

Skin Cancer Prevention

Progress Report 2015



**Centers for Disease
Control and Prevention**
National Center for Chronic
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Skin Cancer Prevention Progress Report 2015

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Background

Skin cancer is the most commonly diagnosed cancer in the United States, yet most cases are preventable. Every year in the United States, nearly 5 million people are treated for skin cancer, at an estimated cost of \$8.1 billion.¹ Melanoma, the deadliest form of skin cancer, causes more than 9,000 deaths each year.² Unlike many other cancers, skin cancer rates have continued to rise in recent years.³

As a public health community, we are taking concrete steps to address this serious public health problem. In July 2014, the Office of the Surgeon General released *The Surgeon General's Call to Action to Prevent Skin Cancer (Call to Action)*, establishing skin cancer prevention as a high priority for our nation.⁴ The *Call to Action* described prevention strategies that

work and called on all community sectors to play a role in protecting Americans from ultraviolet (UV) radiation from the sun and artificial sources, such as indoor tanning devices (Table 1).⁴

The federal government and its partners in skin cancer prevention across the United States have made important progress, but much work remains. This is the inaugural edition of the *Skin Cancer Prevention Progress Report*, which will summarize recent prevention efforts and highlight new data, developments, and success stories following the *Call to Action*. By updating this report annually, we can monitor progress, celebrate and learn from successes, recognize areas that need improvement, and identify opportunities to work with partners in government, health care, education, business, and the community.

Table 1. Strategic Goals and Partners to Support Skin Cancer Prevention in the United States

Strategic Goals

Goal 1: Increase opportunities for sun protection in outdoor settings.

Goal 2: Provide individuals with the information they need to make informed, healthy choices about UV exposure.

Goal 3: Promote policies that advance the national goal of preventing skin cancer.

Goal 4: Reduce harms from indoor tanning.

Goal 5: Strengthen research, surveillance, monitoring, and evaluation related to skin cancer prevention.

Partners in Prevention

- Federal, state, tribal, local, and territorial governments.
- Businesses, employers, and labor representatives.
- Health care systems, insurers, and clinicians.
- Early learning centers, schools, colleges, and universities.
- Community, nonprofit, and faith-based organizations.
- Individuals and families.

Source: *The Surgeon General's Call to Action to Prevent Skin Cancer*.⁴

What's New This Year?

Here are some highlights from recent skin cancer prevention publications and events:

- The latest data from the national Youth Risk Behavior Survey showed decreases in indoor tanning among high school students. Among non-Hispanic white girls, a demographic group with some of the highest rates of indoor tanning, the percentage reporting indoor tanning dropped from 37.4% in 2009 to 30.7% in 2013.⁵
- New research from the Centers for Disease Control and Prevention (CDC) estimated that an average of about 3,200 indoor tanning-related injuries are treated in US hospital emergency rooms each year. Most of these injuries are skin burns, but eye injuries are also common.⁶
- Data from the National Health Interview Survey indicated that more than one-third of all US adults and about half of young adults (aged 18-29 years) get sunburned each year.⁷
- CDC's [Public Health Grand Rounds](#) featured the topic of skin cancer in April 2015, fostering discussions about the key challenges we face in skin cancer prevention, how CDC and its partners are already addressing these challenges, and ideas for future research and practice.
- CDC's [June 2015 Vital Signs](#) examined melanoma incidence and deaths and the potential cost savings of skin cancer prevention efforts. The Vital Signs included a *Morbidity and Mortality Weekly Report*, a fact sheet and web page, a press release, and social media tools.

Success Stories from the Field

Better Melanoma Reporting by Doctors in Arizona

Laws in every US state mandate that melanomas be reported to state cancer registries. Despite these mandates, melanoma is often underreported by doctors, which affects the accuracy of incidence rates. Arizona cancer registry data showed that melanoma incidence had dropped below the national average since 2004. State health officials suspected that underreporting of melanoma incidence might explain the decline and took innovative steps to address the issue.

In 2011, several state and local partners came together to form the Arizona Melanoma Task Force (AMTF) to develop strategies to improve melanoma reporting by doctors in Arizona. These partners included representatives from the Arizona Cancer Registry and the Arizona SunWise Skin Cancer Prevention Program in the state's Department of Health Services, community dermatologists and dermatopathologists from the Tucson and Phoenix Dermatology Societies, and the Arizona Skin Cancer Institute at the Arizona Cancer

