

# Race, Power, and Inequities

## Science Summary

Breast cancer incidence is not distributed equally among different ethnic or racial communities or groups, due to a number of complex, often interrelated factors. For example, Black women are twice as likely as White women to be diagnosed with triple-negative breast cancer, a more aggressive subtype of the disease. In addition, elevated risk among some groups may be misrepresented, such as when rates are reported as lower for all women of Asian and Pacific Islander descent, ignoring potentially elevated breast cancer risk among young Japanese and Filipina women.

## What the Foundational Documents Say

Multiple reports have highlighted the need to report cancer disparities based on ethnicity or country of origin, rather than on major categories of race or ethnicity.<sup>1,2</sup> The 2012 Institute of Medicine report noted that there are 60 distinct ethnicities in the Asian and Pacific Islander population.<sup>2</sup> Similarly, Latinas include women from Mexico, Central America, and South America with heritage from multiple indigenous populations, as well as from European colonizers and West Africans as a result of slavery.

Furthermore, race and ethnicity have complex relationships with socio-economic status in the U.S., and both factors are related to breast cancer risk.

An ongoing concern is the disparity in breast cancer incidence among Black women, who, until 2012, had lower overall incidence of breast cancer than White women but higher incidence among women below age 45.<sup>2,3</sup> Breast cancer incidence among Black women of all ages is now equal to incidence among White women (the group with the highest risk historically).<sup>4</sup>

The complex reasons for disparities in risk along with historical lack of data, particularly for women of color, underscores the need to engage the affected community in conducting research and communicating and disseminating research findings.<sup>3</sup>

## The Current State of the Evidence

Health disparities can be defined as “differences in health, which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust.”<sup>5</sup> Many discussions of disparities acknowledge social inequities and stress throughout the lifespan<sup>6</sup> as contributors to disease, including breast cancer risk. More specifically, social determinants of health are presented as multi-faceted and complex, particularly as they relate to elevated risk of triple-negative breast cancer among Black women.

Race is a cultural construct that refers to a shared heredity as well as shared dietary, environmental, lifestyle, and socio-economic conditions that may affect cancer incidence. Teasing apart these different contributions to health can be nearly impossible, since they overlap in systematic ways.<sup>7</sup> The disparities in power, access, experiences of racism, and lifetime stress are captured by the concept of weathering.<sup>8,9</sup> Weathering characterizes a lifetime of cumulative adversity experiences by U.S. Blacks due to “historically structured differences by race in lived experience, exposure to stressors, and access to coping resources over the life-course.”<sup>10</sup> Another concept, allostatic load, describes the adverse effects of cumulative stressors on multiple physiological systems, and may explain some of the ways that social disparities lead to health disparities.<sup>8</sup> More information on stress, including the impact of adverse childhood experiences (ACEs), is detailed in the “Stress” section of this Plan. Williams and colleagues underscore the need for primary prevention, beginning early in life, to reduce racial disparities in breast cancer risk, citing physical activity, reduced alcohol consumption, and breastfeeding as strategies that could be especially important for Black communities.<sup>8</sup>

Relationships among residential segregation and neighborhood-level SES with breast cancer are complex, with some adverse effects due to lack of resources counterbalanced by shared culture, social ties, and informal networks of support. Some of these protective factors can be disrupted by gentrification, which can result in disruption of these social networks.<sup>9</sup>

Scientific protocols can either hide social factors or highlight them. For instance, when factors such as race or SES are statistically “controlled for,” the impact of those factors is flattened.<sup>11</sup> As the study showed, when those factors are intentionally included by oversampling underserved populations and listening to community stories, research can advance the understanding of disparities and health.

