DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Office of the Director

2016-2018 TRIENNIAL ADVISORY COUNCIL REPORT

CERTIFYING COMPLIANCE WITH THE

NIH POLICY ON INCLUSION GUIDELINES

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Director

National Cancer Institute

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I. Background/Overview

As required by the NIH Revitalization Act of 1993 (PL 103-43), the advisory board or council of each Institute must prepare a biennial report describing the manner in which the Institute has complied with the NIH guidelines on inclusion of women and minorities as subjects in clinical research studies and the NIH requirements for tracking and reporting enrollment to clinical research studies by ethnicity, race and sex/gender. The 21st Century Cures Act amended the frequency of the report from biennial to triennial. Thus, this first triennial report provides information on inclusion of participants in NIH clinical research from FY 2016–2018.

A. Mission Statement

The National Cancer Institute (NCI) is part of the National Institutes of Health (NIH), which is one of 11 agencies that comprise the Department of Health and Human Services (HHS). NCI, established under the National Cancer Institute Act of 1937, is the Federal Government’s principal agency for cancer research and training. The National Cancer Act of 1971 broadened the scope and responsibilities of NCI and created the National Cancer Program. Over the years, legislative amendments have maintained NCI authorities and responsibilities and added new information dissemination mandates as well as a requirement to assess the incorporation of state-of-the-art cancer treatments into clinical practice. NCI coordinates the National Cancer Program, which conducts and supports research, training, health information dissemination, and other programs with respect to the cause, diagnosis, prevention, and treatment of cancer, rehabilitation from cancer, and the continuing care of cancer patients and the families of cancer patients. Specifically, the Institute:

- Provides research grants and cooperative agreements to coordinate and support research projects conducted by universities, hospitals, research foundations, and businesses throughout this country and abroad. Conducts research in its own laboratories and clinics.

- Supports education and training in fundamental sciences and clinical disciplines for participation in basic and clinical research programs and treatment programs relating to cancer through career awards, training grants, and fellowships.

- Supports research projects in cancer control.
• Supports a national network of cancer centers.

• Collaborates with voluntary organizations and other national and foreign institutions engaged in cancer research and training activities.

• Encourages and coordinates cancer research by industrial concerns where such concerns evidence a particular capability for programmatic research.

• Collects and disseminates information on cancer detection, diagnosis, treatment, prevention, control, palliative care, and survivorship

• Supports construction of laboratories, clinics, and related facilities necessary for cancer research.

B. NCI’s Inclusion Portfolio

The inclusion data includes epidemiological, population-based interventions and therapeutic trials according to the NIH definition of clinical research and supported by the following NCI Divisions and Centers:

**Extramural Research**
- Division of Cancer Biology
- Division of Cancer Control and Population Sciences
- Division of Cancer Prevention
- Division of Cancer Treatment and Diagnosis
- OD, Center for Cancer Training
- OD, Center for Cancer Genomics
- OD, Center for Global Health
- OD, Center for Strategic Scientific Initiatives
- OD, Center to Reduce Cancer Health Disparities
- OD, Office of Cancer Centers
- OD, Office of HIV and AIDS Malignancy
- OD, Small Business Innovation Research Development Center

**Intramural Research**
- Division of Cancer Epidemiology and Genetics
- Center for Cancer Research
II. **Strategies for Ensuring Compliance**

The policies and procedures employed by NCI staff to collect, implement, and disseminate information on compliance were reviewed with the Board. Data was presented to the NCAB indicating the overall aggregate accrual to all clinical research as defined by the NIH Office of Extramural Research, as well as subsets of specific types of trials, such as observational vs therapeutic treatment trials.

It was emphasized that it is the responsibility of the staff within individual NCI program divisions, offices, and centers to work with grantees to assure that the original accrual projections are actually attained as the study progresses, and that data indicating significant differences based on gender, race and/or ethnicities must be noted in analyses and reports of study outcomes.

