.

Finding the right incentives to encourage participation.

For many, the long term benefits of improved health, quality of life and better cancer outcomes far outweigh the immediate sacrifice of time, discomfort and embarrassment. However, for underserved men with limited financial resources, little leisure time and/or an inability to fully appreciate the benefits of preventive, prostate cancer health may not be an immediate concern. To address this barrier culturally appropriate incentives that encouraged improved health and wellness were utilized. Haircut vouchers, grocery store gift certificates and calling cards were the most effective methods of encouraging participation. To circumvent men attending events solely to receive goods, without having increased their understanding of prostate cancer, incentives are not tied to attendance alone, but are rewards for displaying increased knowledge as measured by a pre and posttest. Through commitment to con-

tinuous improvement, the program was able to provide 4002 free prostate cancer screenings over the 3 year grant cycle. To date, 37 men have reported being diagnosed and treated for prostate cancer. Hundreds have reported receiving treatment for urological disorders as well as high blood pressure, diabetes, HIV and other medical conditions.

This makes obvious the most important lesson learned over this three year period which is the importance of focusing on the overall health needs of individual participants and not just the disease/illness primary to the grant/program. When providing health education on prostate cancer, it’s best to begin by engaging the participant in a dialogue to ascertain their perceptions of individual health and wellness, and then proceed to engage them in a discourse on the benefits of early prevention in reducing prostate cancer outcomes. As a more holistic approach to providing health information was adopted, there was a dramatic increase in screening participation.

By the year 2 of this grant, Healthy Jacksonville: Healthy Men was recognized, in the urban core, as a program truly concerned to improving the “overall” health of men in our city. Utilizing faith based partners and barbers as gatekeepers; the program has been able to access and provide services to individuals who would not commonly have access to preventive services. The program has continuously displayed a willingness to adjust the programs and services to most effectively meet the needs of the target population while consistently creating unique avenues for entry into the healthcare system.

For more information on Healthy Jacksonville, Health Men, contact Anthony Grissett at 904-665-2276.

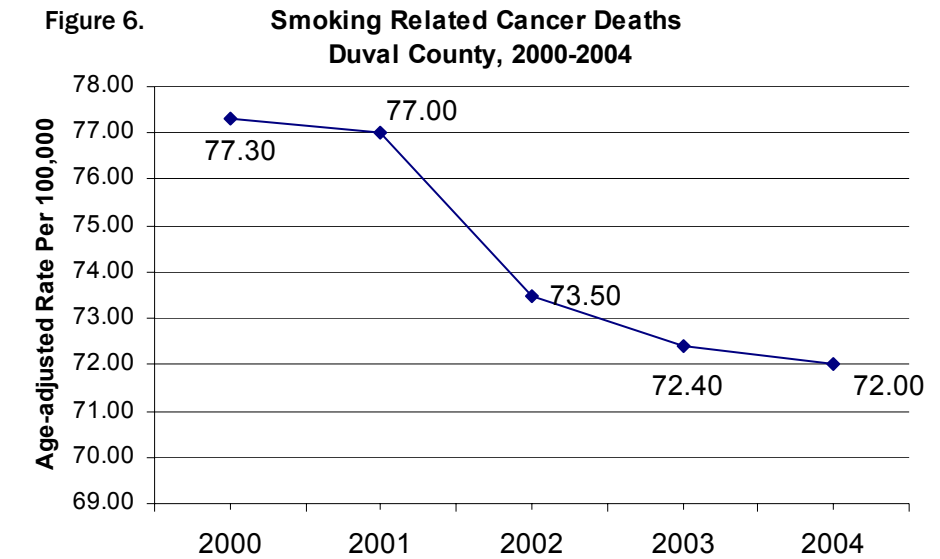
Florida Tobacco Control

Tim C. Volce, Regional Director

American Lung Association of Florida

One of the most important public health achievements of the 20th century was reversing the increase in lung cancer which was being caused by tobacco. However, we have continued to learn more about the harmful effects of tobacco and tobacco-related deaths are still the leading cause of cancer death. Recently, U.S. Surgeon General Richard Carmona issued a new report underscoring the dangers of secondhand smoke, entitled *The Health Consequences of Involuntary Exposure to Secondhand Smoke*. This latest report scientifically confirms that secondhand smoke is a serious health hazard, highlighting the need to strengthen the law that protects non smokers in Florida workplaces.

