Rainbows or Ribbons? Queer Black Women Searching for a Place in the Cancer Sisterhood is a chaper by LaShaune P. Johnson and Jane McElroy from the book, “Black LGBT Health in the United States: The Intersection of Race, Gender, and Sexual Orientation” (2016 Lexington Books) edited by Dr. Lourdes Dolores Follins and Dr. Jonathan M Lassiter. It is reprinted with permission.

In a darkened, smoky room in 1999, there’s a sound of soft rattling, ruffing of skirts, and panted prayers. A disembodied, guttural voice says:

“Papa Legba ouvre baye pou mwen, Ago eh!
Papa Legba Ouvre baye pou mwen,
Ouvre baye pou mwen, Papa
Pou mwen passe, Le’m tounnen map remesi Lwa yo!” (1).

The room is suddenly illuminated and begins to pulsate with thunderous and hypnotic drumming. Dancers enter the room, in a sea of red, yellow, white, and blue, representing a range of expression from old to young, from masculine to coquettish and feminine. The sudden burst of color, light, and sound leaves all in the room breathless, disoriented. The audience is on its feet. As the dizzying flurry of brightly colored dancers march across the stage, the lines between the audience and the performers, the living and dead, become blurred. In this moment, there is unlimited power and possibility; we are rapt with boundless joy and all become temporarily healed, from wounds known and unknown. It was a song dedicated to Papa Legba, the opener of doors, the shape-shifting trickster, the keeper of the gate between the living and the dead. Men and women of all ages, colors, and body sizes leave their cares at the feet of Legba, and everyday differences disappear. It is from moments like these--found in the ordinary and extraordinary--that queer cancer patients and survivors of color may find that they can draw their strength and resilience.

Legba is the spirit who holds a protective hand over those who find themselves at the crossroads, and at the intersection of the Black communities and queer (2) communities is where we begin this chapter. We are not the first theorists to reflect on the dizzying experience being queer, Black, and facing cancer. Most famously, Audre Lorde chronicled her walk at the border between life and death as a cancer patient, and her life as a member of the rarely intersecting Black communities and queer communities. While Lorde spent her life refusing to settle for highlighting one identity, she understood the complex juggling act that queer Black people have to perform to be able to live fully in all of their identities (1984). As one queer Black woman illustrated when talking about multiple social identities:

> One of the things I've been talking about is, when I go to church, my church is open and affirming so I can bring all of me there, but there's certain places you can't always bring all of you. You go here, you have to be the Black person. You go here, here you're the gay person. You go here and you're the religious person. And to be able to bring your whole self to the table… I think we were allowed to do that here. It didn't matter which part; you didn't feel like you had to check it at the door. So I do think we felt very comfortable in bringing our whole selves here where there's a lot of places you don't (McElroy, Washington, Wintemberg, Williams, & Redman, 2016).

Many queer women of color are asked to shapeshift to fit into one-dimensional settings around them, even as they simultaneously experience discrimination against those identities (Remedios & Snyder 2015). Just as Du Bois (1903) suggested in his early theorizing about "double consciousness", these conflicting allegiances "warring" inside the queer woman of color are a heavy burden to bear and are heavier during times of illness. The illness that is the focus of this chapter is cancer. T hese women's opposing allegiances are to a diverse set of communities:

Black, queer, and various cancer organizations that appear along the cancer care continuum. In this chapter we will open the gate to a new way of thinking about queer Black women on the cancer continuum of care by highlighting relevant literature about intersectionality among both Black women and queer women. We present examples from our work that underscores the cross-cutting issues facing the Black and queer communities when addressing Black women's cancer disparities. Finally, we propose ways that each of these communities (Black, queer, and cancer) can improve the experiences of queer Black women facing cancer.

