Caring for Body and Soul: A Workshop on Women's Health

Program Replication Guide

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ABOUT THIS MANUAL

This manual provides a guide for replicating a religiously-tailored, peer-led, group education program that addresses mammography-related barrier beliefs of American Muslims. This education program utilizes peer-educators (individuals recruited and trained from the community) and guest lecturers (a physician and a religious scholar) to deliver didactics and facilitate discussion sessions on breast cancer, mammography guidelines, religion and health, and resources for breast cancer screening.

How to Use this Manual:

The manual details procedures and materials for two primary aspects of the program: 1) Training peer educators to participate in the workshops and 2) Conducting the *Caring for Body & Soul: A Workshop of Women's Health*.
Materials can be adapted based on the specific characteristics and needs of the target mosque community the program will be implemented within.

Tips for Trainings:

Audience Assessment: We recommend that certain elements of the training be tailored to the targeted audience, and this be done in collaboration with community stakeholders, mosque leaders, and health/social service practitioners who can help determine what type of content would be appropriate to deliver and how best to do so. While this particular group education intervention was tested in two Muslim American communities, one being predominantly South Asian and the other being predominantly Arab, there is potential to use this program with other groups.

Content: The content can be edited based on the interests and characteristics of participants. This may include expanding some sessions, removing others, or adding new materials.

Knowledge of Material:

Workshop presenters and peer educators should have working knowledge and expertise in the subject matter of the sessions and should, ideally, be religiously and ethnically concordant with the target mosque community members.

Updating the Materials:

Many of the slides and handouts include various breast cancer statistics, current screening recommendations, and links to websites. Before delivery of a peer education training/group education class, it is recommended that updates be made to any links, resources, statistics that may be outdated, irrelevant, or not working. This updating is especially true for any resources that are relevant to current breast cancer screening recommendations and local resource lists that are handed out to participants.

Citation:

This replication guide should be cited when conducting the program, a citation for the entire program is noted below. If presenters use excerpts from sessions, please cite the specific session title as well:

> *Caring for Body and Soul: A Workshop on Women's Health Program Replication Guide.* University of Chicago Initiative on Islam and Medicine. (January 2018). Retrieved from https://pmr.uchicago.edu/page/developing-religiously-tailored-mammography-intervention-american-muslims

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Background

Generally mistaken for a small homogenous group, American Muslims are many and diverse. They number between 5 and 7 million, [1-4] with greater than 400,000 living in Chicagoland,[5] and are expected to double in number by 2030. [6] Most are African Americans (35%), Arab Americans (25-30%), or South Asian Americans (20-25%). [2, 7] While nearly two-thirds are immigrants, [8] they are as likely as the general population to have household incomes of $100,000 or more, [9] and they also have higher average levels of education. [10] Because of this diversity, and because national health care surveys and databases typically do not collect religious affiliation data, there is limited data on aggregate American Muslim breast cancer outcomes; what is known is based on ethnic group data and community surveys. Ethnic group data suggest that Muslim women present with breast cancer at a younger age, with more advanced disease, and with worse morphological features than other groups, making breast cancer an important health challenge for the community. [11-15] Muslim community surveys evidence mammography rates lower than the 75% national average and the Healthy People 2020 goal of 81%. [16] For example, community surveys among the Chicago Muslim community note biennial mammography rates of 44 and 52%, [17] and California study reported a rate of 54%. [18] Surveys of South Asians and Arabs also note an underutilization of mammograms. A study of 160 Asian-Indian women in Metro Detroit reported a 64% biennial mammography rate, [19] similar to the rates from population-based representative samples of South Asians in California. [20-22] Surveys in the Michigan Arab community report 75% and 58% biennial mammography rates. [23, 24] These low screening rates evidenced a need to understand barriers to screening in this population and the need for targeted and tailored cancer screening interventions.

Although controversial, studies attribute between 15 and 40% of the recent decrease in breast cancer mortality to mammography. [25-28] Accordingly, barriers to screening are important targets for intervention, as early detection can decrease disease morbidity and mortality, as well as reduce costs associated with caring for late-stage disease. Thus, addressing barriers to screening and enhancing women's intentions to pursue breast cancer screening should yield tangible benefits with respect to primary prevention, risk assessment, follow-up care, and treatment of breast and other cancers. [29]

Many studies note that Muslims share health beliefs, values, and experiences that impact healthcare behaviors across ethnic and racial lines. [30] In addition to sharing a theocentric

framework of health and disease, many Muslims look to Islamic ethico-legal guidelines to decide which medical treatments are permissible. Furthermore, diverse groups of Muslims voice concerns about modesty during healthcare encounters. [31-33] What has been less researched is how Islam related beliefs, values, and a shared sense of Muslim identity impact breast cancer screening behaviors. Therefore, our project began by seeking to understand how religion impacts screening behaviors and attitudes towards mammography in an ethnically and racially diverse group of Muslim women. This knowledge was, in turn, mobilized towards the design of a religiously-tailored, peer-led group education workshop conducted in mosques.

Formative Phases of Research in Chicagoland

Surveys, focus groups, and interviews from an ethnically-diverse group of women aged 40 and older sampled from Muslim organizations in the Chicago area were used to gather information about barrier and facilitator beliefs regarding mammography intention, breast cancer screening rates, and religious influences upon these beliefs. In phase one of the project, surveys were collected from 254 women in the Chicago area. Survey domains covered mammography behavior, religiosity, fatalism, modesty, and discrimination. Survey results highlighted that 77 % of respondents had at least one mammogram in their lifetime, yet 37 % had not obtained mammography within the past 2 years. [34] Having a primary care provider was positively associated with receipt of mammogram while positive religious coping and perceiving religious discrimination in healthcare was negatively associated with receipt of a mammogram. [34]

In phase two of the project, fifty women participated in 6 focus groups and 19 in semi-structured interviews, with near-equal numbers of African American, South Asian, and Arab Muslims. [35] Forty-two percent of participants had not had a mammogram within the past 2 years. Across differences in race/ethnicity and mammography status, women voiced four religion-related salient beliefs that inform mammography intention: (1) a perceived duty to care for one's body, and by extension one's health, because the body represents an entrusted loan from God enhanced women's intention for mammography, the beliefs that (2) religious practices are a credible means of preventing illness and (3) that God's decree results in illness and cure, both variably influenced mammography intention as participants shared multiple perspectives regarding the utility of petitioning God to remain disease free and the usefulness of cancer screening, and (4) comfort with gender concordant health care providers because modesty norms

influenced decisions to obtain mammograms. Participants also supported mosque based imam-led and peer-educator led intervention programs. [35]

In our focus groups and individual interviews, eighteen beliefs were consistently reported as impacting mammography intention (Table 1), seven of which had negative influences upon mammography intention (barrier beliefs) while eleven had positive influences on intention (facilitator beliefs). Out of these, six barrier beliefs became targets for religiously-tailored message design, with some of the facilitator beliefs being incorporated into the tailored messages (Table 2).

Intervention Design and Implementation

Our community-engaged project involved the identification of barriers to mammography screening among Muslim women and the design of a religiously-tailored group education intervention to address those barrier beliefs. A multi-sectoral and multi-disciplinary community advisory board (CAB) was formed to inform intervention design and implementation, and included community leaders from mosques and community organizations. CAB members and staff collaboratively designed the curriculum and messaging for a religiously-tailored mosque-based intervention involving peer-led group education classes.

The group education workshop consisted of two class sessions led by trained peer-educators and incorporated guest lecturers to deliver didactics on specific topics (as will be detailed below). The two-session workshop was conducted over a period of 7.5 hours and held on Saturday mornings (See training manual for course details).

Barrier beliefs identified in previous phases of the study were addressed through the 3R methodological model for religiously tailored messaging. [36] This model involved three techniques for message design (i) reframing - introducing a new way of thinking about the belief that is consonant with obtaining a mammogram (ii) reprioritizing -introducing a new "facilitative" belief that coheres with getting a mammogram and reinforcing this belief through repetition so that is has higher valence among participants that the barrier belief and (iii) reforming - confronting the barrier belief by attempting to uncover its logical flaws (Table 2).

The tailored messages that addressed each of the identified barrier beliefs were delivered during the group education intervention in multiple ways and in different sessions (See Table 2). For example, the barrier belief that mammograms are painful was addressed through the tailored

strategies of reframing and reprioritizing. The reframing message communicated that “the pain incurred on the path to completing a good deed (e.g. caring for my body) is rewarded by God” and the reprioritization strategy introduced the importance of one’s stewardship responsibility for the body. [36] This project replication guide provides a methodological model for partnering with mosque communities to overcome religion-related barriers to healthy behaviors.