In November of 2002, Florida voters amended Article X, Section 20, of the Florida Constitution by barring tobacco smoke in most enclosed indoor workplaces. This measure was a substantial step towards eliminating the harmful



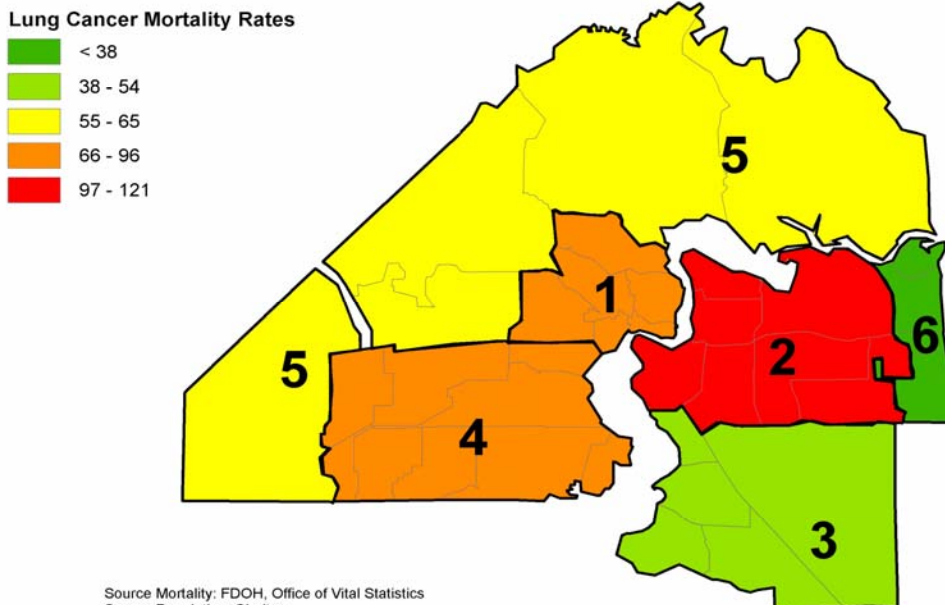
Source: Florida Department of Health, Office of Vital Statistics, 2000-2004
 Prepared by: DCHD, Institute for Health, Policy and Evaluation Research, August, 2006

effects of secondhand smoke; however the legislation still provides an exception for public smoking in many bars and nightclubs. Thousands of Floridians remain at risk from exposure to secondhand smoke during their work and leisure activities. The American Lung Association of Flor-

ida is calling on the governor and state legislators to protect all of Florida's workers from the dangers of secondhand smoke by removing the bar exemption from Florida's Clean Indoor Air Act. Tobacco use is the leading cause of preventable death in the United States, accounting for

(continued on page 11)

Figure 7. Lung Cancer Mortality Rate by Health Zone, Duval County 2004



Source Mortality: FDOH, Office of Vital Statistics
 Source Population: Claritas
 Prepared by: Health, Policy and Evaluation Research, DCHD, July 11, 2006

This product is for reference only and is not to be construed as a legal document. Any reliance on the information contained herein is at the user's own risk. The Florida Department of Health and its agents assume no responsibility for any use of the information contained herein or any loss resulting therefrom.



Cancer: Health Disparities at the Local Level

(continued from page 3)

significantly higher rate of lung cancer death than women, with age-adjusted rates of 80.5 (95% CI= 70.9–91.1) and 51.24 (95% CI=44.5-58.7), respectively. Lung cancer death rates had declined in both men and women since 2000, although not statistically significant.