The implementation of inclusion guidelines involves the participation of review, extramural and intramural program, monitoring, policy, and grants management staff. The responsibilities of each are as follow:

A. **Peer Review**

   Inclusion is first addressed by peer review. Reviewers on NIH peer review panels are given specific guidance on reviewing inclusion based on sex/gender, race, ethnicity, and age when considering clinical research applications. Reviewers evaluate applications for the appropriateness of the proposed plan for inclusion by sex/gender, race, and ethnicity. For NIH-defined Phase III clinical trials, enrollment goals are further assessed for plans to conduct analyses of intervention effects among sex/gender, racial, and ethnic groups. Unacceptable inclusion plans must be reflected in the priority score of the application and documented in the minutes of the review session. Initial review groups make recommendations as to the acceptability of the proposed study population with respect to the inclusion policies.

B. **Program Monitoring and Grants Management Oversight**

   Prior to an award, Program Officials/Program Directors are responsible for assuring that the inclusion information plans are scientifically appropriate. If issues are raised in review, program staff notifies the Principal Investigator(s), who must address these issues prior to funding. Applications with unacceptable inclusion plans receive a bar to funding. NCI staff work with applicants to ensure appropriate revisions are made. An award is not issued until an acceptable resolution is received and the bar has been removed. Program staff monitors annual progress reports to ascertain overall enrollment and consults with the principal investigator, when needed. For NIH-defined Phase III clinical trials Program Officials/Program Directors monitor the requirement for sex/gender and race/ethnicity analyses in applications and annual progress reports. Grants management staff ensure that appropriate terms and conditions of award are included in the Notice of Award, and that this information is appropriately documented in the official grant file.
C. Intramural

All intramural clinical research studies require investigators to provide enrollment plans for the appropriate inclusion of women and minorities and/or a justification whenever representation is limited or absent. These plans are considered during the scientific review process of the proposed clinical research study. With each annual review and renewal, the investigator documents the number, gender, and race and ethnicity of those who were accrued during the past year; any issues with accrual are addressed at the annual review by the investigator and reviewed by the pertinent Institutional Review Board (IRB). The Clinical Center’s Office of Protocol Services (OPS) coordinates annual reporting of demographic participant data to the Office of Extramural Research (OER) and the Office of Research on Women’s Health (ORWH).

D. NCI Training Approaches

Institute Program Officials/Program Directors and Scientific Review Officers attended the May 11, 2018 training entitled, Ensuring Inclusion in NIH Clinical Research: Policies and Procedures for Grants and Contracts. Staff may access the archived training on the NIH intranet.

E. Additional NCI-specific Items Used to Ensure Compliance with the Inclusion Policy

The central branch for assuring the data entry and quality of extramural reports is in the NCI Division of Extramural Activities (DEA). As Director of the DEA, Dr. Paulette Gray oversees the process and provides leadership to all NCI divisions, offices, and centers. Ms. Beth Buschling serves as Lead NCI Representative to the NIH Inclusion Operating Procedures Workgroup. Ms. Buschling and Ms. Clarissa Douglas of the Research Analysis Evaluation Branch, DEA, organize and coordinate the NCI Accrual Working Group with members from the extramural DOCs (see Appendix E). Meetings are held monthly (or as needed) from September to December to resolve reporting issues, reconcile data discrepancies, coordinate training, and communicate policy issues between the NCI Accrual Working Group and the NIH Inclusion Operating Procedures Workgroup.

III. ANALYSIS AND INTERPRETATION OF DATA

NCI Clinical Research: Fiscal Years (FY) 2016-2018

The appended tables show detailed information on the total number of studies/protocols that are referred to as inclusion data records (IDRs) in the NIH Human Subjects System and detailed enrollment data for FY 2016-2018. NCI’s inclusion data is as follows:

In FY 2016, there were 2,666 extramural and intramural clinical research IDRs, including Phase III and other clinical studies, of which 2,372 IDRs reported human subject participation. Of these, 2,114 (89.1%) were domestic protocols and 258 (10.9%) were foreign protocols. In FY 2017, there were 2,733 extramural and intramural clinical research IDRs, including Phase III and
other clinical studies, of which 2,402 IDRs reported human subject participation. Of these, 2,145 (89.3%) were domestic protocols and 257 (10.7%) were foreign protocols. In FY 2018, 3,329 extramural and intramural clinical research IDRs were reported, including Phase III and other clinical studies. Of the 3,329 IDRs, 2,864 reported human subject participation of which 2,483 (86.7%) were domestic protocols and 381 (13.3%) were foreign protocols. As indicated by the data, there was an increase in the number of IDRs reporting human subject participation in FY 2016-2018 (see Table 2-1, Appendix A).