Table 1. Mammography-Related Barrier & Facilitator Beliefs Identified from Muslim Women and Mapped onto the Theory of Planned Behavior

	Barrier Beliefs
Behavioral Beliefs	**Physical pain**: I believe mammograms are painful. **Fear of mammogram results**: Fear of a positive result makes it difficult for me to get mammogram.
Normative Beliefs	**Cultural taboo**: I believe it is difficult to speak about mammograms and breast cancer in my community. **Comfort with Gender Concordant Healthcare**: As a Muslim, I am more comfortable with a female healthcare provider.
Control Beliefs	**Insurance**: Insurance policies or the lack of insurance makes getting a mammogram difficult. **Family over Self**: I put my family's needs and priorities over my own. **Fatalistic Notions about Health**: It is by Allah's will whether I am sick or cured.
	Facilitator Beliefs
Behavioral Beliefs	**Peace of mind**: A negative mammogram result relieves me from worries about my health status. **Positive experiences with technicians**: I believe that I will have access to a "nice" technician. **Getting screened for the sake of family**: I believe my family should know my health status. **Family history leads to an increased risk of breast cancer:** I should get screened because breast cancer may run in my family. **Primary prevention actions**: I believe certain health behaviors, such as cancer screening, can help prevent getting a disease. **Secondary prevention actions**: I believe breast self-exams and mammograms can help detect disease and facilitate opportunities for prevention and treatment. **Methods of Disease Prevention:** I believe certain religious practices, like prayer, can help prevent disease.
Normative Beliefs	**Positive influence from family**: I believe my family members will support my getting a mammogram. **Perceived duty to care for one's health**: I believe it is my responsibility, as a Muslim, to take care of my body. **Positive influence from friends**: I feel comfortable talking to my friends about mammography. **Normative beliefs**: Community members would support my getting a mammogram.

Table 2. Barrier Beliefs, Tailored Messages, and the Intervention Curriculum

Barrier Belief (Relation to TPB)	New Target Beliefs Based on 3R Techniques			Message Deployment within Group Education Activities
	Reframe	**Reprioritize**	**Reform**	
Mammograms are painful (Behavioral belief)	The pain incurred on the path to completing a good deed (e.g. caring for my body by getting screened for cancer) is rewarded by God.	A Muslim is responsible to care for their body and obtaining mammography screening fulfills this responsibility.	***Reforming the barrier belief is not applicable*** because mammograms are painful.	-The reframing message was deployed by a female religious-scholar who conveyed that although mammograms are painful, there will be a spiritual reward for undergoing such hardships. -The reprioritization message was also part of the religious scholar's didactic where the notion of the body being an *amana* (trust) and that fulfilling the rights of this trust might involve discomfort was stressed.
The fear of positive test results makes it difficult for me to get a mammogram. (Behavioral Belief)	Fear is normal, but knowing my cancer status earlier is better than have a later diagnosis with more advanced disease.	A Muslim believes that God is merciful, therefore whatever outcome happens is from God's Mercy, and that reading Qur'an and prayer helps to reduce fear of the unknown.	***Reforming the barrier belief is not applicable*** because fear of a positive result is a normal.	-The reframing message was delivered both in the religious scholar's didactic and in the female healthcare provider's didactic. Illustrative messages include "knowledge empowers you to make decisions about your health." -The reprioritization message was also part of the religious scholar's didactic and included references to the Qur'anic verse "Do not fear, God is with you" (9:40), and the message that "reading the Qu'ran and remembering that God will help you cope."

As a Muslim, I am more comfortable with a female healthcare provider AND I worry about being serviced by a male technician should I go for a mammogram. (Normative Belief)	Most mammography centers have all female staff so I can live out the concordance mandate.	Muslims are responsible to care for their bodies and this duty of stewardship can involve cancer screening and might be more important than modesty guidelines.	Although gender concordance is preferred, in extenuating circumstances religious exemptions exist.	-The reframing message was part of the religious-scholar led didactic. -The reprioritization and reforming messages were also part of the religious scholar's didactic where the idea that "(Islamic) modesty remains intact even though (you are) seeing a male provider" was communicated.
It is by Allah's will that one gets illness or is healed, and I can do nothing to change that fate therefore getting a mammogram is of limited benefit. (Control Belief)	***Reframing the barrier belief is not applicable*** because mammography screening does not implicate God's control over disease and cure.	A Muslim has the responsibility to care for the body God bestowed upon them and actions are judged irrespective of their ultimate outcomes.	Human actions have an effect and prayer can change our decree.	-The reprioritization message was part of the female religious scholar's didactic where she noted that – "While it is by Allah's will that I am sick or cured, it is my responsibility to take care of my health physically, and also spiritually by praying to God." -The reforming message was also part of the religious scholar's didactic.

My family's needs and priorities outweigh my own OR they "should" come first. (Normative Belief)	I cannot take care of my family if I do not take care of myself first.	A Muslim has the responsibility to care for the body God bestowed upon them and cancer screening is part of that responsibility.	The Qur'an and hadith support making supplication for one self before others and worrying about one's salvation before others, hence caring for oneself is a primary responsibility before one's family.	-The reframing message was delivered during a peer educator-led icebreaker session. -The reprioritization and reframing messages were part of the female religious scholar's didactic session.
Insurance policies OR the lack of insurance makes getting a mammogram difficult. (Control Belief)	Cancer care is more costly when the cancer is advanced hence early detection through mammography is preferable.	There are many social service organizations, foundations, and insurance programs that cover the costs of mammograms and cancer care	***Reforming the barrier belief is not applicable*** because the insurance and cost can be barriers to mammography and cancer care.	-The reframing message was utilized during a community-partner led session entitled "Health & Access." -The reprioritization message was also part of the health and access session where the guest speaker provided list of local resources to help participants obtain mammograms.

Suggested Outline of Activities

I. Selection of host community/mosque/place of worship
   a. Community liaising
II. Peer education
   a. Recruitment of peer educators
   b. Selection of peer educators
   c. Development of training materials
   d. Training of peer educators
III. Group education
   a. Recruitment of participants
   b. Selection of participants
   c. Development of class materials
   d. Group education class
IV. Program Evaluation

I. Selection of host community:

The host community should be selected based on population characteristics of interest along with interest and cooperation from community leaders. Based on the community's capacity to host the program, the appropriate number of class participants can be selected. In order for this program to be successful, it is imperative to have community support. We recommend that forming community partnerships with mosques, community partners, and community leaders occurs prior to any other steps, and these partners are involved in the planning and tailoring of the event.
The host community plays several significant role in supporting this group education program including:

- Advising regarding program components and tailoring of content to community
- Providing use of facilities for peer education training and group education programming
- Recruiting of peer educators
- Recruiting of group education participants (through flyers, emails, newsletters)
- Providing support staff for recruitment and program development
- Recruiting of program speakers

II. Peer Education:

Gender concordant peer educators are utilized to lead group education course activities. Peer educators often come from similar social backgrounds or have similar experiences to those who they are trying to teach due to their respect in the community and relatability.

Peer educators characteristics include:

- Self-identified Muslim women that have attended both sessions of the peer health education training course
- Age 40 and over
- Interested in community health issues
- NOT physicians, healthcare workers, or religious authorities as they are not considered "peers"

III. Group Education:

Group Education Participants:

Participants for the group education classes can be recruited through a variety of means, including flyers, emails, and mosque events, and also from one masjid site or across multiple sites. The number of participants will be limited by the capacity of the host community. Workshop participants should be:

- Self-identified Muslim women
- Have not had breast cancer
- Have not obtained a mammogram in the past 2 years
- Aged between 40 and 74 years
- English literate

IV. Program Evaluation:

Program evaluation can be conducted using interviews, focus groups, or surveys, based on the organizers needs. Informal feedback can also be sought from class participants or instructors to determine program strengths and areas for improvement.

Attachments one and two below detail material for the peer education training program and the group education class program respectively. Attachments include outline of classes, course materials, speaker guides, and discussion guides. Materials can be tailored to the needs of the respective community.

Attachment 1. Peer Educator Training Manual

Caring for Body and Soul: A Workshop on Women's Health

Peer Educator Training Manual

(Location)
(Date)

To the Community Peer Educator:

Thank you for your participation in this training program for becoming peer educators in the *Caring for Body and Soul: A Workshop on Women's Health*. Our purpose is to improve knowledge about women's health, preventive care, and specifically breast cancer screening.. As a peer educator, you will be instrumental in helping us carry out our goal of creating a culture of health in the mosque communities.

During this 2-day workshop, you will acquire the skills necessary to facilitate group discussions, educate women about mammography, and motivate women to overcome challenges to breast cancer screening. You will learn about the project, examine key public health theories in behavior change, think about how mosques play a critical part in community health, and discuss the characteristics and responsibilities of peer educators. In addition, the program will incorporate several guest lecturers: a local community organization talking about access to mammography screening, a religious scholar talking about religious dimensions of health, and a healthcare professional talking about breast cancer knowledge, facts, and myths; these individuals will present their material to you in this training class as well.

We thank you again for being a part of this workshop. If you have any questions or concerns, please contact XXX.

