Executive Summary

Breast Cancer Mortality Report: Closing the Gaps in Eight Communities

Susan G. Komen for the Cure

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Researchers retained by Susan G. Komen for the Cure analyzed eight locations in the United States with high rates of breast cancer mortality – six counties, one city neighborhood, and the nation's capital, Washington, D.C. The goals of this analysis were to:

- Understand the circumstances unique to each location that might contribute to the disparity in mortality statistics, as seen through the eyes of front-line care providers and community health care workers;
- Identify common issues, including screening and treatment barriers, that might be factors associated with high breast cancer mortality rates in these locations; and
- Propose policy options and possible funding strategies for reducing breast cancer mortality rates in these locations and similarly affected areas throughout the United States.

The chart below illustrates the extent of the disparity in breast cancer mortality rates between these locations and the nation as a whole:

BREAST CANCER MORTALITY RATE NATIONALLY COMPARED WITH RATES OF LOCATIONS STUDIED IN THIS REPORT

Location	Breast Cancer Mortality Rates (per 100,000)
United States	26.0
Chicago, IL	40.0 (African American); 26.0 (Caucasian)
Madison County, MS	52.9
Moultrie County, IL	47.4
McDowell County, WV	45.7
Edgecombe County, NC	38.2
Harlem, NY	37.0 (Central Harlem); 32.0 (East Harlem)
Washington, DC	33.7
Wayne County, MI	30.9

Madison County, Mississippi has the unwanted distinction of having the highest rate of breast cancer mortality in the nation, fully double the national average. The more positive statistics for Washington, D.C., mask large disparities that exist between African-American neighborhoods in the Southeast, Southwest and Northeast quadrants of the city and the more affluent Northwest quadrant neighborhoods.

Similarly, the numbers for Wayne County obscure the grim state of breast cancer detection and treatment in the city of Detroit, which is wholly located within Wayne County. When the Michigan Breast and Cervical Cancer Control Program ran out of money, breast cancer detection and treatment services for low-income women were largely halted for the entire fourth quarter of the 2005-06 fiscal year. This lack of funding directly translated into a lack of treatment for poor women in inner-city Detroit.

Susan G. Komen for the Cure research included interviews with knowledgeable informants in each location and an analysis of available demographics, breast cancer data, and political and legislative information. A total of 135 interviews were conducted via telephone across the eight locations. Interviewees in each location included state and local public health officials and (where available) Komen Affiliate leadership and state breast and cervical cancer screening program officials. To the extent possible, researchers contacted front-line providers (i.e., social workers, nurses, public health professionals, faith leaders, and staff of community-based organizations engaged in breast cancer outreach and education programs) who work directly with women receiving breast cancer screening and treatment services. The emphasis on interviews with front-line providers yielded an understanding of the "real world" issues facing women in the target locations, which served to complement the theoretical and statistical information available through other research.

Dr. Harold P. Freeman, director of the National Cancer Institute's Center to Reduce Cancer Health Disparities and Medical Director of the Ralph Lauren Center for Cancer Care and Prevention in New York City, stated: "This is really a new kind of approach, because most of us have been looking at the state-level and Centers for Disease Control information in general... but we haven't really sufficiently focused on specific communities… to understand the specific problems in a particular area to highlight this [and] put a spotlight on the problem."

Dr. Freeman described the approach this way: "[If you] go deeply into the social fabric, economics, [and] policy issues that are driving disparities, you could fix some of the problems." His statement clearly suggests the value of this approach in providing a better understanding of the issues and problems unique to each location. Importantly, this approach also provides insight into common concerns across all locations. One challenge with the approach is that some findings are by necessity anecdotal due to a limit on the number of interviewees available with deep knowledge of breast cancer issues in each area.

Acknowledging this, the confidence level in the results is nonetheless high, due to the consistency of conditions reported in all areas – urban and rural – and the similarity in the accounts of those professionals working inside the various health care delivery systems and those on the outside interacting firsthand with these systems.

