Cancer-Related Health Disparities in Women

Karen Glanz, PhD, MPH, Robert T. Croyle, PhD, Veronica Y. Chollette, RN, Vivian W. Pinn, MD

Cancer is the second leading cause of death (after heart disease) among women of all races in the United States. The burden of cancer is not distributed equally—many racial and ethnic minority groups experience higher incidences, higher mortality, and poorer survival rates than do White Americans. All cancer incidence and mortality rates declined from 1992 to 1997, the first such sustained decrease since the collection of cancer data began in the 1930s. For both men and women and in most minority populations, mortality has declined along with most of the leading causes of death from cancer. For some cancers, some ethnic minority groups have lower cancer rates than White Americans. Overall, however, minority groups have still not gained equal ground.

Further progress in reducing the toll of cancer—suffering, loss of life, and health care costs—depends on reducing health disparities by more effectively applying the best available strategies for prevention, early detection, and treatment to all populations.

The nation’s health objectives for the present decade call for the elimination of health disparities and increases in the quality and quantity of healthy life for all Americans. The National Cancer Institute, the Office of Research on Women’s Health, and other federal health research and service agencies are working aggressively to better understand the causes of health disparities and to develop effective interventions to eliminate them. An important step forward in these efforts involves providing a comprehensive overview of the current situation and recent trends in a form that is accessible to scientists, health professionals, public health experts, and communities of color. The Cancer in Women of Color monograph (available on-line)—a collaboration between the National Cancer Institute and the Office of Research on Women’s Health of the National Institutes of Health—provides data on cancer in 9 populations of women of color: Mexican American, Puerto Rican, Cuban American, African American, Asian American, Native Hawaiian, American Samoan, American Indian, and Alaska Native.

Approximately 35 million women in these racial/ethnic groups live in the United States, and their numbers are increasing rapidly. Since 1992, incidence rates for major cancer sites have slowed or decreased among these groups, but declines in mortality have not occurred or have been smaller than for Whites. Gaps in early detection have narrowed, but minority women still lag behind Whites. Smoking and obesity remain common in these populations.

Objectives. This article synthesizes information about cancer in 9 populations of minority women: Mexican American, Puerto Rican, Cuban American, African American, Asian American, Native Hawaiian, American Samoan, American Indian, and Alaska Native.

Methods. Cancer registry data, social indicators, government sources, and published articles were searched for information on the background and cancer experience of these 9 racial/ethnic groups.

Results. Approximately 35 million women in these racial/ethnic groups live in the United States, and their numbers are increasing rapidly. Since 1992, incidence rates for major cancer sites have slowed or decreased among these groups, but declines in mortality have not occurred or have been smaller than for Whites. Gaps in early detection have narrowed, but minority women still lag behind Whites. Smoking and obesity remain common in these populations.

Conclusions. More culturally appropriate interventions and research are needed, and these efforts must involve the community and raise the quality of health services. (Am J Public Health. 2003;93:292–298)
Southeast, mid-Atlantic, and Northeast regions. Most Asian Americans live in California, Hawaii, and New York, although new immigrants are increasingly settling in other regions. Two groups, Puerto Ricans and American Samoans, include people who live both in the US territories (Puerto Rico in the Caribbean, and American Samoa in the Pacific Ocean) and on the US mainland.

Demographic and Social Indicators
Racial differences often reflect differences in socioeconomic status between majority and minority groups. Minority women tend to be younger, less educated, more often living in poverty, and less likely to have adequate access to health care.

With the exception of Cuban Americans, all of the groups indicated have younger median ages than do US women overall. Levels of educational attainment are also lower: Although the percentage of high school graduates in the United States increased from 77.6% to 84.1% between 1990 and 2000, nearly all of the minority groups had significantly lower rates of high school graduation. Only Asian Americans had higher rates of high school and college graduation than the US average.

Minority women are more likely to live in poverty than other groups, on the state level and compared to the nation as a whole. The most recent national figures (1998) report that 11.8% of Americans live below the poverty level. Poverty rates for women in 8 of the minority populations range from 14% to 59%, and only Asian American women have lower poverty rates than the US total. However, this figure for Asian Americans masks wide variation among ethnic subgroups, because some immigrant groups experience significantly higher rates of poverty than do other Asian subgroups.