## Risk Disparities and Social Inequity

One study examined risk of different breast cancer subtypes stratified by both race and ethnicity. Regardless of socioeconomic status, Black women had elevated risk of triple-negative breast cancers compared to risk of HR+ breast cancers. However, for Latina women, risk of triple-negative (and HR+/Her2+) breast cancer was only elevated compared to HR+ breast cancer among those with lower SES.<sup>12</sup>

In the Black Women’s Health Study, however, higher SES (top 4th and 5th quintiles) was associated with ER+ breast cancer but not ER- breast cancer,<sup>13</sup> a pattern that was replicated in a study of women with breast cancer

that found associations of higher SES with increased risk of HR+/HER2- breast cancers and HR+/HER2+ among White, Black, Latina, and API women.<sup>14</sup>

Social inequity in the form of institutionalized racism may affect risk of ER- breast cancer. One study found that among Black women, being born in one of the 21 states and the District of Columbia that practiced legalized racism in the form of Jim Crow laws (from about 1870–1964) was associated with a 9% increased risk of ER- breast cancer compared to Black women born in other states. Furthermore, the risk of ER- breast cancer was 41% higher for Black women born in Jim Crow states than for White women born in those states, but 27% higher for Black women born in non-Jim Crow states compared to White women born in those states.<sup>15</sup> Another study found that women under the age of 50 who experienced major discrimination in the workplace had 32% higher risk of breast cancer compared to women who did not experience discrimination.<sup>16</sup>

### Specific Disparities by Race, Ethnicity, and Country of Origin

Breast cancer incidence is not distributed equally among different communities or groups. Race/ethnicity, country of origin, age, and ancestry all shape patterns of overall breast cancer risk, and, importantly, risk of different subtypes of breast cancer, which vary in aggressiveness and treatment options.

### Defining Racial / Ethnic Categories

Throughout *Paths to Prevention*, the following categories are used to describe race and ethnicity—unless a study specifically disaggregates them into more granular descriptions (e.g. Mexican Americans, Vietnamese, Afro-Caribbean).

We acknowledge that these categories are highly imperfect. Each covers a wide range of backgrounds, cultures, and other complexities and the categories do not account for overlap in individuals' and communities' racial identification. They also do not account for individuals of mixed race, including "bi-racial." While imperfect, these terms provide us with a way to talk about the science showing how breast cancer risk impacts specific races and ethnicities differently, as well as the serious inequities that exist in our society due to racism.

**Asian, Native Hawaiian and Pacific Islander (ANHPI)**—People of Asian and Pacific Island descent unless disaggregated in specific studies (e.g. Japanese, Vietnamese, Native Hawaiian, etc.).

**Black**—People of African descent including African Americans, Afro-Caribbean, and Afro-Latina.

**Latina**—Women of Mexican, South American, and Central American descent, unless disaggregated in studies (e.g. Mexican, Brazilian, Guatemalan etc.). We include research referring to "Hispanic women" under this term as well.

**Native American**—U.S. indigenous people including Alaska Natives (Note: Hawaiian Natives are included in ANHPI).

**White**—People of European, Middle Eastern, or North African descent (as designated by the Equal Employment and Opportunities Commission for the EEO-1 \*), unless disaggregated by studies (e.g. Irish Americans, Moroccans, Iranians, Danish).

\* EEOC Employer Information EEO-1 report instruction booklet. Available at [www.eeoc.gov/employers/eeo-1survey/2007instructions.cfm](http://www.eeoc.gov/employers/eeo-1survey/2007instructions.cfm) Accessed October 2019

## **Black Women**

As noted for other racial and ethnic groups, Black and African-American women include women from many different ethnicities, cultures, and regions, including African, Caribbean, Afro-Latinas, and others who may have distinct risks of breast cancer that are not captured by current research and whose unique experiences may not be addressed through current interventions.

