Integrating an Interdisciplinary Paradigm and Community Voice to Advance Equity in Cancer Prevention and Control

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Abstract

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Background: Cancer disparities among Black populations remains a persistent public health challenge despite advances in cancer prevention and control. Despite growing recognition of structural racism as a determinant of health, there are important gaps in how it is conceptualized, measured, and translated into cancer prevention research. The use of an interdisciplinary approach can expand how social determinants of equity are understood. Nursing science offers a holistic understanding of person-environment relationships, while Public Health Critical Race Praxis (PHCRP) provides an anti-racism framework for interrogating racism. Integrating these paradigms provides a comprehensive approach for understanding how structural racism operates as an environmental factor (i.e., laws and policies) to influence health. Layering both nursing science and anti-racism lenses onto cancer prevention frameworks will provide a more comprehensive conceptualization of socio-ecologic mechanisms affecting cancer outcomes.

Purpose: The overall purpose of this dissertation is to advance understanding of how structural racism influences cancer prevention and control among Black Americans through an anti-racism framework that integrates evidence synthesis, community knowledge, and policy analysis. Rather than examining structural racism from a single perspective, this dissertation employs three complementary studies that

collectively address multiple dimensions of structural racism. Together, these studies generate evidence across different levels of inquiry and contributes to a more comprehensive understanding of how structural racism shapes cancer prevention opportunities.

Specific Aims: The aims of this dissertation are as follows: (1) conduct a scoping review to assess the degree to which anti-racism frameworks or theories are applied in cancer prevention and control; (2) analyze existing community-generated data reports using anti-racism principles to name mechanisms and describe impacts of structural racism and community resilience on Black health and well-being among adults; and (3) examine associations between state-level policies indicative of structural racism and receipt of cancer screening among a representative sample of United States (U.S.) Black adults.

Methods: This study utilizes a mixed methods approach to address each research question. Aim 1 is a qualitative scoping review of three health sciences databases. Aim 2 used qualitative documents analysis and the Rapid Group Analysis Process (Rap-GAP) to examine community-generated reports. Aim 3 conducted a secondary analysis of Behavioral Risk Factor Surveillance System (BRFSS) data to examine associations between state-level policies structural racism-related policies and cancer screening among Black adults using logistic regression analyses.

Importance: This dissertation informs anti-racism strategies for equitable cancer prevention, and contributes to the growing body of knowledge on anti-racism principles as salient to Nursing Science while growing the evidence of anti-racism approaches to health services research. This study also bridges academic and community knowledge about Black health and well-being and emphasizes the importance of utilizing community expertise to generate recommendations for desired change.

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I also wish to acknowledge the Black communities whose lived experiences, wisdom, resilience, and advocacy inspired this dissertation. This work is grounded in the belief that community knowledge is indispensable to advancing health equity. I am honored to contribute to a growing body of scholarship that recognizes community voice as expertise and seeks to strengthen partnerships with the communities they serve.

Finally, I acknowledge every individual who has worked tirelessly to advance health equity and dismantle structural racism within healthcare, public health, and society. It is my hope that this dissertation contributes, in some small way, to the collective effort to create more equitable systems of cancer prevention and control and to improve the health and well-being of future generations.

Chapter 1: Introduction

Despite decades of scientific advances in cancer prevention, screening, and treatment, Black Americans continue to experience disproportionately poorer outcomes than their white counterparts across nearly every stage of the cancer continuum.[1,2] Although cancer mortality has declined substantially in the United States (U.S.), these improvements have not equitably been distributed.[1] Black Americans are more likely to experience delays in diagnosis and treatment, and experience higher mortality rates.[2,3] These inequities cannot be fully explained by individual health behaviors or biologic differences and persist despite the availability of early detection. Increasingly, researchers recognize that individual health behaviors occur within broader social, economic, and political contexts that constrain or facilitate opportunities for health.[4] Understanding cancer inequities requires moving beyond downstream behavioral explanations to examine the upstream structural conditions that produce unequal opportunities for cancer prevention, screening, and treatment. Consequently, an expanding body of evidence demonstrates that structural racism mechanized through policies and practices differentially shapes access to resources and opportunities that influence cancer risk, prevention, and outcomes.[5,6]

Recognition of structural racism as a fundamental determinant of equity[7] represents a paradigm shift in understanding how it is operationalized and influences cancer prevention and control research. Rather than conceptualizing racial inequities as the consequence of individual choices or isolated economic disadvantage, it has become increasingly evident that many social determinants of health (SDOH) are themselves products of historical and contemporary systems that maintain and perpetuate racial inequities (i.e., structural racism). Structural racism manifests as residential segregation, redlining, inequitable educational funding, labor market discrimination, mass incarceration, environmental injustice, and inequitable access to healthcare services collectively shape opportunities for cancer prevention long before individuals encounter the health care system.[8-10] Thus, interventions exclusively focused on changing individual behaviors or other downstream determinants of health are unlikely to eliminate health inequities if the structural conditions that constrain healthy choices remain unchanged.

Within cancer prevention and control, this paradigm shift is particularly important because many cancers are preventable; however, that is dependent upon equitable access to resources. Evidence-based recommendations for breast, cervical, and colorectal screening rely upon the assumption that there is consistent access to primary care, transportation, health insurance, paid-leave, culturally responsive health care providers, and appropriate as well as timely follow-up. Likewise,

recommendations related to smoking cessation, vaccination, nutrition, physical activity, and environmental exposure reduction presume access to conditions that support healthy living. Structural racism shapes each of these opportunities through policies and institutional practices that accumulate over the course of life and result in persistent inequities.

Although the concept of structural racism has gained increasing attention within health disparities research, important knowledge gaps remain. First, definitions of structural racism vary considerably across studies, more rigorous measures are needed, and many investigations fail to distinguish among structural, institutional, and interpersonal racism.[5,11] In cancer prevention and control research specifically, structural racism is often acknowledged as an important determinant, however, rarely operationalized in ways to understand its impact. As demonstrated in the scoping review presented in Chapter 2, the studies reflects considerable inconsistency in how anti-racism frameworks, structural racism, and SDOH are conceptualized and applied. This lack of conceptual clarity limits comparability across studies, constrains theory or framework development, and hinders translation of research into effective structural interventions.

A second limitation within the current literature is the lack of integration of community-generated knowledge into scientific understanding of structural determinants health. Black communities have long documented the structural conditions affecting health through community-generated reports, advocacy documents, and grassroots organizing. These sources often identify structural barriers including housing instability, economic exclusion, educational access, environmental injustice, and policing, that is underrepresented within conventional research. Yet, community-generated evidence remains marginalized and unrecognized as legitimate evidence, despite offering critical insights into the lived realities of structural racism. As demonstrated in Chapter 3, community-generated reports provide a rich source for understanding of the mechanisms through which structural racism influence health and structural solutions that may not emerge through conventional research.

Finally, a third gap concerns the evaluation of structural racism as it operates through public policy on health outcomes. State and federal policies governing health insurance, voting rights, criminal justice, education, labor protections, housing, and economic opportunity collectively shape the environmental contexts within which individuals pursue preventive health care. However, relatively few studies have examined how policy environments indicative of structural racism influence receipt of recommendations for cancer screening among Black populations. Chapter 4 addresses this gap by examining associations between state-level policy environments and receipt of breast, cervical, and

colorectal screening among Black women using nationally representative data. Although state-level policy environments (e.g., laws) represent only one mechanism of structural racism, they provide measurable indicators of broader systems that organize access to resources essential for cancer prevention.

Taken together, these conceptual, methodological, and empirical gaps warrant the need for more comprehensive anti-racist approaches to address structural racism in cancer prevention and control research. These gaps limit researchers from developing anti-racism strategies capable of reducing health inequities in cancer. Advancing cancer prevention and control, requires research that explicitly names and interrogates how racism operates across systems, applying anti-racist conceptual frameworks, and centering community expertise. This dissertation responds to that need by integrating conceptual scholarship, elevating community knowledge, and policy analysis.

Significance to Nursing Science

This dissertation is grounded in nursing science and examines cancer prevention and control within the context of the dynamic interaction between people and their environments. The person-environment relationship is central to nursing science, this disciplinary lens provides a foundation for understanding health as shaped by social and environmental conditions.[12] Increasingly, nursing science emphasizes health equity, addressing structural conditions, and multilevel systems population health approaches.[13] As the largest healthcare profession in the United States, nursing is uniquely positioned to identify and address structural determinants that influence health outcomes across communities. The American Association of Nurses similarly calls for nursing action to address racism and advance health equity.[14] Thus, nursing science provides a foundation for examining how broader social and structural conditions are related to cancer prevention and control.

This dissertation contributes to nursing science by advancing conceptual clarity regarding structural racism, demonstrating the value of integrating community-generated knowledge into health equity research, and providing empirical evidence regarding the influence of policy environments on preventative cancer screening. Collectively, this dissertation adds to the growing commitment within nursing science that seeks to address the root causes of health inequities and generates evidence that informs equitable systems, policies, and practices.

Theoretical Framework and Application

Public Health Critical Race Praxis (PHCRP) provides the theoretical framework for examining how racism operates through social structures, institutions, and systems to produce inequitable health outcomes while centering the knowledge and lived experiences of historically marginalized communities.[15] PHRCP conceptualizes race a social construct shaped by historical and contemporary systems of power. The framework emphasized that racism, not race, is the primary driver of racial health inequities. Through PHCRP researchers are encouraged to interrogate assumptions embedded within scientific knowledge production, critically examine structural determinants of equity, prioritize experiential knowledge, and develop action-oriented research that promotes equity.

The PHCRP foci guided this dissertation. Focus 1, Contemporary Patterns of Racial Relations emphasize understanding present day inequities within their historical context. Focus 2, Know Production encourages critical examinations of how scientific evidence is generated and whose perspectives are represented. Focus 3, Conceptualizations and Measurement challenge researchers to develop more precise measures of structural racism to distinguish among multiple levels of racism. Focus 4, Action underscores the critical need to contribute structural solutions that involve community. These guiding foci provide the conceptual foundation linkage of all three dissertation aims.

Integration of Nursing Science and PHCRP

This dissertation utilizes an interdisciplinary foundation merging nursing science with PHCRP. The core metaparadigm of nursing science focuses on the dynamic interaction between the person and the environment. By leveraging a holistic lens, nursing science provides the disciplinary foundation for viewing structural racism as a critical environmental determinant of health. PHCRP provides the tools to examine how historical, social, political, and policy environments are racialized and contribute to inequitable health outcomes. When nursing science is integrated with PHCRP, this perspective gains a rigorous, race conscious framework for interrogating structural racism and the systems of power through which it operates. This integration maintains attention to the health experiences of individuals while simultaneously situating those experiences within their broader sociopolitical context.

Dissertation Purpose and Aims

The integration of nursing science and PHCRP supports a paradigm shift from responding to the consequences of inequity toward examining the conditions through which inequities are produced and sustained which provides the conceptual foundation for the overall purpose of this dissertation. Across three complementary studies, the dissertation seeks to advance understanding of structural racism as a

determinant of cancer prevention and control, while contributing theoretically grounded, methodologically rigorous research in nursing science committed to health equity and social justice. The aims of the dissertation are as follows:

> Aim 1: Conduct a scoping review of cancer prevention and control literature to examine how structural racism and anti-racism have been conceptualized, measured, and incorporated into existing research. Guided by PHCRP, this study identifies conceptual strengths, limitations, and opportunities for advancing anti-racist scholarship within cancer prevention and control.
>
> Aim 2: Analyze community-generated reports describing the health and well-being of Black communities using reflexive thematic analysis informed by PHCRP. By centering community voices, this study identifies structural barriers and community priorities that may not be fully represented in traditional academic literature, demonstrating the importance of community knowledge in informing health equity research and policy.
>
> Aim 3: Examine associations between state-level policy environments indicative of structural racism and receipt of breast, cervical, and colorectal cancer screening among Black women in the United States. Using Behavioral Risk Factor Surveillance System (BRFSS) data linked with state policy classifications, this study evaluates whether policy contexts associated with structural racism influence preventive cancer screening behaviors.

Together, these three studies move from conceptualization (Aim 1), to community understanding (Aim 2), to empirical evaluation of policy environments (Aim 3). This progression reflects a multilevel approach to understanding structural racism and demonstrates how conceptual frameworks, community knowledge, and policy analyses can collectively inform anti-racism approaches in cancer prevention and control.

Dissertation Organization

This dissertation is presented in a manuscript format consisting of three stand-alone yet conceptually linked studies. Chapter 2 presents a scoping review examining how structural racism has been conceptualized within cancer prevention and control research. Chapter 3 presents a qualitative document analysis of community-generated reports describing structural determinants of health among Black communities. Chapter 4 presents a quantitative analysis evaluating associations between state-level structural racism policies and cancer screening among Black women. Chapter 5 integrates findings

across all three studies, discusses implications for nursing science, research, policy, and practice, and identifies directions for future anti-racism research in cancer prevention and control.

Chapter 2: Addressing Structural Racism in Cancer Prevention and Control: A Scoping Review and Application of Public Health Critical Race Praxis

Abstract

Cancer disparities persist among Black Americans (i.e., descendants of enslaved Africans and African immigrants), with disproportionate rates of cancer morbidity and mortality linked to structural racism. Despite extensive research into health disparities in cancer, race-based inequities remain entrenched. Social determinant of equity (e.g., structural racism), shapes access to social determinants of health (SDOH) such as access to education, employment, housing, and healthcare which impact cancer outcomes.

The purpose of this scoping review, therefore, was to: 1) assess the degree to which anti-racism frameworks or theories are applied in cancer prevention and control; 2) synthesize how anti-racism has been conceptualized across cancer prevention and control using Public Health Critical Race Praxis (PHCRP); and 3) suggest a new conceptual model for cancer prevention and control and strategies for application based on our synthesis. We expect the latter will better specify mechanisms of structural racism to guide systems-level interventions to optimize cancer prevention and control efforts.

Methods included PHCRP as a race conscious research framework to review cancer prevention and control literature; we used the preferred reporting items for systematic reviews and meta-analysis extension for scoping reviews (PRISMA-ScR) to document our search strategy and results. A total of 15 articles were analyzed based on the inclusion and exclusion criteria.

Findings indicate limited application of anti-racism frameworks and a conflation of racial constructs with SDOH across explanatory frameworks for cancer disparities. Structural solutions to address cancer disparities were absent in 9 of 15 studies reviewed. We recommend using critical frameworks to name and interrogate mechanisms by which structural racism and other social determinants of equity shape SDOH and influence cancer disparities. Doing so pushes researchers to explicitly examine the role and measurement of structural racism in cancer research to produce points for systems interventions to mitigate inequities in cancer prevention and control. This approach is vital for advancing cancer equity and enhancing quality of life and well-being for marginalized communities.