Another social indicator of great importance to health status is access to health insurance and a regular source of health care. Minority women are less likely to have health insurance and more likely to be underinsured and to lack a regular source of health care. Moreover, they are further disadvantaged by other barriers: long distances to health clinics, language differences, and a lack of culturally sensitive health care.

Major Historical and Cultural Influences
To better understand the life circumstances contributing to health disparities among women of color and to identify potential remedies, it is important to be aware of the major historical and cultural influences on women in minority ethnic/racial groups. Race is perhaps the most defining social issue in the history of the United States. Historically, White populations invaded and subordinated other racial groups or brought persons of color to the United States to work as slaves. Other minority groups came to the United States through political means, such as annexation of lands, or by immigration as political or economic refugees from their home countries. Most populations of women of color share a common history of discrimination, exclusion, and segregation.

Historical disadvantage, oppression, and racism are common experiences for African Americans, American Indians, Alaska Natives, and Native Hawaiians. Adverse living conditions, displacement, and diseases brought by nonindigenous peoples are well known to Mexican Americans, Native Hawaiians, American Indians, and Alaska Natives. Immigrant groups such as American Samoans, Puerto Ricans, and Asian Americans lose much of their former rural and subsistence lifestyles as they migrate to urban areas to secure employment. For many minorities, traditional spiritual and communal values have been lost through assimilation into the majority culture.

Core cultural values that emphasize close families, interdependence, religiosity, and a holistic view of health are shared by most
ethnic minorities in the United States. Also, women usually have been powerful stabilizing influences in their families, especially in raising children and managing family health. Traditional healing practices and the use of complementary and alternative medicine are widespread. Key factors that affect the acceptability of Western medicine among minority women include culturally based beliefs about diseases (including cancer), communication styles that may differ from those of health providers, linguistic barriers, and actual or anticipated discrimination.

Cancer Incidence, Mortality, and Risk Factors

The 1990s marked a turning point in cancer incidence rates in the United States and a period of increasingly rapid decline in cancer mortality. After increasing steadily until 1992, cancer incidence rates for all cancer sites decreased by an average of 1.3% per year from 1992 to 1997. For cancer deaths, earlier rates of increase slowed from 1984 to 1991 and declined 0.6% per year from 1991 to 1995. They then declined much more rapidly at 1.7% per year from 1995 to 1997. Although the continuing declines in overall cancer incidence and mortality rates are encouraging, ethnic/racial minority groups have not benefited as much as the overall population.

Cancer Incidence and Trends

Table 2 summarizes cancer incidence rates and trends for White and minority women for all sites combined and for breast, lung, colorectal, and cervical cancers, for the most recent available reporting periods. For the period 1992 to 1998, Alaska Native women had the highest overall cancer incidence rates across groups, followed by White women and African American women. From 1992 to 1998, White women experienced slight increases in cancers of the breast and lung and decreases in other cancers. African American women had increases in breast cancer, and Asian American women had modest increases in all major cancers combined. No significant annual increases or decreases were observed among American Indian women. Among the 3 groups for whom incidence rates are not available (Puerto Rican, Cuban American, and American Samoan), case rate data show that breast, lung, and colorectal cancers were the most common cancer diagnoses.

Cancer Mortality and Trends

For all cancers combined, from 1992 to 1998, White women had age-adjusted mortality rates of 138.0 per 100,000 women (Table 3). The rates were higher for African Americans (166.6) and Alaska Natives (181.4). Asian American and Pacific Islander, American Indian, and Hispanic women had substantially lower cancer mortality rates. Although Alaska Natives had the highest mortality rates for colorectal and lung cancers, African Americans had the highest mortality rates for cancers of the breast and cervix. All groups except Alaska Native women experienced lower overall cancer mortality for the period 1992 to 1998 than for the period 1988 to 1992.