In FY 2016, the total number of human subject participants was 10,376,738, which included 5,630,488 (54.3%) females, 4,707,527 (45.4%) males, and 38,723 (0.4%) unknown or not reported sex/gender. In FY 2017, the total number of participants was 8,450,627 (3,759,860 (44.5%) females; 4,586,463 (54.3%) males, and 104,304 (1.2%) unknown or not reported sex/gender). The decrease in FY 2016 resulted from the end of an intramural study (General Studies in of Epidemiology) and two extramural studies (Evaluating Prior Cancer Exclusion Policy to increase Lung Cancer Trial Accrual as well as a Long-Term Multidisciplinary Study of Cancer in Women: The Nurses’ Health Study). From FY 2017-2018, decreases in both female and male participants were the result of a large epidemiology international study (Spatio-Temporal Epidemiology: Methods and Applications) that ended in FY 2017. The study included 4,736,495 participants. In FY 2018, the total number of participants were 3,287,847 (1,921,595 (58.4%) females; 1,168,054 (35.5%) males; and, 198,198 (6.0%) unknown or not reported sex/gender (see Table 5-1-1-C, Appendix B).

Table 5-1-2-C, in Appendix C, show only U.S. studies. This data reflects more accurately the percentages across the race and ethnic categories for FY 2016-2018. The largest minority group was Black or African American at 4.1% females and 7.2% males in FY 2016; 6.8% females and 7.6% males in FY 2017; and, 9.7% females and 6.1% males in FY 2018. The smallest minority group was Native Hawaiian/Pacific Islander at 0.1% females and 0.2% males in FY 2016; 0.2% females and 0.2% males in FY 2017; and 0.2% females and 0.1% males in FY 2018.

**Phase III Clinical Trials**

In FY 2016, there were 225 Phase III studies/protocols or IDRs as referred to in the NIH Human Subjects System (HSS), of which 206 IDRs reported human subject participation. Of these, 137 (66.5%) were domestic protocols and 69 (33.5%) were foreign protocols. In FY 2017, there were 242 Phase III studies/protocols or IDRs, of which 223 IDRs reported human subject participation. Of these, 148 (66.4%) were domestic protocols and 75 (33.6%) were foreign protocols. In FY 2018, there were 325 Phase III studies/protocols or IDRs, of which 295 IDRs reported human subject participation. Of these, 197 (66.8%) were domestic protocols and 98 (33.2%) were foreign protocols. This shows a steady increase in the numbers of IDRs reporting human subject participation in FY 2016 through FY 2018 (see Table 2-2, Appendix D).

In FY 2016, the total number of participants enrolled in Phase III studies were 94,193; 57,150 (60.7%) of the participants were females, 36,974 (39.3%) were males, and 69 (0.1%) were unknown or not reported sex/gender. In the ethnicity category, 76,769 (81.5%) of the participants were not Hispanic, 15,025 (16.0%) were Hispanic, and 2,399 (2.5%) were unknown.
or not reported ethnicity. In FY 2017, the total number of participants were 109,824; 64,678 (58.9%) of the participants were females, 45,076 (41.0%) were males, and 70 (0.1%) were unknown or not reported sex/gender. In the ethnicity category, 89,480 (81.5%) of the participants were not Hispanic, 16,838 (15.3%) were Hispanic, and 3,506 (3.2%) were unknown or not reported ethnicity. In FY 2018, the total number of participants were 146,000; 91,264 (62.5%) of the participants were females, 54,662 (37.4%) were males, and 74 (0.1%) were unknown or not reported sex/gender. In the ethnicity category, 119,332 (81.7%) of the participants were not Hispanic, 20,375 (14.0%) were Hispanic; and, 6,293 (4.3%) were unknown or not reported ethnicity (see Table 5-2-2-C, Appendix E).