INTRODUCTION

While cancer is the second leading cause of death overall and the leading cause among individuals under 85 years in the U.S.,[1] irrespective of race, the burden of disease and mortality is not equitably shared. Despite moderate reductions in race-based cancer disparities resulting from cancer prevention and control efforts,[16] Black Americans (i.e., descendants of enslaved Africans and African immigrants) continue to experience a disproportionate burden of cancer incidence and lower survival rates.[17] Consequently, cancer prevention and control remain critical public health priorities for U.S. Black adults. Approximately 1 in 3 Black men and women will be diagnosed with cancer in their lifetime,[3] with the risk of death from colorectal, breast, and cervical cancer being 40 to 50% higher than for U.S. white adults.[3] Prevention efforts like cancer screening significantly reduce risk of cancer death,[18] yet these efforts have only moderately decreased racial differences in cancer incidence and mortality.[16] Given that these differences in cancer outcomes are preventable, they are therefore classified as cancer disparities.[19]

The persistence of cancer disparities among Black adults reflects deep social injustices that shape and perpetuate structural barriers to quality, timely, and acceptable cancer care.[20] We therefore call for naming racial disparities in cancer as racial cancer inequities when stemming from historic and contemporary manifestations of social injustice. While research on the social determinants of health (SDOH) and disparities in cancer outcomes spans decades, many studies fail to name them as cancer inequities, let alone explicitly examine racism as a fundamental driver of inequities.[21] Racism operates across multiple levels, including discrimination (i.e., differential treatment based on race), institutional (i.e., racially inequitable policies and practices within institutions), structural (i.e., interconnected societal systems that collectively reinforce racial inequities), and systemic (i.e., social, political, and economic systems that maintain racial hierarchy).[22] These forms of racism may co-occur or be experienced simultaneously as intersecting forms of oppression.[7] For clarity, we focus on and refer to structural racism as the totality of ways that laws, institutional policies, social practices, and culture act and interact to systematically reduce collective power, thereby limiting opportunities and access to resources for racialized groups (including ethnic groups) targeted and marginalized by white supremacy.[7,8] Of note, other groups are also marginalized by white supremacy (e.g., women, LGBTQ+ people, people with disabilities, blue collar and essential workers, veterans) given its entanglement with capitalism and the consolidation of land and labor to support the latter in the U.S. context. Structural racism and other systems of oppression (i.e., sexism, racism, agism, "isms"), collectively conceptualized as social determinants of equity,[7] pattern differential exposure to detrimental SDOH including environmental and social conditions that diminish health and well-being among Black and other communities of

color.[9,10] Dismantling structural racism, therefore, is a key strategy for reducing racial and ethnic cancer inequities as well as advancing health equity overall.[11,12]

Despite a long history of racism in health care policy,[23] there has been a lack of naming and interrogating how structural racism impacts cancer outcomes.[20] Color-blind racial ideology (i.e., ignoring race and the impacts of racism);[24] rejects the idea of white supremacy and promotes the belief that racial differences should be ignored to "promote equality."[24,25] Racial color-blind approaches obscure the role of structural racism and perpetuate inequities in health and health outcomes.[24] Therefore, it is essential to utilize race conscious, anti-racism frameworks to identify and elucidate how structural racism contributes to health disparities in cancer to advance health equity and address disparities in cancer.[20]

We define anti-racism frameworks as highly adaptable guides for researchers and practitioners to acknowledge the primacy of racism, contextualize the impact of racialization over time, specific to the communities most impacted, and specify mechanisms by which racism is operationalized. Public Health Critical Race Praxis (PHCRP) is an example of an anti-racism framework that can guide the critical examination of how structural racism impacts health and health outcomes.[15] For example, Doll and colleagues applied PHCRP as an anti-racism framework to understand how structural racism has shaped the experiences of Black women with endometrial cancer as well as critically examine the research evidence base guiding cancer care.[26] Because structural racism is embedded into the fabric of American society and minimized by colorblind practices, it can be hard to identify and/or dismissed.[20] Critical approaches that guide the processes of explicitly naming and identifying the role it plays in cancer health outcomes are imperative to disrupt the perpetuation of such norms, practices, and systems.

It is also important to note that we used the Healthy People 2030 conceptualization of SDOH to categorize the studies. Healthy People 2030 defines SDOH as the environmental and social conditions that influence health, function, and quality of life outcomes (i.e., where people are born, live, learn, work, play, worship, and age).[27] Healthy People 2030 organizes the SDOH across five key domains: economic stability, education access, healthcare access, neighborhood/built environment, and social and community context.[27]

The purpose of this review, therefore, was to: 1) assess the degree to which anti-racism frameworks or theories are applied in cancer prevention and control; 2) synthesize how anti-racism has been conceptualized across cancer prevention and control using PHCRP; and 3) suggest a new conceptual model for cancer prevention and control and strategies for application based on our

synthesis. We expect the latter will better specify mechanisms of structural racism to guide systems-level interventions to optimize cancer prevention and control efforts.

METHODS

Guiding Framework

Public Health Critical Race Praxis (PHCRP) was applied as a methodological framework to bring a race conscious lens to this scoping review,[15] guiding our critical evaluation of how anti-racism principles are being applied to advance health equity in cancer prevention and control. The PHCRP is organized within four focuses: (1) *Contemporary Patterns of Racial Relations*, (2) *Knowledge Production*, (3) *Conceptualization and Measurement*, and (4) *Action*. PHCRP can be layered across any type of process or practice to answer the question "how is racism operating here?" [15]

Review Approach

For this scoping review, we applied the PHCRP to conceptualization and design (e.g., specifying research questions and search terms), data collection and analyses (e.g., article extraction, coding, and interpretation of data), and data dissemination (e.g., contextualizing and framing of introduction, discussion, and recommendations) (Figure 1) for the critique of published literature on cancer prevention and control frameworks. Our review of this literature was guided by the overarching question, "How do cancer prevention and control frameworks incorporate structural racism to understand inequities across the cancer continuum?" We used PHCRP principles to identify additional questions, which guided data extraction and coding (Table 1). Specifically, we asked the following questions: 1) "How are SDOH described?"; 2) "How is structural racism defined and linked to SDOH?"; 3) "Are anti-racism framework or theories applied?"; 4) "Are mechanisms of structural racism explicitly specified; and 5) "Are structural solutions proposed?". Finally, we structured our discussion of review findings by the PHCRP focuses to contextualize and explicitly discuss the role of racism in generating evidence guiding the development of cancer prevention and control frameworks and ultimately individual, community, and health systems-level interventions.

Search Strategy

Using preferred reporting items for systematic reviews and meta-analysis extensions for scoping reviews (PRISMA-ScR) guidelines, data were sourced from three scientific databases, PubMed, Cumulative Index to Nursing & Allied Health (CINAHL), and Web of Science. These databases are extensively used in health sciences and social science fields. The search query included the following key

words: SDOH, cancer prevention and control, neoplasms, health disparities, anti-racism, social justice, critical race theory (CRT), and PHCRP in the title or abstract. The search queries were tailored specifically to each database with the help of the University of Washington School of Nursing librarian, to include medical subject headings (MESH terms) for the PubMed and subject headings for CINAHL databases. MESH terms serve as a controlled thesaurus vocabulary, it groups synonyms, eliminates ambiguity, and provides an organized structure to include broad and more specific sub-terms within the term.

Inclusion Criteria

Included articles described research conducted in the U.S. and were written in English, theoretical or empirical in nature, focused on studies that linked SDOH or structural racism to cancer outcomes, and included an anti-racism focus. Additionally, included articles were published between the years 2000 through 2024, as it is represents a pivotal paradigm at the turn of the millennium, characterized by the formal transition from a fragmented 'web of causation' toward an integrated ecosocial framework.[28] This era marks the period in which health science research moved beyond biomedical individualism to embrace the concept of embodiment, acknowledging the inextricable and ongoing intermingling of social and biological processes.[28] This timeline captures the era in which structural mechanisms, specifically racism, were systematically analyzed as the "spiders" responsible for generating distinct population health inequities.

RESULTS

A search of key words returned 413 total articles (Figure 2). Initial screening involved the resolution of duplicates (n=89). Next, abstracts were reviewed based on the inclusion criteria. A total of 269 articles were excluded because they did not include populations of interest (n=73), did not have a cancer outcome (n=36), or did not name or describe structural racism (n=160). An additional 39 articles were excluded because they did not name or describe anti-racism. A total of 15 articles were reviewed for this scoping review.

Characteristics describing the articles included in this scoping review are: year of publication, cancer type, point on the cancer continuum (i.e., prevention, screening, diagnosis, survivorship, and treatment), SDOH addressed, type (e.g., level) of racism described, anti-racism framework or theory applied, and structural solution(s) identified (Table 2). Most of the anti-racism and cancer research was conducted between the years 2021 through 2024, except for two studies, where the findings were published in the early 2000s.[29,30] Cancer type includes counts for each type of cancer studied within the 15 studies. The most common cancer type studies were breast (n = 11)[29,31-40] and lung (n = 6),[32-36,41]

followed by cervical (n=4)[29,31,37,38] and colorectal cancer (n = 4),[29,31,37,38] prostate cancer (n = 3),[29,31,42] other cancers (e.g., sarcoma, lymphoma, and thoracic),[38] and one study that included all cancers.[43] For point on the cancer continuum, diagnosis and treatment were the most common areas studied (n = 8),[31-36,38,41] followed by cancer screening (n = 4).[37,39,42,44] Three studies focused on the entire cancer continuum.[29,30,43]

Table 3 summarizes reviewed articles by SDOH addressed, type of racism described, anti-racism framework or theory used, and structural solution identified. In this section, we synthesize the evidence and interpretation of these major themes.

Conceptualizations of SDOH

Among the studies reviewed, economic stability (n = 6)[29,30,38,39,42,44] and health care access (n = 6)[32-36,41] were the most frequently identified domains. Neighborhood and built environment were another important domain identified (n = 2).[37,43] Only one study provided a clear multi-domain description for increased burden of cancer and poor cancer outcomes, in alignment with Healthy People 2030.[31] SDOH were inconsistently defined and applied; most studies referenced factors related to racial-ethnic disparities[30,32-36,38,41] and health disparities.[29,37,43] [33,37,38] Few studies used standardized SDOH frameworks (e.g., Healthy People 2030). Four studies conceptualized SDOH as being associated with structural racism.[31,39,42,44] Studies lacked clarity in differentiating upstream determinants (e.g., structural racism) from intermediary conditions (e.g., SDOH). One study misconstrued SDOH as a form of racism,[36] while three studies used SDOH as a proxy term for health disparities. These inconsistencies reveal a lack of conceptual clarity and highlight the need to distinguish between structural determinants like structural racism and the conditions they shape like SDOH.[45]

Conceptualizations of Racism

Racism was evaluated using levels of racism—discrimination, institutional, structural, and systemic.[5,22] Institutional racism was the most common type of racism level described (n = 6),[30-32,34-36] followed by discrimination (n =3),[29,38,42] structural racism (n = 3),[33,37,43] and systemic racism (n =1).[41] In two studies, the level of racism was not specified, resulting in vague or underdeveloped conceptualizations of understanding how racism may operate to impact cancer outcomes.[39,44] Though eight studies explicitly named structural racism as the root cause of health disparities,[29,30,33,37,39,41,43,46] these studies failed to consistently define the level of racism and describe the role racism plays in cancer

prevention and control services. This gap underscores the need for anti-racism frameworks for consistency and conceptual rigor in understanding and identifying mechanisms of structural racism.

Structural Solutions to Address SDOH and Racism in Cancer Prevention and Control

Structural solutions aim to transform the upstream conditions and systems such as laws, policies, institutional practices, and cultural norms that create and sustain health inequities.[47] In this review six of the fifteen studies (40%) identified and described structural solutions to address SDOH and/or racism.[32-36,41] These included multi-level, system-based interventions focused on transparency and accountability in cancer care, most notably the Accountability for Cancer Care through Undoing Racism and Equity (ACCURE) model. The ACCURE model was used in five of the included studies; the intervention targeted institutional processes within cancer care systems to eliminate racial disparities in treatment completion by embedding race-explicit reporting and data accountability mechanisms. In contrast, one study, Freeman (2005) described a federal policy-level intervention, the Patient Navigator Outreach and Chronic Disease Prevention Act of 2005, which was designed to increase access to cancer screening and treatment services through the use of trained patient navigators.[29] Despite a disciplinary call to action to address structural racism and cancer[20] most studies did not propose or describe structural solutions,[30,31,34,37-39,42-44] highlighting and ongoing gap in translating anti-racism research into concrete systems-level changes.

Anti-racism Frameworks or Theories

Seven of the fifteen studies applied anti-racism frameworks or theories to guide their research.[32-38,41] One study employed PHCRP to critically examine how racialization and racism influences cancer screening practices.[37] Another study applied the Critical Race Theory (CRT) tenant of "Dominant Cultural Orientation Privilege and Discrimination", as an interpretive framework to analyze disparities in patient-centered care.[38] Five studies evaluating a systems-level intervention in healthcare settings were grounded in the Undoing Racism Framework, developed by the People's Institute for Survival and Beyond, which emphasizes community accountability, transparency, and the dismantling of structural barriers to equitable care.[32-36] While eight studies claimed to focus on anti-racism, they did not apply any theoretical or conceptual frameworks grounded in anti-racism. Finally, there was no framework that applied an anti-racism framework or principles across the cancer continuum.

We expand on these review findings, therefore, by applying PHCRP to a selected cancer prevention and control framework to offer a multilevel conceptualization of how to address structural

racism and other social determinants of equity and SDOH across the cancer continuum (Table 4). We selected the Neighborhoods and the Cancer Continuum framework by Gomez et al.[48] for adaptation because it integrates two key domains of SDOH (social and community context and neighborhood and built environment) demonstrating how these conditions shape cancer outcomes across the cancer continuum.[48] We therefore propose an adapted Anti-Racism in Cancer Prevention and Control (ARCPC) framework (Figure 3) and set of guiding questions (Table 5) to advance anti-racism research to mitigate health disparities in cancer, allowing for the exploration of context-specific mechanisms of inequity for intervention at multiple levels. This adapted framework calls for cancer researchers to engage in disciplinary self-critique to rethink established conceptualizations and interventions to make room for alternative mental models and approaches.

Guiding questions were also embedded within the ARCPC framework to facilitate deeper inquiry and advance critical examination of how racism structures cancer prevention, screening, diagnosis, treatment, and survivorship. The framework first calls for the assessment of racial hierarchies, guided by the question: "How are people racialized in the context of cancer prevention and control?" The second domain prompts interrogation of the role of racism through the question: "How does racism operate as a driver of cancer-related access to care?" The third domain encourages conceptualization of new data and metrics by asking: "How do current data and measures capture mechanisms and impacts of racism and other forms of marginalization across cancer prevention and control?" Finally, the framework calls for action through the question: "How are we partnering with racially marginalized communities to measure and evaluate the experience and impact of racism and other forms of oppression on cancer outcomes?"

DISCUSSION

The purpose of this review, therefore, was to: 1) assess the degree to which anti-racism frameworks or theories are applied in cancer prevention and control; 2) synthesize how anti-racism has been conceptualized across cancer prevention and control using PHCRP; and 3) suggest a new conceptual model for cancer prevention and control and strategies for application based on our synthesis. We expect the latter will better specify mechanisms of structural racism to guide systems-level interventions to optimize cancer prevention and control efforts. Structural racism is a broad and complex social determinant of equity that necessitates conceptual clarity and a shared understanding of its specification, particularly in addressing the various ways it is experienced and impacts health. The use

of anti-racism frameworks is essential to explicitly define, contextualize, and operationalize these levels of racism.[15] However, our findings demonstrate that most studies did not use anti-racism frameworks or theories, resulting in inconsistent conceptualization and limited ability to identify mechanisms through which structural racism shapes cancer outcomes.

PHCRP offers such a framework. We used each PHCRP focus to structure the discussion of our review findings and critique of how cancer prevention and control frameworks conceptualize and operationalize SDOH and racism.

Focus 1: Contemporary Patterns of Racial Relations

Our findings reinforce the importance of situating cancer prevention and control within the historical and contemporary patterns of racial relations that shape health inequities. Although many studies acknowledged racial disparities in cancer outcomes, few explicitly contextualized these disparities within the broader structural and historical forces that produce them. This lack of contextualization reflects a larger issue of conceptual ambiguity to identify the mechanism through which structural racism operates across the cancer continuum. A race conscious approach is recommended to interrogate how historical and contemporary systems of power shape access to resources, exposures, and outcomes in cancer prevention and control.

Focus 2: Knowledge Production

Focus 2 highlights how the social construction of knowledge influences the ways in which structural racism and SDOH are defined and studied. Our findings revealed that many studies did not employ anti-racism frameworks, increasing the risk of reproducing conceptual ambiguity and reinforcing deficit-based narratives. Inconsistent definitions of SDOH, including conflation with health disparities or misclassification as racism—reflects a lack of attention to how knowledge is constructed with disciplinary norms. PHCRP emphasizes the need for critical and reflexive methodologies that interrogate these assumptions. By integrating critical frameworks, researchers can clarify key constructs, distinguish between structural determinants of equity (e.g., structural racism) and intermediary determinants (e.g., SDOH), and ensure that the research processes do not obscure the root causes of inequities.

