American Cancer Society®

Cancer Facts & Figures

for Asian American, Native Hawaiian, & Other Pacific Islander People 2024–2026

Contents

Disclaimer: The designations employed and the presentation of these materials do not imply the expression of any opinion whatsoever on the part of the American Cancer Society concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Suggested citation: American Cancer Society. *Cancer Facts & Figures for Asian American, Native Hawaiian, & Other Pacific Islander People 2024-2026.* Atlanta: American Cancer Society; 2024.

Fast Facts

- In 2021, approximately 24 million Asian American and 1.7 million Native Hawaiian and Other Pacific Islander (NHPI) individuals (single or mixed race) lived in the United States,[1] representing about 8% of the US population in total (Figure 1).
- Aside from multiracial people, Asian Americans are the fastest-growing population in the United States, with the size projected to double between 2016 and 2060, mostly through international migration.[2]
- Cancer is the leading cause of death in Chinese, Filipino, Korean, and Vietnamese individuals, ranks second in Asian Indian, Native Hawaiian, and Japanese individuals, and third in Samoan individuals, among whom COVID-19 is the leading cause of death (Table 2).
- The most commonly diagnosed cancer in Asian American and NHPI men is prostate cancer (as in the overall US male population), with the exception of Chinese, Vietnamese, Laotian, and Chamorro/Guamanian men, among whom lung cancer ranks first, and Korean, Hmong, and Cambodian men, among whom colorectal cancer ranks first (Table 3).
- Breast cancer is the most commonly diagnosed cancer among women of every Asian American and NHPI ethnic group, ranging from 17% of all cancers among Hmong women to 44% among Fijian women (Table 3).
- Despite Asian Americans having a 40% lower overall cancer death rate than the White population, liver cancer mortality is nearly 40% higher, and stomach cancer mortality is twice as high (Figure 3).
- Disparities in the NHPI population are even more striking; despite 7% lower overall cancer mortality compared to Whites, the death rate is 30% higher for breast cancer, 75% higher for liver cancer, and about 2.5- to 3.3-fold higher for cervical, stomach, and uterine corpus cancers (Figure 3).
- Uterine corpus cancer is the fifth most common cause of cancer death in US women overall, but ranks second in Samoan women and fourth in Native Hawaiian and Asian Indian women (Figure 4).
- Five-year relative survival for breast cancer ranges from 72-74% in Tongan, Chamorro/Guamanian, and Samoan women to 94% in Japanese women (93% in White women), and for colorectal cancer, it ranges from 48% in Cambodian individuals to 71% in Pakistani individuals (65% in White individuals) (Figure 5).
- There is wide diversity between Asian American and NHPI ethnic groups in stage at cancer diagnosis; for example, localized-stage breast cancer was diagnosed in 47% to 55% of Samoan, Tongan, Laotian, Chamorro/Guamanian, Hmong, and Pakistani women versus 73% of Japanese women during 2016-2020 (Figure 6).
- Cancer screening is generally lower among Asian American individuals compared to the White population; for example, based on the 2015 and 2018 National Health Interview Survey, up-to-date colorectal cancer screening in individuals 45 years of age and older was 41% in Asians of unspecified origin and 44% in Asian Indian individuals to 51% in Chinese individuals, compared to 57% in the White population (Table 4).

Introduction

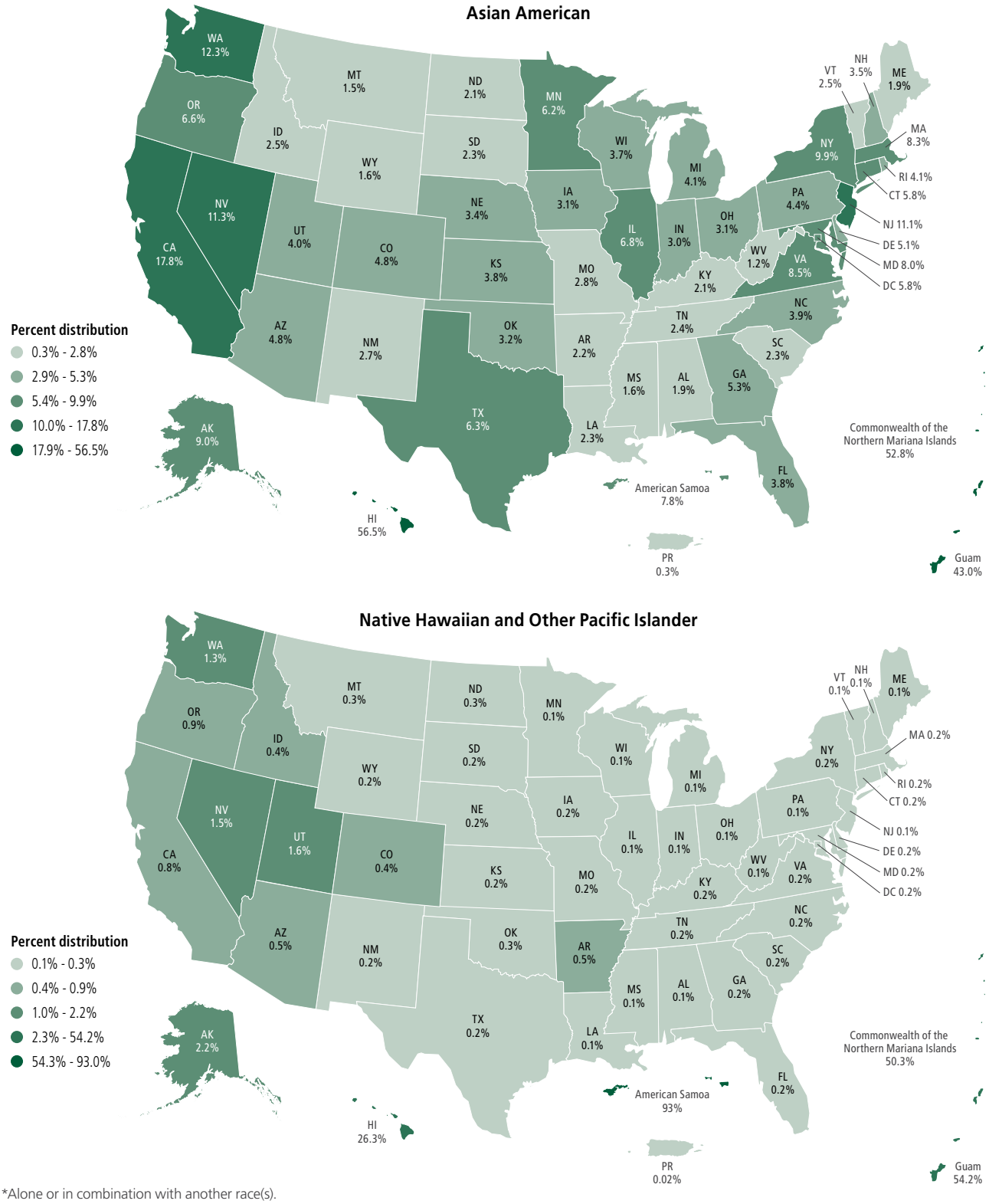
According to the US Office of Management and Budget (OMB), the term "Asian" refers to a person having origins in any of the original peoples of the Far East, Southeast Asia, and the Indian subcontinent.[3] In 2021, approximately 24 million Asian Americans (single or mixed race) lived in the United States,[1] representing about 7% of the US population. Aside from multiracial people, Asian Americans are the fastest-growing population, with the size projected to double between 2016 and 2060, mostly through international migration.[2] The highest concentration of Asian Americans lives in Hawaii (Hawai'i), representing nearly 60% of the state's population, followed by the US territories of the Commonwealth of the Northern Mariana Islands (52.8%) and Guam (Guåhan) (43%). Within the continental US, the majority of Asian Americans live in California (17.8% of the state's residents), followed by Washington (12.3%), Nevada (11.3%), and New Jersey (11.1%, Figure 1). There are over 19 Asian-origin groups living in the US, with the largest groups of known origin being Chinese (21%), Asian Indian (20%), Filipino (18%), Vietnamese (9%), Korean (8%), and Japanese (7%, Figure 2).[1]