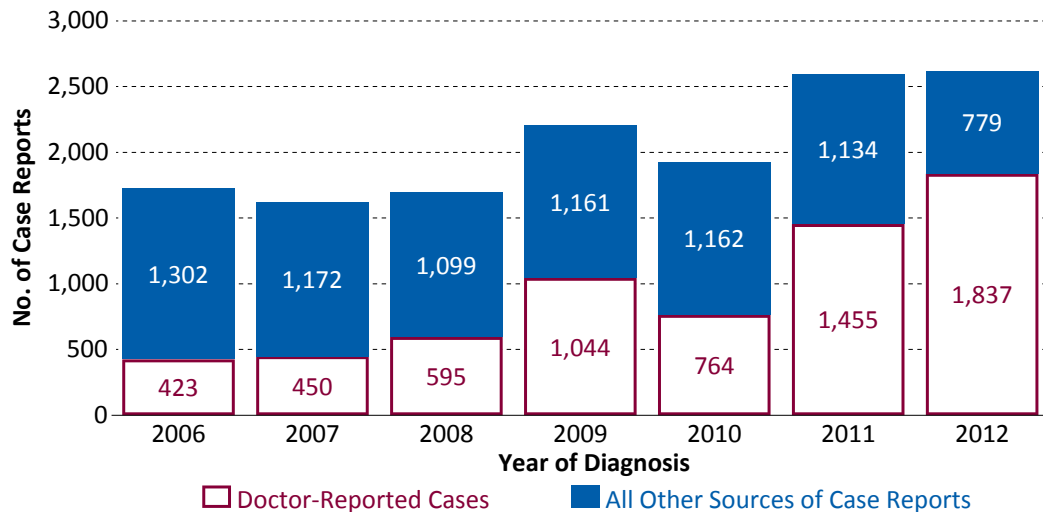
Center. The AMTF conducted a pilot study in 2011-2012 that reviewed all melanoma cases that were diagnosed in 2009 from 15 dermatology clinics in Phoenix and Tucson. This review showed that 72% of the melanoma cases in these practices were not reported to the Arizona Cancer Registry.

Partly because of AMTF efforts to share results of the pilot study and increase doctors' awareness of the melanoma reporting requirement, doctor reporting of new cases increased for the 2011-2012 diagnosis year. Before the pilot study, the Arizona Cancer Registry received most melanoma case reports from sources other than doctors, such as pathology labs. The pilot study found 349 new cases from 2009 that had not been reported at the time of diagnosis. Once identified, these cases were reported to the Arizona Cancer Registry, resulting in an initial increase in doctor-reported cases in 2009 (Figure 1). The 2011 diagnosis year was the first year with more melanoma cases

reported by doctors than from other sources (Figure 1). Reports from doctors are crucial for accurately tracking melanoma incidence rates. As AMTF leader Dr. Nancy Silvis stated in a letter to doctors, “It has been exciting to see the community of dermatologists and

dermatopathologists respond to this public health issue. With your continued efforts, we anticipate even further improvement in accurately determining Arizona’s burden of melanoma.”

Figure 1. Reporting Source for Invasive Melanoma in Situ, Doctors vs. All Other Sources, Arizona, 2006-2012



Note: Doctor-reported cases for 2011 and 2012 are preliminary. All other sources of case reports (from hospitals, pathology laboratories, other state registries, and other sources) were incomplete for 2012 because not all hospital cases had been processed at the time the success story was reported (January 2014). More than one case report may be received for each new melanoma case.

Safer School Playground in Albuquerque, New Mexico

Albuquerque, New Mexico, is a sunny city with high levels of UV rays. At Bandelier Elementary School, parents and staff take steps to protect their students from the strong Albuquerque sun and skin cancer later in life. In 2003, Bandelier parent Erika Harding proposed that the school’s parent-teacher association set up a Sun & Shade Committee. Since then, the committee has worked with the New Mexico Department of Health’s RAYSS (Raising Awareness in Youth About Sun Safety) Project to give wide-brimmed hats to all kindergarteners, teach sun-safe behavior to kids and the community, and make shade a component of all playground improvements.

Harding said she proposed the project because, “We want our kids to be healthy, active, and sun-safe too.”



Principal Glenda Armstrong added that she is proud of the sunshades over the school’s playground. “The Sun & Shade Committee made the case for increasing shade for our students, and our legislators listened, providing funding for playground shade structures.”

If you’d like to make your school campus sun-safe, look for ideas in [CDC’s Shade Planning for America’s Schools](#) tool kit.

Sun Safety for Firefighters in Lakewood, Colorado

Captain Mike Kirkpatrick of the West Metro Fire Protection District in Lakewood, Colorado, takes sun protection for his firefighters seriously.

“Our firefighters put their lives on the line to protect our citizens, and they deserve to be protected from skin cancer,” Kirkpatrick said. “Anyone from Colorado knows the sun here is intense, so we started making small, inexpensive changes to decrease our sun exposure. We provided education to our team about skin cancer prevention and provided sunscreen at all of our fire stations.”

These efforts paid off, according to Kirkpatrick. “Everyone started protecting themselves using a combination of hats, sunglasses, long-sleeved shirts, and sunscreen. It was an easy way to do something valuable for our health.”



Poolside Protection for Children, Parents, and Lifeguards in Boise, Idaho

Pool Cool is a sun-safety education program for children aged 5 to 10 and their parents, as well as for pool staff and other pool users. It is being used at outdoor swimming pools across the United States, including the Ivywild Pool in Boise, Idaho. The program



promotes wearing protective clothing, seeking shade, using sunscreen, and avoiding staying outside too long during peak sun hours.

“As a result of our pool’s participation in the Pool Cool program, we helped create healthy habits for our community and our staff,” said Drew Williams, facility manager at Ivywild Pool. “Our outdoor pool is a popular destination during the hot summer months in Idaho, so we reach many children and adults through the program. Our swimming instructors are able to easily combine the sun-safety lessons with swimming skills, so participants can enjoy healthy, safe fun in the pool.”