A) Barriers

High breast cancer mortality is what drew Komen's attention to each location studied and, in particular, to high rates among low-income women and women of color. Low-income rates and the attendant problem of low health care literacy were common across all locations. It is outside the scope of this report to identify how to address the poverty problem in urban and rural communities, so researchers focused on practical ways to reduce breast cancer incidence and mortality. If poverty were treated as a "disease" then its "symptoms" or manifestations – absence of insurance; inability to afford co-pays for health care; limited access to primary health care providers; lack of reliable, easily accessible, and affordable modes of transportation; limited resources for child care; the inability to take time off from work to access health care; and more – must be dealt with in the context of improving the ability of poor women to receive breast cancer screening, diagnosis, and treatment.

Many of the barriers identified as restricting access to and utilization of free or low-cost screening services are also barriers to breast cancer treatment services. However, collectively these barriers impact more heavily on treatment, as being diagnosed with a tumor even in an early stage is a life-changing, stressful, and multi-faceted crisis that places incredible strain on any woman, but even more so on women already struggling with issues of poverty.

The problem of arranging reliable and affordable transportation was mentioned by respondents in every location studied, but was emphasized most in rural areas where distances are greater and the challenge of setting up a regular schedule to travel an hour or more to a treatment site is commensurately greater. However, urban women face similar challenges as many respondents from cities pointed out. Taking a taxi or renting a car service to get to and from a treatment site is not a choice that most middle-class or affluent women would struggle to make. But for someone living in or on the brink of poverty, the trade-off may be between paying for transportation or paying for food, rent, school fees, or clothing. As one interviewee in Harlem, New York explained, "Public transportation here is difficult enough, but when a woman is sick and not feeling well, it's even harder to get on the subway or bus to get to the doctor." But public transportation is often the only option for a low-income woman in an urban area who has no access to a private vehicle and no money to pay for a car service or a taxi.

Add to the challenge of finding reliable and affordable transportation the need to arrange for time off from work, schedule child care, and save to make co-payments for each treatment, and the difficulties quickly multiply and collectively help to explain why high breast cancer mortality tracks income lines.

One distinction that emerged from the interviews is the difference between a lack of access to breast cancer screening and treatment services due to economic, transportation, or other barriers, and the under-utilization of services because both providers and women were unaware that they were readily available. In many locations, interviewees identified a lack of awareness among health care providers, gatekeepers, and the public at large about the availability of screening and treatment services. Several interviewees urged more publicity and targeted outreach and education to overcome this information gap.

Notably, even in locations where interviewees cited a lack of awareness of the availability of services as the primary reason for under-utilization of screening and treatment services, they also noted that many of the barriers described above hamper access even when there is awareness that detection and treatment services are available.

Despite free screening – and for those diagnosed with breast cancer, free treatment services – in each location surveyed, interviewees repeatedly argued that the costs associated with screening

and treatment were among the most significant barriers facing women in their communities. Further, some called the cost for these services "the leading cause" for high mortality rates in their community. This study could not definitively answer the questions that arose from this paradoxical response: "Yes, there is free screening and free treatment, but the cost of screening and treatment is the leading contributor to higher mortality rates." Further study is recommended in order to fully understand:

- Is cost truly an issue or a perceived problem in each community?
- What is the true extent of coverage for co-payments related to breast cancer screening and treatment services in each community? (Some interviewees specifically identified this as a core problem.)
- How many uninsured women would come in to a state screening / treatment program if it expanded its income eligibility guidelines (i.e. from 200% of the poverty level to 250% of the poverty level)? State and private breast cancer analysts note that this is an extremely difficult number to ascertain.
- How great a problem is lack of comprehensive knowledge about available resources, even among public health workers, physicians, and other gatekeepers?

What is known with certainty is that interviewees in all locations reported that their local health systems are not servicing many of the eligible women, and that there are large numbers of women who need screening and treatment services, but who are ineligible for free services or lack the funds to pay for them.