Native Hawaiian and Other Pacific Islanders (NHPI) refers to people with origins in Hawaii, Guam, Samoa (Sāmoa), Tonga, or other Pacific Islands throughout Polynesia, Micronesia, and Melanesia.[4] In 2021, the US Census Bureau estimated that approximately 1.7 million NHPI individuals (single or mixed race) lived in the United States, representing about 1% of the US population. The NHPI population lives mostly in the US territories of American Samoa (93% of residents), Guam (54.2%), the Commonwealth of Northern Mariana Islands (50.3%), and the state of Hawaii (26%, Figure 1). Native Hawaiian individuals (42%) are the largest NHPI population of known origin, followed by Samoan individuals (15%) and Chamorro (Indigenous CHamoru people of The Marianas, including the US territories of the Commonwealth of the Northern Mariana Islands and Guam) individuals (9%, Figure 2).[1] The 2020 US Census showed that, for the first time, more Native Hawaiians lived in the continental US than in Hawaii, in large part due to the increasing cost of living in Hawaii.

Health statistics are often presented in aggregate for the Asian American and NHPI populations, masking vast diversity and disparities in the cancer burden. The cancer profile differs between Asian American ethnic groups because of variations in immigration patterns, behavior, culture, exposures in country of origin, and social determinants of health. For example, the population living below the poverty level ranges from 6% to 8% among Asian Indian, Filipino, and Japanese individuals to 24% for Burmese individuals, influencing cancer risk and outcomes.[5] In 1997, the OMB disaggregated Native Hawaiian and Other Pacific Islanders from Asian Americans.[6] However, separate incidence and mortality cancer statistics are still not readily available even for these two broad groups, let alone for each disaggregated Asian and NHPI ethnic group, due to the lack of population (denominator) data. The continued reporting of aggregated cancer statistics may also be due to long-standing practices, the reporting of historical trends, and a lack of awareness of the heterogeneity among these populations.

This report provides national information on cancer occurrence, risk factors, and screening for disaggregated Asian American and NHPI ethnic groups in the US to the largest extent allowed by currently available data.

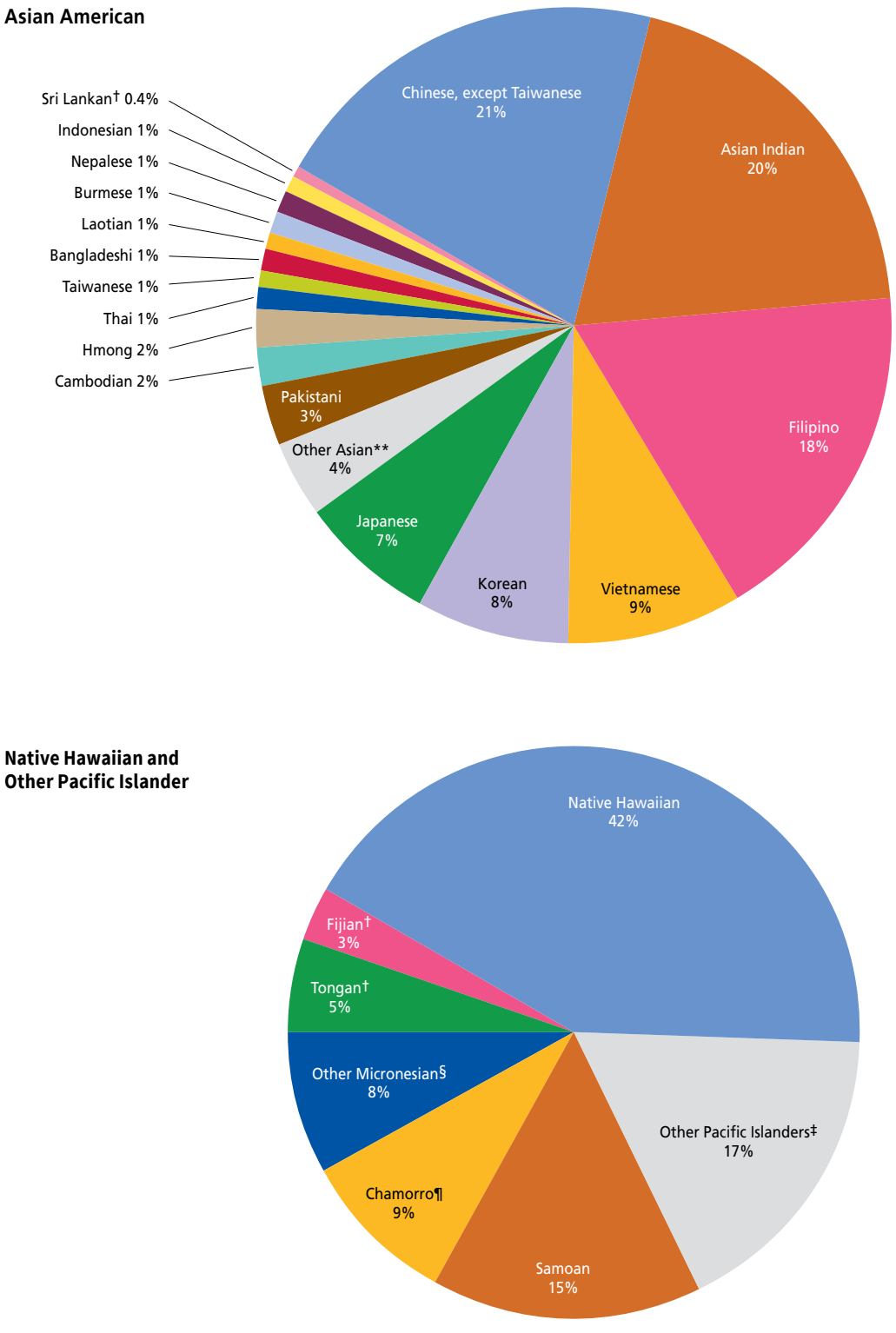
Figure 1. Asian American and Native Hawaiian and Other Pacific Islander* Population Distribution as a Percentage of State/Territory Total, US



*Alone or in combination with another race(s).

Sources: Asian Americans – US Census Bureau, 2021 American Community Survey 1-Year Estimates. Native Hawaiian and Other Pacific Islanders – US Census Bureau, 2017-2021 American Community Survey 5-Year Estimates. Guam, Commonwealth of the Northern Mariana Islands and American Samoa (Asian American and NHPI) - US Census Bureau, 2020 Census.

Figure 2. Asian American, Native Hawaiian, and Other Pacific Islander* Population Distribution by Ethnic Group, US, 2021



*Alone, or in combination with another race(s). **Populations with <50,000 people. †Margin of error is >10% of the population estimate. ‡Includes Other Polynesians, Other Melanesians, Other Pacific Islanders, not specified. §Includes Marshallese and Other Micronesian. ¶Estimates for Guamanian people were not available.