Cancer Statistics for Black Women

Black women have a lower probability of developing invasive cancer, but have worse survival and higher death rates than White women when combining data from all cancer sites (American Cancer Society [ACS], 2016). According the ACS's 2016-2018 *Cancer Facts & Figures for African Americans,* the mortality rates for endometrial cancer for Black women are significantly higher than White women—1 in 108 compared to 1 in 184 (ACS, 2016). The median survival time for Black women facing endometrial cancer is also significantly shorter than that for White women (61 months vs. 121 months; Madison, Schottenfeld, Schwartz & Gruber, 2004). The rates of diagnosis are likely similar for many other cancers (i.e., breast, lung and bronchus, kidney, non-Hodgkin's lymphoma, thyroid, leukemia) among Black women. One important determinant of racial/ethnic differences in cancer survival is stage at diagnosis (Madison et al., 2004; Setiawan, Pike, Kolonel, Nomura, Goodman, & Henderson, 2007). However, Maxwell and colleagues (2008) reported racial differences in cancer survival even for women who were diagnosed at the same stage. Connell, Rotmensch, Waggoner & Mundt (1999) evaluated a large cohort of surgically staged and uniformly treated endometrial cancer patients and found that Black women had worse outcomes which traditional prognostic factors could not predict.

Researchers agree that the factors contributing to the disparities in overall survival rates in Black women are multifactorial and poorly understood (Allard & Maxwell, 2009; Connell et al., 1999; Maxwell, Tian, Risinger, Hamilton, & Barakat, 2008; Setiawan et al., 2007; Yap & Matthews, 2006). The observed racial disparity in endometrial and other cancer survival may be not only due to unevenness in stage, grade, histology, socioeconomic status, adjuvant therapy, known risk factors, and comorbidities (Cote et al., 2015), but also due to Black women's cultural and social environmental factors (ACS, 2016; Connell et al., 1999; Madison et al., 2004; Oliver at al., 2011; Randall, 2003). For example, difficulties in cross-racial patient-physician communication, differences in diet, high-risk social habits, and unique environmental stressors faced by Black women (Freeman, 2004).

Sexual and Gender Minority Women's Cancer Statistics

There is evidence that queer women face increased risk for many cancers due to higher prevalence of cancer risk factors and less access to care compared to non-queer populations (Institute of Medicine [IOM], 2011). Queer populations have the highest rates of tobacco use and excessive alcohol consumption (IOM, 2011). Lesbians and bisexual women are consistently reported to be more likely to be overweight or obese (Boehmer, 2007; Eliason et al., 2015; Struble, Lindley, Montgomery, Hardin, & Burcin, 2011). Members of the queer community have lower levels of preventive health behaviors, such as screening and access to care (Diamant, 2000). Boehmer and colleagues (2005) reported that sexual minority women face exposure to negative societal attitudes, prejudice, discrimination and stigma, and indicate that stigma, as a cultural barrier, can interfere with access to care. Two other risk factors for many chronic diseases--physical activity and dietary choices--also vary by sexual orientation (Minnis et al., 2016). Finally, queer individuals have higher stress levels compared to those outside of the queer community (McElroy et al., 2016), which may also influence cancer survival.

Queer Women's Cancer Experiences and Treatment Journeys (3)

Much of the cancer research has centered on non-queer survivors or caregivers. From the limited qualitative research in which queer participants discuss disclosing their sexual orientation and gender identity, many of the queer Black women surveyed report fears about coming out to health care providers (Kamen, Mustian, Dozier, Bowen, & Li, 2015; Woody, 2014). A 66-year-old Black woman shared her concern about selectively coming out to health care professionals,

> I don't just go into it. If it comes up, [I'll share]. I'm African American; you can see that, and a woman. But somehow things happen that comes up and I just say I'm a lesbian . . . I don't care what they say first do no harm and you're a human being first with biases. . . and who knows . . . once they find out they gonna kill me anyway. Right, so it's a double question mark [gay and Black] (Woody, 2014, p. 153).