Finally, some women are excluded from receiving treatment services because of their citizenship status. Undocumented women are *eligible* for screening services in each of the locations studied, but are *ineligible* for treatment services. Dr. Freeman suggested that "simply providing a test in a poor community is only getting started. You have to ensure that once you are set up to find a problem, that people who have findings will get treated in a relatively short period of time as well as get quality [care]." Essentially, some undocumented women are being tested, diagnosed with a tumor that requires treatment, and then excluded from receiving that treatment.

B) Gaps in Care

There are common gaps in the implementation of the Breast and Cervical Cancer Prevention and Treatment Act of 2000 that are relevant across locations. Each gap contributes to and exacerbates the problems that are then revealed in disparity studies.

- In each of the locations studied, except the two in Illinois, state government prohibits women screened and diagnosed with breast cancer outside of the state breast and cervical cancer screening program from eligibility for Medicaid-funded treatment services. Although the federal government clearly gives states the right to restrict treatment eligibility in this way, interviewees repeatedly described this gap as an unfortunate anomaly, with words like: "unintended consequence of poorly drafted legislation." Whether intended or erroneous, this gap imposes a tremendous hardship and often delays or prevents treatment for women who fall into this category.

- Across locations, many breast and cervical cancer screening programs only provide services to women 50 years of age and older, excluding younger women entirely. Even within programs that are open to women under 50 years of age, outreach often focuses primarily on women 50 and older due to resource limitations.

- Across locations, limited funds and too-few staff force many breast and cervical cancer screening programs to choose between recruiting women for first-time mammograms, and working to establish regular annual mammograms. Whichever is prioritized, women in the lower priority category "fall through the cracks." This Catch 22 results in one population or the other being neglected, or in both receiving only partial service.

C) Racial Disparities

Across the eight locations (with the exception of Edgecombe County, NC), African-American women have significantly higher breast cancer mortality rates than their white counterparts. In discussing this fact during interviews, interviewees offered distinctly different opinions about the reasons for this disparity. Broadly speaking, three "schools of thought" exist:

- Those who believe the disparity in mortality rates for African-American women is due to *biological differences*;

- Those who believe that *cultural issues* restrain African-American women from accessing and utilizing screening and treatment services to the same extent as white women; and

- Those who believe the disparity is caused by a *lack of access to quality care*.

While many interviewees attribute the disparity to more than one or all of these factors, their conclusions about what to do to alleviate it often differ depending on which cause they judge as primary. For example, some feel strongly that a full-scale program should be mounted to investigate the possible biological differences among white and African-American women, but secondarily urge mounting more culturally-appropriate education and outreach programs aimed at encouraging screening and treatment, if required. Others believe quite strongly that money spent on genetic research is wasted compared to understanding and dealing with the cultural influences that help determine women's choice of whether and how to access health care. Still others argue that a focus on cultural attitudes and behaviors feeds into a "blame the victim" mentality.

When addressing the potential of biological differences, Dr. Freeman stated:

> "At the core, every cancer is based on genetic change – every cancer. Cancer, at its heart, would not occur without cellular change on the genetic level. There are also some populations of people who have a particular propensity to develop cancer [more] than others. However, I don't think a great deal of resources should be spent to understand the genetics of race with respect to cancer if you are looking to fix disparities. If you classify people according to race and the categories are determined socially and politically in the first place, it's hard to put that into genetics. That doesn't mean genetics aren't important, but it means that if you were focusing on some specific issue in cancer research, you should look at it across populations and not presume that there is one in particular that should be studied."

Interviewees identified a number of cultural factors within the African-American community as possibly playing a role in breast cancer incidence and mortality, such as:

- Fatalistic attitudes about breast cancer;
- Lack of belief in the efficacy of breast cancer treatment (with many believing surgery actually causes the cancer to spread throughout the body);
- Attitudes about mastectomies that view women who underwent this procedure as "unwhole" or lacking femininity; and
- Distrust of the health care system in general and of health care providers in particular.