Source: US Census Bureau, 2021 American Community Survey 1-Year Estimates.

Table 1. Sociodemographic Characteristics of Asian American, Native Hawaiian, and Other Pacific Islander* People by Ethnic Group, US, 2017-2021

- Asian American and NHPI ethnic groups have highly varied sociodemographic characteristics, which influence cancer occurrence. For example, the median age ranges from 24 in Tongan individuals to 37 in Japanese and Fijian individuals, which contributes to different cancer profiles.
- Only 6% of Asian Indians live in poverty compared to 24% of Burmese individuals, and 80% of Taiwanese people have attained a bachelor's degree or higher compared to 19% of Laotian and 20% of Samoan and Tongan individuals. Lower socioeconomic status is associated with higher cancer incidence (especially smoking and infection-related cancers), later-stage diagnosis, and worse cancer outcomes.[5]
- There is also a wide variation among ethnic groups in immigration history, which influences the extent of acculturation, the prevalence of cancer risk factors, and access to preventive health services.[7-9] For example, Asian ethnic groups that have lived longer in the US and have greater English language proficiency are more likely to undergo cancer screening.[7]
- NHPI populations are more likely than Asian American populations to be US-born and to have US citizenship because of colonization.

		Nativity and Citizenship Status		Educational Attainment†			Socioeconomic Status	
	Median age	Born in US/US territories	Not a US citizen	Less than high school	High school graduate	Bachelor's degree or higher	Median household income (in 2021 inflation-adjusted dollars)	Income below federal poverty level
Asian American								
Asian Indian	34	33%	34%	7%	8%	75%	$131,154	6%
Bangladeshi	33	28%	28%	17%	18%	50%	$64,937	18%
Cambodian	31	52%	11%	29%	25%	22%	$73,942	14%
Chinese, except Taiwanese	35	41%	24%	15%	14%	56%	$90,857	12%
Taiwanese	36	40%	18%	3%	6%‡	80%	$111,025	9%
Filipino	35	50%	13%	6%	16%	48%	$98,827	7%
Hmong	25	67%	6%	21%	25%	24%	$74,583	15%
Indonesian	34	46%	27%	6%	17%‡	51%	$84,238	10%‡
Japanese	37	73%	15%	4%	17%	52%	$91,359	8%
Korean	36	43%	19%	6%	15%	58%	$81,072	11%
Laotian	33	54%	11%	25%	29%	19%	$71,861	12%
Pakistani	31	38%	20%	12%	13%	59%	$93,692	13%
Sri Lankan	36	30%	33%	8%	15%‡	60%	$99,733	9%‡
Thai	35	45%	21%	14%	17%	47%	$74,495	12%
Vietnamese	36	40%	14%	24%	20%	33%	$77,787	12%
Burmese	28	24%	42%	48%	17%	23%	$53,475	24%
Nepalese	30	20%	50%	25%	15%	46%	$72,637	14%‡
NHPI								
Native Hawaiian	29	97%	1%‡	7%	34%	24%	$79,005	13%
Samoan	25	80%	7%	11%	35%	20%	$70,520	15%
Tongan	24	72%	12%‡	12%	34%	20%	$71,075	14%‡
Chamorro/Guamanian	28	93%	2%‡	10%	28%	26%	$79,990	11%
Fijian	37	38%	19%‡	18%	26%	24%	$89,201	10%‡

NHPI=Native Hawaiian and Other Pacific Islander. *Alone, or in combination with another race(s). †Population over 25 years of age. ‡Margin of error is >10% of the estimate.

Source: US Census Bureau, 2017-2021 American Community Survey 5-Year Estimates.

Table 2. Leading Causes of Death Among Asian American, Native Hawaiian, and Other Pacific Islander People by Ethnic Group, US, 2020-2021

- Cancer is the leading cause of death among Chinese, Filipino, Korean, and Vietnamese individuals, ranks second among Asian Indian, Japanese, and Native Hawaiian individuals, and third among Guamanian and Samoan individuals.
- Notably, COVID-19 is the leading cause of death among Samoan individuals and the second-leading cause among Vietnamese and Guamanian individuals.

		Ranking				
	All causes	**1**	**2**	**3**	**4**	**5**
Asian American						
Asian Indian	25,457	Heart diseases 5,641	Cancer 4,091	COVID-19 3,268	Cerebrovascular diseases 1,457	Accidents (unintentional injuries) 1,234
Chinese	40,489	Cancer 9,794	Heart diseases 7,791	COVID-19 4,711	Cerebrovascular diseases 2,788	Alzheimer's disease 1,509
Filipino	36,563	Cancer 7,270	Heart diseases 7,201	COVID-19 6,423	Cerebrovascular diseases 2,523	Diabetes mellitus 1,789
Japanese	18,866	Heart diseases 3,730	Cancer 3,403	Alzheimer's disease 1,706	Cerebrovascular diseases 1,506	COVID-19 1,234
Korean	16,362	Cancer 3,737	Heart diseases 2,546	COVID-19 1,991	Cerebrovascular diseases 1,083	Alzheimer's disease 762
Vietnamese	19,262	Cancer 4,366	COVID-19 2,976	Heart diseases 2,970	Cerebrovascular diseases 1,510	Accidents (unintentional injuries) 870
NHPI						
Native Hawaiian	2,028	Heart diseases 460	Cancer 396	COVID-19 216	Accidents (unintentional injuries) 128	Diabetes mellitus 90
Guamanian	1,059	Heart diseases 205	COVID-19 186	Cancer 166	Diabetes mellitus 83	Cerebrovascular diseases 50
Samoan	2,489	COVID-19 552	Heart diseases 495	Cancer 390	Diabetes mellitus 146	Accidents (unintentional injuries) 124

Note: All estimates exclude individuals of Hispanic ethnicity.

Source: National Center for Health Statistics, 2023.

Table 3. Most Common Cancer Types Among Asian American, Native Hawaiian, and Other Pacific Islander People by Ethnic Group and Sex, US, 2016-2020