In a small endometrial case-control study with a White sample, a pattern of feeling responsible for initiating the conversation about one's sexual orientation identity was observed (Cote, 2015). Of the 18 White queer participants, women with endometrial cancer were 1.5 times more like to be out to their doctor compared to women without endometrial cancer. However, of those that were out, 75% initiated that conversation. In another small study of White queer breast cancer survivors who opted to not have reconstructive breast surgery, all were out to their surgeon (Brown & McElroy, 2016). For several of these women, the disclosure of their queer identity helped their providers to understand the reasoning behind this surgical choice. One participant said,

> I think [provider awareness of sexual orientation and gender identity] influenced me in a positive way. Knowing that I was in a same-sex relationship with a partner whose child I was raising played into the choices I made about treatment, and they respected that. Also, my decisions regarding surgery (I had a bilateral mastectomy) seemed more in keeping with my gender identity and my surgeon got that. I was fortunate to have a surgeon who is a queer woman of color. (Brown & McElroy, 2016)

Whereas others faced difficulties when navigating the health care system. As one participant noted:

> I think [my healthcare providers] were respectful, but didn't know how to react to the decisions I made [choosing to not have reconstructive breast survey] because of my sexual identity. They discourage me in my decision and brought it up in follow-ups as a drastic move that wasn't needed! This was my Oncologist!

Boehmer and colleagues (2014) have reported some particularly useful findings for thinking about how queer women cope during the cancer continuum of care. They found that in comparison to heterosexual women, queer women reported less anxious preoccupation, hopelessness, and cognitive avoidance coping. The authors theorized that these response patterns were possibly “a reflection of skills learned in the context of exposure to minority stress, which they transferred to the cancer experience” (Boehmer et al., 2014, p. 234). While their findings seem to be more reflective of the White participants (approximately 90% of the sample), this is an idea worth exploring with queer Black women who experience a larger a matrix of oppression (Collins, 1990).

Pink Ribbon Culture

There are organized national and local communities designed to offer support, advocacy, and education to people along the cancer continuum of care. National organizations such as Susan G. Komen for the Cure (for breast cancer) or the American Cancer Society (for all cancers) offer support and educational materials for all stages of the continuum, as well as financial resources for research and community projects. In addition to being known for their educational work, these groups' fundraising endeavors provide money for research. Filling in the gaps for the mainstream organizations are specialized factions that educate and support particular subgroups of survivors. For instance, the Sisters Network, Inc. is a national organization that addresses breast cancer disparities for Black women. The LGBT Cancer Network does parallel work for the general queer community. Regardless of their focus population, most groups offer the creation of in-person and virtual support groups for patients/survivors/ caretakers, education materials for patients, survivors, caretakers, and providers, resources for finding providers, and legal information. When someone is newly diagnosed with cancer, one resource often recommended by providers are support groups which have been shown to be an effective forum for providing psychosocial support (Davison, Pennebaker, & Dickerson, 2000). However, less than 10% of patients attend support groups (Stalker, Johnson, & Cimma, 1990).

A lack of participation in support groups may be because the organizations are unwelcoming for those who are people of color, poor, and sexual and gender minorities (King, 2008; Sulik, 2011). This exclusion from mainstream cancer communities comes at a time when breast and gynecological cancer survival disparities between Black and White women are increasing (Hunt, Whitman, & Hurlbert , 2014)—in spite of medical advances and increased access to care for the previously un(der)insured (Berry et al., 2005; Danforth, 2013). In addition, many queer Black women do not find a home in national Black cancer organizations. A telephone call by one of the authors to the Linda Creed Breast Cancer Foundation, which has a robust Black support group (“Safe Circle”), revealed that its LGBTQ support group (“Rainbow Circle”) leadership was unable to provide narratives or references for women of color who were part of the Rainbow Circle (personal communication, June 28, 2016).