“In addition, the training is great for our lifeguards, who are exposed to the strong sun all summer,” Williams added. “Since participating in Pool Cool, our lifeguards have changed their habits for the better. It’s now cool to apply sunscreen regularly and wear protective clothing as a barrier from the sun’s rays.”

For more information about skin cancer prevention for schools, outdoor work sites, parks and recreation, and families, see CDC’s [Skin Cancer Prevention Fact Sheets](#).

Outcome Indicators

Healthy People 2020 Objectives

Table 2 presents the skin cancer-related objectives included in Healthy People 2020, the national agenda for improving the health of all Americans.

Table 2. Progress Toward the Healthy People 2020 Skin Cancer-Related Objectives

Objective for 2020	Target	Baseline	Current Data	Data Source
C-8 Reduce the melanoma cancer death rate	2.4 deaths per 100,000 population	2007: 2.7 deaths per 100,000 population	2011: 2.7 deaths per 100,000 population	National Vital Statistics System-Mortality, US Census
C-20.1 (Developmental ^a) Reduce the proportion of adolescents in grades 9 through 12 who report sunburn	Developmental	NA	NA	Potential data source: Youth Risk Behavior Surveillance System (YRBSS)
C-20.2 Reduce the proportion of adults aged 18 years and older who report sunburn	33.8%	2010: 37.5%	NA	National Health Interview Survey (NHIS)
C-20.3 Reduce the proportion of adolescents in grades 9 through 12 who report using artificial sources of ultraviolet light for tanning	14.0%	2009: 15.6%	2011: 13.3% 2013: 12.2%	YRBSS
C-20.4 Reduce the proportion of adults aged 18 and older who report using artificial sources of ultraviolet light for tanning	3.6%	2010: 5.6%	2013: 4.2%	NHIS
C-20.5 Increase the proportion of adolescents in grades 9 through 12 who follow protective measures that may reduce the risk of skin cancer	11.2%	2009: 9.3%	2011: 10.8% 2013: 10.1%	YRBSS question: "When you are outside for more than 1 hour on a sunny day, how often do you wear sunscreen with an SPF of 15 or higher?" Answers: "always" or "most of the time"
C-20.6 Increase the proportion of adults aged 18 years and older who follow protective measures that may reduce the risk of skin cancer	73.7%	2008: 67.0%	2010: 70.0%	NHIS

Abbreviation: NA, not available.

Source: Healthy People 2020. Topics and Objectives website. Cancer. <http://www.healthypeople.gov/2020/topics-objectives/topic/cancer/objectives>. Accessed March 19, 2015.

^a Developmental objectives lack national baseline data but have a potential nationally representative data source for monitoring progress toward achieving the objective. Developmental objectives indicate areas that need to be placed on the national agenda for data collection.

Disease Surveillance Indicators

Health care providers and pathologists who diagnose or treat melanomas are required to report cases to a central cancer registry in all 50 states, the District of Columbia, and Puerto Rico. These melanoma surveillance data allow for long-term evaluation of skin cancer prevention efforts. Because melanomas often develop after years of exposure to UV radiation, it will likely be several decades before melanoma incidence rates reflect the effects of current prevention efforts.

Tables 3 and 4 and Figures 2 and 3 present data on melanoma incidence and deaths in the United States.



Table 3. Invasive Melanoma Incidence, by Sex and Race/Ethnicity, United States, 2007-2011^a

Race/Ethnicity	US Population		Male		Female	
	Rate	Average Annual Count	Rate	Average Annual Count	Rate	Average Annual Count
All Races	19.7	63,429	25.1	36,679	15.9	26,750
White	22.2	59,882	27.9	34,842	18.2	25,041
White, Hispanic ^b	4.4	1,215	4.8	553	4.2	662
White, non-Hispanic ^b	24.7	58,667	30.6	34,289	20.4	24,378
Black	1.0	336	1.1	145	1.0	191
American Indian/Alaska Native	4.7	131	5.8	69	3.9	62
Asian/Pacific Islander	1.3	177	1.4	84	1.2	93
Hispanic ^b	4.3	1,301	4.7	588	4.1	713

Sources: National Program of Cancer Registries and Surveillance, Epidemiology, and End Results (SEER) Database.⁸

^a Data are from population areas that meet United States Cancer Statistics publication criteria for 2007-2011 and cover about 99.1% of the US population. Rates are per 100,000 people and are age-adjusted to the 2000 US Standard Population.

^b Race and ethnicity are not mutually exclusive. Counts may not always sum to the total because of rounding and because cases with other and unknown race are included in totals.