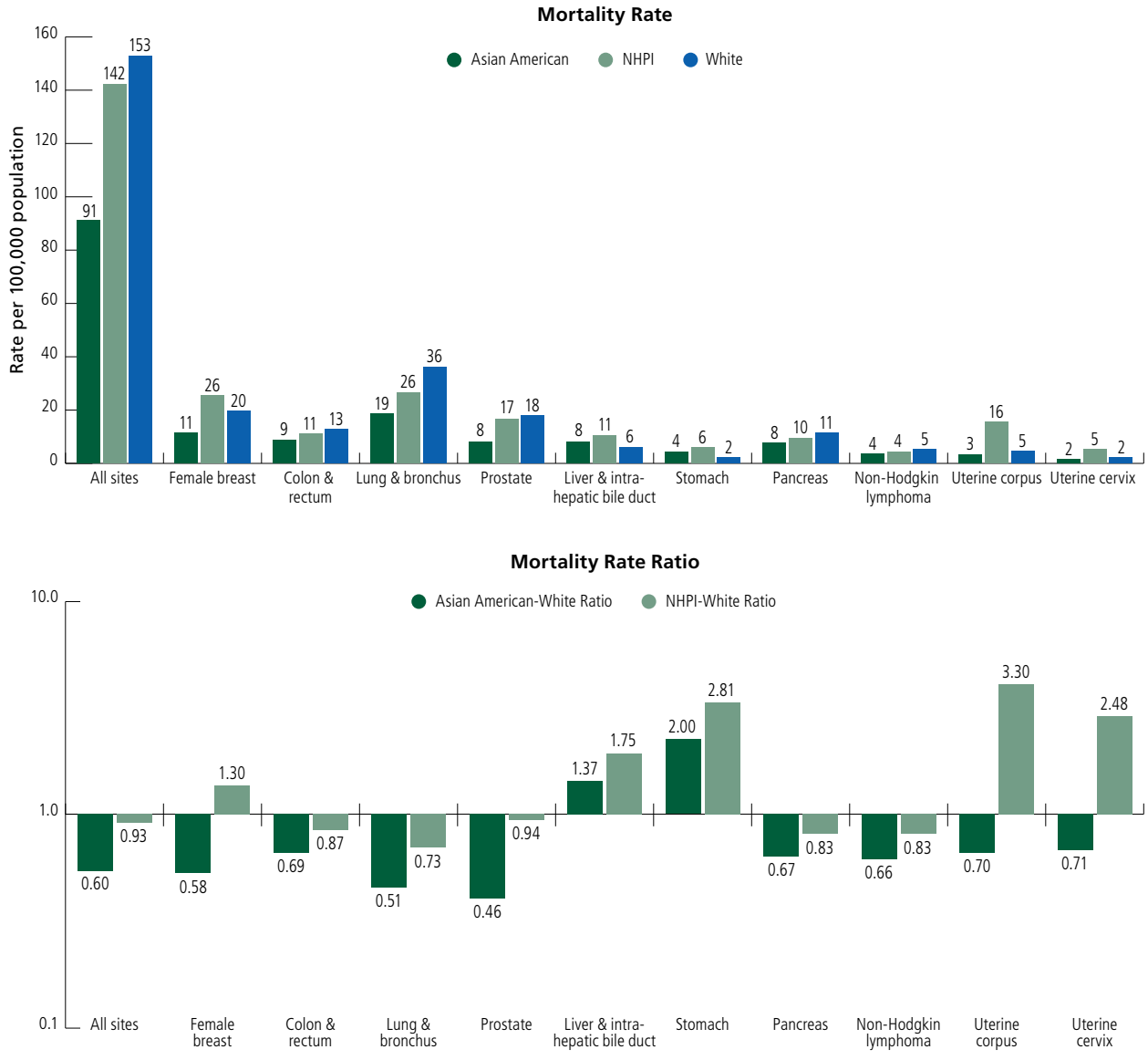
- The most commonly diagnosed cancer in Asian American and NHPI men is prostate cancer, (as in the overall US male population), with the exception of Chinese, Vietnamese, Laotian, and Chamorro/Guamanian men, among whom lung cancer ranks first, and Korean, Hmong, and Cambodian men, among whom colorectal cancer ranks first.
- In contrast, breast cancer is the most common cancer among women of every Asian American and NHPI ethnic group, ranging from 17% of all cancers among Hmong women to 44% among Fijian women.
- Uterine corpus cancer ranks second among Filipino, Asian Indian, Pakistani, Native Hawaiian, Samoan, Tongan, and Fijian women, while ranking fourth in US women overall.
- Liver cancer is the second or third most common cancer in Vietnamese, Hmong, Cambodian and Laotian men and ranks fourth in Chinese, Pakistani, and Tongan men, but is not even among the top 10 cancers diagnosed in US men overall.

	Cancer cases							
	First	%	Second	%	Third	%	Fourth	%
Males								
Asian American								
Chinese	Lung & bronchus	18%	Prostate	16%	Colon & rectum	12%	Liver & intrahepatic bile duct	7%
Japanese	Prostate	27%	Colon & rectum	12%	Lung & bronchus	12%	Urinary bladder	6%
Filipino	Prostate	23%	Lung & bronchus	16%	Colon & rectum	12%	Non-Hodgkin lymphoma	6%
Korean	Colon & rectum	14%	Lung & bronchus	14%	Prostate	14%	Stomach	10%
Vietnamese	Lung & bronchus	20%	Liver & intrahepatic bile duct	15%	Colon & rectum	12%	Prostate	12%
Laotian	Lung & bronchus	18%	Colon & rectum	17%	Liver & intrahepatic bile duct	16%	Prostate	8%
Hmong	Colon & rectum	15%	Liver & intrahepatic bile duct	12%	Lung & bronchus	10%	Oral cavity & pharynx	9%
Cambodian	Colon & rectum	19%	Liver & intrahepatic bile duct	15%	Lung & bronchus	14%	Prostate	8%
Thai	Prostate	18%	Lung & bronchus	13%	Colon & rectum	13%	Non-Hodgkin lymphoma	8%
Asian Indian	Prostate	20%	Colon & rectum	10%	Lung & bronchus	8%	Oral cavity & pharynx	7%
Pakistani	Prostate	16%	Lung & bronchus	10%	Colon & rectum	9%	Liver & intrahepatic bile duct	8%
NHPI								
Native Hawaiian	Prostate	22%	Lung & bronchus	13%	Colon & rectum	10%	Kidney & renal pelvis	5%
Chamorro/Guamanian	Lung & bronchus	19%	Prostate	13%	Colon & rectum	10%	Melanoma of the skin	6%
Samoan	Prostate	18%	Lung & bronchus	17%	Colon & rectum	13%	Stomach	7%
Tongan	Prostate	18%	Lung & bronchus	18%	Colon & rectum	11%	Liver & intrahepatic bile duct	8%
Fijian	Prostate	18%	Colon & rectum	10%	Urinary bladder	9%	Lung & bronchus	8%
Females								
Asian American								
Chinese	Breast	32%	Lung & bronchus	13%	Colon & rectum	8%	Thyroid	6%
Japanese	Breast	35%	Lung & bronchus	11%	Colon & rectum	10%	Uterine corpus	6%
Filipino	Breast	38%	Uterine corpus	9%	Lung & bronchus	9%	Colon & rectum	7%
Korean	Breast	32%	Lung & bronchus	10%	Colon & rectum	10%	Thyroid	6%
Vietnamese	Breast	30%	Lung & bronchus	13%	Colon & rectum	9%	Thyroid	7%
Laotian	Breast	25%	Colon & rectum	12%	Lung & bronchus	9%	Liver & intrahepatic bile duct	6%
Hmong	Breast	17%	Colon & rectum	10%	Uterine corpus	9%	Lung & bronchus	9%
Cambodian	Breast	28%	Colon & rectum	13%	Lung & bronchus	10%	Liver & intrahepatic bile duct	6%
Thai	Breast	35%	Lung & bronchus	13%	Colon & rectum	8%	Uterine corpus	6%
Asian Indian	Breast	39%	Uterine corpus	8%	Thyroid	8%	Colon & rectum	5%
Pakistani	Breast	41%	Uterine corpus	8%	Thyroid	6%	Colon & rectum	5%
NHPI								
Native Hawaiian	Breast	34%	Uterine corpus	12%	Lung & bronchus	10%	Colon & rectum	7%
Chamorro/Guamanian	Breast	31%	Lung & bronchus	13%	Uterine corpus	9%	Colon & rectum	9%
Samoan	Breast	25%	Uterine corpus	23%	Lung & bronchus	9%	Colon & rectum	5%
Tongan	Breast	33%	Uterine corpus	22%	Lung & bronchus	5%	Liver & intrahepatic bile duct	5%
Fijian	Breast	44%	Uterine corpus	11%	Colon & rectum	7%	Lung & bronchus	5%

Note: All percentages exclude individuals of Hispanic ethnicity. Colon & rectum excludes appendix. Excludes ethnic groups with fewer than 50 cases.
Source: North American Association of Central Cancer Registries, 2023.