Survival

As cancer mortality has declined, 5-year survival rates have increased for White and minority women. However, survival rates for minority women have improved more slowly, and these still lag behind for certain minority groups. Overall cancer survival rates from 1988 to 1997 were 0.62 for White women, but they were only 0.50 for American Indian, 0.55 for Alaska Native women, and 0.52 for African American women. Asian American women’s overall cancer survival rates were 0.64.

Most differentials in survival are attributed to the diagnosis of cancer at a later stage. The reasons for late diagnosis and poor cancer outcomes are becoming better understood and include disproportionate poverty and inferior medical care. Recently, several studies showed that equal cancer treatment, particularly in the context of clinical trials, yields equal cancer outcomes among African Americans and Whites for breast, colorectal, and lung cancers. Although clinical trials

| TABLE 2—Cancer Incidence and Trends for White and Minority Women |
|---------------------|-----------------|--------------|--------------|--------------|--------------|
|                    | All Sites       | Breast Cancer | Lung Cancer  | Colorectal Cancer | Cervical Cancer |
| White              | 354.4           | 115.5         | 43.6         | 36.3           | 8.1           |
| Mexican American<sup>a</sup> | 200.6           | 50.8          | 11.9         | 22.3           | 16.0          |
| Hispanic<sup>b</sup> | 237.7           | 68.5          | 18.7         | 23.2           | 14.4          |
| African American   | 337.6           | 101.5         | 45.7         | 44.7           | 11.0          |
| Asian and Pacific Islander | 252.1           | 78.1          | 22.7         | 31.0           | 10.3          |
| Native Hawaiian<sup>c</sup> | 321.0           | 105.6         | 43.1         | 30.5           | 9.3           |
| American Indian    | 140.1           | 36.2          | 12.4         | 13.5           | 6.2           |
| Alaska Native<sup>d</sup> | 400.1           | 118.1         | 57.8         | 76.1           | 7.5           |

Trends and Comments

- Increase in breast, lung; others decreased
- NA; may be comparable to other groups shown
- Decrease in cervical cancer; little change in others for combined Hispanic groups
- Increase in breast; others decreased
- Decrease in colorectal; others increased
- Slight decline 1976–1981 in all sites combined; may not be comparable to other groups shown
- Alaska excluded
- Increase in breast, lung, and colorectal; decreased cervical cancer incidence

Note. NA = not available. Rates per 100,000 women, for 1992–1998, unless otherwise noted. Age-adjusted to the 1970 US standard population. Population-based incidence data are unavailable for Puerto Rican, Cuban American, and American Samoan women.

Source: Surveillance, Epidemiology, and End Results program of the National Cancer Institute. Data from Horm report on New Mexico Surveillance, Epidemiology, and End Results Registry. Hispanic data is for all Hispanic ethnicity groups combined.

<sup>a</sup>Data for 1988–1992 from Miller et al.; unavailable for more recent period.

<sup>b</sup>Data from Alaska Native women derived from American Indian and Alaska Natives in the state of Alaska.
are not identical to the care that is provided in usual practice, the literature is increasingly compelling in showing that the association of race and cancer outcomes is not simply biological, but also appears to be influenced by the quality of treatment.20

**Risk Factors and Early Detection**

When differences in the use of proven early-detection strategies and well-known behavioral risk factors contribute to disparate cancer prevalence and mortality rates, the implications for intervention are clear. Mammography use, regular Papanicolaou tests, tobacco use, certain dietary practices, and obesity may explain some ethnic disparities in women’s cancers (Table 4).

In 1998, 68.1% of White women reported having had a mammogram within the previous 2 years.1 For women of color, rates were lower, ranging from 44.6% to 64%, although the differences narrowed during the 1990s. Physicians’ advice plays a key role in mammography use. Recent findings suggest that socioeconomic status, not race/ethnicity, accounts for much of the racial difference in physicians’ advice about mammography.22

The creation of the Centers for Disease Control and Prevention’s National Breast and Cervical Cancer Early Detection Program in 1990—which provides cancer screening services to underserved women—substantially increased the percentage of women in low-income households nationwide who reported having had a recent mammogram.23

As of 1998,1 80% of White women reported having had a Papanicolaou test within the past 3 years, a rate similar to those for African American, Cuban American, Puerto Rican, American Indian, and Native Hawaiian women. Less frequent use of Papanicolaou tests was found among Alaska Natives, American Samoans, Mexican Americans, and some Asian American groups.