Focus 3: Conceptualization and Measurement

Focus 3 emphasizes the importance of clearly defining racism-related constructs and specifying their relationship to SDOH. Our scoping review identified substantial variability in how SDOH and racism were conceptualized, including inconsistent specification of racism across levels (interpersonal,

institutional, structural, systemic) and frequent conflation between SDOH and health disparities. Although several studies identified structural racism as the root cause of inequities, few specified how it operates or interacts with SDOH across the cancer continuum. This lack of conceptual clarity limits the ability to identify causal pathways and intervention points. PHCRP underscores the need for context specific conceptualization and measurement strategies that explicitly define these relationships and account for intersectionality. Strengthening conceptual clarity is essential for identifying mechanisms linking structural racism to cancer outcomes and informing effective interventions.

Focus 4: Action

The final focus centers on translating research findings into action to dismantle structural racism and advance health equity. Our finding revealed that few studies proposed structural solutions, highlighting a critical gap between identifying disparities and implementing systems level change. Existing interventions, such as ACCURE, utilized within healthcare systems, demonstrate the potential for addressing institutional processes that contribute to inequities. However, the limited number of studies proposing structural solutions draws attention to the need for frameworks that guide the development of upstream interventions targeting policies, institutional practices, and social conditions. By employing critical frameworks such as PHCRP, researchers can move beyond descriptive analyses to generate actionable insights that address the structural determinants of health disparities in cancer.

The conceptual model proposed in this study represents one approach to operationalizing this focus. Integrating PHCRP across the cancer continuum, strengthens methodological rigor by embedding a race-conscious lens throughout the cancer research process. This model supports the identification of points where structural racism shapes cancer risk, prevention, screening, diagnosis, treatment, survivorship, and mortality outcomes. By linking social determinants of equity to SDOH and cancer outcomes, the model encourages the design of interventions that target upstream determinants of health. Embedding PHCRP into cancer prevention and control research can therefore strengthen the translation of evidence into equity focused strategies to address persistent racial disparities in cancer outcomes.

The guiding questions embedded within the ARCPC framework are intended to move the field beyond descriptive inequities, to elucidate the mechanisms that structure these inequities to advance cancer care and research. For example, asking how populations are racialized within cancer prevention research shifts attention from individual behavior to the sociopolitical processes that shape risk, access, and representation. Similarly, interrogating how racism operates across intersecting identities

recognizes that cancer inequities are produced through overlapping systems of oppression that differentially shape exposure, vulnerability, and access to care. Encouraging conceptualization of new measures and use of data is critical to address structural racism along the cancer continuum because it is entrenched within societal systems and manifests differently across communities. New multidimensional metrics are vital to capture upstream systemic drivers.

Limitations

Several limitations should be considered when interpreting the findings of this review. First, relevant studies may have been excluded due to the intentionally focused inclusion criteria, which prioritized studies that explicitly referenced anti-racism within the context of cancer prevention and control. Although this approach strengthened the specificity of the review, it may have omitted studies that implicitly examined structural racism or related constructs without explicitly naming an anti-racism framework. Second, the reviews focus on cancer prevention and control may have limited the breadth of evidence considered, as research examining structural racism and anti-racism approaches in other areas of cancer care, including treatment and survivorship, as well as other health conditions, may have offered additional insights relevant to understanding and addressing structural racism across the cancer continuum. Third, the integration of both the PRISMA-ScR methodology and PHCRP may have presented challenges in maintaining methodological coherence across all stages of the review. While PRISMA-ScR provided a systematic approach for identifying and synthesizing literature, PHCRP required a reflexive and interpretive analytic lens to critically examine how racism was conceptualized and operationalized across studies. Fourth, despite deliberate efforts to apply a race-conscious analytical perspective, interpretive bias may still have influenced the synthesis of the literature. PHCRP emphasizes reflexivity in the research process, yet the interpretation of complex constructs such as structural racism and racialization inherently involves analytic judgment. Finally, this review did not include a formal appraisal of the methodological rigor of each study's research design or analytic approach. Although the review focused on conceptualization and framework application rather than methodological quality, future work could benefit from a more detailed assessment of study design, measurement strategies, and analytic methods used to investigate structural racism in cancer research. Together, these limitations highlight the need for greater conceptual clarity, methodological consistency, and transparency in the application of anti-racism frameworks within cancer prevention and control research.

Conclusion

This review demonstrates how PHCRP can be applied to critically examine and expand cancer prevention and control frameworks by providing a structured, reflexive, and race-conscious methodology. Our findings revealed key gaps in the literature, including inconsistent conceptualization of SDOH, inadequate specification of racism across levels, limited application of anti-racism frameworks, and a lack of structural solutions to address health disparities in cancer.

PHCRP addresses these gaps by offering a framework to explicitly define and interrogate mechanisms through which structural racism operates, distinguish between social determinants of equity and SDOH, and guide the development of equity focused interventions.

As structural racism remains deeply entrenched within social, political, and healthcare systems in the United States, advancing equity in cancer prevention and control requires research approaches that move beyond description to mechanism and action. Integrating anti-racism frameworks such as PHCRP into cancer prevention and control research can improve conceptual clarity, strengthen methodological rigor, and support the development of systems level interventions aimed at dismantling structural inequities and improving cancer outcomes.

Figure 1. Application of Public Health Critical Race Praxis to the scoping review

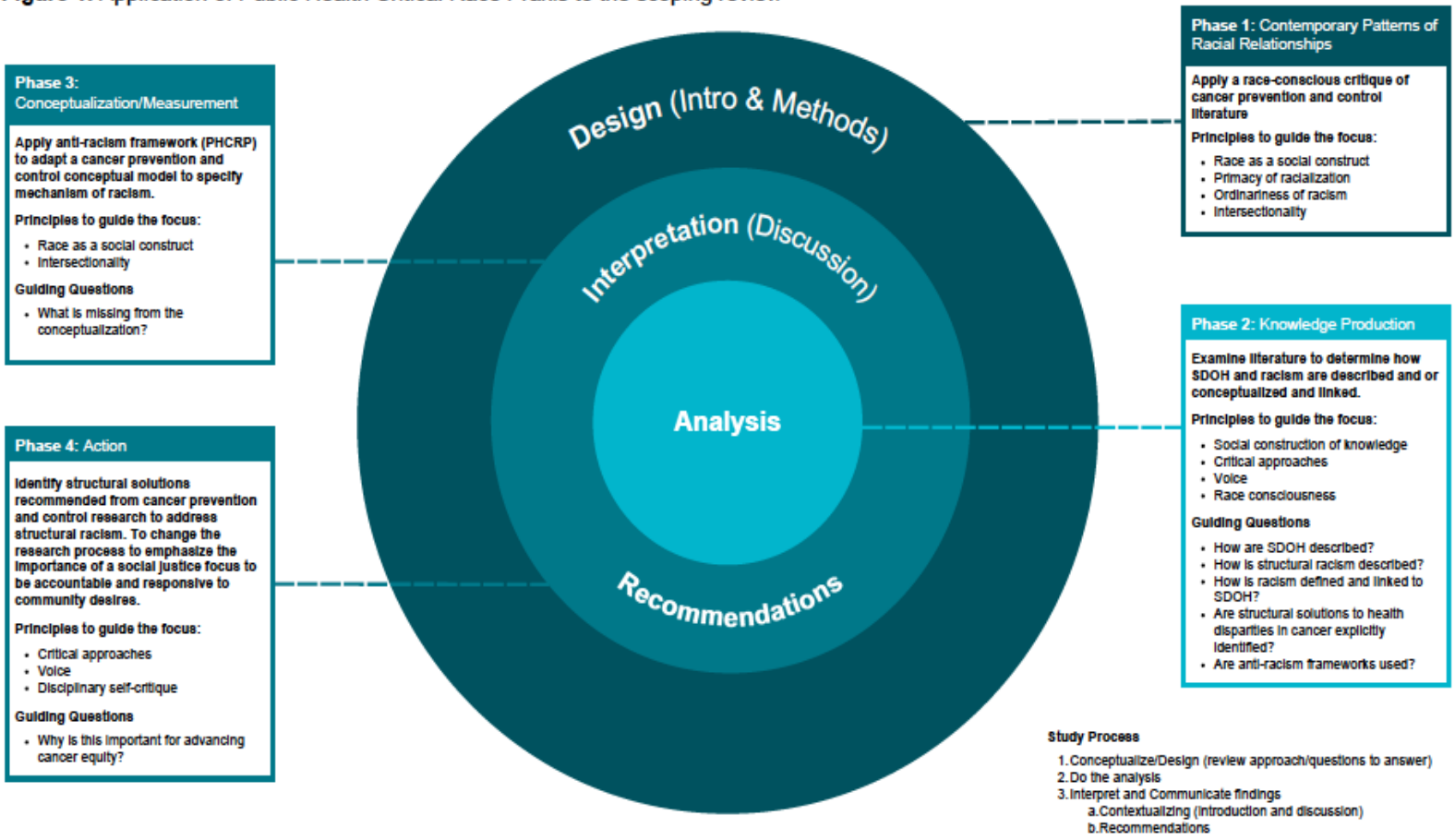


Table 1. Application of Public Health Critical Race Praxis (PHCRP) Focus 2 Principles to Critically Examine Selected Cancer Prevention and Control (CPC) Published Evidence.

Principle(s)	**Definitions**	**Conventional Approach**	**PHCRP Approach**	**Guiding Questions**	**Relevance**
Social Construction of Knowledge	Established knowledge within a discipline can be reevaluated using antiracism modes of analysis	The hierarchy of knowledge generation is not interrogated; hidden power differentials and limitations of conventional research processes are not evaluated. <u>CPC Example</u>: SDOH and neighborhood level factors are described without examining how disciplinary norms or researcher positionality shape these descriptions.	Researchers apply anti-racism principles to interrogate how structural racism may shape, limit, or reinforce CPC efforts (i.e., through researcher biases or disciplinary conventions). Dominant paradigms are challenged to prevent the reproduction of inequities.	How are SDOH described? How is structural racism defined and linked to SDOH?	Clarifies whether CPC literature defines and contextualizes SDOH and racism in ways that expose mechanisms of inequity guiding more precise intervention strategies.
Critical approaches	The deliberate exploration of bias (i.e., personal and or cultural norms) to reveal hidden dynamics.	Little or no attention is given to understand how researcher bias, prejudice or dominate cultural norms may perpetuate inequities. Frameworks are treated as universal not	Researchers actively reflect their own positionality, interrogate cultural norms, and examine how disciplinary bias shapes the research process. Reflection is embedded across study design data	Are anti-racism frameworks or theories applied? Are mechanisms of structural racism explicitly specified?	Ensures CPC frameworks are adapted to revel and disrupt mechanisms of structural racism, improving the precision and equity focus of research.

Principle(s)	Definitions	Conventional Approach	PHCRP Approach	Guiding Questions	Relevance
		examined through an anti-racism lens. CPC Example: Few studies apply anti-racism frameworks or theories to evaluate the role of structural racism in cancer disparities research.	interpretation and recommendations.	Are structural solutions proposed?	
Voice	Prioritizing the perspectives of marginalized populations and privileging the experiential knowledge of "outsiders within".	Conventional methodologies are often academic or institutional perspectives with limited interrogation of lived experience of those most impacted. CPC Example: Community engagement, if present, is often peripheral or consultative rather than fully integrated.	Researchers employ full community based participatory research (CBPR) or other equitable engagement approaches centering the problem, interpretation, and actions steps on the perspectives of impacted communities.	Why is this important for promoting equity in cancer prevention and control? How are community voices incorporated? Do marginalized perspectives inform study aims, measure, and interpretations? Is community-identified action prioritized?	Ensures CPC research is equity promoting by embedding community perspectives into every stage, from framing to implementation, and trust is built with community for sustainable change.

Figure 2. PRISMA Screening Process Diagram.

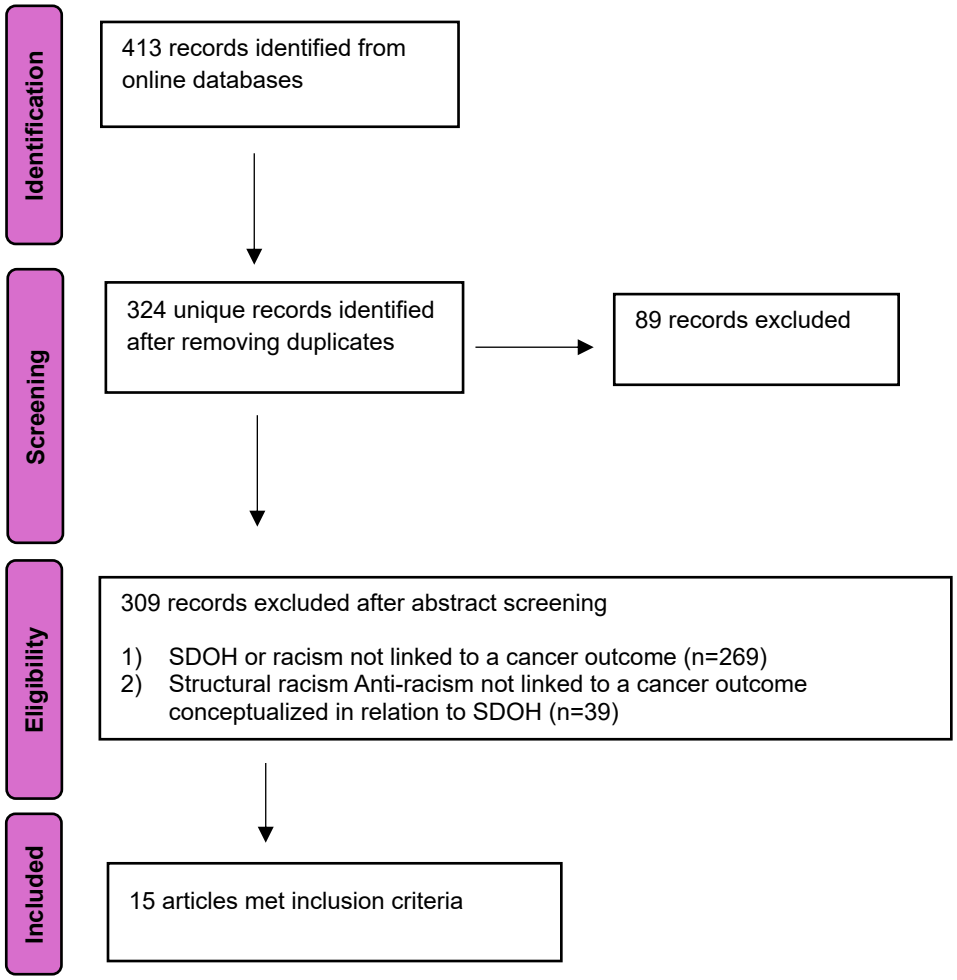


Table 2. Study Characteristics

Study Characteristics	N (%) of Studies	Citations
Cancer Type		
Breast	2 (13)	30,39
Lung	1 (6.67)	41
Prostate	1	42
Oral	1	44
Breast, Cervical, Prostate, Colorectal	2	29,31
Breast, Cervical, Colorectal	1	37
Breast, Cervical, Colorectal, Lymphoma, Thoracic, Sarcoma	1	38
Breast and Lung	5 (33.3)	32-36
All	1	43
Year of Publication		
2000 through 2010	2 (13)	29,30
2010 through 2020	0	
2020 through 2024	13 (87)	31-39,41-44
Point on Cancer Continuum		
Screening	4 (26.6)	37,39,42,44
Diagnosis & Treatment	8 (53.3)	31-36,38,41
Survivorship		
Continuum (across all points)	3 (20)	29,30,43

Table 3. Summary and Major Themes in Cancer Prevention and Control Literature 2000 – 2024.