Figure 3. Age-adjusted Mortality Rate and Rate Ratio Among Asian American and Native Hawaiian and Other Pacific Islander People Compared to White People for Selected Cancers, US, 2018-2021

- Asian Americans are 40% less likely to die from cancer than White people overall, but nearly 40% more likely to die from liver cancer and twice as likely to die from stomach cancer, reflecting cancer risk in Asian countries of origin.
- Disparities in the NHPI population are even more striking; despite 7% lower overall cancer mortality compared to Whites, death rates are 30% higher for breast cancer, 75% higher for liver cancer, and about 2.5- to 3.3-fold higher for cervical, stomach, and uterine corpus cancers.



NHPI=Native Hawaiian and Other Pacific Islander. Note: Rates are per 100,000, age adjusted to the 2000 US standard population, rounded to the nearest whole number and exclude individuals of Hispanic ethnicity.

Source: National Center for Health Statistics, 2023.

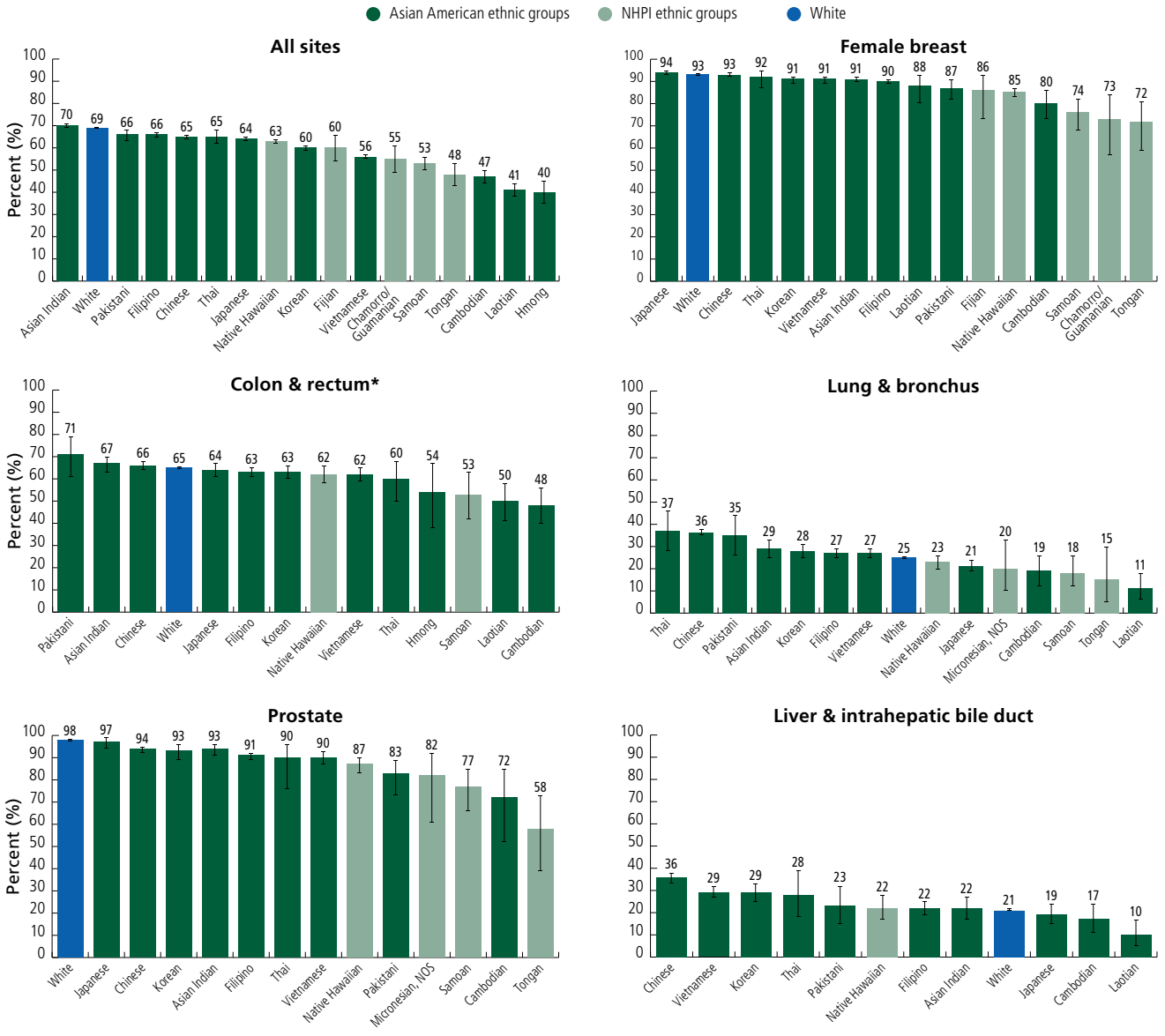
Figure 4. The Four Leading Causes of Cancer Death Among Asian American, Native Hawaiian, and Other Pacific Islander People by Ethnic Group and Sex, US, 2018-2021

- Akin to the US population, lung cancer is the leading cause of cancer death in men for all nine Asian American and NHPI ethnic groups (for which there are sufficient data), ranging from 15% of cancer deaths in Asian Indian men to 27% in Guamanian men.
- Among Asian American and NHPI women, lung cancer is the leading cause of cancer death except in Filipino, Asian Indian, Samoan, and Guamanian women, among whom breast cancer leads.
- Uterine corpus cancer is the fifth most common cause of cancer death in US women overall, but ranks second in Samoan women and fourth in Native Hawaiian and Asian Indian women. Similarly, ovarian cancer ranks sixth among US women but third in Asian Indian women.

Note: All percentages exclude individuals of Hispanic ethnicity and may not sum to 100 due to rounding. Five cancers are shown in the event of a tie.
Source: National Center for Health Statistics, 2023.

Figure 5. Five-year Relative Survival Rates Among Asian American, Native Hawaiian, and Other Pacific Islander People by Ethnic Group, US, 2013-2019

- With the exception of Asian Indian individuals, Asian American and NHPI ethnic groups have lower overall 5-year relative cancer survival compared to White individuals (69%), with rates as low as 40% to 48% among Hmong, Laotian, Cambodian, and Tongan individuals.
- However, 5-year relative survival for lung cancer is higher in many Asian American ethnic groups than in White individuals (25%), including 35% to 37% in Pakistani, Chinese, and Thai individuals.
- For breast cancer, 5-year relative survival ranges from 72%-74% in Tongan, Chamorro/Guamanian, and Samoan women to 94% in Japanese women (93% in White individuals); similarly, colorectal cancer survival ranges from 48% in Cambodian individuals to 71% in Pakistani individuals (65% in White individuals).