In FY 2016, the largest minority groups were Asian (10.3% males and 6.9% females), and Black or African American (9.4% females and 8.7% males). In FY 2017, the largest minority groups were Black or African American (9.7% females and 9.7% males), and Asian (7.0% males and 6.7% females). In FY 2018, the largest minority groups were Black or African American (8.0% females and 10.1% males), and More than One Race (9.9% females and 6.3% males). In FY 2016, the smallest minority group was Native Hawaiian/Pacific Islanders (0.1% females and 0.1% males). In FY 2017, the smallest minority groups were Native Hawaiian/Pacific Islanders (0.2% females and 0.2% males), and More than One Race (0.2% females and 0.2% males). In FY 2018, the smallest minority group was Native Hawaiian/Pacific Islander (0.3% females and 0.2% males) (see Table 5-2-2-C, Appendix E).

IV. NIH RESEARCH, CONDITION, AND DISEASE CATEGORIZATION (RCDC) INCLUSION REPORT

The FY 2018 inclusion data by Research, Condition, and Disease Categorization (RCDC) category will be available in January 2019, accessible at https://report.nih.gov/RISR/.

V. ADDITIONAL INFORMATION

A. Policy changes related to the 21st Century Cures Act.

The 21st Century Cures Act, enacted 13 December 2016, included several new requirements related to inclusion of participants in clinical research. As a result, NIH updated its policy on the Inclusion of Women and Minorities as Subjects in Clinical Research on 28 November 2017 to require studies that are both NIH-defined Phase III clinical trials and applicable clinical trials to report the results of analyses by sex/gender and/or race/ethnicity to https://clinicaltrials.gov/. This requirement is effective for competing grant awards on or after 13 December 2017, as well as contract solicitations and intramural studies initiated after this date. Additionally, NIH revised its Inclusion of Children Policy on 19 December 2017. The revised policy (NIH Policy and Guidelines on the Inclusion of Individuals Across the Lifespan as Participants in Research Involving Human Subjects) applies to individuals of all ages and requires reporting of participant age at enrollment in annual progress reports. The policy is effective for applications submitted on or after 25 January 2019, and contract solicitations and intramural studies initiated after this date. The 21st Century Cures Act amended the frequency of the Report of the NIH Director on the inclusion of women and minorities from biennial to
triennial. Thus, this first triennial report provides information on inclusion of participants in NIH clinical research from FY 2016 – 2018.

VI. APPENDICES

Appendix A. Table 2-1. Total Inclusion Data Records (IDRs) for NIH-Defined Extramural and Intramural Clinical Research Reported Between FY2016 and FY2018

Appendix B. Table 5-1-1-C. Enrollment for All NIH-Defined Clinical Research, Sex/Gender by Race and Ethnicity

Appendix C. Table 5-1-2-C. US Site Enrollment for NIH-Defined Extramural and Intramural Clinical Research, Sex/Gender by Race and Ethnicity

Appendix D. Table 2-2. Total Inclusion Data Records (IDRs) for NIH-Defined Extramural and Intramural Phase III Trials Reported Between FY2016 and FY2018

Appendix E. Table 5-2-2-C. All Enrollment For NIH-Defined Extramural and Intramural Phase III Clinical Research, Sex/Gender, Race, and Ethnicity

Appendix F. NCI Accrual Working Group
## APPENDIX A

### Table 2-1. Total Inclusion Data Records (IDRs) for NIH-Defined Extramural and Intramural Clinical Research Reported Between FY2016 and FY2018

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Total IDRs</th>
<th>IDRs Without Enrollment</th>
<th>IDRs With Enrollment</th>
<th>US Site IDRs</th>
<th>Non-US Site IDRs</th>
<th>Female Only IDRs</th>
<th>Male Only IDRs</th>
<th>IDRs Excluding Male-only and Female-only*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>2,666</td>
<td>294</td>
<td>2,372</td>
<td>2,114</td>
<td>258</td>
<td>391</td>
<td>208</td>
<td>1,773</td>
</tr>
<tr>
<td>2017</td>
<td>2,733</td>
<td>331</td>
<td>2,402</td>
<td>2,145</td>
<td>257</td>
<td>405</td>
<td>208</td>
<td>1,789</td>
</tr>
<tr>
<td>2018</td>
<td>3,329</td>
<td>465</td>
<td>2,864</td>
<td>2,483</td>
<td>381</td>
<td>552</td>
<td>249</td>
<td>2,063</td>
</tr>
</tbody>
</table>