Summary and major themes in cancer prevention and control literature 2000 through 2024		
	N (%) of Studies	Citations
SDOH Described		
Economic Stability	6 (40)	29,30,38,39,42,44
Education Access and Quality		
Healthcare Access and Quality	6 (40)	32-36,41
Neighborhood and Built Environment	3 (13.3)	37,43
Social and Community Context		
Type of racism included in cancer prevention and control		
Discrimination	3 (20)	29,38,42
Institutional	6 (40)	30-32,34-36
Structural	3 (20)	33,37,43
Systemic	1 (6.67)	41
Unspecified (type of racism not described – racism)	2 (13.3)	39,44
Anti-racism Frameworks or Theory used		
Public Health Critical Race Praxis	1 (6.67)	37
Critical Race Theory	1 (6.67)	38
Undoing Racism	5 (33.3)	32-34,36,41
No Anti-racism framework used	8 (53.3)	29-31,39,42-44
Structural Solutions Identified		
Institutional Level Intervention Accountability for Cancer Care through Undoing Racism and Equity (ACCURE)	5 (33.3)	32-34,36,41
Policy Level Intervention Patient Navigator Outreach and Chronic Disease Act 2005	1 (6.67)	29
No structural solutions identified	9 (60)	30,31,35,37-39,42-44

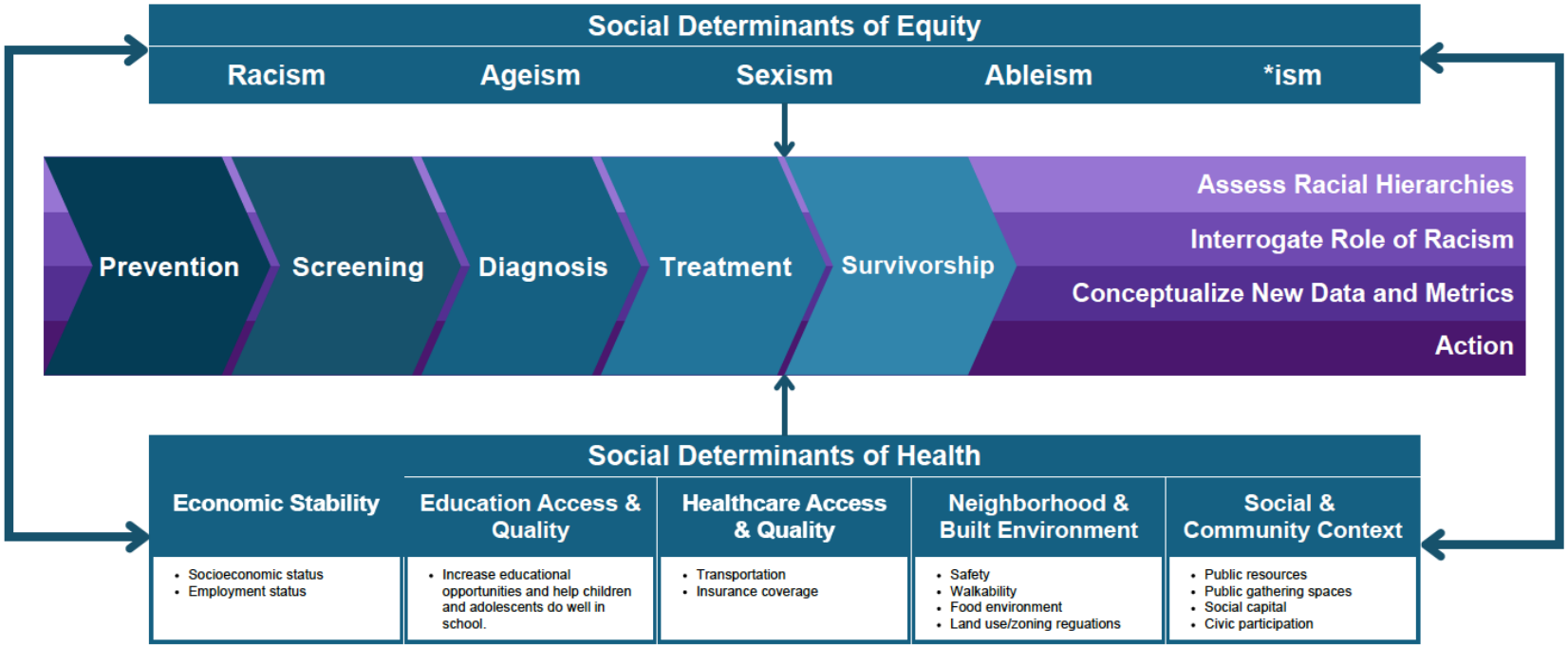
Table 4. Comparison of a Conventional Cancer Prevention and Control Framework vs. Anti-Racism in Cancer Prevention and Control (ARCPC) Framework

Focus	Defining a Process	Affiliated Principles	Gomez et al.[48] Approach (Conventional)	ARCPC Approach
1. **Assess Racial Hierarchies**	Recognizes that racism in embedded into the fabric of society and reinforced through racial stratification. Establishes a race-conscious lens to identify how racism operates to perpetuate health disparities.	*Race Consciousness* *Ordinariness of racism* *Race as a social construct* *Primacy of racialization* *Structural determinism*	Centers SDOH (social and built environment) without explicitly addressing racism as the fundamental cause of health disparities in cancer. Examines factors like residential segregation, racial/ethnic density, and neighborhood socioeconomic status, and healthcare access, but without linking them to structural barriers such as racism.	Centers racism and other forms of oppression as central drivers of disparities. Guides teams to explicitly identify how racism operates in cancer prevention and control and develop shared, definitions. **Guiding Questions:** How are people racialized in the context of cancer prevention and control? How has the process of racialization informed research and practice.
2. **Interrogate Role of Racism**	Identifies and critiques racial bias- both visible and hidden within research processes and professional disciplines (i.e., nursing, medicine, etc.). Acknowledges power dynamics and centers the perspectives of communities most impacted.	*Race as a social construct* *Social construction of knowledge* *Intersectionality* *Disciplinary self-critique* *Voice* *Critical Approaches*	Focus on SDOH influences without interrogating racial bias in scientific knowledge production. Research design and interpretation remain under the control of the academic team; community input may or may not be incorporated.	Acknowledges the pervasiveness of racism and challenges the assumption of scientific objectivity. Guides researchers to identify bias within themselves, their disciplines, and their methods. Elevates community priorities, critiques Eurocentric paradigms, and fosters equitable academic-community partnerships to avoid reinforcing deficit narratives. **Guiding Questions:** How does racism operate as a driver of cancer-related access to care? How might this differ across other social identities?

Table 4. Comparison of a Conventional Cancer Prevention and Control Framework vs. Anti-Racism in Cancer Prevention and Control (ARCPC) Framework				
Focus	Defining a Process	Affiliated Principles	Gomez et al.[48] Approach (Conventional)	ARCPC Approach
3. **Conceptualize New Data and Metrics**	Contextualize the relationships between key racism-related constructs and cancer disparities. Uses insights to inform data collection, measurement, analysis, and recommendations.	*Race consciousness* *Ordinariness of racism* *Race as a social construct* *Structural determinism* *Critical approaches*	Uses race/ethnicity without critically examining context, which can mask racism. Often conflates structural racism with SDOH or omits explicit definitions, leading to incomplete or biased conceptualizations and understanding of the complex connections between racism, SDOH, and health disparities in cancer.	Treats race as a social, not a biologic construct. Promotes a critical evaluation of data, measures, and methods. Establishes clear conceptual links between key racism related constructs (e.g., racism and SDOH). Findings inform interventions and solutions for structural changes across the cancer continuum. **Guiding Questions:** How do current data and measures capture mechanisms and impacts of racism and other forms of marginalization across cancer screening and control? What additional or new data or measures are needed?
4. **Action**	Ensure findings are accessible to communities and include the community priorities and recommendations for interventions and structural solutions.	*Critical approaches* *Voice*	Disseminates findings primarily within academic or policy circles. Interventions may be implemented without prioritizing sustainability or the community's vision for change.	Centers narratives and decision making of the community. Ensures equitable partnerships, transparent sharing of information, and co-development of sustainable solutions. **Guiding Questions:** How are we partnering with racially marginalized communities to measure and evaluate

Table 4. Comparison of a Conventional Cancer Prevention and Control Framework vs. Anti-Racism in Cancer Prevention and Control (ARCPC) Framework				
Focus	Defining a Process	Affiliated Principles	Gomez et al.[48] Approach (Conventional)	ARCPC Approach
				the experience and impact of racism and other forms of oppression on cancer outcomes?

Figure 3. Anti-Racism in Cancer Prevention and Control (ARCPC) Framework.



*We acknowledge and give space to the multiples axes of social oppression grounded in white supremacy, imperialism, and racial capitalism.

**We explicitly center the role of racialization and racism within the U.S. context as these processes inform the patterning of the social determinants of health (SDOH) based on phenotype as well as other characteristics ascribed to race regardless of tribal identity or country of origin. We also acknowledge that the drivers of racialization and racism also structure other dimensions of social oppression based on the ability to take and hold property as well as labor which is tied to reproductive status and physical ability.

Table 5. Guiding Questions for Application of the Anti-Racism in Cancer Prevention and Control (ARCPC) Framework.

Framework Domain	Purpose	Guiding Questions
Assess Racial Hierarchies	Examine racialized assumptions embedded in research and practice	How are people racialized in the context of cancer prevention and control? How has the process of racialization informed research and practice.
Interrogate Role of Racism	Identify mechanisms through which racism shapes access and outcomes	How does racism operate as a driver of cancer-related access to care? How might this differ across other social identities?
Conceptualize New Data and Metrics	Expand measurement approaches	How do current data and measures capture mechanisms and impacts of racism and other forms of marginalization across cancer screening and control? What additional or new data or measures are needed?
Action	Advance accountability and community partnerships	How are we partnering with racially marginalized communities to measure and evaluate the experience and impact of racism and other forms of oppression on cancer outcomes?

Chapter 3: Centering Community Knowledge: A Comparative Document Analysis of Community-Generated Reports on Black Health and Well-Being Using Public Health Critical Race Praxis

ABSTRACT

Background: Persistent inequities in health among Black Americans are well documented across nearly every major health indicator, including cancer incidence and mortality, maternal mortality, chronic disease, mental health, and life expectancy. Although an expanding body of literature identifies structural racism as a fundamental cause of these inequities, most evidence informing public health research and policy is derived from investigator-driven studies and administrative datasets that often privilege researcher defined priorities while marginalizing community-generated knowledge. Public Health Critical Race Praxis (PHCRP) argues that understanding structural racism requires examining not only what knowledge is produced, but also whose knowledge is recognized as legitimate. Community-generated reports represent an underutilized source of evidence that can expand prevailing understandings of structural racism, health, and pathways towards equity.

Purpose: To examine how community-generated reports conceptualize structural racism, define Black health, center community knowledge, and identify solutions towards advancing health and equity, using Public Health Critical Race Praxis as the guiding analytic framework.

Methods: A comparative qualitative document analysis was conducted using five publicly available community-generated reports focused on Black health and structural conditions that influence health. Reports were purposefully selected based on their focus on Black communities or examination of structural conditions relevant to Black health, use of community-engaged strategies, and inclusion of recommendation for structural solutions. Reflexive thematic analysis was integrated with Public Health Critical Race Praxis (PHCRP) to identify recurring conceptual patterns across reports.

Results: Four interrelated themes emerged. First, structural racism was consistently conceptualized as an interconnected system of historically rooted policies that shape access to economic, political, environmental, and social resources necessary for well-being and addressing racial inequities. Second, health was defined as a holistic and collective well-being produced through equitable structural conditions. Third, community-generated knowledge challenged dominant deficit-oriented narratives by positioning lived experience and community expertise as legitimate forms of evidence for understanding structural inequities. Finally, reports consistently identified structural accountability, community

investment, and redistribution of power and resources as essential mechanisms for advancing health equity.

Conclusion: While academic research identifies structural racism as a primary driver of health inequities, this study demonstrates that community-generated reports offer a vital, distinct body of knowledge. Rather than identifying new determinants, these reports reframe existing ones by revealing complex systemic relationships, holistic meanings of health, and alternative forms of expertise often invisible to conventional research. Ultimately, this knowledge challenges these epistemological hierarchies and offers critical recommendations for structural change.

INTRODUCTION

Persistent inequities in health among Black Americans remains one of the most enduring public health challenges in the United States. Black communities experience disproportionately higher rates of chronic disease, adverse maternal outcomes, premature mortality, mental health and cancer incidence and mortality.[5,6,8,49] While these inequities are frequently attributed to exposure to detrimental social determinants such as lower income, education, and access to housing and healthcare, an expanding body of scholarship argues that structural racism functions as the fundamental cause that shapes the distribution of these determinants across the life course.[5,50-52] Structural racism operates across social, economic, political, and institutional systems to collectively produce and maintain racial inequities in exposure to detrimental social determinants of health and the outcomes they produce.[21,53-55]

Consequently, research has increasingly shifted from documenting health disparities toward understanding the structural conditions that produce and perpetuate them, including structural racism. However, considerable variations remain in how structural racism is conceptualized and measured.[49] While these approaches have generated valuable evidence, much of the existing literature emphasizes deficits and disparities while overlooking community assets and alternative conceptualizations of health and well-being. What is currently known about racial health inequities has predominately been derived from investigator driven studies using traditional academic and scientific Western conceptualizations, methods, and data produced from these privileged researcher defined outcomes and priorities.[56] This research is treated as the primary form of trusted evidence for decision making, dismissing and or negating other forms of knowledge.[56] As a result, of these approaches, important dimensions of how Black Americans are adversely affected by structural racism may be overlooked. This limitation of conventional knowledge production highlights the importance and need of including community

knowledge.[15,57] Valuing and centering community knowledge is a critical strategy to understand these conditions and identify solutions to achieve health equity.[15,57] Community-generated reports that focus on Black communities can provide an important yet understudied source of evidence for understanding structural racism and Black health.[56] Collectively, these reports represent an alternative form of knowledge production that may elucidate strategies for advancing health equity for Black communities.

Public Health Critical Race Praxis (PHCRP) offers a framework for addressing limits of traditional research by explicitly examining how racism shapes knowledge production.[15] PHCRP challenges researchers to critically examine whose voices are represented in health research and whose perspectives remain marginalized.[15] Central to PHCRP is the principle of voice, which elevates the expertise of impacted communities and recognizes them as legitimate communities as producers of knowledge.[15] Applying PHCRP to community-generated reports transforms them into action-oriented evidence. By examining these documents collectively, we challenge institutional hierarchies of evidence and uncover community informed strategies for structural change that traditional academic narratives often overlook.[56]

Despite their potential to inform structural approaches to health equity, these reports have rarely been examined collectively to understand how they conceptualize structural racism, define health, and articulate strategies for improving health outcomes. The study addresses this gap by conducting a comparative qualitative documents analysis of community-generated reports focused on Black health and well-being through the analytic lens of PHCRP. Specifically, this study synthesized recurring themes across diverse community-generated reports to examine conceptualizations of how structural racism is understood, health and well-being is defined, how community knowledge is centered, and what structural solutions are proposed for advancing equity. This study seeks to advance understanding of how community driven knowledge contributes to academic conceptualizations of structural determinants of health to inform and advance future health equity research and practice.

METHODS

Study Design

This study employed a comparative qualitative document analysis to examine how community-generated reports conceptualize structural racism, Black health, and solutions for advancing health equity. Documents analysis is a rigorous qualitative methodology that systematically examines written materials as a source of empirical evidence and is particularly well suited for synthesizing policy

documents, organizational reports, and community-generated publications.[58,59] Unlike traditional literature reviews, document analysis enables researchers to investigate how concepts are constructed across diverse sources while identifying shared patterns, convergence, and divergence in meaning.[58]

Theoretical Framework

PHCRP served as both the conceptual framework and interpretive lens guiding this study. Developed by Ford and Airhihenbuwa, PHCRP extends Critical Race Theory into public health by providing a framework for examining how racism shapes both health outcomes and the production of scientific knowledge.[15] PHCRP emphasizes that research is not value-neutral and encourages researchers to critically examine how power, historical context, racialization, and institutional structures influence what is recognized as legitimate evidence. The present study was primarily informed by the PHCRP focus on k*nowledge production*, which calls attention to whose knowledge is represented in health research and whose perspectives remain marginalized.

Report Selection

Purposeful sampling was used to identify publicly available community-generated reports that conceptualized Black health or examined structural conditions relevant to Black health. Reports were eligible for inclusion if they: (1) focused primarily on Black Americans or examined structural conditions directly relevant to Black health; (2) incorporated community-engaged, participatory, or community-informed research methods; (3) examined structural determinants influencing health and well-being; (4) included original data, community narratives, policy analysis, or community-generated recommendations; and 5) were publicly available in English. Reports were excluded if they were: academic research or healthcare specific.