Overall incidence rates among Black women have increased steadily over the past decade, and in 2012 attained levels on par with that of White women (the group with the historically highest rates).<sup>4</sup> Some estimates suggest Black men have elevated risk of breast cancer compared to White men.<sup>17</sup>

Younger Black women (under age 44) have higher risk than White women in the same age range, with estimates varying by study between 2% and 59% higher.<sup>18,19,20</sup> This risk may be most elevated among women aged 20-34; a 2018 study found 32% higher risk among Black women in this age range compared to White women aged 20-34. The same study found a 14% higher risk among Black women aged 35-39 years compared to White women in the same age range.<sup>20</sup> Numerous studies have found elevated risk of triple-negative breast cancer among Black women with breast cancer compared to White women, with estimates ranging from 1.75 to 3 times the risk;<sup>21</sup> a recent study found nearly double the risk of triple-negative breast cancer.<sup>22</sup> This elevated risk of triple-negative appears to sustain across all ages.<sup>23</sup>

Black women with breast cancer are almost twice as likely to have triple-negative breast cancer as the ER+/PR+/HER2 subtype.<sup>24</sup>

## **Latinas**

Breast cancer risk among Latinas depends upon age, Native-American ancestry, and subtype, although most studies report only on Latinas as a large single group. Overall risk may be lower for Latinas under age 44, compared to White women.<sup>19</sup> Among U.S. Latinas of all ages and Mexican women of all ages, those with the highest proportion of Native-American ancestry (>54% and >84%, respectively) had the lowest risk of breast cancer.<sup>25</sup> Latinas with breast cancer appear to have higher rates of both triple-negative and HER2+ breast cancers, compared to ER+/PR+/HER2- cancers.<sup>24</sup>

Among Latinas of Mexican descent, breast cancer risk factors may be shaped by country of residence (U.S. or Mexico) and acculturation. In a series of studies, researchers found that English-dominant Mexican Americans were twice as likely to experience menarche at an earlier age almost 1/8 as likely to breastfeed,<sup>26</sup> and twice as likely to have a BMI >30 and to consume more than one alcoholic beverage a week compared to women living in Mexico.<sup>27</sup> An interview study of Black and Latina women found that both groups experienced major life stressors, such as economic hardship, caretaking responsibilities, distrust of health-care professionals, and inflexible work policies that affected their ability to care for their own health. For Latinas in this study, difficulties around immigration (69% of the women in the study were born outside the U.S.) and a sense of social isolation added to their reports of life stress.<sup>28</sup> See the “Stress” section in this Plan for details on the links between life stress and breast cancer.

## **Native North Americans**

Data on American Indian/Alaska Native (AI/AN) women are sparse, particularly data that disaggregate risk by region or tribe. As an aggregated group, the frequency of specific subtypes is similar to the general population.<sup>24</sup> One study found 15% elevated risk of breast cancer among AI/AN women in Oklahoma compared to White women.<sup>29</sup> Another study disaggregated Native North Americans into six regional groups: Northern Plains, Alaska, Southern Plains, Southwest, Pacific Coast, and East. They found that risk of breast cancer was elevated among native women in the southern plains compared to White women, and modestly, but non-significantly elevated, among Alaska Natives compared to White women.<sup>30</sup>

## **Asian, Native Hawaiian, and Pacific Islanders**

Recent work has sought to disaggregate the overall statistics for Asian, Native Hawaiian, and Pacific Islanders based upon country of origin and specific ethnicity. As an overall group, Asian and Pacific Islanders have the lowest incidence of breast cancer,<sup>31</sup> but rates vary substantially by specific group, place of birth, generation of immigration, and age.

As a group, U.S.-born Chinese, Japanese, Filipina, Korean, South Asian, and Vietnamese women born in the U.S. have 58% higher risk than women born in those same countries.<sup>32</sup> A 2017 analysis found increasing incidence in all Asian-American ethnic groups in California except Japanese between 1988-2013.<sup>33</sup>

**U.S. Chinese women.** Overall, Chinese women have lower risk of breast cancer than White women. However, U.S.-born Chinese women have 84% higher risk than those born in China.<sup>32</sup> Chinese-American women in California have lower risk of triple-negative breast cancer than hormone receptor-positive cancer.<sup>24</sup> However, one study found risk among young Chinese women (under age 45), to be modestly but not statistically significantly elevated, indicating the need for more research on younger Chinese women.<sup>18</sup>