Table 4. Melanoma Death Rates, by Sex and Race/Ethnicity, United States, 2007-2011^a

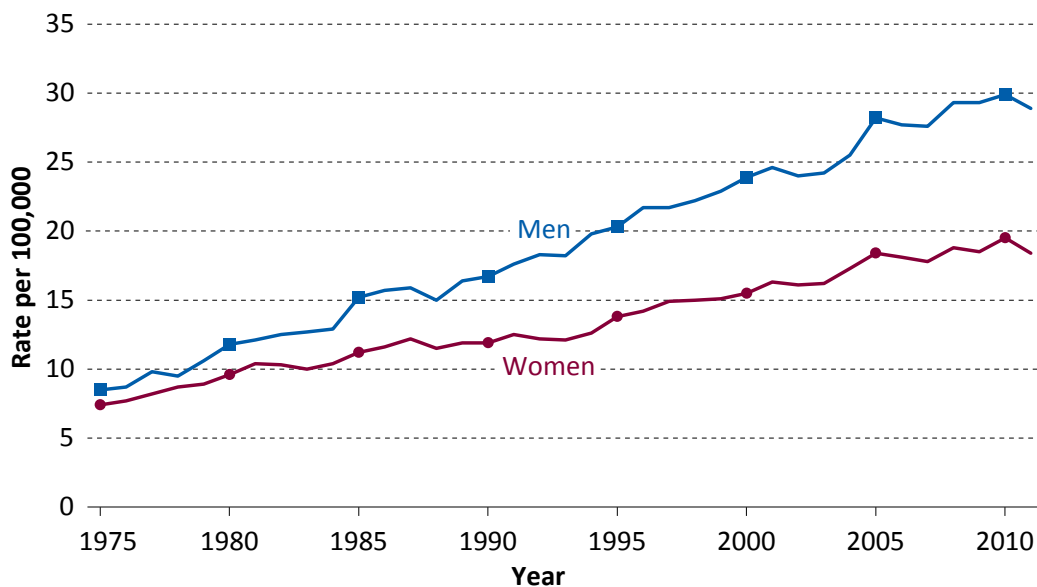
Race/ Ethnicity	US Population		Male		Female	
	Rate	Average Annual Count	Rate	Average Annual Count	Rate	Average Annual Count
All Races	2.7	8,913	4.1	5,834	1.7	3,078
White	3.1	8,716	4.6	5,738	2.0	2,978
White, Hispanic ^b	0.8	205	1.1	120	0.6	85
White, non-Hispanic ^b	3.4	8,503	5.0	5,613	2.1	2,890
Black	0.4	132	0.5	61	0.4	71
American Indian/Alaska Native	0.8	19	1.1	12	0.6	8
Asian/Pacific Islander	0.4	46	0.4	24	0.3	22
Hispanic ^b	0.8	208	1.1	122	0.6	86

Source: CDC WONDER Online Database. Atlanta, GA: Centers for Disease Control and Prevention; 2014. <http://wonder.cdc.gov/CancerMort-v2011.html>. Accessed March 9, 2015.

^a Rates are per 100,000 people and are age-adjusted to the 2000 US Standard Population.

^b Race and ethnicity are not mutually exclusive. Counts may not always sum to the total because of rounding and because Hispanic ethnicity for some cases was unknown.

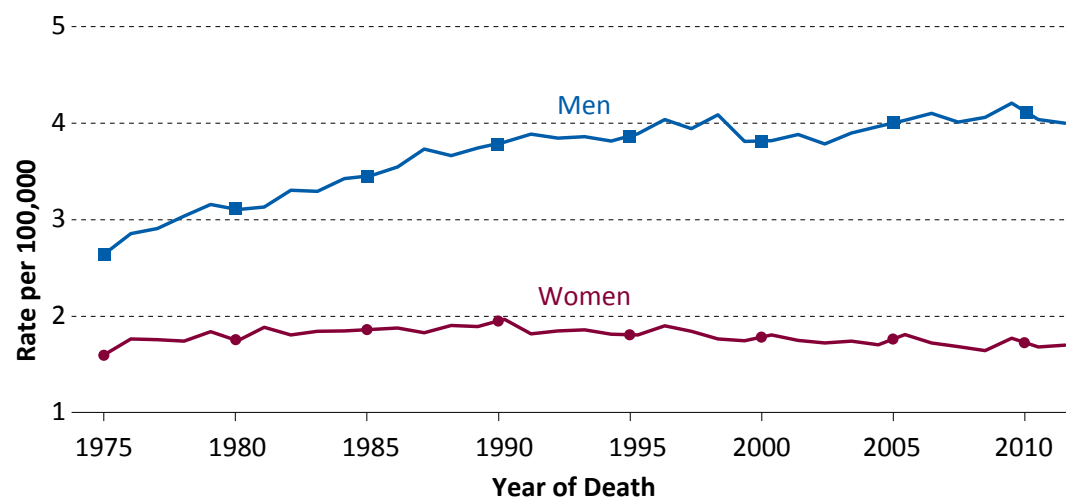
Figure 2. Age-adjusted Melanoma Incidence, by Sex, United States, 1975-2011



Source: Surveillance, Epidemiology, and End Results (SEER) Incidence Database.³

Note: Rates are per 100,000 people and are age-adjusted to the 2000 US Standard Population.

Figure 3. Age-adjusted Melanoma Death Rates, by Sex, United States, 1975-2011



Source: Surveillance, Epidemiology, and End Results (SEER) Mortality Database.⁹ Underlying mortality data from the US Mortality Files, National Center for Health Statistics.

Note: Rates are per 100,000 people and are age-adjusted to the 2000 US Standard Population.