In 1998, 22% of White women smoked, which represents a decrease from 27.7% in 1985.1 Smoking rates were even lower among Mexican American, Asian American, American Samoan, and African American women. However, higher smoking rates were found in Alaska Native, Puerto Rican, and Native Hawaiian women. American Indian tribes vary widely in their tobacco use (from 20% to 37% in recent surveys). The use of smokeless tobacco is also a problem among women in some American Indian populations.

Dietary factors account for as many as 35% of all cancers. Data from the Multiethnic Cohort Study in Hawaii and Los Angeles provide recent comparative information for Latino, Black, Native Hawaiian, and Asian American women.24 Mexican Americans and Native Hawaiians consume high-calorie and high-fat diets, but they also eat large amounts of fruit and vegetables. Asian Americans consume low-fat diets, and Blacks eat few vegetables but many fruits.24 For many ethnic minorities, acculturation to an “American diet” means increasing their intake of animal fat and “junk foods,” whereas traditional Asian, Hispanic, Alaska Native, and Native Hawaiian dietary patterns are high in complex carbohydrates and relatively low in fat.

Obesity is a risk factor for diabetes, cardiovascular disease, and some types of cancer, although its relationship to cancer incidence and mortality for various cancer sites and across the life span is complex. When obesity reflects a low intake of cancer-protective foods (e.g., fruits, vegetables, complex carbohydrates), it is likely to increase the risk of developing cancer. Obesity rates are high in Hispanic, African American, Native Hawaiian, American Samoan, American Indian, and Alaska Native women. For White women, 1994 data yield rates of obesity of 23.5% and rates of overweight (including obesity) of 48%.1

---

**TABLE 3—Cancer Mortality and Trends for White and Minority Women**

<table>
<thead>
<tr>
<th></th>
<th>All Sites</th>
<th>Breast Cancer</th>
<th>Lung Cancer</th>
<th>Colorectal Cancer</th>
<th>Cervical Cancer</th>
<th>Trends and Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>138.0</td>
<td>24.3</td>
<td>34.6</td>
<td>13.9</td>
<td>2.4</td>
<td>Decrease in breast and colorectal; increase in lung cancer</td>
</tr>
<tr>
<td>Mexican American</td>
<td>98.5</td>
<td>16.4</td>
<td>10.1</td>
<td>11.1</td>
<td>3.6</td>
<td>NA; may not be comparable to other groups shown</td>
</tr>
<tr>
<td>Hispanic</td>
<td>84.3</td>
<td>14.8</td>
<td>10.9</td>
<td>8.0</td>
<td>3.3</td>
<td>Little change overall</td>
</tr>
<tr>
<td>African American</td>
<td>166.6</td>
<td>31.0</td>
<td>33.6</td>
<td>19.6</td>
<td>5.7</td>
<td>Increase in lung; slight decreases in others</td>
</tr>
<tr>
<td>Asian and Pacific Islander</td>
<td>82.4</td>
<td>11.0</td>
<td>15.1</td>
<td>8.9</td>
<td>2.7</td>
<td>No overall mortality change</td>
</tr>
<tr>
<td>Native Hawaiian</td>
<td>168.0</td>
<td>25.0</td>
<td>44.1</td>
<td>11.4</td>
<td>NA</td>
<td>May not be comparable to other groups shown</td>
</tr>
<tr>
<td>American Indian</td>
<td>87.7</td>
<td>12.0</td>
<td>20.1</td>
<td>8.2</td>
<td>2.9</td>
<td>Recent data derived from more sites than earlier data</td>
</tr>
<tr>
<td>Alaska Native</td>
<td>181.4</td>
<td>21.5</td>
<td>44.2</td>
<td>30.4</td>
<td>3.1</td>
<td>Increase in breast and colorectal; decrease in cervical cancer mortality</td>
</tr>
</tbody>
</table>

*Note. NA = not available. Rates per 100,000 women, for 1992–1998, unless otherwise noted. Age-adjusted to the 1970 US standard population. Population-based incidence data are unavailable for Puerto Rican, Cuban American, and American Samoan women.