To ensure breadth and methodological rigor, we developed a search strategy with a health science librarian, recognizing that traditional academic databases often underrepresent literature from civil rights organizations, philanthropic foundations, and community-led research. To identify such community-generated reports reflecting the inclusion criteria described, a systematic search for "grey literature" was conducted primarily using Google. Search terms included combinations of: "community-engaged" or "community-led reports" focused on "Black communities", "structural barriers", "Black Health or Well-Being". When reports were identified that met inclusion criteria, search strategy included identifying similar reports. Additionally, targeted searches were performed within the digital libraries for organizational reports (e.g., National Urban League, Annie E. Casey Foundation). A total of six reports

were identified, five reports met the inclusion criteria: *Black Census Project Executive Summary,*[60] *State of Black America 2025,*[61] *Black Well-Being Report,*[62] *Measuring Access to Opportunity in the United States,*[63] *and the Healthy Neighborhood Research Study*.[64] One report, the Well Us Study was excluded because it was specifically limited to Black Americans interaction with the healthcare industry and medical preferences.[65] Collectively, these reports represented national, regional, and local perspectives and provided complementary forms of community-generated evidence (Table 1).

Data Analysis

Rapid Group Analysis Process

Data were analyzed using the Rapid Group Analysis Process (Rap-GAP), a novel rapid qualitative data analysis method designed to be more efficient than traditional approaches, while maintaining rigor.[66] Rap-GAP is characterized by its use of virtual collaborative tools to distribute analytic work across multiple researchers, promote collaborative interpretation, and create a transparent process for synthesis of data to final reporting.[66] The method consists of five core steps: (1) plan and prepare, (2) engage with data individually, (3) engage with data as a group, (4) review and collate learnings, (5) summarize findings.[66] Rap-GAP was appropriate for this study because the analysis required a structured examination of multiple community-generated reports using theoretically informed questions while paying attention to language, priorities, and knowledge represented in the documents. The method also provided a systematic process for integrating two independent coders' interpretations through repeated discussion, calibration, and collaborative synthesis. This study included two coders who led the analysis. We want to acknowledge our positionality with respect to racialized identity and lived experience as it relates to interpretations, as our positions are shaped by our individual journeys including research experience, disciplinary perspectives, and relationship to the topic (e.g., oppression, racism, and white supremacy). STP identifies as a Black woman with experiences leading community-led and mixed methods research. CF is an Asian American researcher, with in depth experience in health equity and Public Health Critical Race Praxis. The analytic process was conducted virtually using Microsoft Excel for data organization, coding, and synthesis.

The first step involved establishing the analytic structure, preparing coding materials, and defining the questions that would guide the analysis. The codebook was developed deductively using PHCRP and the Rap-GAP template structure describe by Hsu et al.[66] PHCRP provided the guiding framework for examining how the reports conceptualized structural racism, define Black health, center

community knowledge, and identify solutions towards advancing health and equity. Four analytic domains were established to guide the analysis: (1) Structural Racism; (2) Health Priorities of Black Communities; (3) Positionality and Context; and (4) Community Strengths and Solutions. Each domain was aligned with one or more PHCRP foci and included specific research questions to structure the review of each report (Table 2). Coders met to review research questions, community-generated reports, analysis plan, code book, and calibration plan.

The coders then met regularly to establish calibration; once a shared approach was established, coders independently reviewed and coded the community-generated reports. Findings for each coder were synthesized into a summary statement for each question in the domains with a supporting quote. Coders did not meet as a group to engage with data; however, coders did meet as needed to discuss the ongoing coding process. Once coding of the five community-generated reports was complete, one coder collated the documents and synthesized findings into a single summary for each question within each domain. Once this process was complete, coders met to discuss interpretations, supporting evidence, and meaning of context. To conclude, the lead coder (STP) synthesized the domain findings into overarching themes following the completion of the secondary analysis (Table 4). This process identified recurring themes that aligned with the PHCRP domains. By focusing on Knowledge Production, the final synthesis situated the community reports within existing literature while highlighting novel perspectives.

SUMMARY OF REPORTS

Characteristics of Community-Generated Reports

The reports varied in geographic scope, methodological approach, and intended audiences, while representing a rich body of community-generated knowledge focused on understanding structural conditions influencing Black health and well-being. The *Black Census Project* documented the priorities of more than 181,000 Black Americans across the United States, providing one of the largest community-generated datasets since the Reconstruction era to highlight that economic instability and low wages are the most urgent concerns for Black communities.[60] The *State of Black America* 2025 report, entitled "State of Emergency", sounded the alarm on a coordinated "war on woke" and the systematic dismantling of voting rights and diversity, equity, and inclusion (DEI) initiatives.[61] The *Black Well-Being Report* centered perspectives of Black Washingtonians through community-engaged research, aiming to reframe the narrative for adverse outcomes being due to structural barriers and provide community identified solutions for health, prosperity, and safety in Washington state.[62] *Measuring Access to*

Opportunity in the United States utilized the Supplemental Poverty Measure (SPM) to analyze the fluctuations in child poverty between 2021 to 2024, demonstrating that government policy interventions such as tax credits and food assistance are essential to reducing poverty rates in every state.[63] Finally, the *Healthy Neighborhoods Research Study* examined neighborhood investment, equitable development, and community wealth-building strategies in nine Massachusetts communities and long-term consequences of structural divestment such as redlining and racial inequity.[64]

Although the reports differed in purpose, methods, and scale, they shared several defining characteristics. They demonstrated consistency in how structural determinants of health were conceptualized. Across reports, inequities were attributed to interconnected systems of policy, institutional practices, and historical divestment rather than individual behaviors or other deficits. Each report incorporated some level of community-engaged perspective. Community-engaged research is categorized by the degree which the community is involved in the research process.[67] This spectrum ranges from simply informing the community about the research, to shared leadership, where community initiates and owns the research.[67] The *Black Well-Being Report* is exemplar for shared leadership models, Black-led organizations intentionally documenting community perspectives, narratives, and solutions for change.[62] All five reports identified structural strategies for advancing health equity through policy, systems change, and community investment.

Comparative thematic analysis identified four interrelated conceptual themes that characterize how community-generated knowledge expands prevailing understandings of structural racism and Black health: (1) structural racism operates as interconnected systems shaping opportunities for health and well-being; (2) Health is understood as holistic collective well-being produced through equitable conditions; (3) community-generated knowledge challenges deficit-oriented narratives by centering lived experiences, strengths, and collective agency; and (4) Achieving health equity requires structural accountability, policy change, community investment, and redistribution of power. These themes collectively describe a framework for understanding health equity.

Theme 1: Structural Racism Is an Interconnected System That Shapes Opportunities for Health and Well-Being

Across all five reports structural racism was conceptualized as an interconnected system of historic and contemporary policies and practices that limit or prohibit access to the conditions necessary for health. The reports consistently described structural racism as operating across mutually reinforcing

systems of housing, education, employment, civic participation, and healthcare. Historical policies were repeatedly identified as foundational mechanism through which contemporary inequities are reproduced. Reports referenced slavery, Jim Crow laws, redlining, residential segregation, as structural practices that continue to shape neighborhood conditions, economic opportunity, educational quality, and political influence. Historical events were used to give context to enduring systems that continue to shape access to resources and opportunities. The culminating effect of these interacting systems was limiting opportunities to thrive.

The *Healthy Neighborhoods Research Study* illustrated how historical divestment and residential segregation have produced persistent neighborhood inequities that influence transportation, housing quality, employment opportunities, environmental conditions, and community wealth. Similarly, the *Black Well-Being Report* emphasized that inequities observed by Black Washingtonians reflect generations of structural exclusion that continue to influence daily life.

Economic opportunity emerged as one of the most consistently identified structural determinants across reports. The *Black Census Project* documented low wages, financial insecurity, affordable housing, and wealth building among the highest priorities among Black Americans nationwide. Respondents linked financial instability to broader systems of political representation and educational opportunity.

Likewise, the *State of Black America* framed contemporary efforts to weaken voting rights protections and dismantle DEI initiatives as extensions of structural racism that threaten the political mechanisms necessary to address inequities across other systems. Civic participation was therefore conceptualized as a structural determinant of health because political representation influences resource allocation, enactment of public policy, and protection of civil rights.

Theme 2: Health is Conceptualized as Holistic and Collective Well-Being Produced Through Equitable Structural Conditions

The reports unify around a paradigm shift that defines health as holistic well-being encompassing physical, mental, emotional, spiritual, and community well-being rather than merely the absence of disease. Health was consistently conceptualized as a multidimensional state that is cultivated through equitable social, political, economic, and environmental conditions. A recurring description within this domain was that health is a natural result of safe, well-resourced environments characterized as stable housing, meaningful employment, quality education, political voice, and safe neighborhoods.

The Black Well-Being Report most explicitly articulated this perspective by reframing health as the ability of individuals and communities to flourish within environments designed to support human dignity, belonging, and opportunity. The report challenged deficit-oriented narratives by emphasizing joy, healing, cultural identity, and collective resilience as essential dimensions of health and overcoming structural barriers. Similarly, the Healthy Neighborhoods Research Study demonstrated the importance of investing in neighborhood infrastructure because environments which people live, work, and raise families influence health. The Measuring Access to Opportunity in United States report further reinforces this conceptualization by highlighting the impact government policies (i.e., tax credit) have on child poverty and economic stability. More importantly, healthcare itself occupied a relatively modest role within the reports. While clinical care was recognized as important, it was not sufficient to eliminate inequities if broader structural conditions remained unchanged.

Theme 3: Community-Generated Knowledge Challenges Deficit-Oriented Narratives by Centering Lived Experiences, Strengths, and Community Expertise

Community-generated reports challenge dominant epistemologies by positioning lived experience as legitimate evidence for understanding structural racism. The reports consistently position Black Americans as the experts, also centering narratives around the communities most impacted by inequities. Disparities are contextualized through a historic and contemporary lens to highlight have the have been shaped over time and community engaged approaches are used to address the power dynamic of traditional research approaches. The community-generated reports recognized that individuals living within systems of structural inequity possess unique understanding often not fully captured through conventional research. Across all five reports community knowledge was portrayed as action oriented and informed structural solutions.

The Black Well-Being Report explicitly centered community voice by framing Black Washingtonians as the authors of their own narratives. Community knowledge was grounded in lived experience, cultural traditions, historical memory, and collective aspirations for future generations. The Black Census Project demonstrated the power of large-scale community engagement by documenting priorities identified directly by more than 181,000 Black Americans. Respondents articulated concerns extending well beyond healthcare, emphasizing wages, affordable housing, education, neighborhood safety, political representation, and economic opportunity as fundamental determinants of well-being. Historical context also emerged as an important component of community knowledge. Reports consistently situated contemporary inequities within histories of racial exclusion, emphasizing that

present-day disparities cannot be understood without acknowledging historical processes that continue to shape opportunities across generations. Collective memory therefore functioned as a legitimate source of evidence that contextualized contemporary patterns of inequity. A recurring theme among the reports is community members already possess the brilliance to architect their own futures. Therefore, structural remediation must involve shifting decision making authority and funding directly into communities experiencing systemic marginalization.

Theme 4: Achieving health equity requires structural accountability, policy change, community investment, and redistribution of power

The final theme concerned how the reports envisioned solutions towards advancing equity and well-being. Solutions identified across the reports extended beyond healthcare access. Instead, advancing equity and well-being called for coordinated policy reforms, institutional accountability, equitable resource allocation, community investment and sustained efforts to dismantle structural barriers that perpetuate racial inequities. Policy was identified as the primary mechanism through which structural inequities are either maintained or dismantled. Across the reports, it was consistently emphasized that laws governing education, housing, employment, voting participation, and civil rights, shape the conditions under which communities experience health. Improving health requires multisectoral policy levers aimed at dismantling systems that perpetuate inequities.

The Measuring Access to Opportunity in the United States report illustrated the substantial impact of government investments on reducing child poverty, demonstrating that economic inequities are neither inevitable nor immutable but are responsive to deliberate policy decisions. Similarly, the Healthy Neighborhoods Research Study emphasized equitable neighborhood development, affordable housing, community wealth-building, and transit-oriented investment as structural interventions capable of improving population health over time.

A distinguishing feature across reports was the emphasis on redistributing decision-making authority to Black communities themselves. Rather than advocating for greater consultation alone, reports consistently called for sustained investment in community leadership, Black-led organizations, and resident-driven planning processes. The Black Well-Being Report argued that communities already possess the knowledge necessary to develop effective solutions and therefore require resources, institutional support, and political authority to implement those solutions.

The State of Black America similarly emphasized the preservation of civil rights protections, democratic participation, and voting rights as prerequisites for achieving health equity. Political power was viewed as essential because communities cannot influence the structural conditions affecting health without meaningful participation in policy development and governance.

Across reports, accountability was framed as extending beyond symbolic commitments to equity. Institutions were encouraged to examine how organizational policies, funding decisions, and governance structures reinforce racial inequities while adopting mechanisms that shift resources and authority toward communities most affected by structural racism.

DISCUSSION

This comparative document analysis examined how community-generated reports conceptualize structural racism, Black health and well-being, community knowledge, and pathways towards advancing health and equity. Guided by PHCRP, the analysis identified four themes: (1) structural racism as an interconnected system shaping opportunities for health and well-being; (2) health as holistic and collective well-being produced through equitable structural conditions; (3) community-generated knowledge challenges deficit-oriented narratives by centering lived experiences, strengths, and community expertise; and (4) achieving health equity requires structural accountability, policy change, community investment and redistribution of power. Together these findings do not contradict the existing academic literature on structural racism and health. Rather, they extend it by demonstrating what becomes more visible when structural racism and health are examined through community-generated reports.

The central contribution of this study is that community-generated reports provide a more integrated account of structural racism than is typically available through academic evidence alone. The integrated account was illuminated by the firsthand memory, historical context, and lived experience of structural racism that has organized access to opportunity over the life course for Black communities. These systems (i.e., laws and institutional policies) were understood to be mutually reinforcing and intentionally designed to exclude Black Americans. Existing scholarship has established structural racism is a fundamental cause of racial health inequities and has documented its operation through policies related to housing, employment, education, healthcare, the environment, and political participation.[5,6,51] Increasingly, researchers have also developed measures intended to operationalize structural racism and measure its relationship to health outcomes.[40,49,50,68,69] The community-generated reports analyzed in

this study add a different dimension to the evidence base--they reveal how structural racism is experienced as interconnected conditions that collectively shape the ability of Black communities to flourish. By prioritizing reports like the *Black Census Project* or the *Black Well-Being Report* as legitimate evidence, this aligns with frameworks such as the Framework for Applied Intersectionality Research (FAIR) and PHCRP, that argues it is critical to conduct research that is community initiated or community-led for transformative action.[15,70]

The first theme, structural racism as an interconnected system shaping opportunities for health and well-being, extends current academic understandings of structural racism by demonstrating systems that connect, that are often examined separately in conventional research. Economic instability was connected to wages, housing, and education. Neighborhood conditions were connected to redlining, public investment, and community wealth. Political participation was connected to the ability to protect civil rights and influence public policy and the distribution of public resources. Academic scholarship has documented relationships between structural racism and specific structural conditions, including residential segregation, economic inequality, environmental exposure, healthcare policy and political exclusion.[21,36,51,53] This perspective illustrates that structural conditions interact and reinforce one another across time.

The second theme, holistic and collective well-being, broadens what is understood as health. Increasingly academic research has evidenced that social and structural conditions influence health outcomes and racism is a fundamental driver.[6,55] However, health research continues to operationalize health through disease outcomes, mortality, healthcare utilization, or individual-level risk factors. The community-generated reports in this study offered a broader conceptualization. Health was understood as the ability of individuals and communities to live, grow, heal, and thrive within environments characterized by safety, economic stability, opportunity, and political agency. Housing, livable wages, education, neighborhood investment, and civic participation were understood as conditions that actively produce or constrain well-being. This finding is particularly important because it redirects attention toward the structures responsible for distributing resources and opportunities unequally. While these findings seemingly mirror the social determinants of health (SDOH) framework, they divergence in how the conditions are systematically structured by structural racism, elucidating interlocking power relations.[70] The SDOH framework aims to address the conditions (e.g., transportation, housing), while the community-generated reports call for addressing the interlocking systems of power.