**U.S. Filipina women.** Overall, Filipina women have rates similar to that of White women; however, those born in the U.S. have slightly higher risk (about 32%) than foreign-born Filipinas.<sup>32</sup> Among young Filipina women, risk is 72% higher than for young White women.<sup>18</sup> Of women with breast cancer, risk of hormone receptor-negative breast cancers is about two-thirds that of ER+/PR+ positive breast cancers, but risk of HER2-positive cancers is about 23% higher than ER+/PR+ breast cancer risk.<sup>24</sup>

**U.S. Japanese women.** Japanese women may have slightly higher risk of breast cancer overall (about 2%) than White, with no difference among U.S.-born Japanese women and women born elsewhere.<sup>32</sup> When subtypes are examined, Japanese women overall have a 15% higher risk of ER+/PR+ positive cancers and Japanese women aged 20-44 have a 59% higher risk of breast cancer compared to White women in the same age range.

**U.S. Korean women.** Korean-born women have incidence rates that are approximately 1/3 of that of U.S. White women. There is no data on the risk for U.S.-born Korean women.<sup>32</sup> Korean women have 63% higher risk of HER2+ breast cancers, compared to ER+/PR+ breast cancers.<sup>24</sup>

**U.S. Southeast Asian women.** Data on breast cancer risk among Vietnamese women is fairly sparse. One study found reduced risk among Vietnamese women, with rates about 60% of White women.<sup>32</sup> Among the broader group of women from Southeast Asia, risk of hormone receptor-negative cancers appears to be similar to that of White women. Risk of HER2+ breast cancer may be modestly (about 17%) higher than ER+/PR+ breast cancer.<sup>24</sup> Incidence rates among women from Cambodia (35/100,000), Laos (41.7/100,000) and Vietnam (61.4/100,000) are considerably lower than for White women (around 139/100,000).<sup>34</sup>

**Pacific Islander.** Pacific Islander women have been defined differently across different studies. However, there are variations in breast cancer incidence within this group. Samoan women's overall breast cancer incidence rates are approximately 116 breast cancer cases per 100,000 women, while Native-Hawaiian women's incidence is 135.9/100,000.<sup>34</sup> One study looking at Pacific Islander women with breast cancer as a group found that risk of triple-negative breast cancer was 31% lower than HR+/PR+ breast cancers.<sup>24</sup>

**South Asian & Indian.** South Asian women (defined in this study as women from India, Sri Lanka, and Bangladesh) have 23% lower risk of breast cancer overall than White women.<sup>32</sup> However, in a study of California women from the Indian subcontinent, researchers reported 25% higher risk of triple-negative breast cancers than ER+/PR+/HER-2- breast cancers.<sup>24</sup>

## Risk Perception / Awareness

Several studies examined communities' understanding of breast cancer risk. One study examined risk perceptions and found that women of average risk had fairly accurate understanding of their risk, but only 18% of women at higher risk perceived themselves to be at higher risk. Black women below age 50 had notably higher concern about breast cancer than women of any other ethnicity.<sup>35</sup>

Two studies have examined Black women's understanding of breast cancer risk. Lewis and colleagues conducted six focus groups with a total of 50 Black women in the U.S. Southeast. Women mentioned personal care products, plastic, medication, aluminum-coated items, pollution, and chemicals in food as potential causes of breast cancer. Many discussed food, including pesticides, plastic water bottles being left in cars, and local pollutants as potential risk factors. Women also shared a sense of mistrust of medicine, as a result of historical mistreatment by medical researchers.<sup>36</sup>

The second study by Kaiser and colleagues conducted four focus groups with 35 Black women in Chicago. Women in these focus groups generally saw breast cancer as equally likely among all women, regardless of race. However, stories shared in the focus groups that focused on the effects of breast cancer on Black women were more personal and more detailed than accounts about breast cancer's effect on all women.<sup>37</sup>

Both sets of focus groups expressed a desire for more information, and in the Lewis, et al. study, participants specifically expressed a need for accurate and reliable information, presented visually and in clear language.<sup>36</sup>