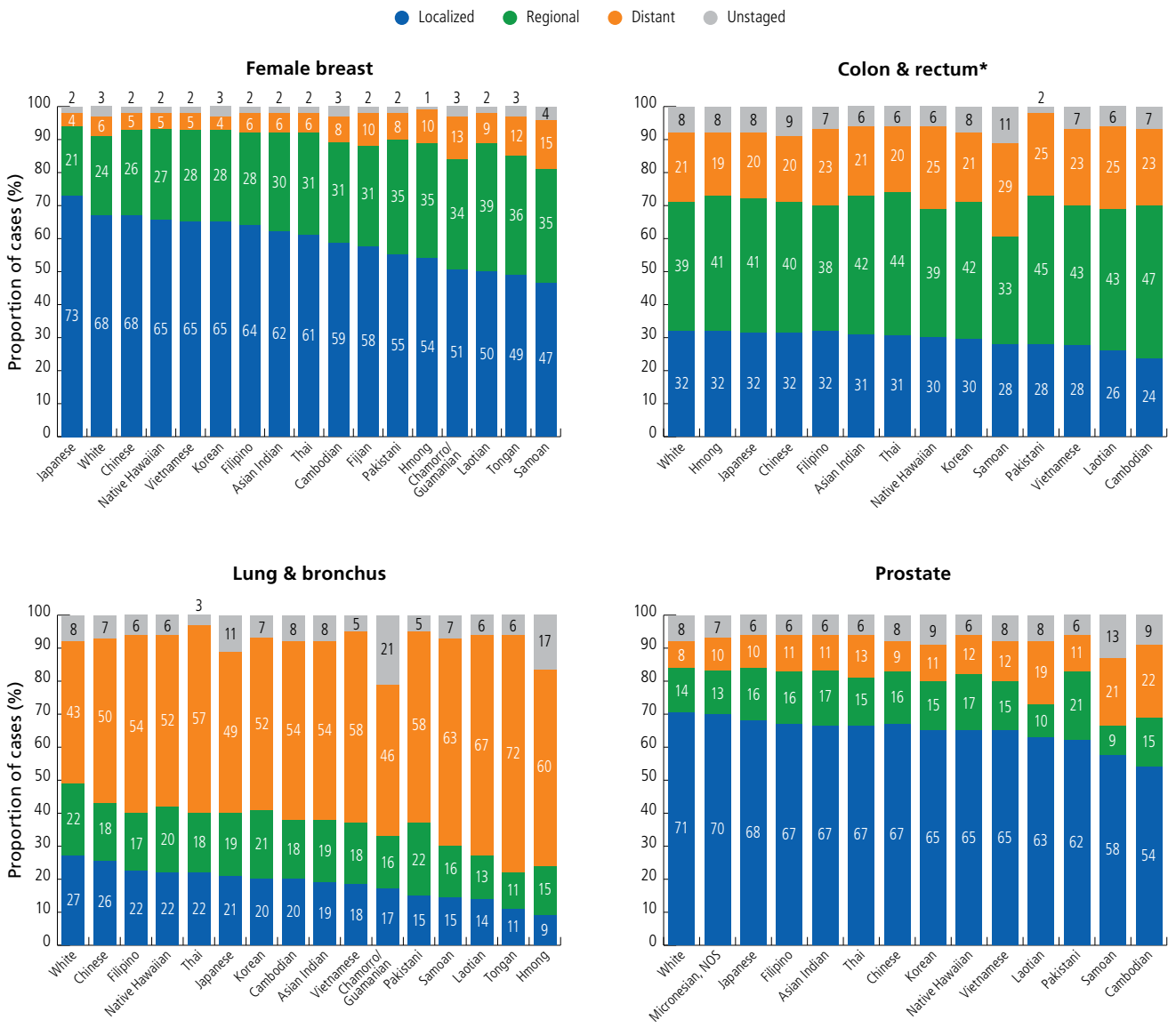


NHPI=Native Hawaiian and Other Pacific Islander. NOS=Not otherwise specified. Note: All estimates exclude individuals of Hispanic ethnicity. Excludes ethnic groups with fewer than 50 cases. *Excludes appendix.

Source: Surveillance, Epidemiology, and End Results Program, 2023.

Figure 6. Stage Distribution Among Asian American, Native Hawaiian, and Other Pacific Islander People by Ethnic Group, US, 2016-2020

- Asian American and NHPI ethnic groups generally have later-stage cancer diagnosis than White individuals, with the gaps consistently largest for Laotian, Samoan, and Tongan individuals.
- The largest disparities in stage distribution are for breast cancer, with localized-stage disease diagnosed in 47% to 55% of Samoan, Tongan, Laotian, Chamorro/Guamanian, Hmong, and Pakistani women versus 73% of Japanese women (68% of White women), partly reflecting barriers in access to breast cancer screening.
- Japanese individuals are most similar to Whites in terms of stage at diagnosis except for lung cancer, which is diagnosed at a distant stage or is unstaged in 60% of Japanese individuals versus 51% of White individuals.



NOS=Not otherwise specified. Note: All percentages exclude individuals of Hispanic ethnicity and may not sum to 100 due to rounding. Excludes ethnic groups with fewer than 50 cases. *Excludes appendix.

Source: North American Association of Central Cancer Registries, 2023.

Table 4. Prevalence of Cancer Screening and Other Preventive Health Care (%) Among Asian American People for Major Ethnic Groups, US, 2015-2018

- Cancer screening is generally lower among the Asian American population compared to the White population; for example, based on the National Health Interview Survey, prevalence of cervical cancer screening with the Pap test was 69% among Chinese women and 74% among Asian Indian women versus 84% among White women.
- Up-to-date colorectal cancer screening in individuals 45 years of age and older ranged from 41% in Asians of unspecified origin and 44% in Asian Indian individuals to 51% in Chinese individuals, compared to 57% in White individuals; however, uptake of stool testing was higher in Asian ethnic groups, ranging from 8% in Asian Indian individuals to 13% in Filipino individuals compared to 6% in White individuals.
- Unfortunately, national survey data do not contain information on cancer screening and other preventative health care for the NHPI ethnic groups.

	Asian American Ethnic Groups				
	Asian Indian	Chinese	Filipino	Other Asian	White (Reference only)
Cervical cancer screening* (women 25-65 years; 2015, 2018)					
Up-to-date**	76	73	87	80	87
Pap test within the past 3 years	74	69	86	77	84
Pap test and HPV test within the past 5 years	20	28	42	32	41
Breast cancer screening (women 45+ years; 2015, 2018)					
Up-to-date†	55	61	69	47	63
Colorectal cancer screening (45+ years; 2015, 2018)					
Up-to-date‡	44	51	47	41	57
Men	47	49	49	47	58
Women	41	52	44	36	56
Home-based blood stool test in the past year	8	9	13	9	6
Colonoscopy in the past ten years	38	46	39	36	54
HPV vaccination (18-29 years; 2016-2018)					
≥1 dose	15	27	27	31	33
≥3 doses	12	18	–	23	21
Hepatitis B vaccination (18+ years; 2017, 2018)					
≥3 doses	32	31	42	37	32
Hepatitis B virus testing (18+ years; 2016, 2017)					
Has received Hepatitis B test	23	34	30	27	30

Note: All percentages exclude individuals of Hispanic ethnicity and are rounded to the nearest whole number. Blank indicates sparse data. Percentages are age adjusted to the 2000 US standard population with the exception of HPV vaccination. *Among women with intact uterus. **Pap test in the past 3 years OR Pap test and HPV test within the past 5 years among women ages 25-65 years. †Mammogram within the past year (ages 45-54 years) or past two years (ages ≥55 years). ‡For ages ≥45 years: Fecal occult blood test (FOBT)/fecal immunochemical test (FIT), sigmoidoscopy, colonoscopy, OR computed tomography (CT) colonography, in the past 1, 5, 10, and 5 years, respectively.