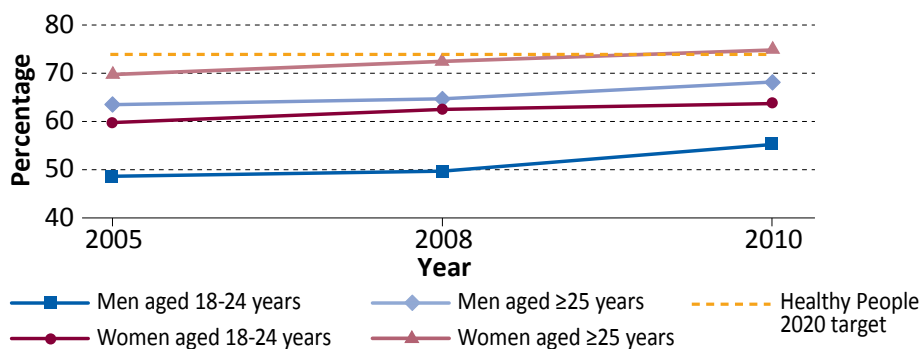
Behavioral Surveillance Indicators

Increasing the use of sun protection and decreasing the prevalence of sunburn and indoor tanning are critical to preventing future cases of skin cancer. While it may be decades before skin cancer incidence rates reflect the effects of prevention efforts, these behavioral surveillance indicators can provide more immediate information about our progress.

Sun Protection

Although use of sun protection appears to be increasing, there is still much room for improvement. More than one-quarter of women and one-third of men do not consistently use sun protection (Figure 4). Use of sun protection strategies differs by sex (Figure 5).

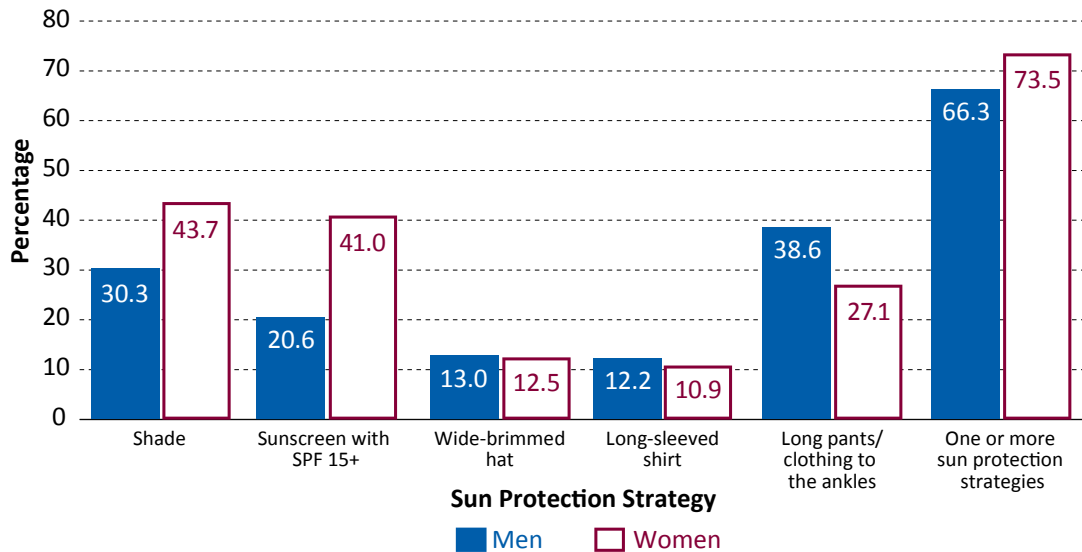
Figure 4. Percentage of US Adults Who Usually or Always Protect Themselves from the Sun, by Sex and Age, 2005-2010



Source: National Health Interview Survey. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Health Statistics. <http://www.cdc.gov/nchs/nhis.htm>. Accessed May 19, 2015.

Note: Data are age-adjusted to the 2000 US Standard Population. Ages 18-24 are age-adjusted using age groups 18-19 and 20-24. Ages ≥25 are age-adjusted using age groups 25-34, 35-44, 45-64, and ≥65.

Figure 5. Percentage of US Adults Who Use Sun Protection Always or Most of the Time When Outside on a Warm Sunny Day for More Than 1 Hour



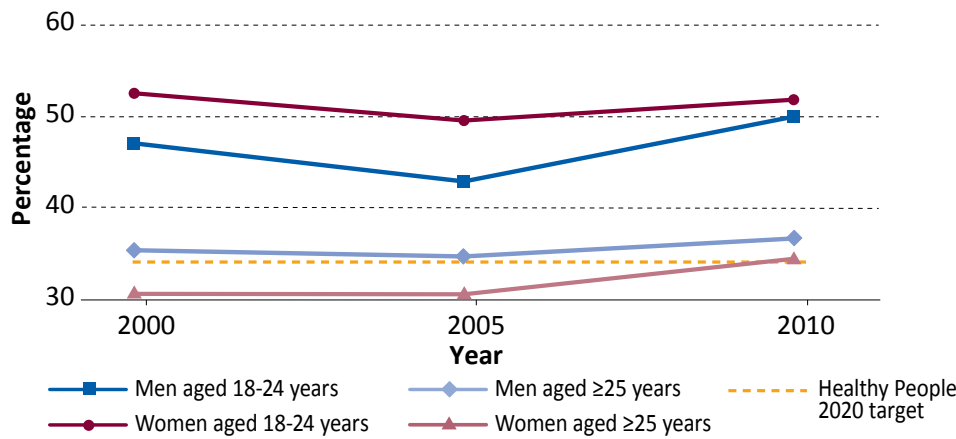
Source: National Health Interview Survey. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Health Statistics. <http://www.cdc.gov/nchs/nhis.htm>. Accessed May 19, 2015.
 Note: Data are age-adjusted to the 2000 US Standard Population using age groups 18-24, 25-34, 35-44, 45-64, and ≥65 years.