*Inclusion Data Records (IDRs) excluding male-only and female-only include unknown sex/gender, and combination of unknown and any sex/gender(s).
## Table 5-1-1-C. Enrollment for All NIH-Defined Clinical Research, Sex/Gender by Race and Ethnicity

<table>
<thead>
<tr>
<th>Year</th>
<th>Sex</th>
<th>Gender</th>
<th>% Minority</th>
<th>Ethnicity</th>
<th>Total Enrollment</th>
<th>% Total</th>
<th>% Not Hispanic</th>
<th>% Hispanic Latino</th>
<th>% Hispanic Latino</th>
<th>% Unknown</th>
<th>% Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>Female</td>
<td>561,370</td>
<td>10.0</td>
<td>Not Hispanic</td>
<td>2,257,542</td>
<td>40.1</td>
<td>189,508</td>
<td>3.4</td>
<td>3,183,438</td>
<td>56.5</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>Male</td>
<td>372,614</td>
<td>7.9</td>
<td>Not Hispanic</td>
<td>1,414,034</td>
<td>30.0</td>
<td>136,656</td>
<td>2.9</td>
<td>3,156,837</td>
<td>67.1</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>Unknown</td>
<td>10,699</td>
<td>27.6</td>
<td>Not Hispanic</td>
<td>11,153</td>
<td>28.8</td>
<td>1,049</td>
<td>2.7</td>
<td>26,521</td>
<td>68.5</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>Female</td>
<td>2,271,725</td>
<td>60.4</td>
<td>Not Hispanic</td>
<td>3,343,498</td>
<td>88.9</td>
<td>184,035</td>
<td>4.9</td>
<td>232,327</td>
<td>6.2</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>Male</td>
<td>3,328,218</td>
<td>72.6</td>
<td>Not Hispanic</td>
<td>4,271,627</td>
<td>93.1</td>
<td>118,711</td>
<td>2.6</td>
<td>196,125</td>
<td>4.3</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>Unknown</td>
<td>10,552</td>
<td>10.1</td>
<td>Not Hispanic</td>
<td>11,806</td>
<td>11.3</td>
<td>832</td>
<td>0.8</td>
<td>91,666</td>
<td>87.9</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>Female</td>
<td>574,047</td>
<td>29.9</td>
<td>Not Hispanic</td>
<td>1,576,153</td>
<td>82.0</td>
<td>143,287</td>
<td>7.5</td>
<td>202,159</td>
<td>10.5</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>Male</td>
<td>248,624</td>
<td>21.3</td>
<td>Not Hispanic</td>
<td>999,889</td>
<td>85.6</td>
<td>84,300</td>
<td>7.2</td>
<td>83,865</td>
<td>7.2</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>Unknown</td>
<td>11,280</td>
<td>5.7</td>
<td>Not Hispanic</td>
<td>11,806</td>
<td>6.0</td>
<td>557</td>
<td>0.3</td>
<td>185,835</td>
<td>93.8</td>
<td></td>
</tr>
</tbody>
</table>

The data presented in this report show only inclusion data records labeled as prospective data. Inclusion data records labeled as existing data are excluded.
Table 5-1-2-C. US Site Enrollment for NIH-Defined Extramural and Intramural Clinical Research, Sex/Gender by Race and Ethnicity

<table>
<thead>
<tr>
<th>Year</th>
<th>Sex</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>% Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Minority</td>
<td>Minorit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total Enrollment</td>
<td>% Total</td>
</tr>
<tr>
<td>2016</td>
<td>Female</td>
<td></td>
<td>3,607,046</td>
<td>69.5%</td>
</tr>
<tr>
<td>2016</td>
<td>Male</td>
<td></td>
<td>1,562,641</td>
<td>30.1%</td>
</tr>
<tr>
<td>2016</td>
<td>Unknown</td>
<td></td>
<td>18,507</td>
<td>0.4%</td>
</tr>
<tr>
<td>2017</td>
<td>Female</td>
<td></td>
<td>1,707,496</td>
<td>53.0%</td>
</tr>
<tr>
<td>2017</td>
<td>Male</td>
<td></td>
<td>1,427,887</td>
<td>44.4%</td>
</tr>
<tr>
<td>2017</td>
<td>Unknown</td>
<td></td>
<td>84,126</td>
<td>2.6%</td>
</tr>
<tr>
<td>2018</td>
<td>Female</td>
<td></td>
<td>1,627,675</td>
<td>58.0%</td>
</tr>
<tr>
<td>2018</td>
<td>Male</td>
<td></td>
<td>1,427,887</td>
<td>44.4%</td>
</tr>
<tr>
<td>2018</td>
<td>Unknown</td>
<td></td>
<td>84,126</td>
<td>2.6%</td>
</tr>
</tbody>
</table>