For breast cancer, disparities were seen in the black female population. The YPLL for blacks was 412.8 per 100,000 in 2004 and 303.0 per 100,000 for whites. For combined years, blacks were much higher in breast cancer deaths than whites for both 1999-2001 and from 2002-2004. While white females decreased from these years, black women had not. According to the BRFSS in 2002, more black women over the age of 40 had more mammograms in the past 2 years than white women, 78.5 % and 74.9 % respectively. This higher percentage could be an indication of routine checks for

those diagnosed with breast cancer.

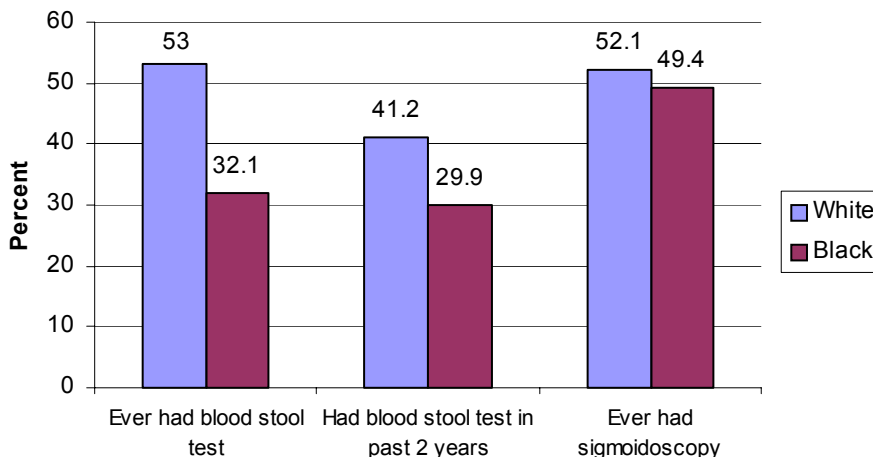
Prostate cancer death disparities were dramatic among the black and white populations. The YPLL for white men was 61.1 per 100,000, up by 76.6% since 2000. However, the YPLL for black men was 137.1, which was 124% higher than for

white men and an increase of 73.3% since 2000.

Colorectal cancer deaths also showed a racial disparity with blacks having a YPLL of 239.5 per 100,000 in 2004, 78% higher than for whites. In addition, while whites YPLL have decreased since 2000, by 2.3%, blacks YPLL had increased by 25.2% since 2000. There were no statistically significant disparities for colorectal deaths between men and women. In addition, while rates had decreased for both genders since 2000, 30.9% for women and 35.8% for men, these decreases were not statistically significant. According to the BRFSS in 2002, more men than women had been screened for Colorectal Cancer, specifically screenings that include blood stool testing and sigmoidoscopy. Also, more whites than blacks had these same screening tests. (See Figures 8 and 9).

Sources:
 Florida Department of Health, Office of Vital Statistics, 2000-2004
 Behavioral Risk Factor Surveillance System, 2002

Figure 8. Colorectal Screenings by Race Duval County, 2002



Source: Behavioral Risk Factor Surveillance System, 2002
 Prepared by: DCHD, Institute for Health, Policy and Evaluation Research, August 2006

Figure 9. Colorectal Screenings by Gender Duval County, 2002



Source: Behavioral Risk Factor Surveillance System, 2002
 Prepared by: DCHD, Institute for Health, Policy and Evaluation Research, August 2006