Source: National Health Interview Survey, 2015-2018. Public-use data file.

Table 5. Prevalence of Cancer Risk Factors and Health Care Access (%) Among Asian American People for Major Ethnic Groups, US, 2016-2018

- While the prevalence of major behavioral cancer risk factors is generally lower in the Asian American population, substantial variations exist by ethnicity. For example, current smoking during 2016-2018 varied nearly 2-fold from 4% in Asian Indian individuals to 10% in Filipino individuals.
- The prevalence of excess body weight varied nearly 2-fold within Asian ethnic groups in 2018, ranging from 31% in Chinese individuals to 57% in Asian Indian individuals. Although there is some evidence that standard BMI cutpoints may not be appropriate for Asian populations because of higher disease risk at lower weight (e.g., diabetes), more research is needed to determine whether this association includes cancer.[10]

	Asian American Ethnic Groups				
	Asian Indian	Chinese	Filipino	Other Asian	White (Reference only)
Cancer risk factors					
Smoking* (18+ years; 2016-2018)					
Current					
Total	4	6	10	11	16
Men	6	10	12	16	17
Women	–	–	9	6	15
Former					
Total	10	8	17	13	25
Men	18	15	30	21	28
Women	–	4	8	7	22
Never					
Total	86	85	73	76	59
Men	76	75	58	63	55
Women	98	94	83	87	63
Alcohol† (18+ years; 2017-2018)					
Light	29	30	33	28	35
Moderate	7	7	10	8	19
Heavy	–	–	–	3	7
Body weight (18+ years; 2018)					
Overweight/obese (BMI ≥25 kg/m^2)	57	31	52	45	65
Overweight (25≤BMI≤29.9)	43	18	30	30	33
Obese (BMI≥30)	14	13	22	14	32
Physical activity (18+ years; 2018)					
No leisure-time physical activity in the past week	16	22	23	22	22
Met recommended levels of aerobic activity in the past week‡	63	58	56	48	58
Health care access (18-64 years; 2017-2018)					
Uninsured	5	6	9	9	9
No usual source of care	13	12	14	19	14

BMI=Body mass index. Note: All percentages exclude individuals of Hispanic ethnicity, are age adjusted to the 2000 US standard population, and rounded to the nearest whole number. Blanks indicate sparse data. *Smoking definitions: current, ever smoked 100 cigarettes and now smokes every day or some days; former, ever smoked at least 100 cigarettes but had quit smoking by the time of interview; never, smoked less than 100 cigarettes. †Alcohol definitions: light, has had 12+ drinks in a lifetime and ≤3 drinks per week in the past year; moderate, 12+ drinks in a lifetime, and (male) >3 drinks per week up to 14 drinks per week in the past year OR (female) >3 drinks per week up to 7 drinks per week in the past year; heavy, 12+ drinks in a lifetime, and (male) >14 drinks per week in the past year OR (female) >7 drinks per week in the past year. ‡Aerobic activity recommendation includes 150 minutes of moderate-intensity activity or 75 minutes of vigorous-intensity activity each week.

Source: National Health Interview Survey, 2016-2018. Public-use data file.

Table 6. Prevalence of Cancer Risk Factors and Screening (%) in Hawaii Among Native Hawaiian Versus White People, 2022

	Native Hawaiian	White
Cancer risk factors		
Smoking* (18+ years)		
Current		
Total	18	10
Men	19	10
Women	16	9
Former		
Total	27	29
Men	25	30
Women	29	29
Never		
Total	55	61
Men	56	60
Women	55	62
Alcohol† (18+ years)		
Light	25	29
Moderate	13	24
Heavy	11	13
Body weight (18+ years)		
Overweight/obese (BMI ≥25 kg/m²)	73	54
Overweight (25≤BMI≤29.9)	29	35
Obese (BMI≥30)	44	19
Physical activity (18+ years)		
No leisure-time physical activity or exercise in the past 30 days	24	13
Screening		
Cervical cancer screening‡ (women 25-65 years)		
Up-to-date‡‡	79	88
Pap test within the past 3 years	72	79
Pap test and HPV test within the past 5 years	52	53
Breast cancer screening (women 45+ years)		
Up-to-date§	68	66
Colorectal cancer screening (45+ years)		
Up-to-date¶	61	63
Men	67	68
Women	56	58
Home-based blood stool test in the past year	9	12
Colonoscopy in the past ten years	54	54

BMI=Body mass index. Note: All percentages exclude individuals of Hispanic ethnicity, are age adjusted to the 2000 US standard population, and rounded to the nearest whole number. *Smoking definitions: current, ever smoked 100 cigarettes and now smokes every day or some days; former, ever smoked 100 cigarettes and now smokes not at all; never, smoked less than 100 cigarettes. †Alcohol use definitions: light, has had drinks in the past 30 days and consumed less than 3 drinks in the past week; moderate, has had drinks in the past 30 days and (male) >3 drinks per week up to 14 drinks in the past week OR (female) >3 drinks in the past week up to 7 drinks per week; heavy, has had drinks in the past 30 days, and (male) >14 drinks in the past week OR (female) >7 drinks in the past week. ‡ Among women with intact uteri. ‡‡Pap test in the past 3 years OR Pap test and HPV test within the past 5 years among women ages 25-65 years. §Mammogram within the past year (ages 45-54 years) or past two years (ages ≥55 years). ¶Fecal occult blood test (FOBT)/fecal immunochemical test (FIT), sigmoidoscopy, colonoscopy, computed tomography (CT) colonography, OR sDNA test in the past 1, 5, 10, 5 and 3 years, respectively.

Source: Hawaii Behavioral Risk Factor Surveillance System, 2022.

Table 6. Prevalence of Cancer Risk Factors and Screening (%) in Hawaii Among Native Hawaiian Versus White People, 2022

- Native Hawaiians living in Hawaii are more likely to smoke, have obesity, and not participate in leisure-time physical activity than their White counterparts. For example, smoking prevalence is almost twice as high in Native Hawaiians (18%) as in White people (10%), and obesity prevalence is more than twice as high (44% versus 19%).
- Cancer screening among Native Hawaiians is generally similar compared to White people with the exception of cervical cancer screening, which is 79% among Native Hawaiian women compared to 88% among White women in Hawaii.

Data Methods and Limitations

Incidence and Mortality

Data sources

Incidence. The source for cancer incidence (distribution by cancer type and stage) was a customized dataset provided by the North American Association of Central Cancer Registries (NAACCR) comprised of information from cancer registries in the National Cancer Institute's (NCI) Surveillance, Epidemiology, and End Results (SEER) program and the Centers for Disease Control and Prevention's (CDC) National Program of Cancer Registries. These data include cancer cases from every state except Nevada (data did not meet high-quality standards for all years during 2016-2020) and Kansas and New Mexico (≥50% of Asian cases were classified as unknown origin).

Survival. Cancer survival rates were based on individuals residing in the 22-registry SEER catchment area (excluding Illinois and Massachusetts) diagnosed from 2013 through 2019, all followed through 2020. Cancer survival is presented in terms of 5-year relative survival, which is a measure of life expectancy among cancer patients compared to that among the general population of the same age, race/ethnicity, and sex.