Note: The data presented in this report show only inclusion data records labeled as prospective data. Inclusion data records labeled as existing data are excluded.
## APPENDIX D

### Table 2-2. Total Inclusion Data Records (IDRs) for NIH-Defined Extramural and Intramural Phase III Trials Reported Between FY2016 and FY2018

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Total IDRs</th>
<th>IDRs Without Enrollment</th>
<th>IDRs With Enrollment</th>
<th>US Site IDRs</th>
<th>Non-US Site IDRs</th>
<th>Female Only IDRs</th>
<th>Male Only IDRs</th>
<th>IDRs Excluding Male-only and Female-only*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>225</td>
<td>19</td>
<td>206</td>
<td>137</td>
<td>69</td>
<td>48</td>
<td>19</td>
<td>139</td>
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<td>2017</td>
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<td>223</td>
<td>148</td>
<td>75</td>
<td>55</td>
<td>16</td>
<td>152</td>
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<tr>
<td>2018</td>
<td>325</td>
<td>30</td>
<td>295</td>
<td>197</td>
<td>98</td>
<td>72</td>
<td>20</td>
<td>203</td>
</tr>
</tbody>
</table>

*Inclusion Data Records (IDRs) excluding male-only and female-only include unknown sex/gender, and combination of unknown and any sex/gender(s).

**The data presented in this report show only inclusion data records labeled as prospective data. Inclusion data records labeled as existing data are excluded.
## APPENDIX E

Table 5-2-2-C. All Enrollment for NIH-Defined Extramural and Intramural Phase III Clinical Research, by Sex/Gender, Race, and Ethnicity

<table>
<thead>
<tr>
<th>Year</th>
<th>Sex</th>
<th>Gender</th>
<th>Minority</th>
<th>% Minority</th>
<th>Total Enrollment</th>
<th>% Total</th>
<th>Ethnicity</th>
<th>% Not Hispanic</th>
<th>% Hispanic Latino</th>
<th>% Hispanic Latino</th>
<th>% Unknown Not Reported</th>
<th>% Unknown Not Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>Female</td>
<td>21,492</td>
<td>37.6</td>
<td></td>
<td>57,150</td>
<td>60.7</td>
<td></td>
<td>44,049</td>
<td>77.1</td>
<td>11,825</td>
<td>20.7</td>
<td>1,276</td>
</tr>
<tr>
<td>2016</td>
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<td>10,397</td>
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<td>32,179</td>
<td>88.5</td>
<td>3,200</td>
<td>8.7</td>
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</tr>
<tr>
<td>2016</td>
<td>Unknown</td>
<td>0</td>
<td>0.0</td>
<td></td>
<td>69</td>
<td>0.1</td>
<td></td>
<td>1</td>
<td>1.4</td>
<td>0</td>
<td>0.0</td>
<td>68</td>
</tr>
<tr>
<td>2017</td>
<td>Female</td>
<td>23,728</td>
<td>36.7</td>
<td></td>
<td>64,678</td>
<td>58.9</td>
<td></td>
<td>49,999</td>
<td>77.3</td>
<td>12,695</td>
<td>19.6</td>
<td>1,984</td>
</tr>
<tr>
<td>2017</td>
<td>Male</td>
<td>11,879</td>
<td>26.4</td>
<td></td>
<td>45,076</td>
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The data presented in this report show only inclusion data records labeled as prospective data. Inclusion data records labeled as existing data are excluded.
Appendix F

NCI ACCRUAL WORKING GROUP

Division of Extramural Activities (DEA)
Ms. Beth Buschling, Chair
Ms. Clarissa Douglas

Division of Cancer Biology (DCB)
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Dr. Tiffany Wallace

OD, Office of HIV and AIDS Malignancy
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OD, Small Business Innovation Research Development Center (SBIRDC)
Ms. Tamar Boghosian