Source. Surveillance, Epidemiology, and End Results program of the National Cancer Institute.15

1Data from Horn report on New Mexico Surveillance, Epidemiology, and End Results Registry. Hispanic data is for all Hispanic ethnicity groups combined.

2Data for 1988–1992 from Miller et al.; unavailable for more recent period.


4Data for American Indian women derived from American Indian and Alaska Natives in 11 Surveillance, Epidemiology, and End Results areas (Alaska excluded).

5Data for American Indian women derived from American Indian and Alaska Natives in the state of Alaska.

---

**Beyond The Numbers: Subgroup Variation**

More data is available on cancer incidence, mortality, survival, risk factors, and early detection among racial/ethnic minority women than ever before. Even so, some racial/ethnic categories reflect numerous and diverse subgroups. One source of variation is geographic location. For example,
TABLE 4—Risk Factors and Early Detection for Minority Women

<table>
<thead>
<tr>
<th>Minority Group</th>
<th>Mammography Within 2 Years, Aged 40 Years and Older</th>
<th>Papanicolaou Test Within 3 Years</th>
<th>Tobacco Use</th>
<th>Diet and Obesity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mexican American</td>
<td>59% (1998); lowest use of mammograms among Hispanic women</td>
<td>73% (1998)</td>
<td>Smoking 13.6%; more smoking with increased acculturation</td>
<td>29%–39% overweight and obese; high-calorie, high-fat diet, also high in fruit and vegetables</td>
</tr>
<tr>
<td>Puerto Rican</td>
<td>64% (1998)</td>
<td>77% (1998)</td>
<td>30.3% smoking; highest among Hispanic groups</td>
<td>28%–39% obesity; high animal fat intake in Puerto Rico</td>
</tr>
<tr>
<td>Cuban American</td>
<td>62% (1998); previously low, increased in the 1990s</td>
<td>78% (1998); Papanicolaou test use increased after outreach programs</td>
<td>24.4% smoking rate</td>
<td>31.6% overweight; 34.9% eat a variety of foods, and 75.5% eat junk food daily</td>
</tr>
<tr>
<td>African American</td>
<td>65.9% (1998)</td>
<td>80% (1998)</td>
<td>21% smoking in 1998, down significantly since 1985</td>
<td>66.6% overweight or obese; low intake of vegetables but high intake of fruit</td>
</tr>
<tr>
<td>Asian American</td>
<td>60.7% overall (1998); variable across ethnic subgroups, range 31%–70%</td>
<td>67% overall (1998); ranges 43%–95%; lowest use among Vietnamese, recent immigrants, and non-English speaking</td>
<td>Low smoking rates among females, varying 7%–19% by ethnic group</td>
<td>13%–26% obese, varying across ethnic groups; traditional Asian diet is protective; animal fat increases with acculturation</td>
</tr>
<tr>
<td>Native Hawaiian</td>
<td>63% reported recent mammogram; 73% ever had a mammogram</td>
<td>83% reported recent Papanicolaou test, although rates declined in older women (aged 65 years and older)</td>
<td>30% smoking rate, highest in state of Hawaii</td>
<td>More than 60% overweight or obese; high caloric intake, high fat, meat, fruit, and vegetable intake</td>
</tr>
<tr>
<td>American Samoan</td>
<td>40%–70% reported recent mammogram</td>
<td>46% reported recent Papanicolaou test</td>
<td>Estimated 11% smoking rate</td>
<td>High rates of obesity and related risks; migration accompanied by shift to high-fat foods</td>
</tr>
<tr>
<td>American Indian</td>
<td>44.6% (1998) combined American Indian/Alaska Native</td>
<td>72% combined American Indian/Alaska Native (1998)</td>
<td>Wide variation across tribes and regions; 20%–37% in recent surveys; smokeless tobacco use a problem</td>
<td>High obesity rates (in 1 urban area, 69.6% overweight and 41.6% obese)</td>
</tr>
<tr>
<td>Alaska Native</td>
<td>No information available separate from American Indians (44.6% in 1998)</td>
<td>62% within 3 years; 15% annual Papanicolaou test (72% American Indian/Alaska Native combined, 1998)</td>
<td>High rates, estimated 35.6% nationwide</td>
<td>More than 60% overweight, with 32.8% obese; dietary fat in nontraditional foods is high; fish intake also is high</td>
</tr>
</tbody>
</table>