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Peer Educator Training Manual

Training Agenda

Day 1 – (LOCATION)

30 minutes	Refreshments & registration
30 minutes	Ice-Breaker
25 minutes	Course Overview
25 minutes	How Mosque Plays a Role in Community Health
25 minutes	Peer Educators: Who They Are & What They Do?
25 minutes	Health Behavior Theory and Activities: Stages of Change & Theory of Planned Behavior
10 minutes	Question & Answer
10 minutes	Break
20 minutes	Access and Insurance
70 minutes	Lunch & Break
40 minutes	Group Facilitation Skills & Ethical Considerations in Research
60 minutes	Breast Cancer Screening Guidelines & Procedures *(Healthcare Professional)*
20 minutes	Break & Prayer
30 minutes	Q&A, Day 1 Recap, and Day 2 Forecast

Caring for Body and Soul: A Workshop on Women's Health

Peer Educator Training Manual

Training Agenda

Day 2 – (LOCATION)

30 minutes	Refreshments
10 minutes	Welcome, Day 1 Recap, and Day 2 Forecast
60 minutes	Group Education Class 1 & 2 Overview
45 minutes	Religious Dimensions of Health *(Religious Scholar)*
10 minutes	Break
70 minutes	Part 1 of Mock Group Education Session on Icebreakers and Women & Health
45 minutes	Lunch & Prayer
60 minutes	Part 2 of Mock Group Education Session on Cancer Care Videos
15 minutes	Closing

Class 1: Icebreaker

25
Minutes

Materials:

- Markers
- LCD projector
- Laptop computer with MS PowerPoint
- Handout on belief table (x 20 copies)
- Name tags (x 20)

Methods:

- Discussion

Learning Objectives:

- Become familiar with data about barriers to and facilitators of preventive health within the Muslim community with particular reference to breast cancer screening.
- Get to know staff members and other potential peer educators

1. **Staff members** introduce themselves to peer educators.

2. **Staff member** says:

   To get to know one another better, we will engage in a fun icebreaker. You will now introduce yourselves to one another, answer health-related questions, and discuss other people's responses.

3. **Staff member** explains that each person will introduce themselves to each other answering the following questions:
   a. Name
   b. An adjective that describes you using the first letter of your name (ex: My name is Fatimah and I am "Fun").

4. After each peer educator introduces herself, **staff members** will facilitate discussion around the questions:
    a. What prevents you from taking care of yourself?
    b. Who in your life supports good health practices?

5. **Staff member** says:
   So the two questions we just discussed are among the questions you will be asking other women in the workshop that you will be leading. Let's think about some of the responses or ideas you might encounter from women in the community, and how to motivate women to think more about their health.

6. **Staff member** then presents barriers and facilitators to preventative care from the extant research literature. Discuss with peer educators the challenges that women in the community may have in practicing preventive care and the ways in which peer educators can change the women's beliefs.

Class 1: Course Overview

25 Minutes

Materials:

- LCD projector
- Laptop computer with MS PowerPoint

Methods:

- Lecture

Learning Objectives:

- Identify underlying motivations for the project
- Be able to describe format and agenda of the peer educator training program
- Become familiar with data that guided this project
- Learn about barriers to and facilitators of preventive health
- Learn about responsibilities of a peer educator in the study

See the following articles for program background and details:

Padela, AI., Murrar, S., Adviento, B., Liao, C., Hosseinain, Z., Peek, and M., Curlin, F. 2015 Associations between Religion-Related Factors and Breast Cancer Screening among American Muslims. Journal of Immigrant and Minority Health. 17:660-9.

Padela, A. I., Vu, M., Muhammad, H., Marfani, F., Mallick, S., Peek, M., & Quinn, M. T. (2016). Religious beliefs and mammography intention: findings from a qualitative study of a diverse group of American Muslim women. *Psycho-Oncology*, *25*(10), 1175-1182.

Vu, M., Muhammad, H., Peek, M. E., & Padela, A. I. (2017). Muslim women's perspectives on designing mosque-based women's health interventions—an exploratory qualitative study. *Women & Health*, 1-13.

Staff member will use PowerPoint slides to provide an overview of the study and talk about the motivations underlying creating a culture of health in the mosque.

Class 1: How Mosque Plays a Role in Community Health

25

Minutes

Materials:

- LCD projector
- Laptop computer with MS PowerPoint

Method:

- Discussion
- Lecture

Learning Objectives:

- Delineate the role of the mosque and the role of the imam in American Muslim health
- Describe how this program utilizes the mosque to improve American Muslim health

1. **Staff member** asks participants:

   What do *you* think is the role of the imam in American Muslim health?

   Reference:

   Padela, A. I., Killawi, A., Heisler, M., Demonner, S., & Fetters, M. D. (2011). The role of imams in American Muslim health: perspectives of Muslim community leaders in Southeast Michigan. Journal of religion and health, 50(2), 359-373.

2. **Staff member** describes the roles of the imam in American Muslim health:
   a. Encouraging healthy behaviors through scripture-based messages in sermons
   b. Performing religious rituals around life events and illnesses
   c. Advocating for Muslim patients and delivering cultural sensitivity training in hospitals
   d. Assisting in the health care decisions

3. **Staff member** delineates challenges/barriers associated with the idea of the imam playing a role in women's health:
   a. Lack of medical knowledge on the part of some imams
   b. Lack of access to/availability of imams
   c. Some women don't want imams to talk about breast cancer; modesty concerns

d. **Staff member** gives a quote/example: One woman says, "I just think in Islam, everything is about modesty. So when you think about modesty, those types of female issues, women should address…"

4. **Staff member** then says:
   Peer educators and community health workers can address these issues -- to segue into the next section.

5. **Staff member** discusses examples of projects that utilized the mosque to address community health issues:
   a. The Mosque Campaign: A Cardiovascular Prevention Program for Female Turkish Immigrants [37]
      - Mosque campaign for CVD prevention conducted in 28 mosques in Tyrol, Austria (from 1999-2002)
      - Resulted in a significant increase in the awareness of main CVD risk factors among Muslim women
   b. Bagamoyo Bednet Project [38]
      - Sermons used to promote the use of bednets in 4 villages in Tanzania to control Malaria
      - Positive feedback regarding the sermons and 52%-98% regular use of bednets, except in one village (only 25%)
   c. Spiritually Enhanced Drug Addiction Rehabilitation (SEDAR) program [39]
      - Mosque-based methadone maintenance treatment strategy for Male Muslim heroin users (n=36) in Malaysia over 12-month period
      - Medical checkups, administration and adjustments to methadone dosage, counseling support, and spiritual intervention issued by imam
      - Index scores in drug use, HIV risk behavior, social dysfunction, criminality, and health problems all decreased post-intervention, with changes in drug use, social dysfunction, and health problems reaching statistical significance

6. **Staff member** says:

Our project will be using the mosque to build upon the following facilitator/normative beliefs: Perceived duty to care of one's health, Getting screened for sake of family, and Positive influence from family (See Table 1).

✓ Class 1: Peer Educators: Who They Are & What They Do

25

Minutes

Materials:

- LCD projector
- Laptop computer with MS PowerPoint

Methods:

- Lecture

Learning Objectives:

- Identify characteristics and responsibilities of successful peer educators
- Learn about prior projects that have utilized peer educators in promoting breast cancer screening

1. **Staff member** says**:**

   Let's now talk about who peer educators are and what they do.

   A peer educator is a community member who carries out educational activities that promote healthy behaviors and reduce health risks among their peers. Peer educators often come from similar social backgrounds or have similar experiences to those who they are trying to teach. Peer educators engage their peers in conversations about the health issue of concern, seeking to promote health-enhancing knowledge and skills.

   Successful peer educators possess the following characteristics:

   a. They understand the culture, needs, and values of community members. They are passionate about improving the health of their community members.
   b. They are able to bridge the gap between the community and health agencies or services and can help community members understand or connect to medical and care resources.
   c. They are good communicators who can effectively deliver health information, listen to concerns from community members, and answer health-related questions with a supportive and positive attitude.

2. In our project, duties of peer educators include leading group classes on women's health, breast cancer, and mammography. In these classes we will discuss and address several barriers to and facilitators of obtaining mammography. Our goal is to improve group participants' intention to get mammography. You will also be facilitating the participation of guest speakers on topics of religion and health, breast cancer, and cancer survivorship.

3. In addition to those responsibilities, peer educators in other programs have also performed many other duties. While you will not be personally conducting these activities, we want to give you a sense of what peer educators in other programs have done. Additional example duties and responsibilities include:
    a. Recruitment of eligible people for a health promotion program
    b. One-on-one counseling
    c. Liaison with churches, community groups, and other organizations to provide culturally appropriate health information
    d. Distribution of posters, flyers, and brochures
    e. Telephone calls or home visits
    f. Participation in staff meetings to share ideas of outreach to their target population
    g. Emotional and practical support
    h. Advocacy on behalf of individuals and communities for more responsive services and living conditions
    i. Enabling services to help families navigate health services systems (i.e., locating and coordinating both medical and social service resources)

4. An important point of consideration is that while peer educators always aim to improve the health and well-being of their community members and do their best to deliver health information and serve as a bridge between the community and the healthcare system, peer educators are ultimately NOT responsible for changing health behaviors of community members. No matter how well a peer educator performs, they cannot guarantee that all community members will adopt healthy practices or refrain from risky behaviors. Thus, peer educators should not take a community member's failure to change behaviors personally, or think that it's their fault.