## Nuances and Emerging Considerations

Several researchers have examined whether the racial/ethnic differences in risk of breast cancer subtypes can be explained by reproductive history. In one study, about 10% of the elevated risk of ER+ breast cancer among White women compared to Black women could be explained by age at first birth, parity, and lactation/breast-feeding.<sup>38</sup> In another study, socio-economic position and reproductive factors mitigated risk for hormone receptor-negative breast cancers, suggesting a social influence on risk by subtype.<sup>39</sup> Another study found that late menarche and multiparity were protective for ER+ tumors among White women, but not Black women, while late age of first live birth increased risk of ER+ breast cancer for both Black and White women. White women who were nulliparous (women who have not given birth) also had increased risk of ER+ breast cancer, while nulliparous Black women did not.<sup>40</sup>

## Research Gaps

As several studies have indicated, it is important to estimate risk for specific populations because of the tremendous variability within large categories of race, based upon country of origin, ancestry, and acculturation. Studies have noted these disparities among women of Asian descent from different countries and regions, highlighting the need for more research to understand these patterns. However, we found no studies that offered a similar disaggregation of women from Mexico, Central America, and South America, who are often described by the broad category of

Hispanic or Latinx. Similarly, very little research examines risk among indigenous women from different regions. Among Alaska Natives, breast cancer rates tripled between 1969 and 2008,<sup>41</sup> and a study of native women in Oklahoma found elevated risk.<sup>29</sup> Poverty, historical trauma, subpar housing, and gaps in chemicals regulation on tribal lands suggest several exposures of concern among AI/AN women. As discussed in the Introduction to this Plan, established science reflects similar racial and ethnic biases as the rest of our society. In seeking to overcome those biases, research must incorporate community wisdom and experience in order to fully understand the impact of breast cancer on the diversity of women in California.

Sexual minority (lesbian, bisexual, transgender) women may have an elevated risk of breast cancer of 6-10%.<sup>42</sup> Future research should examine changing reproductive patterns among these communities to determine if these findings can be explained by reproductive patterns, other group differences, and social strains associated with heterosexism (societal privileges based upon heterosexuality).

Overall, it is difficult to isolate the varied contributions to differential risk among individuals from different ethnic backgrounds and cultures, because residential segregation, socio-economic status, heredity, and exposures to racism co-occur in systematic ways.

### **Take-Home Message**

- Health inequities are differences that are unfair and inequitable but potentially preventable with systemic interventions that address the root cause of the inequities.
- Black women have increased risk of more aggressive subtypes of breast cancer, which may be partially explained by historical and institutionalized racism.
- There is a need to disaggregate breast cancer risk from large static categories of race/ethnicity (e.g. “Asian and Pacific Islander” and “Latina”), and consider country of origin, place of birth, acculturation, and the features of the neighborhood or community where people live, which can impact other risk factors.
- People want accurate, reliable information about breast cancer risk factors, presented in a clear manner.

### **Race, Power, and Inequities: Context for Interventions**

California is home to a large and diverse population. Nearly 40 million people live here,<sup>43</sup> yet no race or ethnic group constitutes a majority of the state’s population.<sup>44</sup> In 2014, Latinos surpassed Whites to become the state’s largest ethnic group.<sup>44</sup> There are 109 federally recognized Native-American tribes and 78 more seeking recognition.<sup>45</sup> More than a quarter of the people surveyed in the 2010 Census who live here were not born in this country,<sup>43</sup> with immigrants from more than 60 different countries<sup>44</sup> speaking at least 220 languages.<sup>46</sup>

In 2018, 144 billionaires lived in the state,<sup>47</sup> yet 19% of the population lived in poverty.<sup>48</sup> Nearly 1.5 million lesbian, gay, bisexual, or transgender people live here.<sup>49</sup> Approximately 22% of the population has a disability.<sup>50</sup> More than 110,000 people are refugees.<sup>51</sup>



Despite our diversity, political underrepresentation persists. In 2019, more than half of the people in the California Legislature were White, 70% were male, none were transgender, and none made under \$100,000 per year. Only 10 out of 126 were African American and one was Native American.<sup>52</sup> This leaves a significant portion of the population lacking legislative power and representation.