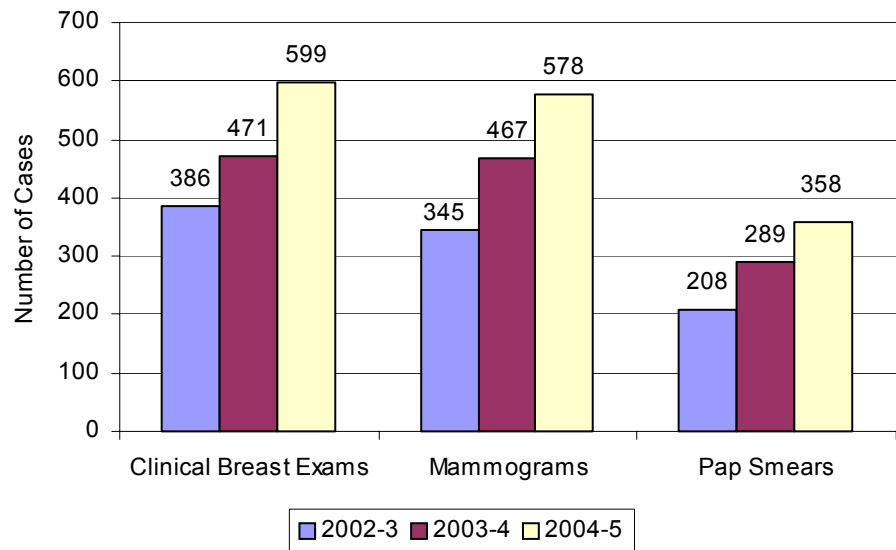
Tomorrow's Rainbow: Progress Review

Irina Kolomeyer, M.S.H., C.H.E.S.
Program Coordinator

"Early detection through screening is our best defense against morbidity and mortality from breast and cervical cancers and precancers." (Julie Gerberding, MD, MPH, Director, CDC).

The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) is a nationwide, comprehensive public health program that helps uninsured and underserved women gain access to screening services for the early detection of breast and cervical cancer. Breast cancer is the most commonly diagnosed cancer and the second leading cause of cancer death among women in the United States.¹ Screening for and early detection of breast and cervical cancer reduces death rates and greatly improves cancer patients' survival.² However, there is a disproportionately low rate of screening among minorities and among under- or unin-

Figure 10. Tomorrow's Rainbow Service Growth 2002-2005



Source: Tomorrow's Rainbow, Florida Breast and Cervical Cancer Early Detection Program
Prepared by: Tomorrow's Rainbow, DCHD, 2006

sured women, which creates a wide gap in health outcomes between such women and other women in the United States.³ To address this health disparity, Congress authorized the NBCCEDP in

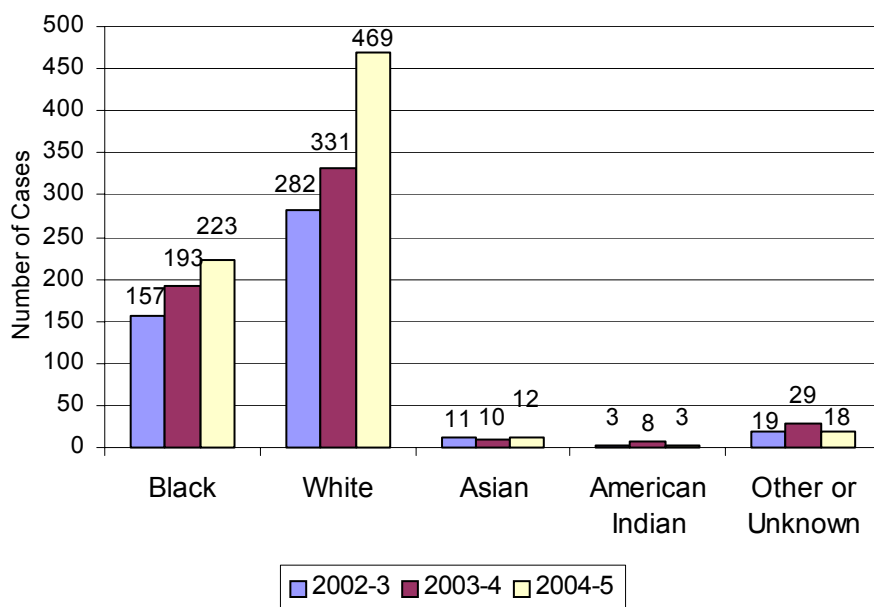
1990, giving CDC the ability to implement a national strategic effort to increase access to mammography and Pap test screenings for women in need.