5. The following list includes federally-funded projects that use peer educators to increase breast cancer screening rates in diverse populations. Note that these projects can use the titles of community health workers, lay health educators, or lay health advisors to refer to the person performing similar duties to those of peer educators.

    a. Better Breast Health for Korean American Women (Maryland):

        Han, H. R., Lee, H., Kim, M. T., & Kim, K. B. (2008). Tailored lay health worker intervention improves breast cancer screening outcomes in non-adherent Korean-American women. *Health education research*, *24*(2), 318-329.

        - Trained lay health educators recruited 100 Korean-American women 40 years of age or older who had not had a mammogram during the past 2 years. A 120-min, in-class education combined with follow-up counseling and navigation assistance through the health care system was provided. This program results in a 31.9% increase in mammography rates after 6 months.

    b. Racial and Ethnic Approaches to Community Health 2010: Promoting Access to Health for Pacific Islander and Southeast Asian Women (California)

        Tanjasiri, S. P., Tran, J. H., Kagawa-Singer, M., Foo, M. A., Foong, H. L., Lee, S. W., & Wang, J. S. (2004). Exploring access to cancer control services for Asian-American and Pacific Islander communities in Southern California. Ethnicity and Disease, 14(3; SUPP/1), S1-14.

        - Community health workers were deployed in communities of Cambodians and Laotians. During 4 years, community health workers conducted educational sessions and outreach activities via mass media and one-on-one home visits, and educated a total of 24,077 community members and helped 573 receive mammograms.

    c. North Carolina Breast Cancer Screening Program: Save the Sisters (North Carolina)

        Earp, J. A. L., Altpeter, M., Mayne, L., Viadro, C. I., & O'Malley, M. S. (1995). The North Carolina Breast Cancer Screening Program: foundations and design of a model for reaching older, minority, rural women. *Breast Cancer Research and Treatment*, *35*(1), 7-22.

- Lay health advisors conducted one-on-one counseling, group education sessions, and held health fairs and events on breast cancer screening with 807 older rural African-American women. This program results in a 6% increase in mammography rates.

Do you all have any questions?

Class 1: Health Behavior Theory and Activities: Theory of Planned Behavior & Stages of Change Model

25

Minutes

Materials:

- LCD projector
- Laptop computer with MS PowerPoint
- Handout on belief table (x 20 copies)

Methods:

- Lecture

Learning Objectives:

- Understand theoretical components of two health behavior theories: (i) Theory of Planned Behavior and (ii) the Stages of Change or Transtheoretical Model
- Understand how the theories map onto data from previous phases of the study

1. **Staff member** says:
   Now we will talk about the scientific theories that identify motivating factors for a person to adopt healthy behaviors. While there are many different health behavior theories, today we will discuss two theories that are most applicable to our study: the Theory of Planned Behavior [40] and the Stages of Change or Transtheoretical Model. [41]

2. **Staff member** says:
   Let's begin with the Theory of Planned Behavior. This model was proposed by Icek Ajzen in 1985 to look at the relationship between a person's beliefs and their health behavior. In this model, a person's intention to perform an action is the best predictor of actually performing this action. The beliefs that inform a person's intention include three categories: behavioral beliefs, normative beliefs, and control beliefs. [40]

3. Show the model on PowerPoint slides and discuss the definition of three categories of beliefs.

4. While discussing the three categories of beliefs, illustrate the beliefs by examples from our study:
    a. Behavioral Beliefs and Beliefs Statements:
        - **Family history leads to an increased risk of breast cancer:** I should get screened because breast cancer may run in my family
        - **Physical pain**: I believe mammograms are painful.

    b. Normative Beliefs and Beliefs Statement:
        - **Perceived duty to care for one's health**: I believe it is my responsibility, as a Muslim, to take care of my body.
        - **Cultural taboo**: I believe it is difficult to speak about mammograms and breast cancer in my community.
        - **Positive influence from family**: I believe my family members will support my getting a mammogram.
        - **Comfort with gender-concordant healthcare**: As a Muslim, I am more comfortable with a female provider.

    c. Control Beliefs and Beliefs Statements
        - **Insurance**: Insurance policies or the lack of insurance makes getting a mammogram difficult.
        - **Family over self**: I put my family's needs and priorities over my own.
        - **Fatalistic notions about health**: It is by Allah's will whether I am sick or cured.

4. **Staff member** says:
   As you can see, the Theory of Planned Behavior is helpful for categorizing different types of beliefs informing an intention to perform a health-related action. [40] Once we have identified these beliefs, we can think about the best approach to target these beliefs and motivate women's intention towards getting mammograms. For example, if someone believes that physical pain is a barrier to getting mammogram, we can suggest that mammograms are related to good deeds, and good deeds are rewarded by God. If someone believes that they put family's needs and priorities over their own, we can suggest that unless

the woman takes care of herself and be healthy, she won't be able to take care of her family (See Table 2).

5. **Staff member** says:
   Ok, now we will move on to discuss the Stages of Change, also known as the Transtheoretical Model. [41] The model was proposed by James Prochaska in 1997. He suggests that behavioral change is a journey with several stops and starts along the way. We know that most people are not ready to commit to taking action to adopt a healthy behavior. In fact, the vast majority are at early stages of change – for example, precontemplation (or not even thinking about it) and contemplation (or thinking about it but not ready to commit to some action.

6. **Staff member** shows the model on PowerPoint slides and discuss the different stages of change.

7. **Staff member** says:
   In the interest of time, we will not go into a detailed discussion of the different strategies we can offer to individuals at each stage to move them along the change continuum. However, we want to introduce the model to highlight how behavioral change is a multi-step process, and how we are ultimately interested in women obtaining not just a one-time mammogram, but maintaining their mammogram schedule every 2 years.

8. If time permits, **staff member** have participants use the handout of beliefs to identify behavioral, control, and normative beliefs and explain why they think the beliefs fall into these categories.

Class 1: Access & Insurance

20 Minutes

Materials:

- Mammography screening programs/services handout (x 20 copies)

Methods:

- Lecture

Learning Objectives:

- Identify resources for setting up mammography screening appointments and possible follow-up visits

Staff members from (local community organization) will discuss their program, which offers a pathway to mammograms for all women and social support throughout the process of getting the test and the results and any follow-up care that might be needed.

Class 1: Group Facilitation Skills

50 Minutes

Materials:

- LCD projector
- Laptop computer with MS PowerPoint

Methods:

- Lecture
- Discussion

Learning Objectives:

- Gain critical skills for group facilitation
- Understand ethical considerations

1. **Staff member** says:

   Let's discuss the importance of setting the mood during a peer educating session. It is essential to acknowledge each member of the group verbally and through non-verbal communication in order to:

   a. Promote respectful environment where people feel safe to express their views
   b. Allow you to generate group's ideas and elicit their experiences

2. **Staff member** discusses four critical techniques for steering conversations: Open-ended questions, reflective listening, empathic statements, and probing to gain group views.

3. **Staff member** discusses the importance of question format by first giving an example of how a question can be made better. For example:

   Tell me what you know about screening for cancer."

   vs.

   "So, have you been screened for cancer?"

4. **Staff member** says:

   Open-ended questions are better because they

a. Allows participants to tell their story, in his/her own language
b. Helps you understand the participant's experience, not just facts
c. Promotes a respectful, safe environment, where there are no right or wrong answers.

5. **Staff member** says:
   Reflective listening is used for the following reasons:
   a. Communication is not perfect
   b. Lets you check your understanding, modify as needed
   c. Shows you care about what each person has to say and that you "want to get it right"
   d. Clarifies viewpoints for others in the group
   e. Example: "What I'm hearing you say is…"

6. **Staff member** says: Empathic statements are used so a person knows they are heard and understood. They are not an expression of sympathy; however, they show respect for a person's experience and promote a respectful, safe environment for sharing.
   For example: "So when your doctor talked about screening for cancer, you got pretty scared..."

7. **Staff member** discusses how theme saturation can be achieved:
   a. "Anyone have anything else to add to what has been said?"
   b. "Any other views on this issue?

8. **Staff member** discusses:
   a. To moderate group discussion, you allow, encourage discussion to be generated by group, without losing focus. For example, "You're all nodding in agreement. Why is that?"
   b. Probe for range of experience, views, by questions such as: "How do others feel?" or "What other experiences have you had?"
   c. Avoid simultaneous talk

9. **Staff member** says:

Redirection and encouragement are also essential in dealing with the following:

a. Self-appointed experts: “Thank you. What do others think?”
b. Dominator: “That’s interesting. Let’s have some other comments.”
c. Rambler: Stop eye contact and look at watch. Interrupt at inhale.
d. Shy participant: Make eye contact and smile. Call on them.
e. Quiet talker: “I’m sorry I couldn’t hear. Would you mind repeating?”