The problem goes beyond formal decision-making structures. Racism is a fundamental cause of adverse health outcomes, leading to significant racial and ethnic inequities in health.<sup>53</sup> Even reaching greater levels of economic security does not reverse this reality. In fact, racial inequities in health tend to be more pronounced for people of color, especially Black people, who are at the upper end of the socio-economic spectrum, likely linked to the consistency of acute (specific events) and chronic (ongoing, “everyday”) discrimination.<sup>54</sup>

Much more research is needed to understand the differential rates of breast cancer subtypes in women of various races and backgrounds, and how that relates to differences in risk factors. However, at community listening sessions across the state, women were confident that multi-generational trauma—for example, the living legacy of enslaving people from Africa or the genocide of Native Americans—plays a role in their increased risk.

Participants described living intersectional lives—experiencing multiple forms of oppression simultaneously. Where economic opportunities were lacking, there was also often high exposure to air and water pollution, lack of access to healthy food, and other concerns. This is no accident; it is a result of intentional policies to oppress communities of color and other marginalized groups by creating barriers to financial, material, and social opportunities, as well as emotional and community safety.

Addressing racism while also addressing economic instability and other forms of marginalization and oppression is critical to reducing inequities. Failure to address social problems from an intersectional lens can lead to unintended consequences and perpetuate systems of oppression that created many of the problems in the first place. There are cultural, social, economic, and biological factors that together give shape to breast cancer risk.<sup>8</sup>

There are no simple solutions to heal the depth of harm that many Californians have and continue to experience. However, there are models of healing justice<sup>55</sup> that are taking root, inviting communities to develop healing pathways out of oppression through building resilience and reimagining how to live beyond the trauma. Many movements<sup>56</sup> use this framework in storytelling, healing rituals, and other approaches, and it has the power to transform the way social change work is done. Any interventions to address inequities must ensure that affected communities lead the way and have the opportunity for collective healing.

A true vision of preventing breast cancer in California must take a radically inclusive approach to addressing the needs of our highly diverse population. Community organizing, especially in communities of color, has demonstrated success in developing effective policy solutions that address structural inequalities.<sup>57</sup> Central to all interventions must be a commitment to having the affected communities lead in identifying both the problems and the solutions.

Power inequities run so deep in our society that it is beyond the scope of this project to identify all aspects of what could be done to address this. Additionally, reducing breast cancer risk is only one aspect of the overall goal of ending racism and other oppressions, yet breast cancer prevention provides an additional lens in support of these societal struggles. Here we focus on some of the ways California could build capacity to tackle these problems and heal the trauma of oppression. The connection between oppression and breast cancer risk crosses a number of other topics covered in this Plan and are explored in further detail in other sections.

### **Community Input on Race and Inequity**

Community listening session participants described living intersectional lives—experiencing multiple forms of oppression simultaneously. Where there was lack of economic opportunities there was also often high exposure to air and water pollution, lack of access to healthy food, and other concerns. Participants largely understood this to be a result of intentional policies to oppress communities of color and other marginalized groups by creating barriers to financial, material, and social opportunities as well as emotional and community safety.

Women also expressed deep concern about the need to address and heal multi-generational trauma, for example, the living legacy of enslaving people from Africa or the genocide of Native Americans, as an important commitment to reducing a wide range of breast cancer risk factors they experience.

Throughout the community listening sessions, we heard many Black women discuss how they often do not get full and appropriate treatment even when they have access to quality clinics and doctors. One of the specific issues raised was that Black women are often not believed when they display symptoms, causing them to be diagnosed with later-stage cancer and die more frequently. While access to and quality of care is outside the scope of this Plan, this issue was raised multiple times and is of high concern for general health, and can therefore undermine prevention efforts.

Reducing breast cancer risk is only one aspect of the overall goal of ending racism and other oppressions, yet breast cancer prevention provides an additional lens in support of these societal struggles.