Sunburn

Sunburn is an indicator of both the intensity of a person’s UV exposure and the person’s sun sensitivity, making it a useful measure of our progress toward

reducing skin cancer incidence rates. Although use of sun protection has increased slightly in recent years, sunburn prevalence remains high (Figure 6).

Figure 6. Percentage of Adults Who Were Sunburned in the Past Year, by Sex and Age, 2000-2010



Source: National Health Interview Survey. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Health Statistics.
 Note: Data are age-adjusted to the 2000 US Standard Population. Ages 18-24 are age-adjusted using age groups 18-19 and 20-24. Ages ≥25 are age-adjusted using age groups 25-34, 35-44, 45-64, and ≥65 years.

Indoor Tanning

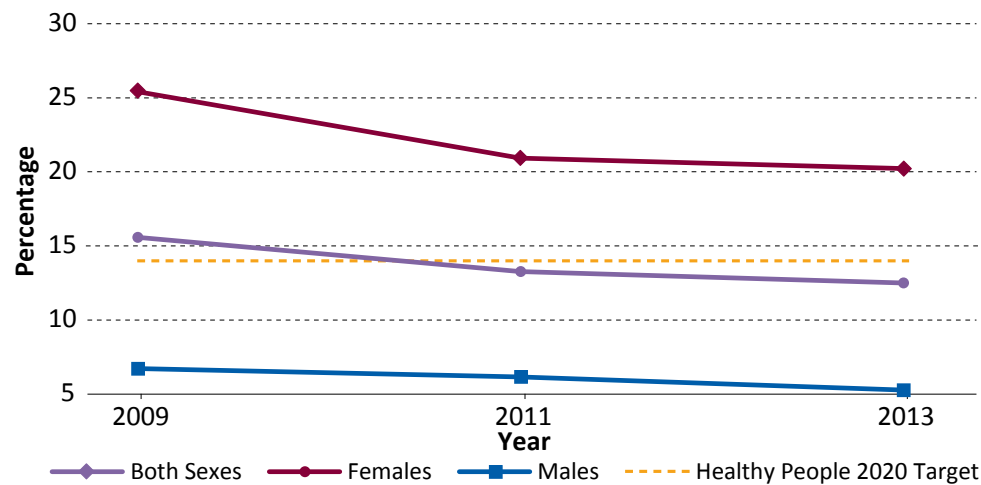
Data from the national Youth Risk Behavior Survey and the National Health Interview Survey show that use of indoor tanning may be decreasing among US high school students (Figure 7) and US adults (Table 5).^{5,10}

Indoor tanning remains highest among young

women and non-Hispanic whites (Table 5).

Decreases among high school students may be due in part to increased state restrictions on the use of indoor tanning among minors.¹¹

Figure 7. Trends in Indoor Tanning Among High School Students, 2009-2013



Source: High School Youth Risk Behavior Survey. Atlanta, GA: Centers for Disease Control and Prevention. <http://nccd.cdc.gov/youthonline/>. Accessed December 12, 2014.

Note: Indoor tanning defined as using an indoor tanning device in the last 12 months.

Table 5. Prevalence of Indoor Tanning Among Adults, National Health Interview Survey, 2010 and 2013^a

Characteristic	Total, %		Women, %		Men, %	
	2010 N = 25,233	2013 N = 33,912	2010 N = 14,107	2013 N = 18,777	2010 N = 11,126	2013 N = 15,135
Total	5.5	4.2 ^b	8.6	6.5 ^b	2.2	1.7 ^b
Age, y						
18-29	11.3	8.6 ^b	18.9	14.2 ^b	3.9	2.9
30-39	5.9	5.5	9.2	8.5	2.5	2.2
40-49	5.9	4.3 ^b	9.2	6.8 ^b	2.6	1.8
≥50	2.1	1.5 ^b	3.0	2.0 ^b	1.0	0.9
Race/ethnicity						
Non-Hispanic white	7.4	5.7 ^b	11.5	8.9 ^b	3.1	2.3 ^b
Nonwhite	1.3	1.1	2.1	1.5	0.3	0.6 ^b
Type of indoor tanner						
Infrequent (1-9 times/y)	2.6	1.9 ^b	3.7	2.8 ^b	1.4	1.0 ^b
Frequent (≥10 times/y)	2.9	2.2 ^b	4.8	3.6 ^b	0.9	0.8

Source: Adapted from Guy GP, et al.¹⁰

^a Indoor tanning is defined as using an indoor tanning device (such as a sunlamp, sunbed, or tanning booth) one or more times during the 12 months before the survey. It does not include getting a spray-on tan. Estimates are based on weighted data. Sample sizes are unweighted and may not add to the total because of missing data. Percentages are based on weighted population estimates.

^b The value for 2013 is significantly different than the value for 2010 ($P < .05$).