Late-stage diagnosis of African-American women was also specifically raised by interviewees as a factor in the higher mortality rates reported in several locations studied. Interviewees suggested a number of possible causes for late-stage diagnosis, including:

- A genetic factor that causes breast cancer to progress among African-American women;
- Reduced access to early-detection screening services and/or reduced access to quality screening services; and
- That African-American women (perhaps due to some of the cultural attitudes described) are possibly reluctant to utilize screening services available through the health care system.

Several common themes emerged from the interviews. Most of the barriers identified pertain to both screening and treatment:

Screening Issues

- Too few screenings performed on a timely basis (i.e. women may receive an initial mammogram but are not being screened regularly according to screening guidelines).
- Lack of radiologists to read mammograms.
- Digital mammography is not covered (or not fully covered) by Medicaid and Medicare and is thus often inaccessible for low-income women. Studies show digital mammography is particularly effective in detecting breast cancer in younger women and women with dense breasts.

Treatment Issues

- A lack of coordinated treatment services, compounded by the fact that many poor women lack the resources or energy to obtain a full understanding of how to navigate the health care system.
- Lack of oncologists and other specialists in rural areas.

Barriers Relating to Both Screening and Treatment

- Long wait times for screenings and follow-up care with physicians.
- Difficulties with transportation. Even though most of the urban locations surveyed provide public transportation, these services are not optimal in some areas and/or higher quality care services are not located on public transportation lines. This can be an even more profound difficulty for women undergoing treatment.
- Too few primary care physicians and oncology specialists. In rural communities, interviewees reported a lack of available health care providers; in urban areas, they more often cited an under-utilization of primary care and an over-utilization of emergency departments.
- Low-literacy and low health care literacy hamper utilization of screening services, understanding of the importance of early detection, and knowledge about treatment options.
- Medicaid/Medicare reimbursement rates are low, limiting the number of providers who are willing and/or able to provide screening and treatment services through the BCCCP.
- Busy women, many with more than one job and childcare responsibilities, do not or cannot take the time required to be fully compliant with screenings, follow-up after abnormal mammograms, or comply with treatment plans. If a child is too sick to leave the house on the day of a treatment appointment, many women make the rational decision to skip treatment.
- Low-income working women often do not or cannot take time off work for screenings and/or treatment.

Common themes raised by interviewees in the urban locations studied primarily dealt with the impact of poverty, lack of access to and utilization of primary health care, long wait times to receive mammograms and/or follow-up care with a physician, cost barriers (of co-pays, transportation, and childcare) and the plight of undocumented women eligible for screening services but not for treatment. Racial disparity was also noted as an issue in urban areas, as previously described in this report. In addition, several of the urban locations, particularly Chicago and the neighborhood of Harlem in New York City, identified a scarcity of radiologists performing breast imaging work as a barrier to timely mammography services. In some urban locations, there were also reports of unequal distribution among health care institutions serving insured and fee-paying women and those providing indigent care.

Chicago, IL

Low-income uninsured women in Chicago face exceptionally long wait times for mammograms and follow-up care with a physician if the mammogram indicates an abnormality. Several people in Chicago noted that area hospitals serving low-income residents only offer mastectomies to breast cancer patients. However, there is widespread knowledge among women in the community that one institution (Stroger Hospital) provides completely free medical care. This hospital is easily accessible via public transportation, and the combination of no-cost and convenience has led large numbers of low-income women to opt for care at Stroger even though other options are available. As a result, waits of up to six months to receive a mammogram are common, as are significant delays in receiving diagnoses. The majority of interviewees identified a need for additional resources for outreach, screening, and treatment in the city. However, there were some who reported that the more significant problem was lack of coordination among existing screening and treatment service providers, which is one of the reasons why Stroger is over-subscribed and other facilities under-utilized. Notably, African-American women living in Chicago have a 54% higher breast cancer mortality rate than white women in the city.