Mortality. Mortality data were based on the underlying cause of death reported on death certificates provided by the National Center for Health Statistics for single-race categories accessed from CDC WONDER (wonder.cdc.gov/ucd-icd10-expanded.html). Mortality rates, or death rates, are defined as the number of people who die from a specified disease during a given time period and are presented per 100,000 population and age adjusted to the 2000 US standard population for comparison across populations.

Analysis

All statistics excluded individuals of Hispanic ethnicity for improved accuracy of racial classification. The mortality rate ratio was calculated by dividing the rate for the population of interest by the rate for non-Hispanic White people. Chamorro and Guamanian groups were combined for incidence and survival statistics according to the Office of Minority Health data collection standards due to sparse data. Data for Chamorro and Guamanian groups are labeled consistent with the data source. Fiji Islander ethnicity includes both Fijian and Fiji Islander individuals, consistent with SEER reporting, and is referred to herein as Fijian. Due to sparse case counts, data were presented for Micronesian NOS instead of Chamorro/Guamanian for prostate cancer stage distribution and survival and for lung cancer survival. Incidence and survival statistics were calculated using SEER*Stat software version 8.4.2.

Screening and Risk Factors

The prevalence of cancer screening and risk factors among Asian American individuals was obtained from the National Health Interview Survey (NHIS) 2015-2018 data files (cdc.gov/nchs/nhis.htm). The CDC's NHIS has monitored the health of the nation since 1957 and is designed to provide national estimates. Data are gathered through a computer-assisted in-person interview of adults ages 18 years and older living in households in the US. The NHIS underwent a significant redesign in 2019 and stopped the disaggregation of Asian American persons by national origin groups, so the information presented herein is not strictly comparable with estimates from 2019 and later. Estimates for Native Hawaiian residents of Hawaii were obtained from the 2022 Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS was designed to provide state health behavior prevalence estimates and is collected from computer-assisted telephone interviews. Cancer screening and risk factor estimates were adjusted to broad age groups according to CDC standards. All estimates excluded individuals of Hispanic ethnicity for improved accuracy of classification.

Data Limitations

The data presented in this report have several limitations and should be interpreted with caution. First, updated incidence and mortality rates could not be calculated for disaggregated Asian American and Native Hawaiian and Other Pacific Islander (NHPI) ethnic groups because those population (denominator) data are currently unavailable. Similarly, disaggregation for national-level risk factors and screening data are limited to the three largest Asian American ethnic groups (Indian, Chinese, and Filipino) because of sparse data for other groups in the NHIS. The lack of risk factor and screening data for the NHPI population is especially unfortunate given the alarming cancer disparities highlighted in this report.

Second, some of the demographic information in health records and on death certificates, such as place of birth and racial identity, is incorrect or incomplete, resulting in misclassification that leads to inaccurate, often underestimated disease risk. For example, it has been shown that a small percentage of decedents who had previously self-reported as Asian American or NHPI were not recorded as such on death certificates. The standard US death certificate was revised in 2003 to include several Asian American and NHPI ethnic groups and has been adopted by all states as of 2018. This change has improved the availability of disaggregated death data for Asian American and NHPI populations, although misclassification issues will likely persist.

Third, there are challenges when calculating statistics for racial and ethnic groups, especially those rapidly growing and changing. For example, population size, which is necessary for computing rates, is often difficult to accurately estimate. Inherent to small populations, an additional challenge with reporting cancer statistics for disaggregated Asian American and NHPI populations is sparse data that may result in unreliable estimates.

References

1. US Census Bureau. Asian American, Native Hawaiian and Pacific Islander Heritage Month: May 2023. Updated 5/3/2023. Accessed 8/15/2023, https://www.census.gov/newsroom/facts-for-features/2023/asian-american-pacific-islander.html#:~:text=5.2%20million,and%20Japanese%20.

2. Vespa JM, Lauren; Armstrong, David M. Demographic Turning Points for the United States: Population Projections for 2020 to 2060. Current Population Reports. P25-1144. February 2020. https://www.census.gov/library/publications/2020/demo/p25-1144.html.

3. Hoeffel E, Rastogi, S., Kim, MO., Shahid, H. The Asian Population: 2010. 2010 Census Briefs. C2010BR-11. https://www.census.gov/library/publications/2012/dec/c2010br-11.html.

4. Hixson L, Hepler, B.B., Kim, M.O. The Native Hawaiian and Other Pacific Islander Population: 2010. 2012. 2010 Census Briefs. C2010BR-12. https://www.census.gov/library/publications/2012/dec/c2010br-12.html.

5. Islami F, Baeker Bispo J, Lee H, et al. American Cancer Society's report on the status of cancer disparities in the United States, 2023. *CA: A Cancer Journal for Clinicians*. 2021;113(12):1648-1669. doi:https://doi.org/10.3322/caac.21812.

6. Office of Management and Budget. Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. Washington, D.C.1997.

7. Lee S, Chen L, Jung MY, Baezconde-Garbanati L, Juon HS. Acculturation and cancer screening among Asian Americans: Role of Health Insurance and Having a Regular Physician. *J Community Health*. Apr 2014;39(2):201-12. doi:10.1007/s10900-013-9763-0.

8. Park SY, Anastas J, Shibusawa T, Nguyen D. The impact of acculturation and acculturative stress on alcohol use across Asian immigrant subgroups. *Subst Use Misuse*. Jun 2014;49(8):922-31. doi:10.3109/10826084.2013.855232.

9. Ra CK, Pehlivan N, Kim H, Sussman S, Unger JB, Businelle MS. Smoking prevalence among Asian Americans: Associations with education, acculturation, and gender. *Prev Med Rep*. Dec 2022;30:102035. doi:10.1016/j.pmedr.2022.102035.

10. Murtha JA, Liu N, Birstler J, et al. Obesity and "obesity-related" cancers: are there body mass index cut-points? *Int J Obes (Lond)*. Oct 2022;46(10):1770-1777. doi:10.1038/s41366-022-01178-0.

Acknowledgments

We gratefully acknowledge all cancer registries and their staff for their hard work and diligence in collecting cancer information, without which this report would not exist. We also thank the following subject matter experts and production staff for their valuable contributions: Priti Bandi; Angela Giaquinto; Scarlett Lin Gomez; Ahmedin Jemal; Tyler Kratzer; Adair Minihan; Scott Simpson; Jessica Star; Hyuna Sung; Kekoa Taparra; Lynn Urquhart; and Dana Wagner.

Cancer Facts & Figures for Asian American, Native Hawaiian, & Other Pacific Islander People 2024-2026 is a publication of the American Cancer Society, Atlanta, Georgia.

For more information, contact:
Rebecca Siegel or Nikita Sandeep Wagle
Surveillance and Health Equity Science Department

American Cancer Society Recommendations for the Early Detection of Cancer in Average-risk Asymptomatic People*

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

CT-Computed tomography. *All individuals should become familiar with the potential benefits, limitations, and harms associated with cancer screening.
†All positive tests (other than colonoscopy) should be followed up with colonoscopy.

The American Cancer Society's mission is to improve the lives of people with cancer and their families through advocacy, research, and patient support, to ensure everyone has an opportunity to prevent, detect, treat, and survive cancer.

American Cancer Society®

Every cancer. Every life.®

cancer.org | 1.800.227.2345

BBB ACCREDITED CHARITY

bbb.org/charity

PUTTING PATIENTS FIRST

National Health Council

Standards of Excellence Certification Program ®