Vitamin D

Vitamin D is needed for health and to maintain strong bones.^{12,13} The human body makes vitamin D when skin is directly exposed to the sun.^{12,13} Vitamin D is also found in some foods.^{12,13} Recommended dietary intakes of vitamin D are set on the assumption of little sun exposure because of public health concerns about skin cancer.¹³ However, improving sun protection across the population could potentially lead to reduced vitamin D concentrations for some people if they do not compensate for it by increasing their vitamin D intake from diet or supplements.

The National Health and Nutrition Examination Survey regularly collects data on serum vitamin D concentrations in the US population (Table 6).¹² These data can be used to monitor vitamin D levels and document potential unintended consequences of skin cancer prevention interventions, such as increases in vitamin D deficiency. According to the Institute of Medicine, people with serum vitamin D levels less than 40 nmol/L are at increased risk of adverse health outcomes, and levels higher than 125 nmol/L may also be reason for concern.¹³

Table 6. Prevalence of Low Serum Vitamin D Concentrations (<40 nmol/L) for the US Population Aged 6 Years or Older, National Health and Nutrition Examination Survey (NHANES), 2001-2006^a

Year	Sample Size	Percentage (95% CI)	No. ^b
2001-2002	7,807	18.2 (15.5-21.3)	46,723,000
2003-2004	7,403	17.2 (13.3-21.9)	45,025,000
2005-2006	7,402	18.9 (15.3-23.1)	50,461,000

Abbreviation: CI, confidence interval.

Source: *Second National Report on Biochemical Indicators of Diet and Nutrition in the US Population*.¹²

^a These are the most recent years for which data on serum vitamin D levels in the US population are available. These data will provide a baseline for comparison as future NHANES data become available, allowing us to monitor changes over time.

^b Estimates of the total number of people who met the definition of having low serum vitamin D concentrations were generated by multiplying the weighted prevalence estimate by the population size of interest, derived from the Current Population Survey at the midpoint of the available 2-year cycle.

Policy and Program Indicators

Interventions that change the context in which health behaviors occur can help to make the healthy choice the default or easy choice. Many potential points of intervention can decrease overexposure to UV radiation and increase use of sun protection.

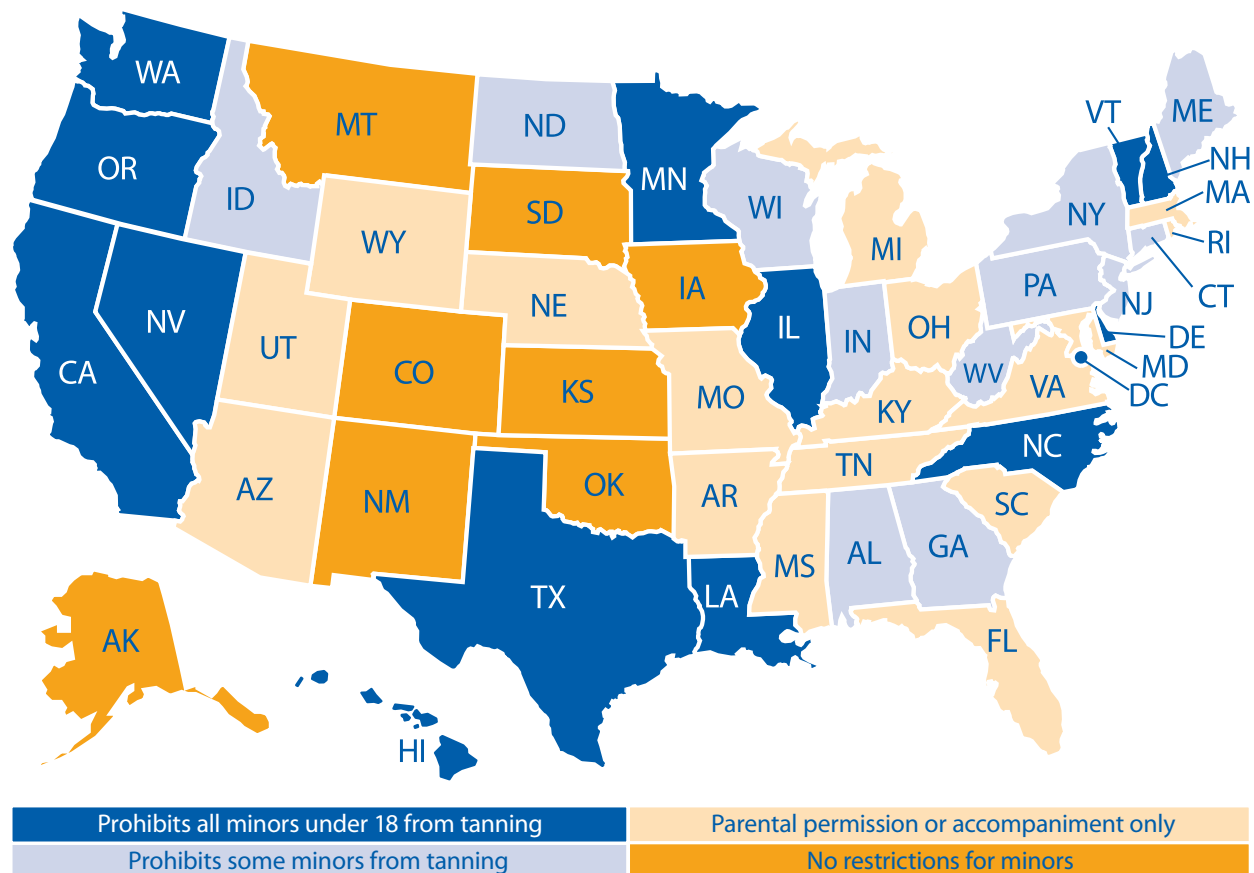
Indoor Tanning Restrictions for Minors

The US Food and Drug Administration states that indoor tanning devices should not be used by minors younger than 18.¹⁴ CDC research suggests that indoor tanning laws that include age restrictions may be effective in reducing indoor tanning, particularly