The reports also added a dimension of human experience that is less frequently captured in conventional structural racism health research. The Black Well-Being report connected structural racism to trauma, harm, healing, joy, and collective affirmation. This is an exemplar of resisting deficits narratives, often encountered by traditional research that does not utilize critical frameworks that center community expertise or contextualize findings within the context of power and resilience. Failing to do so often frames Black communities as the source of the problem.[70] These perspectives suggest that structural racism is also experienced through cumulative emotional and social harms. At the same time the reports resisted reducing Black communities' experiences to harm by simultaneously emphasizing resilience, strength, and the capacity to create a brighter future. This approach highlights the assets belonging to the community to overcome adversity, builds collective power and participation (i.e., collective agency of the individuals and the community), and inspires perseverance.

The third theme, reclamation of narratives, marks a key distinction between reports and academic research. Academic research has generated extensive documentation of racial disparities, but it has often centered adverse outcomes more than community strengths. The reports intentionally reframe that narrative by positioning Black communities as knowledgeable and capable of defining solutions; it represents a different perspective by centering community-defined understanding. The Black Census Project demonstrated the value of large-scale community-generated evidence in identifying priorities that conventional research may miss. The Black Well-Being further centered community defined understandings of well-being and collective wisdom. Through the lens of PHCRP, these findings highlight the perspective that how knowledge is produced shapes how problems are defined and how solutions are developed. Community participation can remain extractive when communities provide data but have limited influence over the questions asked, interpretation of findings, and recommendations for change.

The fourth theme, structural remediation through accountability, redistribution, and community investment, extends existing research by connecting the identification of structural racism to explicitly identified pathways calling for structural change. While academic scholarship increasingly calls for structural interventions, the research identifying interventions for redistributing power and resources remains less developed. The reports consistently moved from diagnosis to action and clearly emphasized that the communities most impacted should have meaningful authority in defining priorities and directing solutions.

Several limitations should be considered when interpreting these findings. First, it included five purposively selected community-generated reports. Although the reports represented diverse geographic scopes, organizations, purposes, and forms of evidence, they do not represent all community-generated knowledge concerning Black health and well-being. The findings should therefore be understood as a synthesis of recurring conceptualizations across the selected reports rather than a comprehensive account of all Black communities or community-generated research. Second, the reports were publicly available documents and therefore reflected the perspectives and priorities of the organizations that produced them. They may also have been shaped by advocacy goals, funding environments, and intended audiences. These characteristics do not diminish their value as evidence, but they do reflect the contexts in which community knowledge is produced. Despite the limitations, the consistency of the findings across independently developed reports suggest that community-generated knowledge is meaningful and an underutilized source of evidence for understanding structural racism and Black health.

CONCLUSION

Prior to this study, academic research had established structural racism as a fundamental cause of racial health inequities and documented its operation through policies and institutions affecting housing, education, employment, healthcare, the environment, and political participation. However, less was known about what becomes visible when community-generated reports are examined collectively as a distinct body of knowledge. This study shows that community-generated knowledge adds important dimensions to current understanding. The contribution of this study is not the discovery of new determinants, but the demonstration that community-generated knowledge changes how existing determinants are understood. It reveals relationships among systems, meanings of health, forms of expertise, and pathways toward change that are less visible in academic and institutional evidence alone. Through the lens of PHCRP, community-generated reports emerge as more than supplemental sources of information. They are important knowledge products that challenge assumptions about whose evidence counts.

Table 1. Community-Generated Reports

Report	Purpose	Data Source & Community Engagement	Primary Focus	Region	Contribution to Black Health	Inclusion Rationale
2023 Black Census Project Executive Summary	To capture the diverse experiences of Black Americans and transform Black communities into powerful constituencies capable of influencing political power at local, state, and national levels.	National survey of Black Americans, engaging over 200,000. Methods include personal campaigns, text messaging, focus groups, and collaborations with Black influencers and local community groups.	Economics (low wages, affordable housing), gun violence, and education quality.	National	Identified the "genesis of struggles" in low wages, economic instability that correlate with affordable housing and healthcare.	Represents one of the largest community-generated datasets centering Black voices and illustrates PHCRP's emphasis on knowledge production through community expertise.
State of Black America 2025 (National Urban League)	To serve as a benchmark and source for thought leadership around racial equality, specifically, "sounding the alarm" on threats to democracy and civil rights.	Research insights from elected officials, civil rights advocates, and scholars, supported by 92 affiliates and serving 300 communities.	Inequities across economics, education, housing, criminal justice, and civic participation.	National (37 states and D.C.)	Unpacks how systemic attacks on Diversity Equity and Inclusion (DEI) and civil rights fuel oppression.	Offers a policy-oriented structural analysis that complements community-generated reports by linking measurable inequities to structural racism and institutional accountability.
Black Well-Being Report (2022)	To flip the frame and focus on structural barriers rather than just unequal outcomes, aiming to support collective organizing and inform policy change.	A statewide survey translated into 11 languages, (over 600 respondents), focus groups, and interviews.	Civic engagement, education, economic mobility, public safety and health.	Washington State	Defines health as holistic well-being (mental, physical, spiritual, emotional) and identifies structural racism as a primary barrier.	Exemplifies community-generated knowledge and aligns closely with PHCRP by centering Black voices, contextualizing racism historically and structurally, and

						emphasizing community-defined solutions
Measuring Access to Opportunity in the United States (2025 Update)	To provide a complete picture of how families are faring economically and how public policies effectively shape child poverty outcomes.	United States Census Bureau data, specifically comparing the Official Poverty Measure (OPM) with the Supplemental Poverty Measure (SPM)	The impact of economic policies (tax credits, SNAP) on child poverty rates.	National	Highlights how incorporating medical and childcare expenses into poverty metrics reveals true baseline for family well-being.	Although not exclusively focused on Black Americans, the report provides an important structural framework illustrating how neighborhood opportunity reflects systemic inequities central to understanding Black health.

Table 2. Domains and Structured Analysis guided by Public Health Critical Race Praxis (PHCRP)

Public Health Critical Race Praxis – Foci (1 to 4)	Guiding Orientation for Analysis	Domain	Questions	Coding Stage
(1) Contemporary Patterns of Racial Relations (3) Conceptualizations and Measurement	Recognizes that racism is "normal and integral to society", therefore structural racism continues to operate and evolve; a chronic consequence of historical racialization. Aids in developing deeper understanding to how structural racism is understood and experienced (i.e., operationalization).	Structural Racism	How is structural racism defined or explained (currently or historically)? What mechanisms of structural racism are described? How does structural racism "operate"? What are the impacts of structural racism on health?	Primary, Representative Quotes, Memo
(2) Knowledge Production	Involves shifting the point of discourse form the majority group's perspective to that of marginalized groups. Prioritizes experiential knowledge and seeks to understand how health is defined within the context of the community itself.	Health Priorities	How do Black communities define health? How is health assessed? What are the priorities for addressing health (criteria, values, or knowledge used in prioritization)	Primary, Representative Quotes, Memo, Secondary
(1) Contemporary Patterns of Racial Relations	Race consciousness provides opportunity to engage in critical consciousness (e.g., understanding personal biases and relationship to	Positionality and Context	Do the authors engage in reflexivity and or share positionality? (values, bias, relationship to the topic)	Primary, Representative Quotes, Memo

(2) Knowledge Production	the topic) Opens space for reflexivity, to share social positions and identify how these factors might inadvertently influence the research process and interpretation.		Do author center voice? (Describe how) Do the authors present a race conscious contextualization? What evidence do the authors cite for how health inequities are understood?	
(4) Action	Praxis is an "iterative process" where theory, research, and personal experience inform one another to create theory-informed action. Involving community in the research process to redress power imbalances and understanding the communities' priorities for enacting change.	Community Strength and Solutions	How are community strengths (e.g., acts of resistance and healing) described in the report? What structural solutions or policy changes are proposed or suggestions for accountability?	Primary, Representative Quotes, Memo, Secondary

Table 3. Example - Primary Coding Community-Generated Reports

Domain – Structural Racism						
	Structural Racism Definition	Supporting Quote	How Structural Racism "Works"	Supporting Quote	Health Impacts of Structural Racism	Supporting Quote
2023 Black Census Project Executive Summary	Structural racism is not defined or described in the report. However, the report emphasizes unjust political and civic systems that do little to address disparities housing/economic stability) among Black Americans, favoring those with wealth and privilege.	"In the last two decades, we have suffered through a major housing crisis, a recession that in Black communities and other communities of color was an economic depression, an ineffective political system that has bailed out the banks and other wealthy interests at the expense of people, and a judicial and police system that punishes Black people while letting the agents of the state get away with murder."	Because structural racism was not explicitly mentioned in this report, some extrapolation is necessary. It is evident that is the social political systems - policies: high cost of living, low paying jobs for Black people, housing, unfair political system, racist policing/criminal justice system, unfair corporations, disenfranchisement.	"Overall, the Black Census Project represents a significant effort to elevate the voices of Black Americans and ensure they are heard in political and social discourse."(pg.2)	The health impacts of structural racism are not explicitly discussed. However, it is implied that structural racism is the root cause that influence poorer outcomes in these systems and social determinants of health (housing, employment, criminal justice system) are emphasized as issues that impact Black Americans well-being. The report is written for and from a Black perspective and it is well understood that structural racism is the root cause of problems the community faces, specifically being intentionally disenfranchised from	"Participants in the focus groups explained in their own words the role of wages in their lives. They raised concerns about inflation and the rising cost of living. Even when the news and other reports show indicators suggesting the economy is strengthening, many working people have not felt the "relief." Housing, food, and transportation are expensive, and jobs do not pay well enough to catch up." (pg. 4)

					economics and opportunities.	
State of Black America 2025 (National Urban League)	Structural racism is not explicitly defined; however, it is conceptualized as a violation of civil and human rights enacted through policies and practices that oppress and restrict access to opportunities and resources.	"Almost daily, since January 20, 2025, the federal government, at the direction the White House, has set fire to policies and entire departments dedicated to protecting civil and human rights, providing access to an equal education, fair housing, safe and effective healthcare, and ensuring that our democratic process is adhered to across the nation. " (pg.7)	Structural racism is described as manifesting through institutional policies and practices embedded in our economy, justice system, educational system, workplaces and other institutions.	"After centuries of inhumane bondage, the legacies of slavery continue to haunt every corner of American Life--embedding themselves in our economy, justice system, education, and workplaces through institutionalized racism." (pg. 18)	The impacts of structural racism are layered and combined increased risk of chronic illness. Structural racism manifests as economic and housing instability, poorer education, unsafe living conditions, and access to employment, healthcare, and other opportunities.	"Hunger, unstable housing, inadequate health care, unsafe neighborhoods and other pressures undermine healthy development, school success and long-term well-being. These experiences can increase the risk of chronic illness, limit employment prospects and create lasting barriers to opportunity." (pg. 3)
Black Well-Being Report (2022)	Structural racism is systems rooted in the historical legacy of slavery and white supremacy norms, that systematically create and	"Since 1492, we've fought an uphill battle." (pg.13) "Our social systems have been centuries in the making. Although we've made progress, the rules by which our	Structural racism is intersectional and multifaceted, interconnected system of social structures, laws, institutional policies/practices, and cultural (e.g., economic,	"Those root causes operate on individual, interpersonal, community, organizational, and structural levels and	Harm and trauma that is burdensome and disproportional, detrimental to well-being and the ability to thrive. It has resulted in poorer outcomes in physical and mental	Black people continue to be disproportionately harmed.9 We felt those impacts most harshly on our physical health, jobs, housing, education,

	maintain racial inequities, structural barriers, intergenerational trauma, unequal access to power, resources, and opportunities.	social systems function are the same as they've always been — only the flavor of harm has shifted." (pg. 13)	educational, justice system, civic engagement, and health). (It has been cultivated and perpetuated through coded language that spreads hate, racial prejudice, inferiority, and fear).	function across sectors." (pg. 15)	health, employment, education, public safety, health care, political engagement, housing and overall living conditions.	and mental health — all the result of systems that have not produced well-being for us." (pg. 14)
Measuring Access to Opportunity in the United States (2025 Update)	Structural racism is not explicitly defined in this report. However, the report focuses measuring opportunity to access and addressing barriers to economic stability, through supportive public economic policies to ensure the health and well-being for children, families, and communities.	"Measuring child poverty gives us a window into children's day-to-day lives and our nation's long-term health. By tracking shifts, we can better understand the consequences of different policy decisions and economic conditions — proving that poverty levels are not simply inevitable." (pg. 3)	Inequities manifests through policies within systems (Economic, housing, justice, education, etc.) and are evident from Social Determinants of health (SDOH) or social systems such as unequal access in employment, housing, healthcare, education, justice system, and overall access to resources and opportunities.	"Schools in high-poverty areas face greater resource constraints and lower academic achievement than wealthier districts.5 Hospitals in low-income communities absorb more uncompensated care when families lack insurance.6 And neighborhoods with concentrated	Though structural racism is not explicitly named, the language of barriers to opportunity, infers systemic obstacles, bias such as structural racism. Systems that favor certain groups thus there is not equal access for upward mobility. This lack of access (data and statistics reveal poverty, unstable housing, economic instability, lower educational attainment, unsafe living environments and other conditions	"Hunger, unstable housing, inadequate health care, unsafe neighborhoods and other pressures undermine healthy development, school success and long-term well-being. These experiences can increase the risk of chronic illness, limit employment prospects and create lasting barriers to opportunity." (pg. 3)

				poverty often have more crime, weaker civic infrastructure and fewer community resources." (pg. 3)	predominately among certain racial and ethnic groups) that impact health well-being, and increased risk for chronic conditions.	
Healthy Neighborhood Research Study	Structural racism is defined as policies and practices enforced by racial bias across institutions (i.e., banks, government, real estate). This report focuses on historical practices such as redlining, that still have negative repercussions today.	"Redlining was a form of structural racism, race-based practices across multiple institutions (banks, real estate, government), that resulted in residential segregation." (pg. 13)	Structural racism is mechanized through policies and practices, specifically by race. These policies and practices shape and impact health, well-being, and health outcomes by restricting access, resources, and opportunities. This report specifically highlights how neighborhoods are shaped (historically and contemporarily) by policies and practices and either facilitate or impede health and well-being.	"Communities of color, especially at the lowest income levels, have the worst health outcomes in our society. Neighborhoods of color have the highest pollution levels; the fewest basic services, amenities, and support structures; the most limited access to fresh foods, park space, and other resources for health; and the most entrenched	Structural racism shapes individual and community health through the environments which they live, these environments often lack health promoting features (pollutants, no green spaces) and limited access to resources and opportunities (employment, accessible healthcare).	"Some neighborhoods have been well resourced and developed to have features and amenities that are proven to support good health like clean air, water and soil, quality housing, healthy food, and walkable streets. At the same time, other communities have gone decades without significant investments in development, and lack many of those same health-

				obstacles to economic and social opportunities." (pg. 8)"		promoting features." (pg. 3)

Table 4. Secondary Analysis: Cross Report Similarities, Differences, and Contributions to Academic Perspectives