Locally this program is known as Tomorrow's Rainbow and is functioning in collaboration with numerous community agencies and organizations through the Healthy Jacksonville 2010 initiative. The program is directed to low-income, uninsured women ages 50 through 64 in Duval, Baker, Clay, Nassau, and St. Johns counties. Tomorrow's Rainbow program provides clinical breast examinations, mammograms, and Pap tests for eligible women who participate in the program as well as surgical consultations and diagnostic testing for women whose screening outcome is abnormal. The program is dedicated to ensuring that eligible women receive high-quality screening services and prompt follow-up.

Tomorrow's Rainbow was established in 1995. The number of women screened has increased every year since.

(continued on page 10)

Figure 11. Women Screened and Reported by Race 2002-2005



Source: Tomorrow's Rainbow, Florida Breast and Cervical Cancer Early Detection Program
Prepared by: Tomorrow's Rainbow, DCHD, 2006

Examining the Influence of Culture on Cancer Health Disparities

(continued from page 4)

population, and this influence may positively or negatively impact a patient's outlook on cancer. Relying on faith and spirituality can be a powerful coping mechanism that supports cancer care and treatment. However, in some instances, believing that a higher power will heal and cure cancer, may also cause a patient to be unwilling to submit to recommended cancer treatment.

“Family and Relationships”—The family unit is the focal point of many cultures. In addition, family interdependence is a strong value and influence. In the Latino/Hispanic culture, it is sometimes customary for certain members of the family or the family as a unit to be involved in a patient's decision-making regarding cancer care and treatment. Key family members such as elders (parents and grandparents), and male authority figures in the family are respected and may be involved in a patient's response to cancer diagnosis.

“Cultural Myths”—Cultural and family myths about cancer may cause suspicion and mistrust of a cancer diagnosis or treatment option. Also, there may be a belief that a cancer diagnosis means death. In some cultures, talking about cancer or a cancer diagnosis is shunned because there is a belief that acknowledging cancer invites the disease into the body.

Recognizing and acknowledging these cultural values, beliefs and barriers is critical to addressing cancer health disparities, and more health-

care providers are working to integrate cultural values and health beliefs of racial and ethnic populations. Healthcare providers are pursuing new language skills and utilizing interpreters and health navigators who understand the culture and background of specific racial and ethnic groups. In addition, healthcare professionals are participating in cultural diversity education and training opportunities.

Locally, the Healthy Jacksonville 2010 Cancer Coalition is working to address cancer health disparities through strategies and activities that address increasing community and professional education, awareness and advocacy. Utilizing the framework of the Florida Cancer Plan, the Coalition has worked to connect local initiatives to address cancer disparities to statewide activities and priorities. One of those priorities is working to develop initiatives that address cultural barriers to cancer screening and treatment. The Coalition, in partnership with the American Cancer Society, is currently implementing a colorectal cancer education campaign aimed at reducing African American death rates and increasing colorectal cancer screening for African Americans over age 50. The Coalition has also worked to address cultural influences and barriers related to prostate and breast cancer screening. In addition to these initiatives, the Coalition is working to identify and garner support to expand cancer education and screening in minority populations, and to increase education regarding cancer clinical trials and the importance of racial and ethnic populations.

For more information on cancer health disparities or on becoming a member of the Coalition, please call the Healthy Jacksonville office at 665-2598.

Tomorrow's Rainbow: Progress Review

(continued from page 9)

In 2005 with the help of Tomorrow's Rainbow 578 eligible women received mammograms, of which 332 women had a mammogram for the first time in their life. This was 68% higher than in 2002. Three hundred and fifty eight women received cervical cancer screening (Pap smear), of which 234 women were rarely or never screened before. In addition, 599 clinical breast exams were performed in 2005, up 55% since 2002 (see Figure 10). The number of white women screened increased by 66% from the 2002-2203 period to 2004-2005 period. Likewise, the number of screenings also increased by 42% for black women over this same time period (see Figure 11). The program identified 16 women with various stages of breast cancer and seven women were diagnosed with early stages of cervical cancer. All of them were able to receive timely treatment through the program. Treatment for these women is made possible through the Mary Brogan Medicaid Waiver Act of 2001.

For more information on the Tomorrow's Rainbow program, please call 904-630-3395.