## INTERVENTIONS

**Overarching Goal:** Build power and create accountability to address the historical roots and ongoing trauma of discrimination and systemic oppression based on race, ethnicity, income status, gender identity and orientation, sexual orientation, immigration status, disability, or other factors that may increase breast cancer risk.

### Intervention Goal 1

Create accountability to address historical harm and trauma, which have lasting effects on the opportunities and structures that shape many aspects of breast cancer risk today.

**Objective 1:** Explicitly name historical harm as it relates to government agencies and programs.

- **Strategy 1:** Declare racism a public health crisis. Milwaukee County in Wisconsin was the first in the country to do so and can serve as a model for cities, counties, and the state of California.<sup>58</sup>

**Objective 2:** Take action to right the wrongs of the past that affect people's well-being today.

- **Strategy 1:** Support the recognition of tribal identity and tribal lands for Native-American people in California.<sup>59</sup>
- **Strategy 2:** Support California's voting rights efforts and encourage—and safeguard to the extent possible—full participation in the 2020 U.S. Census to ensure representation of the state's diverse populations.
- **Strategy 3:** Support and protect California's sanctuary state status at the city, county, and state level.
- **Strategy 4:** Call on Congressional leaders, through state legislative action, to support federal efforts to address historical wrongs; for example, offer reparations to Blacks or return land to Native-American tribes.
- **Strategy 5:** Shift investments from policing, criminalizing communities of color, and incarceration to investment in community resources and restorative justice models.<sup>60</sup>
- **Strategy 6:** Adequately fund mental health services, especially those services that support people who experience historical trauma from cumulative emotional and psychological wounding across generations, such as is prevalent in Native-American communities.<sup>61</sup>
- **Strategy 7:** Expand anti-discrimination and civil rights legislation to strengthen fairness in housing, employment, education, policing, planning, and distribution of state funds, as well as protect the religious, spiritual, and cultural traditions of marginalized communities.
- **Strategy 8:** Expand school curricula to ensure a more complete, accurate, and representational history of all people. Curricula should include the atrocities (slavery, genocide, etc.) and challenges different groups have experienced as well as the culture, political movements, and victories of different groups.<sup>62</sup>

### Intervention Goal 2

Build power and capacity for women in California to drive societal change that reduces breast cancer risk.

**Objective 1:** Grow women's leadership in community organizing, advocacy, and election to public office.

- **Strategy 1:** Expand foundations' investment in non-profit organizations specializing in educating, training, and capacity building for women—particularly women of color, low-income women, disabled women, and

### Intervention Goal 2 (continued)

Build power and capacity for women in California to drive societal change that reduces breast cancer risk.

LGBTQAI people—to be involved in the political process, including training to prepare women to seek and serve in decision-making positions.

- **Strategy 2:** Support policies that improve women’s capacity to support themselves and engage in the public process. Examples include laws that establish a living wage, so that women working in lower-wage jobs (where they are over-represented) do not need multiple jobs to make ends meet; and policies that provide free, high-quality childcare to anyone who needs it, including young mothers in high school and college so they are free to continue their education.
- **Strategy 3:** Educate and train women, particularly girls and young women, to understand breast cancer risk and how to advocate on their own behalf to reduce those risk factors.
- **Strategy 4:** Expand representation of people of color, low-income people, and other under-represented people on local, county, and state boards and commissions.

**Objective 2:** Build capacity in California’s rural communities, especially in unincorporated areas, for women to advocate on their own behalf to ensure basic public-health needs are met.

- **Strategy 1:** Develop educational tools and training programs for people in rural and unincorporated areas to learn best practices to influence decision makers.
- **Strategy 2:** Conduct comprehensive needs assessments at the county level to ensure that the needs of under-represented people are understood and addressed, especially in planning and infrastructure investment (See the “Social and Built Environment” section for more details on why and how this relates to breast cancer risk).
- **Strategy 3:** Build a greater awareness in state legislatures of the need to include the concerns of unincorporated areas in their efforts, specifically to address the tendency for local and county decision-makers to exclude the interests of people living there.