Note. Information from various sources (see Cancer in Women of Color monograph).
Americans, Puerto Ricans, Cuban Americans) have not yet been published. Limitations exist on data collected through the SEER program because of variation in clinicians’ use of diagnostic tests and cancer staging. Also, national data for racial/ethnic groups may be insufficient to describe the cancer experience in specific locations, tribes, and people from various countries of origin. Some experts have called for the inclusion of socioeconomic status as a stratification variable in cancer statistics to help disentangle race/ethnicity and socioeconomic status as correlates of cancer causation and outcomes.  

Accurate data on cancer incidence, mortality, and survival rates depend on accurate contemporaneous census data. The 2000 census represents remarkable advances in the identification of racial groups but raises new complexities that must be addressed. The use of self-identification for mixed-race persons as “race in combination with other races” presents new challenges, among them the question of whether it is possible for hospitals to report cancer cases by both single- and mixed-race ethnic groups. Health care privacy laws and concerns about discrimination must be considered in efforts to collect more accurate data on cancer diagnoses, treatment, and outcomes.

A further consideration in cancer research involving minorities relates to the need for greater minority participation in cancer research, including behavioral and risk factor surveys and clinical trials. Although accrual patterns now reveal that women and ethnic/racial minorities are proportionately represented, the numbers often are too small to allow subgroup analyses. It is also important to conduct studies that are large enough to include sufficient numbers of minority respondents at various levels of educational attainment, so that the effects of this important variable can be more carefully differentiated.

A CALL TO ACTION

Understanding cancer-related health disparities in women is an important step toward improving health and the quality of life for millions of minority women. Recent trends in decreased incidence and mortality from most cancers show that preventive strategies, early detection methods, and successful treatments of cancer are more readily available. More research is needed to address social, cultural, and biological determinants of differential cancer profiles.

Traditional beliefs of many ethnic groups include a strong sense that an individual’s health is just one part of the holistic balance of life. By working with this philosophy rather than against it, researchers and practitioners can develop effective and culturally sensitive interventions. Health care practitioners and researchers must respect the traditional beliefs and appreciate the cultural contexts of the groups with which they work. They must also understand the skepticism and distrust that many minority groups have for researchers and health providers, which is based on a history of discrimination and exclusion.

Inferior medical care for racial and ethnic minority women must be considered unacceptable. Issues that require attention include socioeconomic status, educational and language barriers, differences between minority women and mainstream health care providers in verbal and nonverbal communication styles, expectations for care, and beliefs regarding the efficacy of complementary and alternative therapies.

Aggressive and comprehensive plans to expand cancer registries, improve the ascertainment of racial/ethnic information, collect socioeconomic data along with cancer statistics, support intervention research, improve access to care, and improve the translation of research to application are all priorities for the National Cancer Institute’s Special Populations Networks. The Cancer in Women of Color monograph establishes a baseline for further research and will advance progress toward eliminating health disparities. It provides direction for those who are planning programs, services, and policies to combat cancer in women and minority populations.

CONCLUSIONS

Cancer affects women in various population subgroups in distinct ways. Historically, women have been underrepresented in cancer research and cancer control programs and often have not received state-of-the-art cancer treatment. Extensive and up-to-date information on the cancer experience and its determinants in women from racial and ethnic minority groups is now available. The Cancer in Women of Color monograph establishes a baseline for further research and will advance progress toward eliminating health disparities. It provides direction for those who are planning programs, services, and policies to combat cancer in women and minority populations.