10. Staff member discuss ethical considerations in conducting group moderations and research.

11. S**taff member** says**:**

Let’s volunteer to play leader of discussion about your favorite Islamic scholar and use--

a. Open-ended questions
b. Reflective listening
c. Empathic statements
d. Probe to theme saturation

✓ Class 1: Breast Cancer Screening Guidelines & Procedures

60

Minutes

Materials:

- LCD projector
- Laptop computer with MS PowerPoint

Methods:

- Lecture
- Discussion

Learning Objectives:

- Distinguish myths and facts of breast cancer
- Understand the benefits and process of mammography

1. **Healthcare professional** speaks on the following topics: Family history of breast cancer, prevention actions, perceived duty to care for one's health
2. **Healthcare professional** facilitates the following discussion on myths & facts of breast cancer:

- **Belief**: Only older women get breast cancer (**FALSE**)

  Fact: Most breast cancers occur in women over the age of 50. Although age is the most important risk factor for breast cancer, younger women also get breast cancer.

- **Belief**: Persons without a family history of breast cancer do not get breast cancer. (**FALSE**)

  Fact: A woman's chance of developing breast cancer increases if her mother, sister, and/or daughter have a history of breast cancer. Again, this doesn't mean every woman with a family history will get breast cancer. Likewise, even those without a family history can get breast cancer.

- **Belief**: Only the family history of breast cancer in mother's side increases the risk for breast cancer (**FALSE**)

  Fact: While breast cancers occur more frequently in women, a family history in any side of the family can increase the risk for breast cancer.

- **Belief**: Contraceptives cause breast cancer (**TRUE**)

Fact: Studies report that the use of oral contraceptives for years can increase the risk for breast cancer.

- **Belief**: People with high fat diet are more likely to get breast cancer (**TRUE**)

  Fact: This may not be a direct link; rather, high fat diet increases the risk for obesity, an independent risk factor for breast cancer.

- **Belief**: Diagnosis of breast cancer is a life sentence (**FALSE**)

  Fact: If you find your breast cancer early, you have a higher and better chance to survive.

- **Belief**: A lump in a breast means breast cancer (**FALSE**)

  Fact: Many times, breast lumps are benign.

- **Belief**: Men get breast cancer (**TRUE**)

  Fact: A Small proportion of breast cancer is found in men.

- **Belief**: One in eight women develops breast cancer. (**TRUE**)

  Fact: Over a lifetime, a women has a one in eight chance of developing breast cancer by the time she reaches age 85. But her risk is much lower when she is younger. For instance, the risk at the ages of 30-39 is 1 in 69, at the ages of 50-59 is 1 in 38, and at the ages of 60-65 is 1 in 25.

- **Belief**: The radiation from a mammogram can cause breast cancer. (**FALSE**)

  Fact: While high doses of radiation can cause cancer, such as in atomic bomb survivors, the dose from a modern mammogram is only 0.1 to 0.2 rads per picture. During a screening mammogram, in which 4 pictures are usually taken, the amount of radiation a woman receives is equal to what she would be exposed to in her natural environment (background radiation) over a 3-month period, and less than that of dental x-rays.

- **Belief**: Mammograms may miss a cancer if breast tissue is very dense. (**TRUE**)

  Fact: A mammogram report will contain an assessment of breast density. Breast density is based on how fibrous and glandular tissue tissues are distributed in your breast, vs. how much of your breast is made up fatty tissue.
  Dense breasts are not abnormal, but they are linked to a higher risk of breast cancer. Dense breast tissue can make it harder to find cancers on a mammogram.

- **Belief**: Mammograms can tell if a mass is cancer or not. (**FALSE**)

  Fact: A mammogram cannot show for sure whether or not cancer is present. If your mammogram shows something that could be cancer, a biopsy is needed in which a sample of breast tissue is removed and looked at under a microscope.

- **Belief**: If you feel a mass in your breast and your mammogram was normal 6 months ago, you don't have to do anything. (FALSE)

Fact: Any time a breast abnormality or change is determined, medical care should be sought.

- **Belief**: If an abnormality is seen on a screening mammogram, then additional mammograms are taken called diagnostic mammogram. (TRUE)

  Fact: A woman with a breast problem (for instance, a lump or nipple discharge) or an abnormal area found in a screening mammogram typically gets a diagnostic mammogram. During a diagnostic mammogram, the images are reviewed by the radiologist while you are there so that more pictures can be taken if needed to look more closely at an area of concern.

- **Belief**: Everyone has BRCA genes. (**True**)

  Fact: Everyone has BRCA1 and BRCA2 genes. The function of the BRCA genes is to repair cell damage and keep breast cells growing normally. But when these genes contain abnormalities or mutations that are passed from generation to generation, the genes don't function normally and breast cancer risk increases.

- **Belief**: Most patients with breast cancer will have the BRCA gene mutation (**FALSE**)

  Fact: Together, BRCA1 and BRCA2 mutations account for about 20 to 25 percent of hereditary breast cancers and about 5 to 10 percent of all breast cancers

Breast Cancer Quiz

Please complete the following true/false quiz to test your knowledge about breast cancer. This is for your reference only and will not be collected.

1. A lump in the breast means breast cancer. TRUE FALSE
2. Men can get breast cancer. TRUE FALSE
3. Mammograms can tell if a mass is cancer or not. TRUE FALSE
4. Only older women get breast cancer. TRUE FALSE
5. Contraceptives can cause breast cancer. TRUE FALSE
6. Everyone has BRCA genes. TRUE FALSE
7. One in eight women develops breast cancer. TRUE FALSE
8. Persons without a family history of breast cancer do not get breast cancer. TRUE FALSE

✓ Class 1: Q&A, Day 1 Recap, Day 2 Forecast

30

Minutes

Methods:

- Discussion

Learning Objectives:

- Clarify questions about training content
- Able to summarize learning goals for day 1
- Able to anticipate activities for day 2

Staff members will hold a 15-minute question and answer session, 5-minute recap of activities and goals accomplished in day 1, and 10-minute forecast of activities that take place during day

✓ Class 2: Day 1 Recap, Day 2 Forecast

10

Minutes

Materials:

- Name tags (x 20)

Methods:

- Discussion

Learning Objectives:

- Able to summarize learning goals for day 1
- Able to anticipate activities for day 2

Staff members will give a recap of activities and goals accomplished in day 1 and a forecast of activities that take place during day 2.

✓ Class 2: Group Education Overview

60

Minutes

Materials:

- LCD projector
- Laptop computer with MS PowerPoint
- Group Education Manual (x 20 copies)
- Handout on belief table (x 20 copies)

Methods:

- Lecture

Learning Objectives:

- Learn the content of group education manual
- Understand different skillsets necessary to lead discussions during the group education training

1. A s**taff member** walks peer educators through the group education manual, highlighting different learning objectives for group education participants and different skillsets that peer educators will be using to lead discussions. Tell peer educators that staff members will meet with them before deployment of group education training to finalize logistical details and answer any questions.

2. **Staff member** summarizes responsibilities of peer educators in Class 1:
    a. Class 1: Icebreaker
        - Peer educators will ask group education participants the four questions listed in the manual. Peer educators take note of the discussion in their group and report back. Peer educators will also select points of discussion that align with the following data from previous phases, ask participants about current ways of thinking about preventive health, and propose some new ways of thinking. This activity of proposing new ways of thinking is important because it leads the way for understanding how targeted beliefs apply throughout our training content.

- Beliefs discussed in this section include: the barrier belief Family over self and the facilitator beliefs, Positive influence of family members, Positive influence of friends, and Perceived religious duty to care for one's health.

b. Class 1: Women & Health
   - Peer educators discuss their own background and the reasons for why they chose to be a peer educator. Peer educators follow the script in the group education manual to discuss the importance of women's health.
   - Beliefs discussed in this section include: the barrier belief Family over self and the facilitator belief normative beliefs.

3. **Staff member** summarizes responsibilities of peer educators in Class 2:
   a. Class 2: Welcome & Icebreaker
      - Peer educators discuss the question "What are you doing now to maintain good health?" and encourage participants to think about barriers to and facilitators of good health as well as ways to address barriers.

   b. Class 2: Cancer Care Video & Debrief (See below)
      - Peer educators summarize the stories, ask questions using the facilitator guide, and moderate group discussions.
      - Beliefs discussed in this section include: the barrier beliefs, Physical pain, Comfort with gender-concordant healthcare, and Fear of mammogram results and the facilitator beliefs, Getting screened for the sake of family, Positive influence of family members, and Positive influence of friends.

4. **Staff member** summarizes responsibilities of peer educators in Class 3:
   a. Class 3: Welcome & Icebreaker
      - Peer educators discuss the question "What's one major decision you'll make in the next 6 months to improve your health?" and encourage participants to think about barriers to and facilitators of good health as well as ways to address barriers.

Dina's Breast Cancer Screening Story

https://www.youtube.com/watch?v=ooJA7JYRIw0

Transcript

My name is Dina. I am from Sudan. Until recently, I had not had a mammogram.
That's because I heard that it is really painful. I became frightened.
I changed my mind when I attended a workshop about cancer screening.
I learned about the benefits and risks of having a mammogram.
It made me worry about my health, so I decided to have a mammogram.
I was surprised that it was not as painful as I had heard it was. The staff were all female and it only took 10 minutes.
The best thing is when you get your results and you realize that you are healthy.
Even if you have cancer, at least you find out early and can get treated before it gets worse.
Thankfully, after finding out that the results are normal, I can finally relax and be carefree.
There is nothing better than being sure that you are healthy so that you can enjoy your time with family and friends.