among high school girls.¹¹ As of June 2015, a total of 13 states had banned indoor tanning for minors younger than 18 years (Figure 8).

Figure 8. State Indoor Tanning Restrictions for Minors Younger than 18 Years, as of June 2015



Source: AIM at Melanoma, 2015 Indoor Tanning Legislation website (<http://www.aimatmelanoma.org/en/aim-for-a-cure/legislative-accomplishments-in-melanoma/2015-indoor-tanning.html>).

Note: State laws in Oregon and Washington allow minors younger than 18 years to use indoor tanning facilities with a doctor's prescription. The District of Columbia's under-18 ban is pending approval by Congress. "Prohibits some minors from tanning" is defined as restrictions for any other age group, including for minors younger than 17, 16, 15, or 14 years.

Skin Cancer Prevention Policies in Schools

Schools are an important setting for addressing skin cancer prevention among youth. Students are typically at school during midday hours when the UV rays from the sun are the strongest. Recess and other outdoor activities during midday can put students at risk if they aren't protected. School policies can promote skin cancer prevention for students and

encourage behaviors that will help them avoid a skin cancer diagnosis later in life (Table 7).

Schools can implement policies to support students' use of sun protection. Currently, most districts neither recommend nor require sun-safety strategies for their students, which represents a missed opportunity for prevention (Table 8).

Table 7. Percentage of US States and Districts with School Policies to Support Skin Cancer Prevention, 2012

Policy Activity	States, %	Districts, %
Developed, revised, or helped develop model policies, policy guidance, or other materials	31.4	NA
Distributed or provided such materials to district or school staff	32.0	NA
Provided funding for professional development ^a or offered professional development on how to implement school policies and programs during the 2 years before the School Health Policies and Practices Study	25.0	18.1
Provided technical assistance ^b to district or school staff during the 12 months before the study	42.0	NA

Abbreviation: NA, not available.

Source: *Results from the School Health Policies and Practices Study 2012*.¹⁵

^a Workshops, conferences, continuing education, graduate courses, or any other kind of inservice.

^b One-on-one, tailored guidance to meet the specific needs of the district or school that may be provided through phone, e-mail, Internet, or in-person meetings during the 12 months before the study.

Table 8. Percentage of US School Districts that Require or Recommend Certain Sun-Safety Strategies in Schools, 2012

Strategy	Require, %	Recommend, %	Neither Require nor Recommend, %
Allow students to apply sunscreen while at school	1.5	44.4	54.2
Encourage students to wear hats or visors when in the sun during the school day	0.9	36.1	63.1
Encourage students to wear protective clothing (e.g., long-sleeved shirts or long pants) when in the sun during the school day	1.3	39.6	59.0
Encourage students to wear sunglasses when in the sun during the school day	0.3	25.0	74.7
Schedule outdoor activities to avoid times when the sun is at peak intensity during the school day	5.3	38.3	56.5

Source: *Results from the School Health Policies and Practices Study 2012*.¹⁵



Comprehensive Cancer Control Programs and Skin Cancer Prevention

The Centers for Disease Control and Prevention funds Comprehensive Cancer Control (CCC) programs in all 50 states, the District of Columbia, seven tribes and tribal organizations, and seven US territories to form or support existing coalitions to fight cancer. These coalitions use data to determine the greatest cancer-related needs in their area and

to develop and carry out cancer plans to meet those needs.

Including skin cancer prevention in CCC plans or objectives is an indicator of commitment to skin cancer prevention (Table 9). Using evidence-based interventions and monitoring and evaluating activities also helps to ensure success.

Table 9. State Comprehensive Cancer Control (CCC) Programs that Mention “Melanoma” or “Skin Cancer” in Their Current Plans or Objectives, 2014-2015

Plan/Objective	No. of Programs
Long-term objective ^a	15
Short-term objective ^b	14
Long-term objective OR short-term objective	17
CCC plan (2014 or later)	35
Long-term objective OR short-term objective OR CCC plan	38

^a Set by National Comprehensive Cancer Control Program (NCCCP) awardees at the beginning of the 5-year project period.

^b Set by NCCCP awardees each year in their annual action plans.

Conclusion

This inaugural *Skin Cancer Prevention Progress Report* highlights new data, developments, and success stories following the release of *The Surgeon General's Call to Action to Prevent Skin Cancer* in July 2014. The report also outlines the indicators we will use to track our

progress toward reducing skin cancer incidence and deaths over time. The *Call to Action* provided a clear roadmap for prevention in the United States, and with the continued effort of partners across all sectors, we can stop the increasing incidence of skin cancers.

References

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