A more troubling telephone conversation which possibly reflects the reality for queer Black women seeking assistance occurred when one of the authors contacted the Black Women’s Health Imperative. The retired Black lesbian founder, Byllye Avery, once mentioned in an interview that she “never felt that the Black women rejected me so much as they didn't know what to do with me. By the time I got to the Black Women’s Health Project, there were several women on the planning committee who were lesbian, and one of the things we worked on was homophobia” (Correspondent, 2015). Yet, in a recent telephone call inquiring about queer Black women, the staff member remarked, “We serve Black women, not queer women". When co-author Johnson said, "Well, I'm quite sure there are queer Black women", the staff member responded by telling Johnson to call the queer cancer organizations and said, "We don't ask women that stuff" (personal communication, June 30, 2016).

A scan of two national African American cancer organizations’ (Sister Network, Inc. and Witness Project) materials reveals nothing specific to queer community health needs. In a search of the Sisters Network, Inc. national website, one can read about their general program and targeted programming for young women and teens, but there is no such program for queer women. Additionally, although websites list some of the commonly understood lifestyle and biological risks for developing breast cancer, nothing is listed about the special risks for queer populations, in spite of that information being available on the website of its primary source. (4) Scores of cancer-related websites, marathons, and other marketing campaigns flood televisions, social media, and shopping carts. One need not look far for an inspirational “cancer journey” story. Yet, finding a cancer story or blog online that reflects the social identities of queer Black women is daunting, if not impossible.

Culturally appropriate and equitable access to cancer prevention, as well as detection and treatment are important (Hunt et al., 2014), but they are only part of the story. While recent research (Giwa & Greensmith, 2012; Isoke, 2014; Petzen, 2012; Stone & Ward, 2011) has highlighted queer Black women and their outsider roles in the queer and Black communities, less is understood about how these women view, enter, and participate in the cancer care continuum. In the maelstrom of often-changing cancer screening recommendations, multi-layered tumor diagnoses, and complex treatment regimes, how and where do queer Black women find solace, information, and support during their time on the cancer continuum of care (5)?

Besides the lack of inclusion, these programs have a darker side. The events that they host are sometimes critiqued for promoting a “tyranny of cheerfulness” (King, 2008). This overarching perspective does not allow for anger (at disparities or diagnosis), questions about the causes of cancer (including debated environmental factors), and conversations about death (King, 2008). According to King, this cheerful emphasis also reduces the likelihood of addressing complicated social justice issues related to experiences and access to cancer screening, diagnosis, treatment, and survival for different classes, races, ethnicities, gender identities, and sexual orientations. The second prong of the major cancer organizations is secondary prevention through screening which allows for early detection of cancer. However, the founders of Breast Cancer Action argue that the emphasis on awareness campaigns and screenings diverts attention from the broader, social, economic, policy and environmental causes of breast cancer (King, 2008).

Faith and Black Women's Cancer Journeys

Womanist theology offers Black women the strength to cope with life's hardships and allows Black women to center their experiences in Western faith practices. Numerous studies have shown that the illness explanations, coping, and healing are linked to faith in Black communities (Mytko & Knight, 1999; Laubmeier, Zakowski, & Bair, 2004; Stroman, 2000). For example, a 2.5-year Black breast cancer survivor provided evidence of the importance of faith in coping with cancer diagnosis: "If it hadn't been for God, I couldn't cope with nothing" (Holt et al., 2009, p. 6). Among queer women of faith who have an accepting community, numerous aspects of coping with cancer can be supported through their belief system (Holt et al., 2009).

In a study of Black cancer patients and their caregivers, Sterba and colleagues (2014) found three overarching themes in the patients' and their caretakers' discussions about the role of faith in their experiences with cancer. After treatment, religiousness and spirituality played a major role in both survivors' and caregivers' lives by: "1) providing global guidance, 2) guiding illness management efforts and 3) facilitating recovery" (Sterba et al., 2014, p. 1). Faith did not immobilize or deter the believers, but provided them with the confidence that they would be healed by a higher power, often through the Christ-guided hands of their provider (Sterba et al., 2014). Womanist theology also gives Black women a way to push back against one-dimensional descriptions of them and their beliefs (i.e., all Black women are fatalistic about cancer). It gives them an opportunity in religious and broader settings to turn the "sassy Black woman" stereotype on its head (Davis, 2015). They do so with the stealth and skill acquired after generations of their voices being silenced by Black women, White men, and White women. Hotz (2014) cites the work of Mitchem (2005):

> …Attitude is a protective stance, a kind of preventive medicine against the world's cruelty.