Harlem, NY

High rates of immigration make breast cancer screening and treatment for undocumented women a significant challenge in Harlem. As previously described, these women are eligible for free screening, but not for treatment services. New York City is in the midst of an audit and has been required to reimburse the federal government for medical care deemed “non-emergent” that the city provided to undocumented residents. This is not a small matter. For example, 40% of the women receiving services at the Manhattan Breast Health Partnership in Harlem are undocumented. In the seven years of the program’s operation, only 22 of the 92 women diagnosed with breast cancer were eligible for treatment services due to their immigration status. A shortage of radiologists was also reported as a major concern in Harlem, because it results in long delays between screening and diagnosis. Additionally, the gap that prohibits women screened outside of the state screening program from receiving state-funded breast cancer treatment is a major public policy problem in Harlem.

Washington, DC

When compared to all states in the nation, Washington, D.C. has the second highest mortality rate in the country at 33.7%, surpassed only by Louisiana. It also leads the nation in breast cancer incidence at 147.8 per 100,000. Interviewees report a significant lack of coordinated services in D.C., with women having great difficulty navigating the health care system. A large homeless population (12,000 residents) and a "transient" population that frequently changes addresses and telephone numbers complicates tracking and follow-up care for women following mammograms. This hampers efforts to notify women to return to see a physician after an abnormal finding or to return for regular screenings. Another problem is lengthy waits for mammography as well as for appointments with a physician following an abnormal mammogram.

Wayne County/Detroit, MI

Wayne County, Michigan – and particularly the city of Detroit, which is wholly located within the county – is home to a racially diverse population. Eighty-two percent of Detroit residents are African-American. Dearborn, located just outside of Detroit, has the largest population of people of Middle Eastern descent outside of the Middle East. Poverty in Detroit is profound, with 31.4% of individuals living below the poverty level. Despite having the highest federal contribution rate of any state, Michigan's Breast and Cervical Cancer Control Program ran out of funds in the third quarter of the last fiscal year, resulting in a backlog for those seeking screening services. The loss of funding halted a successful grassroots outreach effort to educate and draw women into the program. Finally, as in Harlem, undocumented women pose a significant challenge in Detroit, with high numbers of women ineligible for treatment services due to their immigration status.

Within the rural locations studied, several common issues were raised, including the impact of poverty, inadequate transportation, too few health care providers accessible to residents in the area, low literacy and low health care literacy, lack of education, and social and cultural attitudes that do not prioritize healthy behaviors or preventive health care.

Edgecombe County, NC

Edgecombe County is a very poor area in rural North Carolina with a large population of African-American residents, who outnumber whites living in the county by 57.5% to 40.1%. Edgecombe's breast cancer mortality rate is the 16th highest county in the nation, and it is the only county studied where the breast cancer rate for white and African-American women is the same. The county has been adversely impacted by natural disasters (Hurricane Floyd in 1999, as well as a history of flooding). Edgecombe has a very low education attainment level. Only 66% of residents have a high school degree or higher, and the state has large numbers of uninsured individuals. North Carolina is one of 25 states where county governments share Medicaid costs with the state government, imposing a major strain on county's finances. In addition to the lack of health care providers reported in Edgecombe County (as is the case in other rural areas studied), there are reports of a lower quality of health care in the county, with very few specialists available to provide services to residents.

Madison County, MS

Madison County has the highest breast cancer mortality rate of any county in the United States. At 52.9 per 100,000, Madison's breast cancer mortality rate is more than double that of the United States as a whole. Zip code level data, not currently available, would be very helpful in targeting interventions in Madison County, as there is great socio-economic diversity within the county. The rural northern part of the county has a single hospital which only began providing mammography four years ago. There is an absence of breast cancer screening and treatment services for women aged 40 to 49, since the state's breast and cervical cancer program only provides services to women 50 years and older unless they are at higher than average risk for breast cancer. While other programs have stepped up to provide screening services for women aged 40 to 49, they do not have the resources to provide treatment for women if cancer is detected.