Domain	Similarities Across Reports	Differences Among Reports	What Community-Generated Perspectives Add Beyond Conventional Academic Approaches
Structural Racism	Across all five reports, Black health and well-being were conceptualized as shaped by conditions beyond individual behavior and healthcare access. Economic security, housing, education, political participation, neighborhood conditions, safety, environmental conditions, and access to opportunity were interconnected with well-being.	The reports emphasized different mechanisms through which inequity is produced. The Black Census Project centered community-identified priorities and lived experiences; State of Black America emphasized civil rights, political power, and institutional accountability; the Black Well-Being Report emphasized healing, joy, resilience, and flourishing; Measuring Access to Opportunity emphasized policy mechanisms affecting economic opportunity; and the Healthy Neighborhood Research Study emphasized place, historical disinvestment, and neighborhood conditions.	They demonstrate that Black well-being includes material security, political power, safety, belonging, healing, joy, resilience, cultural connection, and collective flourishing.
	The reports consistently identified structural and institutional conditions as important drivers of racial inequity. Racism was reflected through the distribution of resources, opportunities, protections, political power, and community investment.	Structural inequity was made visible at different levels. Some reports focused on national systems and policy, while others examined state-level experiences or neighborhood-level conditions. The reports therefore varied in scale and in the specific institutions through which racial inequity was examined.	Community perspectives help reveal how abstract systems are experienced in everyday life. They connect structural conditions to lived consequences and demonstrate how policies and institutions become materially experienced in homes, neighborhoods, communities, and daily routines.
	Historical conditions were consistently relevant to understanding contemporary inequities. Present-day disparities were connected to longstanding racialized systems and decisions.	Historical analysis was more explicit in some reports than others. *The State of Black America* emphasized the relationship between racial justice, civil rights, and contemporary conditions, while the Healthy Neighborhood Research Study most directly connected historical development and disinvestment to current neighborhood conditions.	Community-generated knowledge treats history as living knowledge rather than simply background context. Collective memory and community histories help explain how past policies continue to shape present-day health, opportunity, and well-being.
	Collectively, the reports demonstrated that structural racism operates across	Each report illuminated different domains of structural inequity, including economic	The cross-report perspective provides a systems-level understanding of structural racism

	multiple interconnected domains rather than as a single exposure or isolated institutional practice.	policy, civil rights, political participation, housing, neighborhood development, transportation, environmental conditions, and community well-being.	that is difficult to capture through single-dataset or single-domain academic studies. It reveals how multiple systems interact to produce cumulative and interconnected effects on Black health and well-being.
Health Priorities	Across all five reports, health was conceptualized as extending beyond the absence of disease. Health and well-being were consistently linked to conditions (i.e., economic and housing stability) that constrain health and well-being.	Although all reports adopted broad conceptualizations of health, they prioritized different dimensions. *Black Well-Being* defined health as holistic well-being encompassing physical, mental, emotional, and spiritual flourishing. *Healthy Neighborhood Research Study* emphasized neighborhoods and the built environment as foundational to health. *Measuring Access to Opportunity* prioritized poverty, economic opportunity, and policy measures as indicators of well-being. *State of Black America* framed justice, equity, and civic inclusion as prerequisites for health. *Black Census Project* emphasized community-defined priorities, including economic security, safety, healthcare access, and political representation.	This perspective broadens health beyond biomedical outcomes to include dignity, belonging, opportunity, autonomy, justice, healing, and collective flourishing, providing a more comprehensive understanding of what constitutes health equity. Lived experience is treated as evidence not just information. Across the reports policy change to address structural inequities and reallocation of resources were consistently highlighted as priorities to address health and well-being.
Positionality and Context	Community voice and experience were important across the reports. The reports reflected priorities, experiences, and interpretations generated from or grounded in Black communities.	The forms of community knowledge differed. The Black Census Project provided direct community-generated survey data; other reports combined community perspectives with policy analysis, historical analysis, research, or secondary data.	Communities are positioned as knowledge producers rather than simply research subjects. Their experiences and interpretations help define the questions that matter, identify meaningful outcomes, and explain mechanisms of inequity that may be missed by researcher-defined measures.
	The reports linked health and well-being to power, including who makes decisions, who receives resources, and whose knowledge is recognized.	Power was examined through different domains, including voting and political representation, economic opportunity, institutional decision-making, neighborhood investment, and community control.	The reports demonstrate that health equity is fundamentally a question of power. This perspective adds an explicit analysis of decision-making, resource distribution, voice, and accountability that is often underdeveloped in conventional health research.

	The reports emphasized the importance of context and place in understanding inequity.	The geographic focus varied from national to state and neighborhood levels, allowing different dimensions of structural inequity to become visible.	Community-grounded knowledge demonstrates that structural racism is simultaneously systemic and place-based. National policies and historical systems are translated into specific conditions in particular communities and neighborhoods.
Community Strengths and Solutions	Across reports, solutions were primarily structural rather than individual. The reports emphasized policy change, institutional accountability, resource redistribution, community investment, political representation, and increased community power.	The preferred pathways to change differed. Some reports emphasized political and civil rights action, others policy reform and economic investment, while others emphasized healing, community strengths, neighborhood reinvestment, and community wealth-building.	Community perspectives redefine the question from "How can individuals change their behavior?" to "What must change in the systems and conditions that constrain health and opportunity?" This shifts responsibility for change from individuals and communities alone toward institutions and policymakers.
	Across the reports, meaningful change required more than documenting disparities. The reports emphasized action, accountability, and transformation.	The reports differed in the specific actions proposed, including policy reform, civil rights protections, economic investment, community healing, neighborhood reinvestment, and wealth-building.	Community perspectives connect knowledge production directly to action. Rather than treating research as an endpoint, the reports frame knowledge as a tool for accountability, advocacy, resource redistribution, and community-defined transformation.
	The reports recognized Black communities as possessing strengths, knowledge, agency, and capacity for collective action.	The emphasis on strengths varied. The Black Well-Being Report most explicitly centered healing, joy, resilience, and flourishing, whereas other reports focused more heavily on policy, political, economic, or neighborhood conditions.	Community-generated knowledge counters deficit-based academic representations of Black communities. It documents not only exposure to inequity but also resilience, resistance, collective action, cultural knowledge, healing practices, and community assets.

Chapter 4 Examining Associations Between State-Level Policies Indicative of Structural Racism and Receipt of Cancer Screening Among U.S. Black Women

ABSTRACT

Background

Structural racism is increasingly recognized as a fundamental driver of health inequities. However, there are relatively few studies that have examined state-level policy environments as an upstream determinant of cancer screening. This study examines associations between structural racism-related state policy environments and receipt of guideline-concordant breast, cervical, and colorectal cancer screening among U.S Black women.

Methods

Data was analyzed from the Behavioral Risk Factor Surveillance System (BRFSS) in 2014 and 2016 among Black women eligible for breast, cervical, and colorectal screening. Structural racism was measured using a state-level policy classification derived from a database of laws across 10 legal domains in 2013 that captures variation in state laws that promote or mitigate polices associated with structural racism. Logistic regression models estimated associations between harmful versus protective policy environments and cancer screening after adjusting for sociodemographic characteristics and healthcare access. Sensitivity analysis examined interactions by household income and educational attainment.

Results

Primary analyses were not statistically significant, albeit a potential association with public health significance was suggested. To explore whether the association evidenced among subgroup most likely to be impacted by the exposure, we tested for interaction by socioeconomic status (SES). Sensitivity analyses identified evidence of effect modification by SES, among low-income Black women living in harmful policy environments demonstrating reduced odds of cancer screening for breast (20.5%), cervical (23.5%), and colorectal (13.6%) relative to their counterparts in protective states in 2014.

Conclusion

Although state-level structural racism related policy environments were not statistically significantly associated with cancer screening adherence in our primary analyses, subgroup analyses suggest potential vulnerabilities among low-income Black women living in harmful policy environments. These findings highlight underscore the methodologic challenges of measuring structural racism as an

upstream determinant of cancer prevention and control while supporting the need for continued research using policy-based, intersection approaches to study racial inequities.

INTRODUCTION

Despite significant advancements in cancer detection, diagnosis, and treatment, cancer remains the second leading cause of death in the United States Black Americans (defined as people of African ancestry living in the U.S.) continue to experience profound and persistent disparities in cancer incidence, mortality, and survival across multiple cancer types compared to other racial and ethnic groups.[71,72] These inequities are especially pronounced among Black women, who bear a disproportional burden of mortality across breast,[52] cervical,[73] and colorectal cancers.[74]

Early detection through screening is a proven strategy to reduce cancer-related mortality.[75,76] However, Black Americans are consistently less likely to receive timely, guideline-concordant cancer screening, contributing to persistent disparities in outcomes.[9] While individual-level factors have been extensively studied, a robust and growing body of literature identifies structural racism as the fundamental driver of health inequities.[23] Structural racism is operationalized through interconnected systems that shape access to resources and opportunities,[6,7,9,21] such as Jim Crow laws, redlining, inequitable distribution of healthcare resources, and discriminatory institutional practices. These mechanisms create systemic barriers that constrain access to timely, high-quality preventive care.[7,21]

Structural racism also influences social determinants of health (SDOH), which includes neighborhood and social environment, education, economic stability, and healthcare access. Together these mechanisms can interact making access to cancer screening, treatment, and care exponentially difficult to navigate.[6,23] Prior research demonstrates that lack of access to preventive services results in later stage diagnosis, delays in care, and suboptimal treatment, all of which contribute to higher cancer mortality among Black populations.[6,9] Importantly, these patterns highlight that disparities are not simply the result of individual-level biologic risk factors but rather reflect the cumulative impact of structurally patterned disadvantage.

While research on cancer disparities has expanded, significant gaps remain in identifying mechanisms linking structural racism to access to preventative care.[21,69] Much of the existing literature focuses on downstream determinants (e.g., SDOH) without examining upstream mechanisms including policy environments that produce and sustain these conditions.[6,23] Addressing this gap is critical for identifying actionable policy level interventions.

Methodological challenges—including the lack of theory-driven and policy relevant measures of structural racism, have limited progress in this area.[68,69] To address this limitation, we leverage a novel measure of structural racism developed by Agenór and colleagues, which captures variation in state-level laws associated with racism across multiple policy domains.[40,68] State-level policies are especially salient because they shape institutional access to health promoting resources such as housing, employment protections, and legal safety and influence the broader context in which individuals make health decisions.[23] Polices governing housing, employment, healthcare access, and legal protections can function as mechanism that either reproduce structural racism or promote structural protections and redress.[21,23] By focusing on these upstream determinants, this study seeks to grow the body of evidence in support of anti-racist, policy-centered approaches in cancer disparities research. Findings from this research may inform efforts to refine measurement of structural racism and guide interventions aimed at dismantling policy driven inequities in cancer prevention and care.

METHODS

Data Source

This study used data from the 2014 and 2016 Behavioral Risk Factor Surveillance System (BRFSS), a nationally representative, cross-sectional survey administered annually by the Centers for Disease Control and Prevention (CDC).[77] The BRFSS collects information on health-related behaviors, chronic conditions, and use of preventive services, including cancer screening, among adults aged 18 and older across all 50 states and the District of Columbia. Surveys are administered in English and Spanish using random digit dialing of landline and cellular phones. A complex sampling design and post-stratification weights are used to ensure demographic and geographic representativeness.

Study Sample

The analytic sample included Black women 18 years or older who participated in the BRFSS in years 2014 and 2016. Participants were eligible if they identified as Black or African American, met the age specific eligibility criteria and completed the cancer screening modules. Women residing in Washington D.C. or U.S. territories were excluded because structural racism policy classification were only available for the United States. Participants with missing data were excluded from analyses.

Exposure: State-Level Structural Racism-Related Policy Environment

The exposure was state-level structural racism-related policy environment. Structural racism was measured using a policy-based measure developed by Agenór and colleagues, which catalogs a comprehensive database of state laws across 10 legal domains (e.g., voting rights, racial profiling, immigrant protections, housing, minimum wage, education discipline policies) for the years 2010-

2013.[40] Unlike proxy measures based on health disparities or neighborhood characteristics, this measure captures mechanisms of structural racism as enacted through law and policy. For this study, we used a measure developed by Jahn and colleagues that captures state policy environments that reinforce or mitigate structural racism.[68] [40,68] This measure was empirically derived using a latent class analyses that distinctly categorized states into three categories: 1) Harmful, 2) Protective, and 3) Mixed, states with a combination of both harmful and protective polices.[68] Harmful and mixed categories were combined to create a binary exposure. State classifications were linked to BRFSS participants using respondents' state of residence.

Outcomes

The primary outcomes were receipt of guideline-concordant breast, cervical, and colorectal cancer screening according to United States Preventive Services Task Force (USPSTF) screening guidelines in effect during BRFSS survey years. USPSTF is a governmentally-charged body that works to improve the health of people nationwide by making evidence-based recommendations on effective ways to prevent disease & prolong life.[78] Breast cancer screening was defined as having received a mammogram within the past 2 years among women aged 50-74 years according to USPSTF clinical screening guidelines in place the year of BRFSS data collection.[79] BRFSS items to assess receipt of a mammogram included two questions including: 1) "A mammogram is an x-ray of each breast to look for breast cancer. Have you ever had a mammogram?" and 2) "How long has it been since you had your last mammogram?"

Cervical cancer screening was defined as having, a pap test within the past 3 years for women aged 21-65 years according to USPSTF clinical screening guidelines in place the year of BRFSS data collection.[80] Cervical cancer screening was evaluated with three questions including "A Pap test is a test for cancer of the cervix. Have you ever had a Pap test?" and "How long has it been since you had your last Pap test?" among women who reported not having a prior hysterectomy.

Colorectal cancer screening was defined as having a fecal occult blood test in the past year, a sigmoidoscopy in the past 5 years, or colonoscopy in the past 10 years for women aged 50-75 years according to USPSTF clinical screening guidelines in place the year of BRFSS data collection.[81] Five questions were asked to assess colorectal screening including: 1) "A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. Have you ever had this test using a home kit?"; 2) "How long has it been since you had your last blood stool test using a home kit?"; 3) "Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. Have you ever had either of these exams?"; 4) "For a

SIGMOIDOSCOPY, a flexible tube is inserted into the rectum to look for problems. A COLONOSCOPY is similar, but uses a longer tube, and you are usually given medication through a needle in your arm to make you sleepy and told to have someone else drive you home after the test. When was your MOST RECENT exam a sigmoidoscopy or a colonoscopy?"; and 5) "How long has it been since you had your last sigmoidoscopy or colonoscopy?".

Covariates

Covariates were selected a priori based on previous literature examining cancer screening. We included these covariates because we wanted to understand whether associations between a state-level measure of structural racism were evidenced above and beyond individual circumstance (i.e., traditional demographic characteristics) as well as health care access. State-level demographic covariates were not included in models as hypothesized to lie on the causal pathway, thereby potentially subtracting from the total association between structural racism and cancer screening outcomes.

Statistical Analysis

Associations between state-level structural racism-related policy environments and receipt of cancer screening were estimated using logistic regression with cluster-robust standard errors to account for clustering of respondents within states. Survey weights were not deployed because respondents' answers were not related to age, sex, or gender. Model 1 estimated the unadjusted to associations between structural racism and receipt of cancer screening. Model 2 included additional adjustment for individual-level age, educational attainment, employment status, marital status, and household income. Model 3 was further adjusted for health care access by including health insurance coverage and having a primary provider.

Results are presented as odds ratios (OR) and 95% confidence intervals (CI), comparing women residing in harmful policy environments with those living in protective policy environments. We also conducted several sensitivity analyses to explore if associations were evident among more at-risk populations. We note that structural racism is experienced most acutely among those with limited access to health promoting resources. Therefore, we tested to determine whether associations differed according to socioeconomic status as dichotomized measures of household income and educational attainment. All analyses were conducted using R version 2025.

RESULTS

Demographic characteristics and receipt of cancer screening utilization among U.S. Black women participating in 2014 and 2016 BRFSS are presented in Table 1. In total, 21,381 women were included in 2014 and 22,828 women in 2016. Women were between the ages of 21 and 74 years per eligibility for

breast, cervical, and colorectal cancer screening guidelines. Across both survey years, most women were single, unemployed, graduated from college or technical school, reported an annual income above $50,000, and had both a primary healthcare provider and health insurance. Among women eligible for screening, most reported receiving guideline-concordant breast, cervical, and colorectal screening.

Associations between state-level structural racism-related policy environments and receipt of breast, cervical, and colorectal cancer screening are presented in Table 2. Across both survey years, findings suggested that Black women residing in states classified as having harmful policy environments consistently had lower odds of receiving breast cancer screening than women living in protective policy environments which were attenuated when accounting for individual-level demographic characteristics and health care access; however, findings were not statistically significant. No evidence of association between state policy environments and receipt of cervical cancer screening was observed. Across both survey years, odds ratios remained close to the null in all models and were also not statistically significant. Adjustment for individual level characteristics and healthcare access produced little to no changes in the estimates. For colorectal cancer screening, women residing in harmful policy environments demonstrated lower odds of screening than those living in protective states. However, these associations were attenuated when adjusted for sociodemographic characteristics and healthcare access. Primary analyses were not statistically significant, albeit a potential association with public health significance was suggested. To explore whether associations differed by socioeconomic status we conducted sensitivity analyses.

Sensitivity Analyses

Sensitivity analyses examined whether associations between structural racism-related policy environments and cancer screening differed by socioeconomic status (Table 3). Specifically, we tested for multiplicative interaction between structural racism-related policy environments and income status and education attainment. Although the primary analyses did not demonstrate any statistically significant associations, evidence of effect modification emerged for selected subgroups.