Facilitator Guide

Summary of story:

Dina came to Canada from Sudan. She was hesitant to have a mammogram because she heard that they were painful. She changed her mind when she attended an educational workshop about cancer screening. The test was quick and not painful. Dina had a normal mammogram result, which gave her a sense of relief.

Discussion:

These topics are based on Dina's comments. Choose 2 discussion topics and have the group discuss the set of questions. You are not expected to cover all of the topics in 30 minutes, however we require you to address at least the following list of selected concepts:

Barrier Beliefs Targeted:

- ✓ Physical Pain (can be addressed through question 1a, 4a, 4b)
- ✓ Comfort with Gender-Concordant Healthcare (can be addressed through question 3a, 3b)

Facilitator Beliefs Discussed:

- ✓ Getting Screened for the Sake of Family (can be addressed through question 1b, 4b)

Discussion Topics:

1. What happens during a mammogram?

a. Ask if anyone has had a mammogram. What are the steps? Who is in the room?

b. How long does it take? How would you make time to have a mammogram with your busy schedule (e.g., work, family)?

2. Finding the cancer when it is small

a. Why is cancer easier to treat when it is small?

b. A mammogram can find the early signs of cancer, when it is the size of a pin head. How large would the cancer tumor have to be to find it yourself?

3. Requesting a female technologist

a. Almost all technologists are female. If there was a male technologist at your test, what would you say if you wanted a female?

b. Are there other ways that you could request a female technologist (e.g., having a friend or family member present)?

4. Feeling discomfort during a mammogram

a. Dina was hesitant to have a mammogram because she heard it was painful. Has anyone here had a mammogram? How was the pain? How did you think about dealing with the pain?

b. What other medical tests involve discomfort (e.g., dentist, taking blood, urine sample)? Are they worth it?

Vanita's Breast Cancer Screening Story

https://www.youtube.com/watch?v=NUOOa7J9FFQ

Transcript

My name is Vanita. I am from India.

A mammogram was one of the tests I had when I first visited a doctor in Canada.

The doctor told me a mammogram checks for breast cancer.

I was scared!

But the doctor told me that if breast cancer is caught early, when it is the size of a corn kernel, it is easier to treat.

If it grows bigger, it is harder to treat.

For peace of mind, I decided to go for a mammogram.

I tried to manage the discomfort and I stayed calm when the nurse put my breasts between the two plates for a mammogram.

Since then, I have been getting tested regularly.

I encourage my friends and neighbours go for a mammogram.

I provide them with directions, interpretation, support and company.

Facilitator Guide

Summary of story:

Vanita came to Canada from India. One of the first medical tests she had in Canada was a mammogram. She remembers the doctor telling her that if breast cancer is caught early, when it is the size of a corn kernel, it is easier to treat. The doctor said that if it grows bigger, it is more difficult to treat. Vanita managed the discomfort and stayed calm while she had the mammogram. She gets tested regularly and encourages her friends to do the same. She even accompanies them to provide support and help with interpretation.

Discussion

These topics are based on Vanita's comments. You are not expected to cover all of the topics in 30 minutes, however we require you to address at least the following list of selected concepts:

Barrier Beliefs Targeted:

- ✓ Physical Pain (can be addressed through question 3a)
- ✓ Fear of Mammogram Results (can be addressed through question 2a, 2b)

Facilitator Beliefs Discussed:

- ✓ Positive Influence from Friends (can be addressed through question 4a, 4b)
- ✓ Positive Influence from Family Members (can be addressed through question 4a, 4b)

Discussion Topics:

1. Finding the cancer when it is the size of a corn kernel

a. Why is cancer easier to treat when it is small?

2. Having peace of mind about her health

c. Vanita wanted to have peace of mind, so she decided to go for a mammogram. Do you agree with Vanita? What does peace of mind mean to you?

d. Have you been worried about your health, had a test and then had peace of mind? Give an example.

3. Feeling discomfort during a mammogram

a. Vanita says that she managed the discomfort as the nurse put her breast between two plates for the mammogram. Does pain of a mammogram scare you? How do you think we should manage the pain aspect?

4. Going to a mammogram appointment with a friend or family member

c. Vanita helps friends and family members by going with them to their mammogram appointments. Would going with someone help you? Who would you bring if so and why?
d. What would you say to friends or family members to encourage them to go with you?

✓ Class 2: Religious Dimensions of Health

60

Materials:

- LCD projector
- Laptop computer with MS PowerPoint

Methods:

- Lecture
- Discussion

Methods:

- Learn about religious dimensions of health

Religious scholar speaks on the following topics (See Religious Scholar guide):

Barrier Beliefs Targeted:

- ✓ Family over Self
- ✓ Physical Pain
- ✓ Fear of Mammogram Results
- ✓ Fatalistic Notions about Health
- ✓ Comfort with Gender-Concordant Healthcare

Facilitator Beliefs Discussed:

- ✓ Perceived Religious Duty to Care for One's Health
- ✓ Methods of Disease Prevention
- ✓ Getting Screened for the Sake of Family

Guide for Female Religious Scholar

Dear _____,

The XXX thanks you again for agreeing to participate in our health education program. During your 45-minute-lecture we ask that you address different aspects of how Islam encourages attention to one's health and answer questions that participants may have about the relationship between health and religion. Through surveys, focus groups and interviews we have researched how religion-related ideas act either as barriers to, or facilitators of, preventive health behaviors such as breast cancer screening. The list enclosed below are those ideas that are particularly salient, we ask you to cover all of them during your talk. We also provide points of discussion for addressing these beliefs and suggest new ways of thinking about mammograms. We hope that this list will help you in crafting a speech that emphasizes how religion can motivate women to pay more attention to preventive care and breast cancer screening.

Barriers to Obtaining Mammograms			
Concept	**Current Way of Thinking**	**Suggested New Way of Thinking**	**Points of Discussion**
Physical Pain	I believe that mammograms are painful.	Although mammograms are painful, I believe that I will be spiritually rewarded for that hardship OR that it is my responsibility as a Muslim to take care of my health despite the discomfort I may experience in the process.	- One receives a reward for experiencing hardships on the path towards good deeds - Concept of *amana* – responsibility despite discomfort
Fear of Mammogram Results	Fear of positive test results makes it difficult for me to get mammogram.	I believe fearing a positive test result is normal, but knowledge of my mammography status will empower me to make decisions about my health and I believe reading the Qu'ran and remembering that God is with me will help me cope with my fear of a positive test result.	- Knowledge empowers one to make decisions about their health. - Discuss coping with reading and recitation of Quran as a means to deal with the fear of the unknown. - "Do not fear, God is with you" (Quranic verse)
Fatalistic Notions about Health	It is by Allah's will that I am sick or cured and I can do nothing to change my fate therefore getting a mammogram is of no benefit.	While it is by Allah's will that I am sick or cured, I believe it is my responsibility to take care of my health both physically (i.e. through cancer screening) and spiritually by praying to God.	- Concept of the body and health as an *amana*. - You can change your fate by appealing to God through prayer.
Family Over Self	My family's needs and priorities are more important to me than my own needs. OR they "should" come first.	While my family's needs are important, I believe it is my religious obligation to take care of my health and I cannot take care of my family unless I take	- Concept of the body and health as an *amana* - taking care of my health is my Islamic

		care of myself first.	responsibility. - Quran and hadith support on making *dua* for yourself first and then family, i.e. you can prioritize yourself
Comfort with Gender Concordant Healthcare	As a Muslim, I am more comfortable with a female provider.	My modesty remains intact even though I'm seeing a male technician.	- Understanding modesty is not compromised in the limited health encounter
Facilitators of Obtaining Mammograms			
Perceived Duty to Care for One's Health	I believe it is my responsibility, as a Muslim, to take care of my body.	I believe getting a mammogram is one way to fulfill the religious practice of caring for my body.	- Discuss concept of body and health as an *amana*.
Methods of Disease Prevention	I believe certain religious practices can help prevent disease.	I believe there are physical (i.e. cancer screening) and spiritual (i.e. prayer) methods of caring for my health to help prevent disease.	- Use "tying camel" concept from hadith to explain responsibility to do both spiritual and physical acts of prevention. - Getting a mammogram helps me to practice, in part, the religious concept of *amana*.
Getting Screened for Sake of Family	I believe my family should know my health status, so that I can prepare my family if I am sick.	Having knowledge empowers me to prepare others in my life if I am sick or enjoy quality time with my family if I am not.	- Family as a supportive unit (verse: supporters of one another); idea of the sick having rights within families

✓ Class 2: Part 1 of Mock Education

70

Minutes

Materials:

- LCD projector
- Laptop computer with MS PowerPoint
- Group Education Manual (x 10 copies)

Methods:

- Role-play
- Discussion

Learning Objectives:

- Master the content of group education manual for Icebreakers and Women & Health sections
- Able to use skillsets to lead discussions

1. A s**taff member** walks peer educators through the questions used in the Icebreakers. Three **peer educators** rotate as moderators, each asking two questions from the list. Mock group participants consist of the remaining peer educators and staff members. Feedback will be given to peer educators.