Moultrie County, IL

Moultrie County is a small county in Central Illinois that is home to the oldest and largest Amish population in the state. The socio-economic data for the county is surprising given its ranking as the county with the 5th highest breast cancer mortality rate in the nation. Moultrie County residents earn at or above the national income average and they are employed at a rate roughly equal to the national average. There is no available data providing the exact size of the Amish community living with the county, but interviewees estimate the Moultrie Amish population at approximately 2,000. Interviewees repeatedly characterized the Amish as being hard to reach, underserved, and dying of breast cancer at higher than the average rate. Amish women do, in fact, have higher rates of breast cancer mortality than their non-Amish white counterparts, according to national findings and a recent study conducted by Project Hoffnung in Ohio. Among the factors believed to be at play include Amish women not prioritizing breast cancer screening, overestimating the protective benefits of breastfeeding, and opting for homeopathic treatments rather than conventional medicine when diagnosed with breast cancer. The rural nature of Moultrie County is certainly another significant issue, with transportation barriers consistently reported by interviewees, as well as a lack of providers – primary care and specialists – in the county. The only sites for mammography are in Sullivan, the county seat.

McDowell County, WV

McDowell County is a rural Appalachian community populated by low-income and poorly educated residents. McDowell also has a rapidly aging population, with the 5th largest percentage of residents aged 65 and older (16.1%) of any county in the nation. Employment rates are only half the national average, with 33.8% of families and 37.7% of individuals living below the poverty level, and only half of residents having high school degrees or higher. The state's breast and cervical cancer program only provides services to women aged 50 and older, creating a significant gap for women aged 40 to 49. West Virginia has a paucity of health care providers, with 30% of residents lacking any access to primary health care. Low literacy and lack of education are also significant barriers. West Virginia is ranked 43rd in health status among states, with lack of insurance, smoking, and obesity specifically cited as key factors.

There are many opportunities for public policy initiatives that could positively impact breast cancer mortality in these locations and likely reduce both incidence and mortality rates. They include:

❖ **Close the gap that prevents women screened outside the state breast and cervical cancer programs from accessing state-funded treatment services.**

This restriction is a result of states choosing the most restrictive (and therefore least expensive) option available to them under the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000. Under the BCCPTA, states must provide Medicaid-funded breast cancer treatment to any low-income, uninsured woman screened through their state breast and cervical cancer screening program. However, states are not required to provide Medicaid-funded treatment to women screened outside of the program, even if they meet income eligibility guidelines. Among the locations studied, only two states – Michigan and Illinois – have closed this gap. As of 2006, the Illinois Breast and Cervical Cancer Program and the Michigan Breast and Cervical Concer Control Program are now able to provide treatment services to needy women regardless of where they were diagnosed. This is a worthwhile policy change to pursue in other states. Few policymakers believe that low-income uninsured women screened outside of the program should be denied breast cancer treatment.

❖ **Eliminate co-pays for screening and treatment services.**

The cost of co-pays was raised as a barrier to screening and treatment in virtually every location studied. This is an issue worthy of exploration on both the state and federal levels and should encompass Medicaid, Medicare, and private insurance plans.

❖ **Explore potential solutions for treating undocumented women, such as having cancer treatment defined as emergency treatment.**

This is a very challenging issue, particularly given the current national political climate and controversies associated with "undocumented or illegal residents." However, it is a critical issue for a large number of women and was raised in many of the locations studied. One approach would be to explore the possibility of changing federal guidelines so that cancer treatment, including mastectomies and chemotherapy, is defined as "emergency care." Dr. Freeman summed this issue up by saying: "At a minimum, our American society should assure that anyone that has cancer should be treated. Call it insurance, call it anything, but it's not morally acceptable that you can diagnose cancer and not provide treatment. [It] doesn't even save money because you end up paying for late-stage treatment."

❖ **Provide scholarships or stipends to create incentives for health care providers to practice in rural areas.**

The lack of providers available to women in rural areas is a significant factor in the reduced health status of low-income women, under-utilization of preventive health care services, and lack of access to breast cancer screening services. Scholarships or stipends provided to health care providers who commit to practicing in rural areas might provide incentives to increase the numbers of providers in rural areas, thus increasing women's access to quality care.