A CALL TO ACTION

Understanding cancer-related health disparities in women is an important step toward improving health and the quality of life for millions of minority women. Recent trends in decreased incidence and mortality from most cancers show that preventive strategies, early detection methods, and successful treatments of cancer are more readily available. More research is needed to address social, cultural, and biological determinants of differential cancer profiles.

Traditional beliefs of many ethnic groups include a strong sense that an individual’s health is just one part of the holistic balance of life. By working with this philosophy rather than against it, researchers and practitioners can develop effective and culturally sensitive interventions. Health care practitioners and researchers must respect the traditional beliefs and appreciate the cultural contexts of the groups with which they work. They must also understand the skepticism and distrust that many minority groups have for researchers and health providers, which is based on a history of discrimination and exclusion.

Inferior medical care for racial and ethnic minority women must be considered unacceptable. Issues that require attention include socioeconomic status, educational and language barriers, differences between minority women and mainstream health care providers in verbal and nonverbal communication styles, expectations for care, and beliefs regarding the efficacy of complementary and alternative therapies.

Aggressive and comprehensive plans to expand cancer registries, improve the ascertainment of racial/ethnic information, collect socioeconomic data along with cancer statistics, support intervention research, improve access to care, and improve the translation of research to application are all priorities for the National Cancer Institute’s Special Populations Networks. The Cancer in Women of Color monograph establishes a baseline for further research and will advance progress toward eliminating health disparities. It provides direction for those who are planning programs, services, and policies to combat cancer in women and minority populations.

CONCLUSIONS

Cancer affects women in various population subgroups in distinct ways. Historically, women have been underrepresented in cancer research and cancer control programs and often have not received state-of-the-art cancer treatment. Extensive and up-to-date information on the cancer experience and its determinants in women from racial and ethnic minority groups is now available. The Cancer in Women of Color monograph establishes a baseline for further research and will advance progress toward eliminating health disparities. It provides direction for those who are planning programs, services, and policies to combat cancer in women and minority populations.

A CALL TO ACTION

Understanding cancer-related health disparities in women is an important step toward improving health and the quality of life for millions of minority women. Recent trends in decreased incidence and mortality from most cancers show that preventive strategies, early detection methods, and successful treatments of cancer are more readily available. More research is needed to address social, cultural, and biological determinants of differential cancer profiles.

Traditional beliefs of many ethnic groups include a strong sense that an individual’s health is just one part of the holistic balance of life. By working with this philosophy rather than against it, researchers and practitioners can develop effective and culturally sensitive interventions. Health care practitioners and researchers must respect the traditional beliefs and appreciate the cultural contexts of the groups with which they work. They must also understand the skepticism and distrust that many minority groups have for researchers and health providers, which is based on a history of discrimination and exclusion.

Inferior medical care for racial and ethnic minority women must be considered unacceptable. Issues that require attention include socioeconomic status, educational and language barriers, differences between minority women and mainstream health care providers in verbal and nonverbal communication styles, expectations for care, and beliefs regarding the efficacy of complementary and alternative therapies.

Aggressive and comprehensive plans to expand cancer registries, improve the ascertainment of racial/ethnic information, collect socioeconomic data along with cancer statistics, support intervention research, improve access to care, and improve the translation of research to application are all priorities for the National Cancer Institute’s Special Populations Networks. The Cancer in Women of Color monograph establishes a baseline for further research and will advance progress toward eliminating health disparities. It provides direction for those who are planning programs, services, and policies to combat cancer in women and minority populations.

CONCLUSIONS

Cancer affects women in various population subgroups in distinct ways. Historically, women have been underrepresented in cancer research and cancer control programs and often have not received state-of-the-art cancer treatment. Extensive and up-to-date information on the cancer experience and its determinants in women from racial and ethnic minority groups is now available. The Cancer in Women of Color monograph establishes a baseline for further research and will advance progress toward eliminating health disparities. It provides direction for those who are planning programs, services, and policies to combat cancer in women and minority populations.
References