> Both sassiness and attitude are modes of Black women’s operations in the world as independent agents…Sassiness, in other words, is not simply a disposition or a culturally specific form of expression, but also a mode of resistance that encourages agency. Sass can express itself in ways we might traditionally recognize as a form of ’attitude,’ but it also manifests as a fierce, persistent will to endure in spite of circumstances that would cause others to give up (Mitchem, 2005, cited in Hotz, 2014, p. 2217).

This sassiness and attitude can be understood from the perspective of Black women, but oppression based on sexual orientation and gender identity also provides an impetus for assuming this protective stance. This review of the literature has illustrated a severe lack of information about and support for queer Black women along the cancer continuum. Informed by these facts, the authors of this chapter created and implemented a faith-based breast cancer healthy lifestyle program for women and girls in Central Missouri that ran from 2012 to 2013.(6) The theories of intersectionality (Pastrana, 2006), Black feminism (Collins, 1986), and womanist theology (Davis, 2015; Harvey, Johnson, & Heath, 2013) provided the theoretical frameworks from which we developed the program.

Walking in the Spirit, Shouting in a Womanist Voice

This program was created in response to breast cancer disparities faced by Black women and used public health critical race (PHCR) methodology. The PHCR methodology, which is an adaptation of Critical Race Theory, allows researchers to improve the conceptualization and measurement of racism’s effects on health (Ford & Airhihenbuwa, 2010, p.1397). As an exercise of disciplinary self-critique, it calls for the contributions of those in racial and ethnic minority communities; as a result, the conceptualization of effects on health is made more robust by the theorizing of those living the experiences. The sharing of lived experiences provides depth to the theory and potentially introduces new variables into the understanding of health disparities. The program was implemented in two cities in Central Missouri and was co-designed with community members to give Black women and girls an opportunity to be empowered about their health. The symbol for the program included a dove that represented the Holy Spirit. In the Christian Bible, the dove appears during Jesus' baptism, and also plays a prominent role in the Noah flood story. The program's symbol also included a footprint, invoking both walking and the "Footprints in the Sand" poem(Zangare, 1984) that was familiar to many of the church members.

The use of the footprint was also intended to remind community members of the Bible verse: "If we live in the Spirit, let us also walk in the Spirit" (Galatians 5:25, KJV). This verse appeared on all of the materials. Understanding the Black community's sometimes troubled history with mainstream cancer organizations generally [and specifically Komen (7)], it was essential to co-create a project that would be sustainable and that felt 'true' to the community. We understood that the project had to be attendant to health literacy, ethnic diversity within the Black community, and if possible, create ties between Black community, the two authors and facilitators' university, and funding agencies.

While many in leadership positions in these close-knit Black communities understood the importance of breast cancer and had participated in "Pink Sunday" events, cancer education and prevention fell far down on the priorities list of many women. The lead author was regularly told that women did not have time for breast cancer in their lives. As suggested by secondary marginalization theory (Pastrana, 2006), at the start of the project, breast cancer felt like an issue of importance to the educated elites of the community (i.e., pastors' wives, sorority members, pink collar professionals (8)with health insurance), and a problem to be ignored by the rest of the Black community. In order not to leave any of the women behind, the authors made explicit that the project's goals were addressing disparities in the Black community by encouraging awareness and discussion; acknowledging broader social, economic, and health issues in the community (e.g., poverty, food insecurity, diabetes, heart disease, violence); and integrating faith into health outreach.