### Intervention Goal 3

Expand culturally appropriate education and awareness efforts related to breast cancer prevention.

**Objective 1:** Require medical providers and health care systems<sup>63</sup> to be adequately prepared to serve the language and cultural needs of their patients, including offering adequate translational services, providing culturally appropriate education and support services; and receiving ongoing training on how to ensure implicit bias against specific groups of women does not interfere with ensuring fair and equitable medical care for everyone.

**Objective 2:** Develop breast cancer prevention messages in partnership with the communities they are intended to inform to ensure cultural appropriateness.

**Objective 3:** Offer culturally relevant education, including public service announcements and ads, on breast cancer risk factors, targeted to various under-served populations and provided in a wide range of languages.

**Objective 4:** Develop or support existing campaigns to reform the media’s representation of women, and women of color in particular, to offer positive examples of women’s relationship to their bodies, their beauty, their sexuality, their self-worth and, if relevant, their roles as breastfeeding mothers, in order to encourage and support women’s advocacy and engagement in activities to reduce breast cancer risk.

## Intervention Goal 4

Endorse and support movements that address discrimination, marginalization, and oppression that can underlie and exacerbate breast cancer risk factors.

**Objective 1:** Organizations working for social change in California should adopt frameworks and principles that support justice, including the Jemez Principles,<sup>64</sup> Environmental Justice Principles,<sup>65</sup> and the Louisville Charter for Safer Chemicals.<sup>66</sup>

**Objective 2:** Community organizers and social change advocates should work in multi-cultural, multi-racial solidarity to ensure that policy and intervention proposals aimed to prevent breast cancer and other illnesses do not lead to unintended consequences.

- **Strategy 1:** Support the principles and efforts of movements that advocate for oppressed and marginalized communities, including racial justice (for example, Black Lives Matter), Native-American rights, and immigrant rights; Lesbian, Gay, Bisexual, Transgender, and Queer rights; disability rights; and others.
- **Strategy 2:** Build organizations and institutions that work within a racial justice framework. In particular, predominantly White-led organizations (including breast cancer and public-health organizations) must invest time and energy in building a workplace that is diverse and inclusive, and in developing strategies that promote racial justice and address White privilege and unconscious bias within their organizations and their social-change strategies.
- **Strategy 3:** Strengthen connection and collaboration between health and justice advocates in California to promote cross-movement work, address the full spectrum of social concerns in the state, serve as strategic advisers to each other's efforts and vet each other's work for unintended consequences. As an example, share knowledge and promote cross-cultural collaboration between Black and Native-American women who share similar experiences and outcomes on metastatic breast cancer.

## Intervention Goal 5

Expand research to better understand how various social determinants of health (SDOH) impact breast cancer incidence and risk.

**Objective 1:** Support research on breast cancer risk factors as they relate to specific groups of women; for example, women from different races (especially for women of mixed-races),<sup>67</sup> immigration status, socio-economic status, gender identity, sexual identity, abilities, etc.

**Objective 2:** Support research on the connection between racial and ethnic background and breast cancer subtype, as well as the role of racial discrimination and violence in elevating breast cancer risk.

**Objective 3:** Promote the systematic collection of data on Social Determinants of Health (SDOH) to facilitate surveillance and research on how these determinants impact breast cancer risk.<sup>68</sup>

**Objective 4:** Support research regarding breast cancer and incarcerated women, including surveillance of incarcerated women during and after incarceration and risk factors unique to this population.

**Objective 5:** Support research on the link between breast cancer risk and multigenerational trauma and the chronic stress of racism.

**Objective 6:** Support research on the effectiveness of policies and interventions to reduce breast cancer risk, particularly among marginalized groups.

**Objective 7:** Expand funding for community-based participatory research to better understand breast cancer risk and how to prevent the disease by increasing the California Breast Cancer Research Program's funding through expansion of the current Breast Cancer Fund cigarette tax to all tobacco products.

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