2. List of questions used in Icebreakers:
    a. Class 1: Icebreaker
        - What is your favorite exercise and why?
        - What prevents you from taking care of yourself?
        - Who in your life supports good health practices?
        - Why is preventive health important?

    b. Class 2: Icebreaker
        - What are you doing now to maintain good health?

    c. Class 3: Icebreaker

- What's one major decision you'll make in the next 6 months to improve your health?

✓ Class 2: Part 2 of Mock Education

60

Minutes

Materials:

- LCD projector
- Laptop computer with MS PowerPoint
- Group education manual (x 20 copies)
- Transcripts and facilitator guides (x 20 copies)

Methods:

- Role-play
- Discussion

Learning Objectives:

- Master the content of group education manual for Cancer Care Videos
- Able to use skillsets to lead discussions

1. **Staff members** play Cancer Care videos to peer educators and hand out the transcripts and facilitator guides.

2. **Staff members** pick a question and model group facilitation skills to peer educators.

3. **Peer educators** rotate as moderators and ask questions, targeting the beliefs of Physical pain, Comfort with gender-concordant healthcare, Getting screened for the sake of family, Fear of mammogram results, Positive influence of family members, and Positive influence of friends. Feedback will be given.

✓ Class 2: Closing

15

Minutes

Materials:

- LCD projector
- Laptop computer with MS PowerPoint
- Sign up sheets (x 10)

Learning Objectives:

- Recap underlying motivations for the project and goals of the training program in improving women's health knowledge and mammography intention
- Able to clarify information or remaining questions

Staff members will summarize the goals of the training program, answer remaining questions, and ask women to sign up for being the peer educators.

Attachment 2. Group Education Class Peer Educator Manual

Caring for Body and Soul: A Workshop on Women's Health

Participant Manual

INSTRUCTIONS FOR PEER EDUCATORS

Important things that should happen at every workshop:

1. Ensure a warm, relaxed and friendly atmosphere.
2. Encourage question-asking. If you do not know the answers, obtain them from the principal investigator or program coordinator and report back at the next class.
3. Monitor individual participation to prevent individual monopoly.
4. Keep discussions directed toward the subject.
5. Encourage class participants to examine their own experiences and to share these with the group.
6. Reinforce verbally or nonverbally (with nods of head, eye contact, etc.) every person, every class.
7. Keep to the time limits for each part of the workshop.
8. Do not add anything to the course.
9. If you have questions or problems, please call XXX

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Caring for Body and Soul:
A Workshop on Women's Health

Group Education Manual
Workshop Agenda

8:30am – 12:00pm

Class 1: Good Health Starts With You

30 minutes	Registration & Breakfast
15 minutes	Welcome
20 minutes	Program Overview (*Staff)*
25 minutes	Icebreaker (*Peer Educators)*
15 minutes	Break
15 minutes	Women & Health (*Peer Educators)*
20 minutes	Health & Access *(Local Organization)*
45 minutes	Religious Dimensions of Health *(Religious Scholar)*
	Lunch & Dismissal

Caring for Body and Soul:
A Workshop on Women's Health

Group Education Manual
Workshop Agenda

Class 2: All About Breast Health

30 minutes	Registration & Breakfast
30 minutes	Welcome & Icebreaker *(Peer Educators)*
30 minutes	Cancer Care Video and Debrief *(Peer Educators)*
25 minutes	Survivorship Story *(Cancer Survivor)*
10 minutes	Break
65 minutes	Breast Cancer Screening Guidelines & Procedures *(Healthcare Professional)*
30 minutes	Closing Ceremony
	Lunch & Dismissal

CLASS 1. GOOD HEALTH STARTS WITH YOU

Class 1: Welcome

30 Minutes

Materials:

- Meals (x 100)
- Pens (x 100)
- Markers (x 10)
- Name tags (x 100)
- Slides/handouts (x 100 copies)
- Sign-in sheets (x 10 copies)
- LCD projector
- Laptop computer with MS PowerPoint

Learning Objectives:

- Get to know staff members and other peer educators

Staff members and peer educators welcome participants at a table, ask them to sign-in and create nametags for themselves, and invite them to get their meal.

After most women have gotten their food, **staff members as well as the peer educators** will introduce themselves.

Class 1: Study Overview

20 Minutes

Materials:

- LCD projector
- Laptop computer with MS PowerPoint

Methods:

- Lecture

Learning Objectives:

- Identify underlying motivations for the project
- Be able to describe the goals of the training program in improving women's health knowledge and mammography intention
- Become familiar with data from previous phases of the study
- Learn about barriers to and facilitators of preventive health (targeted beliefs)

A staff member will use PowerPoint slides to provide an overview of the study and talk about the motivations underlying creating a culture of health in the mosque. During the study overview, another staff member or peer educator will distribute 4 types of granola bars to participants in the room.

Facilitator Beliefs Discussed:

- ✓ Positive Influence from Family
- ✓ Positive Influence from Friends
- ✓ Normative Beliefs

Class 1: Icebreaker

25 Minutes

Materials:

- Butcher Paper (x4)
- 4 boxes of different flavor granola bars
- Markers

Methods:

- Discussion

Learning Objectives:

- Become familiar with data from previous phases of the study
- Identify and discuss personal barriers to and facilitators of preventive health

1. **Peer educators** say:

   To get to know one another better, we will engage in a fun icebreaker. I will divide you all up into 4 equal groups where you will then introduce yourselves to one another and answer a health related question in your corner. Each corner has a different question. Groups will meet for 10 minutes and then we will discuss each group's response to their question for 15 minutes.

2. **Peer educators** explain that each group (based on granola bar division) will be directed to a corner of the room where they will introduce themselves to each other answering the following questions:
   a. Name
   b. An adjective that describes you using the first letter of your name (ex: My name is Fatimah and I am "Fun").

3. After each woman introduces herself, the **peer educator** assigned to each group will facilitate discussion around the question posted on the butcher paper. After 10 minutes of

discussion, all groups will be called back to their seat and the facilitator of each group will report back discussion points. The four questions are:

c. What is your favorite way to stay active and why?
d. What prevents you from taking care of yourself?
e. Who in your life supports good health practices?
f. Why is preventive health important?

4. During facilitated report back, **peer educators** will present barriers of and facilitators to preventative care from data that align with what participants mentioned.

Barrier Beliefs Targeted:

- ✓ Family over Self

Facilitator Beliefs Discussed:

- ✓ Positive Influence from Family Members
- ✓ Positive Influence from Friends
- ✓ Perceived Religious Duty to Care for One's Health

Class 1: Women & Health

15 Minutes

Materials:

- LCD projector
- Laptop computer with MS PowerPoint

Methods:

- Lecture

Learning Objectives:

- Get to know peer educators and understand their motivations for joining the project
- Understand barriers to and facilitators of preventive health for women

Peer educators will now discuss their own background and the reasons for why they chose to be a peer educator as well as the importance of women's health for the Muslim community. **Peer educators** discuss the following points:

1. We are all sisters in Islam. We are a family. We will learn a lot about one another during the three classes we have with each other. By the end of class 2 we hope that you will take what you learn and spread knowledge among other women in the community to radically change how our friends, sisters, mothers, and daughters think about their health, especially their breast health.

2. Ghanaian scholar, Dr. James Emmanuel Kwegyir-Aggrey, says "If you educate a man you educate an individual, but if you educate a woman you educate a family (nation)." This quote illustrates how important women are to society. Women are the backbones of our families and communities.

3. We learned from our focus groups and interviews that some women did not get a mammogram because they prioritized their family's needs above their own. One woman explained: "Especially when you have kids, you ignore all those pains and aches because your life is so busy and hectic. You have to do all your tasks by a certain time. Take care of

the kids, take care of the house. There are so many things. That's the reason avoid yourself. 'Okay. It's alright.'"

4. By participating in preventative care activities such as maintaining a healthy diet, exercise, and regular visits to the doctor (i.e. mammogram) one can enhance the quality of their life to better perform their daily tasks. Your participation in these classes demonstrates how much you care about your health and your family's well-being because if you do not take care of yourself first, you will not be able to take care of anyone else. We hope that you all will become community members who will support other women to improve their health and get a mammogram!

Barrier Beliefs Targeted:

- ✓ Family over Self

Facilitator Beliefs Discussed:

- ✓ Normative Beliefs

Class 1: Health & Access

15 Minutes

Materials:

- Mammography screening programs/services handout (x 100 copies)

Methods:

- Lecture

Learning Objectives:

- Identify resources for setting up mammography screening appointments and possible follow-up visits

Staff members from (local community organization) will discuss their program, which offers a pathway to mammograms for all women and social support throughout the process of getting the test and the results and any follow-up care that might be needed.