Over the span of a year, we created several events that took place at churches, health departments, and other community organizations. These events were planned with community liaisons assigned from each church. As promised to the community, all of the events had a spiritual health moment along with its physical health focus. The spiritual health moment, just like the physical health theme, had an accompanying worksheet with suggestions for spiritual exercises such as prayer, Bible study, meditation, and kind acts. The following is an excerpt from one of the spiritual health moments, which featured passages from the Biblical chapters of John and Matthew (9)and was titled: “Not your ordinary fish tale.” It begins with a summary of the story in John about Christ creating food for masses when there was very little and ends with a summary of the Sermon on the Mount. These summaries were approved by the church liaisons, and were connected to the event of the month (e.g., cooking demonstration, barbeque). The themes in the spiritual moment reflected themes found in other studies about the role of faith for African American breast cancer patients. A qualitative study by Holt and colleagues (2009) found that reliance on God for healing and the importance of prayer and scripture study were among some of the important elements for coping with cancer. These themes appear to have resonated with the community members—often, they would ask to take extra copies of the spiritual health worksheets to take home with them, for sharing with other family members and friends.

Using the PHCR methodology, our program agenda aligned to its foci in this way: Focus 1—Contemporary Patterns of Racial Relations: We had frank discussions about the history of Black community with Susan G. Komen, the history of Black community food deserts, structural racism, and others' lack of understanding of diversity within the Black community. For Focus 2—Knowledge Production, we engaged community members in critical discussions of the racism and classism of the "pink ribbon" culture. We encouraged them to find more like-minded communities that would support them as Black women. Focus 3—Conceptualization and Measurement: In thinking about how to measure success, co-author Johnson and the community liaisons discussed how to talk about breast cancer along with broader chronic health conditions in the community in order to achieve increased breast cancer screening. Johnson was encouraged by community liaisons to think about health disparities as the new Civil Rights issue, with the Black Church in the center of organizing. Focus 4—Action: During the twelve months of the project, Johnson encouraged community partners to learn grant writing skills and to look for partners to help them continue the work after the *Walking in the Spirit* grant was over.

Throughout the project, the women of the community were honest and very sassy—calling out the dietician's first cooking efforts as being "too white" because it included ingredients that were uncommon and unfamiliar in Black soul food staples; pushing against a guest speaker for her patronizing tone when speaking to a community well-versed in heart disease; and chastising Johnson for not recognizing the cultural difference between Christian denominations when setting up Zumba classes. (10) Integrated into the process from the beginning, the Black women used this program as what Patricia Hill Collins (1990, p. 114) calls a "site of resistance." The participants adapted the single-issue organization's purpose–focus on breast cancer--to meet their needs and concerns. Throughout the project, the women of *Walking in the Spirit* remained defiantly Christian, sassy, and Black. They actively participated in the project and shared the information with others, but they did it their way, making their allegiances and priorities clear. Although this program did not specifically engage queer Black women, the authors believe the basic tenets of the program would be appropriate. Specifically, co-designing the program with community members so that their needs were addressed; having frank discussion about the intersection of multiple social identities – Black, queer, cancer survivor; and lastly being responsive to community feedback would be important components for success.

The Way Forward

We began this chapter in the giddy embrace of one of the Vodun *lwa* Papa Legba, imploring him to provide us safe passage to a place in the cancer continuum of care where queer Black women can embrace their racial and queer identities. Much like the dancers in the Introduction, we breathlessly struggled to maintain our footing through a vertiginous formation of relevant literatures and of cancer- and queer-serving organizations that did not lead us to that safe place for queer Black women. While the answer was not found, the call still rings in our ears, and we leave the reader with a map for the way forward. We provided evidence about cancer in Black women and cancer risk factors in queer women, and pointed out that there is little research focusing on queer Black women impacted by cancer. In addition, no current models allow for a multilayered approach to understanding and addressing the needs of queer Black women seeking cancer care. What does a queer-friendly Black cancer education and support structure look like? How do we create that golden moment, where the gates are open to all who seek entry and healing is collective and empowering? A model might have the following elements:

- Strategically provide medically accurate and accessible information written in conjunction with members of the queer Black community.
- Lovingly embrace women of all ages, genders, sexualities, body sizes, and abilities and allow space to honor their histories and struggles.
- Critically reflect the PHCR methodology and be attuned to the broader social, economic, and political struggles facing queer Black women and their families.
- Constantly challenge mainstream cancer culture and demand respect for queer Black women's "sass" and gender nonconforming ways of being.
- Willingly position itself in religious and secular places, recognizing that not all women are Christian or religious, but accept the importance of gathering places for sisterhood.
- Regularly disrupt and communicate with the larger queer community so that it acknowledges the contributions of queer Black people in its broader history, and understands that issues of race must remain a part of the larger dialogue of the community.
- Boldly demand 'a seat at the table' with healthcare providers to insist on a healthcare system that treats queer Black bodies with respect and humanity.

Embracing queer Black female cancer patients requires a shift within and outside several communities—the queer community, the Black community, the cancer survivor community, and the medical community. Reducing cancer disparities among queer Black women requires the inclusion of voices from queer Black cancer patients and increased acceptance of all cancer patients' multiple social identities. The lessons learned from the *Walking in the Spirit* program have great potential to help healthcare professionals create more inclusive spaces for queer Black women along the cancer continuum.

Notes

1.
"Papa Legba, open the gate for me, Ago eh
Papa Legba, open the gate for me
Open the gate for me, Papa
For me to pass, when I return I will thank the Lwa!"
This is a common prayer for the Vodun Iwa, Papa Legba. He is the first Iwa invoked in the Vodu ceremonial order.

2. For consistency, the authors of this chapter have chosen to use the term "queer" to represent the members of the LGBTQ/sexual and gender minority (those who identify as lesbian, gay, bisexual, transgender, queer, questioning, or other labels) communities. We recognize that this not the preferred term for all members of the community or for all researchers.

3. In a 2013 study on LGBTQ patient-centered outcomes, the authors called for systematic changes in the support of cancer LGBTQ cancer patients and survivors, citing their poorer outcomes. In their conclusion, they state: "A well-intentioned one-size-fits-all approach too often gives a message of unwelcome to LGBT patients, leading those who can avoid the system to do so, and suggesting to others that they need to remain silent about their lives, their support systems and their needs" (p. 29). This study has limitations, however: the sample was comprised of only 9% people of color. http://www.cancer-network.org/downloads/lgbt-patient-centered-outcomes.pdf

4. The American Cancer Society, which serves as one of the primary sources for the website, documents specific to the queer community and cancer: http://www.cancer.org/healthy/findcancerearly/womenshealth/cancer-facts-for-lesbians-and-bisexual-women.

5. San Diego Affiliate of the Susan G. Komen for the Cure's Continuum of Care Model: http://komensandiego.org/wp-content/uploads/2014/06/2012Continuum_of_Care_Model.pdf.

6. Funded by Susan G. Komen Mid-Missouri Affiliate (PI: Jane A. McElroy; post-doctoral fellow, LaShaune Johnson; Dr. Johnson took leadership on the project and met regularly with Dr. McElroy about the project.)

7. At the time, the national Susan G. Komen brand had taken a hard hit within the Black community due it its controversial decision—and ultimate reversal—to break its relationship with Planned Parenthood, often one of the only sources of preventive care in underserved communities. http://www.cnn.com/2012/02/03/politics/planned-parenthood-komen-foundation/.

8. Pink collar jobs are ones traditionally held by women. For instance: customer service work, childcare/teaching, healthcare, administrative and beauty industry positions.

9. John 6:35 (KJV) "And Jesus said unto them, I am the bread of life: he that cometh to me shall never hunger; and he that believeth on me shall never thirst." Matthew 5:6 (KJV) "Blessed are they which do hunger and thirst after righteousness: for they shall be filled."

10. One of the churches was more conservative and its pastor was nervous about the "sexual" tone of Zumba. Fortunately, the Zumba instructor was able to adapt the movements to something more acceptable to the community.

For References please see refer to the book.