Sources:

1. American Cancer Society. *Cancer Facts and Figures*. Atlanta, GA: American Cancer Society; 2004.
 2. US Preventive Services Task Force (USPSTF). *Guide to Clinical Preventive Services*, 2nd Edition. Washington, D.C.: U.S. Department of Health and Human Services, Office of Public Health and Science; 1996:105-117.
- Anderson LM, May DS. Has the use of cervical, breast, and colorectal cancer screening increased in the United States? *American Journal of Public Health* 1995; 85(6): 84-842.
- This report was based on the information obtained from the www.cdc.gov

National Challenge and Progress

(continued from page 1)

Indian/Alaskan Native, and 26.7 for Asian/Pacific Islander) and colorectal cancer (43.9 for white, 51.8 for black, 34.9 for Hispanic, 32.9 for American Indian/Alaska Native, and 26.7 for Asian/Pacific Islander). The leading causes of death among women are lung (42.6 for white, 40.2 for black, 14.2 for Hispanic, 27.5 for American Indian/Alaska Native, and 17.6 for Asian/Pacific Islander), breast (24.9 for white; 34.1 for black, 15.7 for Hispanic, 13.9 for American Indian/Alaskan Native and 12.9 for Asian/Pacific Islander), and colorectal (16.5 for all racial and Hispanic origin populations). Among all cancers combined, incidence rates for women are highest among whites (408.9), followed by blacks (377.5), Hispanics (310.4), Asian/Pacific Islanders (264.5) and American Indians/Alaska Natives (215.4). Death rates are highest among blacks (190.9), followed by whites (161.9), American Indians/Alaska Natives (114.5), Hispanics (107.4), and Asian/Pacific Islanders (96.6).³ The most common cancers in children aged 0-19 years are Leukemia (4.1) and brain/central nervous system cancer (0.7). The most common causes of cancer death in children are Leukemia (0.8) and brain/central nervous system (0.7).³

Many cancers can be prevented. All cancers caused by cigarette smoking and heavy alcohol use can be prevented completely. The American Cancer society estimates approximately 170,000 cancer deaths in 2006 due to tobacco use. Scientific evidence suggests that about one-third of the 564,830 cancer deaths expected to occur in 2006 will be related to nutrition, physical inactiv-

ity, and overweight or obesity, and thus could also be prevented. Other cancers related to infectious agents, such as hepatitis B virus, human papillomavirus, human immunodeficiency virus, and others could be prevented through behavioral changes, vaccines, or antibiotics. In addition, many of the more than 1 million skin cancers that are expected to be diagnosed in 2006 could be prevented by protection from sun's rays.¹

Sources:

¹ Citations from American Cancer Society, Cancer Facts and Figures 2006, Atlanta, GA: American Cancer Society, 2006.

² Healthy People 2010., Progress Review, www.healthypeople.gov/data/2010prog/focus03/

³ United States Cancer Statistics 2002 Incidence and Mortality, Centers for Disease Control and Prevention, www.cdc.gov/cancer/npcr/uscs/index.htm

Florida Tobacco Control

(continued from page 7)

more than 440,000 deaths each year, specifically smoking related cancers. In Florida, nearly 29,000 deaths are attributable to tobacco use annually, and the threat of tobacco is greatest among youth. In fact, more than 35,900 children under the age of 18 become new, daily smokers each year, and about one-third of those will eventually lose their lives to this addiction. According to the American Lung Association's Estimated Prevalence and Incidence of Lung Disease, there are an estimated 9,419 people with Emphysema in Duval County in 2004 and 604 residents of Duval County were newly diagnosed with Lung Cancer in 2002. In addition, there were 72.3 per 100,000 smoking related deaths in Duval County in 2004 and 206.5 per 100,000 smoking attributable deaths in individuals over age 35. Decreases in smoking related cancer deaths are shown from 2000 to 2004, although decreases are not significant. (see Figure 6). Health Zone 2 in Duval County had the highest rate of Lung Cancer death in 2004 (see Figure 7). Florida's Tobacco Control Program was once

regarded as one of the country's best youth tobacco use prevention programs, resulting in a 57 percent decrease in smoking among middle school students and a 36 percent decrease among high school students since 1998. Initially funded with a \$70 million annual budget, today Florida's Tobacco Control Program receives only \$1 million. Nevertheless, marketing by the tobacco industry is higher in Florida than in any other state. In 2002, a staggering \$772.6 million was spent by the tobacco industry to market their products to a new generation of Florida smokers.