In 2014 evidence of an interaction emerged by income among low-income Black women living in harmful policy environments associated with lower odds of breast cancer screening relative to protective policy environments. An interaction by income was observed for breast cancer screening with an odds ratio of 1.42, CI 1.11 to 1.80, and p-value of 0.02. For cervical cancer screening, there was no evidence of an interaction. And for colorectal cancer screening, the odds ratio was 1.32, CI 1.06 to 1.63, and p-value 0.03. For education there was only evidence of an interaction for cervical cancer screening with an OR of 1.32, CI 1.06 to 1.64, and p-value 0.03. A similar finding for an interaction by income was

observed for breast cancer screening in 2016 only, OR of 1.54, CI 1.07 to 2.21, and a p-value of 0.04. Further findings of an interaction by SES were not replicated for cervical or colorectal cancer screening using 2016 BRFSS data. The findings from the sensitivity analyses suggest a relationship between structural racism-related policy environments and preventive cancer screening may differ across socioeconomic subgroups, with economically marginalized Black women potentially experiencing greater barriers than those with greater socioeconomic resources.

DISCUSSION

This study examined associations of state-level structural racism-related policy environments and receipt of guideline-concordant breast, cervical, and colorectal cancer screening among Black women in the U.S. Three key findings emerged. First, state-level structural racism-related policy environments were not statistically significantly associated with cancer screening. Second, though there was not statistical significance, women living in harmful policy environments demonstrated lower odds of breast and colorectal cancer screening. Third, the sensitivity analyses suggested that harmful policy environments may have greater implications for populations with lower SES. These finding contribute to an existing body of literature examining structural racism as an upstream determinate of cancer prevention, while highlighting the challenges of measuring its influence on health outcomes.

Relatively few studies have examined structural racism in relation to cancer screening,[52] however there is substantial research that has evidenced a strong linkage of structural racism to healthcare access barriers, delayed diagnosis, and poorer cancer outcomes among racially marginalized populations.[6,21,69] Majority studies operationalize structural racism using residential segregation, historical redlining and neighborhood deprivation.[50,52,82] These studies have demonstrated that structural racism influences access to healthcare resources and contributes to later-stage diagnosis, poorer outcomes, and survival.[50,52] Our findings extend this literature by evaluating a policy measure of structural racism that captures legal environments across multiple domains rather than relying on downstream proxies. The findings of the sensitivity analyses indicate lower odds of receiving breast and colorectal cancer screening among low-income Black women living in harmful policy environments, these findings are consistent with other studies that also suggest upstream influences policies related to structural racism.[21,49,50]

Our explanation for these findings is that structural racism operates through multiple connected systems that influence preventive healthcare through multiple pathways. State policy environments shape access to education, housing, employment, transportation, healthcare resources and economic

opportunity, all of which influence an individual's ability to obtain preventive services. These distal structural conditions are likely to manifest through more proximal and downstream measures. Preventive screening behaviors may be shaped by more immediate set of downstream factors (i.e., transportation, insurance hurdles, and geographic location of care) that obscure broader structural effects.[83,84] Rather than suggesting that structural racism is unrelated to cancer prevention, these findings underscore the methodological challenges of detecting upstream structural influences. However, we did try to account for that in our sensitivity analyses by exploring associations among subgroups we thought would most likely be impacted by the exposure.

Differences across cancer screening varies markedly for cervical cancer versus breast and colorectal cancers. Although breast and colorectal screening demonstrated consistently lower odds among women living in harmful policy environments, cervical screening did not. Unlike mammography and colonoscopy, cervical cancer screening can be done as part of a primary care visit without referral to specialty services or additional appointments. Also, mammography and colonoscopy require invasive procedures that may require additional time off, creating additional barriers and disrupt completion of screening once a referral is made. Consequently, upstream policy environments may exert more influence on preventive services that require more complex healthcare navigation than those already integrated into routine primary care.

Although the primary models were not statistically significant, sensitivity analyses identified important subgroup differences. In 2014, low-income Black women living in harmful policy environments had lower odds for breast (20.5%), cervical (23.5%), and colorectal (13.6%) cancer screening relative to their counterparts in protective states, with evidence of interaction by SES. These finding suggests that structural racism may differently shape preventive care access among economically marginalized Black women. These subgroup findings are consistent with intersectionality informed health disparities research that suggest structural racism often does not uniformly impact populations.[49,50] Its effects instead may be intensified where racialized disadvantage intersects with economic instability. While these subgroup findings should be interpreted cautiously, the findings provide some preliminary evidence that inform future investigations to consider how structural racism interacts with socioeconomic and influence cancer prevention.

This study contributes to cancer prevention and control research in serval important ways. First, it addresses an important area of research to examine the upstream impacts of policy environments on cancer prevention versus downstream SDOH. Second, is applies a novel policy measure of structural racism rather than relying on commonly used proxies such as residential segregation. Finally, the

inclusion of the sensitivity analyses demonstrates that structural racism may not produce uniform effects across populations but instead may disproportionately affect individuals experiencing intersecting forms of social and economic disadvantage. Together these findings support continued development of intersectional, policy-oriented approaches to understanding and addressing race-based health inequities in cancer prevention and control.

Limitations

It is important to acknowledge the limitations of this study. First, the use of logistic regression with robust standard errors could result in residual correlation at the state level and introduce some bias or imprecision with these estimates. Multilevel modeling is one statistical approach to addressing nested hierarchical clusters within states. However, we chose cluster-robust standard errors estimations because it provides valid inference under a relatively small number of state clusters while avoiding assumptions required by multilevel random effects modeling. Second, the categorical exposure variable is based on the 2013 latent class analysis by Jahn et al.,[68] which is grouped into harmful, protective, and mixed legal environments, which assumes that policy environments are stable over time. However, laws may shift, vary in enforcement, or interact in ways not fully captured by the typology. Third, the cross-sectional nature of the BRFSS data limits causal inference or longitudinal trends accurately. Fourth, though Jahn and colleagues' classification offers a novel and rigorous mechanism-based measure of structural racism, it does not account for intersectionality—the overlapping effects of race, gender, class and other axes of oppression. This is important because these identities interact simultaneously to create distinct forms of discrimination and can compound the effects of how structural racism is experienced. Finally, and perhaps most importantly, BRFSS respondents do not include more vulnerable racial and ethnic or lower SES groups among whom we would most expect associations to be demonstrated. This could explain our lack of findings.

Conclusion

This study found no statistically significant associations between state-level structural racism-related policy environments and receipt of breast, cervical, or colorectal cancer screening among U.S. Black women in the primary analyses. However, the absence of statistically significant findings should not be interpreted as evidence that structural racism is unrelated to cancer prevention. More importantly it should highlight the complexities of accurately measuring and capturing the cumulative and intersecting pathways through which structural racism shapes healthcare access across the life course. Future studies should employ longitudinal, multilevel, and intersectional analytic strategies to

accurately measure the cumulative exposures of structural racism. Researchers could also consider stratified analyses that identify subgroup vulnerabilities.

Table 1. Demographic Characteristics of US Black American Women, BRFSS, 2014 and 2016

Year	2014	2016
Black Women	N = 21,381	N = 22,828
	N (%)	N (%)
State Law Classification		
Class 2 (protective)	5,701 (27%)	6,961 (30%)
Class 1 (harmful)	15,680 (73%)	15,867 (70%)
Age, in years		
18-24	1,205 (6%)	1,335 (6%)
25-35	2,325 (11%)	2,757 (12%)
35-44	2,820 (13%)	2,988 (13%)
45-54	3,838 (18%)	3,861 (17%)
55-64	5,223 (24%)	5,185 (23%)
65+	5,970 (28%)	6,702 (29%)
Relationship Status		
Partner	6,207 (29%)	6,760 (30%)
Single	15,205 (70%)	15,897 (70%)
Unknown	149 (0.7%)	171 (0.7%)
Employment		
Employed	9,303 (44%)	10,224 (45%)
Unemployed	11,936 (56%)	12,348 (54%)
Unknown	142 (0.7%)	256 (1%)
Educational Attainment		
Graduated high school	2,659 (12%)	2,558 (11%)
Did not graduate high school	6,610 (31%)	7,381 (32%)
Graduate college or technical school	6,121 (29%)	6,377 (28%)
Attended college or technical school	5,790 (27%)	6,431 (28%)
Unknown	201 (1%)	81 (1%)
Income		
<15K	4,273 (20%)	3,917 (17%)
15 – 25K	4,602 (22%)	4,839 (21%)
25 – 35K	2,310 (11%)	2,310 (10%)
35 – 50K	2,393 (11%)	2,501 (11%)
>50K	4,503 (21%)	5,133 (22%)
Unknown	3,300 (15%)	4,128 (18%)
Health Care Provider		

Had primary care provider	16,602 (78%)	18,386 (81%)
Did not have primary care provider	2,066 (9%)	1,703 (7%)
Unknown	2,713 (13%)	2,739 (12%)
Health Insurance		
Had health care coverage	19,016 (89%)	20,769 (91%)
Did not have health care coverage	2,288 (11%)	1,965 (8.9%)
Unknown	77 (0.4%)	94 (0.4%)
Breast Cancer Screening		
Screening Eligible	15,031 (70%)	15,748 (69%)
Screened	8,392 (56%)	8,706 (55%)
Not screened	1,592 (11%)	1,576 (10%)
Unknown	5,047 (33%)	5,466 (35%)
Screening Ineligible	6,350 (30%)	7,080 (31%)
Cervical Cancer Screening		
Screening Eligible	10,356 (48%)	9,054 (40%)
Screened	8,531 (82%)	7,235 (80%)
Not screened	1,381 (13%)	1,379 (15%)
Unknown	444 (5%)	440 (5%)
Screening Ineligible	11,025 (52%)	13,774 (60%)
Colorectal Cancer Screening		
Screening Eligible	15,031(70%)	15,748 (69%)
Screened	7,105 (48%)	7,472 (47%)
Not screened	2,769 (18%)	2,663 (17%)
Missing	5,157 (34%)	5,613 (36%)
Screening Ineligible	6,350 (30%)	7,080 (31%)

Table 2. Prevalence rate ratios as estimate of association between structural racism and cancer screening.

	Model 1			**Model 2**			**Model 3**		
	OR	95% CI	p-value	OR	95% CI	p-value	OR	95% CI	p-value
2014									
Breast Cancer Screening									
State Structural Racism									
Class 2 - Most Protective	1.0			1.0			1.0		
Class 1- Most Harmful	0.82	0.62, 1.08	0.19	0.84	0.65, 1.09	0.22	0.86	0.67, 1.09	0.25
Cervical Cancer Screening									
State Structural Racism									
Class 2 – Most Protective	1.0			1.0			1.0		
Class 1- Most Harmful	0.89	0.67, 1.20	0.48	0.98	0.77, 1.24	0.85	0.99	0.75, 1.30	0.95
Colorectal Cancer Screening									
State Structural Racism									
Class 2 – Most Protective	1.0			1.0			1.0		
Class 1- Most Harmful	0.87	0.64, 1.17	0.37	0.88	0.68, 1.14	0.35	0.91	0.72, 1.16	0.49
2016									
Breast Cancer Screening									

State Structural Racism									
Class 2 - Most Protective	1.0			1.0			1.0		
Class 1- Most Harmful	0.87	0.67, 1.13	0.32	0.89	0.72, 1.11	0.33	0.96	0.79, 1.17	0.71
Cervical Cancer Screening									
State Structural Racism									
Class 2 - Most Protective	1.0			1.0			1.0		
Class 1- Most Harmful	0.98	0.84, 1.14	0.82	1.0	0.85, 1.21	0.89	1.0	0.86, 1.28	0.63
Colorectal Cancer Screening									
State Structural Racism									
Class 2 - Most Protective	1.0			1.0			1.0		
Class 1- Most Harmful	0.96	0.74, 1.24	0.77	.98	0.78, 1.22	0.85	1.0	0.83, 1.29	0.76

Table 3. Sensitivity Analyses

2014	**Breast**			**Cervical**			**Colorectal**		
	OR	95% CI	p-value	OR	95% CI	p-value	OR	95% CI	p-value
Sensitivity Analysis #1									
Education	1.03	0.79, 1.35	0.83	1.55	1.69, 2.13	0.002	1.67	1.37, 2.03	0.002
Classification	0.72	0.47, 1.12	0.19	0.81	0.59, 1.10	0.21	0.91	0.66, 1.27	0.61
Edu x Classification	1.26	0.92, 1.72	0.19	1.32	1.06, 1.64	0.03	0.98	0.76, 1.23	0.84
Sensitivity Analysis #2									
Income	1.47	1.35, 1.59	< 0.001	2.46	1.53, 3.92	0.01	1.24	1.06, 1.44	0.04
Classification	0.83	0.66, 1.05	0.15	0.97	0.78, 1.19	0.74	0.88	0.65, 1.17	0.39
Inc x Classification	1.42	1.11, 1.80	0.02	1.06	0.63, 1.76	0.84	1.32	1.06, 1.63	0.03
2016	**Breast**			**Cervical**			**Colorectal**		
	OR	95% CI	p-value	OR	95% CI	p-value	OR	95% CI	p-value
Sensitivity Analysis #1									
Education	0.89	0.62, 1.27	0.55	1.56	1.16, 2.09	0.04	1.40	1.16, 1.69	0.01
Classification	0.69	0.52, 0.92	0.04	0.93	0.68, 1.27	0.67	0.94	0.73, 1.22	0.67
Edu x Classification	1.55	1.05, 2.29	0.06	1.17	0.84, 1.64	0.39	1.13	0.89, 1.41	0.32

Sensitivity Analysis #2									
Income	1.29	0.95, 1.76	0.17	1.89	1.46, 2.44	0.006	1.59	1.27, 2.00	0.02
Classification	0.84	0.69, 1.04	0.15	1.01	0.81, 1.27	0.91	1.03	0.79, 1.34	0.85
Inc x Classification	1.54	1.07, 2.21	0.04	1.21	0.90, 1.63	0.23	1.01	0.77, 1.32	0.94

Chapter 5: Conclusion

Structural racism has increasingly been acknowledged as the root cause of health inequities in cancer prevention and control, yet there remain important challenges in how structural racism is conceptualized, examined, and addressed within cancer prevention and control. This dissertation, guided by PHCRP, examined these challenges across three aims. Aim 1 examined the conceptualization of structural racism and application of anti-racism approaches within cancer prevention and control research. The findings demonstrated the importance of using critical frameworks to structure a race conscious approach for examining and addressing structural racism. In response to this gap, the Anti-Racism in Cancer Prevention and Control (ARCPC) framework was introduced.

Aim 2 examined community-generated reports as a distinct form of knowledge production. The findings illuminated what becomes visible when other forms of knowledge are considered as legitimate forms of evidence within traditional research. The reports revealed a different perspective of structural racism, health and well-being, and recommendations for change, which is less visible in academic evidence alone.

Finally, Aim 3 contributed to this work by examining the relationship between state-level policy environments indicative of structural racism and receipt of recommended breast, cervical, and colorectal screening among Black women. The findings further demonstrate the methodological challenges and complexities of evaluating structural racism. Though the primary analysis did not identify any statistically significant findings, the sensitivity findings provided an important direction for continued investigation. The observed pattern of lower odds of cancer screening among low-income Black women is consistent with this study findings and existing literature, that structural racism may operate differently depending upon the intersecting ways by which structural racism is experienced.

Together the aims reveal that advancing anti-racism within cancer prevention and control research requires the use of critical frameworks that guide clarity in how structural racism is conceptualized and measured, and attention to whose knowledge informs the research and solutions. Most importantly, anti-racism research needs researchers committed to examining power imbalances, bias, and positionality within the research process itself. Reflexivity alone cannot eliminate bias, but critical examination of research practice can help identify how disciplinary norms and institutional structures influence what is studied, how it is studied, and whose knowledge is recognized. This dissertation reflects an interdisciplinary paradigm grounded in nursing science and public health

research, guided by PHCRP, that centers anti-racism as both an analytic and epistemological commitment. By interrogating knowledge production across multiple forms of evidence, this work advances a more equitable informed approach to cancer prevention and control.

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