❖ **Provide scholarships or stipends to create incentives for medical students to study breast imaging and to expand this as a career choice for medical practitioners.**

A report by a New York City physician, Stephen A. Feig, MD of New York's Mt. Sinai Hospital, found that 64% of physicians refused to enter the field of breast imaging because of lawsuits, low-pay, high-stress, and the perception that it is a "female" field of work. Scholarships or stipends to medical students, as well as outreach and education to medical students about the need for breast imaging services, might increase the number of students and providers opting to specialize in breast imaging.

❖ **Promote access to and utilization of primary health care services.**

High numbers of low-income women, particularly in urban areas, do not utilize primary health care services and rely instead on emergency rooms for acute medical care. This reduces referrals to mammography services, as women who do not receive primary care services are less likely to receive physician counseling and anticipatory guidance, and emergency rooms are often too busy to address anything but acute injuries and illnesses. Policy options that might increase access to primary health care warrant further exploration, such as initiatives that create partnerships with obstetricians, emergency room physicians and school nurses to facilitate access to and utilization of primary health care services. These outreach initiatives might be an extension of patient navigator programs, described below.

❖ **Establish (or expand) patient navigator programs.**

Patient navigator programs have proven to be effective in Harlem as well as rural areas such as Edgecombe County. Patient navigators assist women in finding their way through the complex network of the health care services for breast cancer screening and treatment. Navigators recruit women to participate in breast cancer screening programs, track their progress, and then help them obtain follow-up care, if needed. These programs could and should be instituted where they do not currently exist, and should be expanded in areas where they do. In speaking of the patient navigator program in Harlem, Dr. Freeman said, "You've got this program that is a good concept if applied appropriately in the right places – it is a good policy change for local communities."

❖ **Conduct breast cancer outreach and education through churches and community-based organizations that serve the African-American population.**

The influence of churches in African-American communities is profound, and ministers and their congregations can become partners in interventions aimed at African-American women. Funding should be made available to churches and community-based organizations that serve the African-American community to educate women and men in order to raise awareness about survivorship, assist in navigating the health care system, reduce cultural taboos about health care and breast cancer treatment, and promote compliance with early detection screening guidelines.

❖ **Encourage support for state-level legislation that would provide paid work leave for breast cancer screenings.**

When considering the economic barriers to women receiving breast cancer screenings, it is critical to examine all financial impacts. For low-income women who are often employed without health benefits or paid sick leave, paychecks will often be "docked" or they may be fired for time missed from work in order to attend a breast cancer screening or follow-up. Taking time off for preventive health care is therefore neither desirable nor realistic for many low-income women. Given this barrier – as well as the increased health care costs of late-stage diagnosis and treatment – legislation to provide paid work leave for preventative health care such as screenings should be explored and supported.

❖ **Establish transportation and childcare assistance programs.**

For all low-income women, whether in rural or urban areas, transportation and the cost of childcare often limit their ability to access breast cancer screening and treatment services. Transportation and childcare assistance vouchers, free rides provided to screening and treatment services, and on-site babysitting at screening and treatment facilities are initiatives that merit further exploration.

❖ **Apply political pressure to local, state, and federal politicians to increase their support, and promote breast cancer policy champions.**

As other advocacy groups have discovered, grassroots organizing and mobilization can have a powerful impact on the policy process. In discussing such an approach, Dr. Freeman said: "To put the idea forward that we should score local and federal politicians on how they stand on cancer issues…That does have an effect… Breast cancer is a very emotional issue for women and the country… [there is] a lot of potential for how to use this."

In Dr. Freeman's words, "We should be talking about the core problem—inequity and injustice—and how that has an impact on who survives and who doesn't…I'm suggesting that the health-care element happens in the context of a much larger universe… one of the things that is driving disparities big time is injustice and the unequal distribution of medical resources."

As eloquently pointed out by Dr. Freeman and many of those interviewed, there is tremendous injustice and unfairness at the heart of breast cancer mortality disparities. These are large and difficult challenges. However, addressing these challenges will have a long-reaching, life-saving impact on low-income women all across the United States, including those living in each of the locations studied.