Recognizing this critical public health issue, the American Lung Association of Florida, along with the American Cancer Society, Florida Division; American Heart Association, Florida/Puerto Rico Affiliate; and the Campaign for Tobacco Free Kids, have once again come together to form Floridians for Youth Tobacco Education to support a ballot initiative to amend Florida's Constitution in November 2006. The amendment would require the Florida Legislature to annually designate 15 percent of the tobacco settlement payments to fund a comprehensive, statewide tobacco education and prevention program to keep kids tobacco-free. Additionally, by preventing kids from becoming adult smokers, Florida can help reduce the enormous financial costs and taxpayer burdens associated with smoking.

For more information on the amendment, to volunteer or to view complete text of the amendment, visit the campaign's website at www.KeepKidsSmokeFree.org. For more information about the American Lung Association of Florida or to view the American Lung Association's State of Tobacco Control: 2005, log onto www.lungfla.org or call 1-800-LUNG-USA.

Duval County Health Department
Institute for Health, Policy & Evaluation Research
900 University Blvd. North, Suite 604 (MC-99)
Jacksonville, Florida 32211

Phone: 904-630-3255
Fax: 904-665-3111

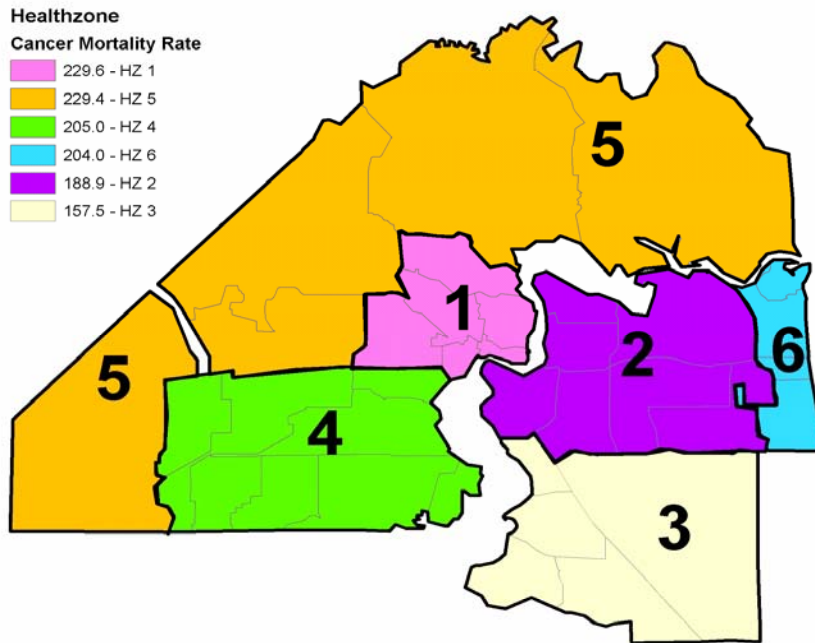
If you would like to receive this report electronically, please send an email to DCHD_DataReports@doh.state.fl.us and type the word subscribe in the subject line.



Visit our website!
www.dchd.net

Figure 12.

Age-Adjusted Cancer Mortality Rate by Health Zone, Duval County 2004



Source: FDOH, Office of Vital Statistics 2004 Death File
Prepared by: DCHD, Institute for Health, Policy and Evaluation Research, August 2006
This product is for reference only and is not to be construed as a legal document. Any reliance on the information contained herein is at the user's own risk. The Florida Department of Health and its agents assume no responsibility for any use of the information contained herein or any loss resulting therefrom.