Barrier Beliefs Targeted:

- ✓ Insurance

Class 1: Religious Dimension of Health

45 Minutes

Materials:

- LCD projector
- Laptop computer with MS PowerPoint

Methods:

- Lecture

Learning Objectives:

- Learn about different religious dimensions of health

Peer educators introduce the religious scholar to the group.

Religious scholar should address the following beliefs during their presentation.

Barrier Beliefs Targeted:

- ✓ Family over Self
- ✓ Physical Pain
- ✓ Fear of Mammogram Results
- ✓ Fatalistic Notions about Health
- ✓ Comfort with Gender-Concordant Healthcare

Facilitator Beliefs Discussed:

- ✓ Perceived Religious Duty to Care for One's Health
- ✓ Methods of Disease Prevention
- ✓ Getting Screened for the Sake of Family

Guide for Female Religious Scholar

Dear _____,

The XXX thanks you again for agreeing to participate in our health education program. During your 45-minute-lecture we ask that you address different aspects of how Islam encourages attention to one's health and answer questions that participants may have about the relationship between health and religion. Through surveys, focus groups and interviews we have researched how religion-related ideas act either as barriers to, or facilitators of, preventive health behaviors such as breast cancer screening. The list enclosed below are those ideas that are particularly salient, we ask you to cover all of them during your talk. We also provide points of discussion for addressing these beliefs and suggest new ways of thinking about mammograms. We hope that this list will help you in crafting a speech that emphasizes how religion can motivate women to pay more attention to preventive care and breast cancer screening.

Barriers to Obtaining Mammograms			
Concept	**Current Way of Thinking**	**Suggested New Way of Thinking**	**Points of Discussion**
Physical Pain	I believe that mammograms are painful.	Although mammograms are painful, I believe that I will be spiritually rewarded for that hardship OR that it is my responsibility as a Muslim to take care of my health despite the discomfort I may experience in the process.	- One receives a reward for experiencing hardships on the path towards good deeds - Concept of *amana* – responsibility despite discomfort
Fear of Mammogram Results	Fear of positive test results makes it difficult for me to get mammogram.	I believe fearing a positive test result is normal, but knowledge of my mammography status will empower me to make decisions about my health and I believe reading the Qu'ran and remembering that God is with me will help me cope with my fear of a positive test result.	- Knowledge empowers one to make decisions about their health. - Discuss coping with reading and recitation of Quran as a means to deal with the fear of the unknown. - "Do not fear, God is with you" (Quranic verse)
Fatalistic Notions about Health	It is by Allah's will that I am sick or cured and I can do nothing to change my fate therefore getting a mammogram is of no benefit.	While it is by Allah's will that I am sick or cured, I believe it is my responsibility to take care of my health both physically (i.e. through cancer screening) and spiritually by praying to God.	- Concept of the body and health as an *amana*. - You can change your fate by appealing to God through prayer.
Family Over Self	My family's needs and priorities are more important to me than my own needs. OR they "should" come first.	While my family's needs are important, I believe it is my religious obligation to take care of my health and I cannot take care of my family unless I take	- Concept of the body and health as an *amana* - taking care of my health is my Islamic

		care of myself first.	responsibility. - Quran and hadith support on making *dua* for yourself first and then family, i.e. you can prioritize yourself
Comfort with Gender Concordant Healthcare	As a Muslim, I am more comfortable with a female provider.	My modesty remains intact even though I'm seeing a male technician.	- Understanding modesty is not compromised in the limited health encounter
Facilitators of Obtaining Mammograms			
Perceived Duty to Care for One's Health	I believe it is my responsibility, as a Muslim, to take care of my body.	I believe getting a mammogram is one way to fulfill the religious practice of caring for my body.	- Discuss concept of body and health as an *amana*.
Methods of Disease Prevention	I believe certain religious practices can help prevent disease.	I believe there are physical (i.e. cancer screening) and spiritual (i.e. prayer) methods of caring for my health to help prevent disease.	- Use "tying camel" concept from hadith to explain responsibility to do both spiritual and physical acts of prevention. - Getting a mammogram helps me to practice, in part, the religious concept of *amana*.
Getting Screened for Sake of Family	I believe my family should know my health status, so that I can prepare my family if I am sick.	Having knowledge empowers me to prepare others in my life if I am sick or enjoy quality time with my family if I am not.	- Family as a supportive unit (verse: supporters of one another); idea of the sick having rights within families

Class 1: Administrative Info

(In Preparation for Class 2)

Materials:

- Half sheet reminders for Class 2
- Article 9 – Survivor Story (x 50)

Peer educators will thank participants for their time, pass out half sheet reminders for Class 2, and ask women to read the survivor story for homework, as participants exit the class.

Reference

Ahmad, F., Cameron, J., & Stewart, D. (2005). A tailored intervention to promote breast cancer screening among South Asian immigrant women. *Social Science & Medicine* 60

Barrier Beliefs Targeted:

- ✓ Fear of Mammogram Results
- ✓ Comfort with Gender-Concordant Healthcare
- ✓ Family over Self
- ✓ Fatalistic Notions about Health

Facilitator Beliefs Discussed:

- ✓ Perceived Duty to Care for One's Health
- ✓ Positive Influence from Friends

Cancer Survivor Story

***This story reflects the views and personal experiences of one individual. Current screening guidelines are not reflected in this story. Please see "Breast cancer screening recommendations for women of average risk" for current guidelines.*

At age of 49, Sonia came to Canada with her husband and two kids as an immigrant from South Asia. She worked as a cashier in a grocery store in Toronto where she also made some friends. One day, a co-worker and a friend suggested that they go together to a community centre course on health issues including breast cancer. After the presentation, Sonia asked the speaker for more information on breast cancer. The speaker gave her some telephone numbers to call. Sonia called Canadian Breast Cancer Society and the Breast Cancer Foundation and got some brochures.

Sonia told us that "on receiving the brochures I was amazed to learn that I should be getting regular medical breast examinations and should be feeling my breasts each month for suspicious changes. Something I missed knowing before coming to Canada". One of the pamphlets had pictures explaining how to do breast self-examination, but Sonia felt embarrassed and uncomfortable about it. Still she thought a visit to the doctor might be a good idea.

Inquiring how to find a suitable doctor, one of Sonia's colleagues suggested that she see a woman physician working nearby. While making her appointment with the doctor, Sonia requested for a complete physical examination as her last thorough physical examination was done three years before at the time of immigration. Sonia says, "I am so glad that I discussed my personal risk of breast cancer with new my family doctor. She not only examined both breasts in lying and sitting positions but also referred me to the clinic nurse to learn self-examination of my breasts". Her medical check-up also included blood and urine tests, as well as weight, height, blood pressure measurements and a Pap test (looking for abnormalities of the uterus and cervix). The doctor advised her to come back for a breast exam every year. She also told her that she should examine her breasts every month and have a mammogram (breast X-ray) every two years as a routine because she was already 50 years of age.

As some of us might not feel comfortable touching ourselves, we asked Sonia how she overcame these feelings and did regular self-examinations of her breasts. She replied "I thought more about the long term benefits of this simple method; discussed it with my husband and friends; and made it a routine to do my breast self-examination after every menstrual cycle. Believe me, gradually I became very comfortable and confident to detect any changes in my breasts". Sonia also started to have regular mammograms. Although the first two were clear, the third one when she was 57 years old showed something odd in the left breast. The radiologist took extra X-ray pictures and then told her she would probably need a biopsy "to take samples of tissue from the suspicious area" and that she should discuss it with her family doctor.

Although Sonia couldn't feel any lump in her breast, the doctor said the "thickening" shown on the mammogram needed further investigation. Two weeks later, she was back in the X-ray (imaging) department for her biopsy, having tiny "cores" of tissue taken from her left breast, under X-ray guidance. The sample was sent to the lab for analysis. The biopsy procedure didn't hurt - no more than a needle-prick - and she went back to work afterwards.

The worst and most stressful part was having to wait two weeks for the biopsy results. Talking to friends helped Sonia to overcome some of the stress. Sonia's husband was worried about the whole thing and Sonia gave him some brochures to read so he would know at least a little about it. Finally, the family doctor called to say the "bad" news was that the pathology report showed the lump was cancer, the "good" news was that it had been caught at an early stage.

Today, Sonia says, "I feel lucky that my breast cancer was diagnosed early at a curable stage". She was sent to a surgeon to discuss her options and treatment possibilities. Being a small cancer, she did not lose the whole breast and surgery left only a small scar. Sonia was one of the "lucky ones" who probably had only local disease and the cancer had likely not spread beyond her breast because the lymph nodes in her armpit did not show any signs of cancer.

Since the cancer had been caught early, her survival chances were good. However, she needed radiation after surgery to cut the risk that it would return. She had radiation on the operated breast which was not painful but left her breast a little red and sore afterwards. Once the radiation was finished Sonia was put on a hormone (Tamoxifen) treatment as her type of cancer was "estrogen receptor positive" and this medicine would further prevent return of the cancer.

The doctors suggested Sonia attend group meetings with other breast cancer survivors and she found these immensely helpful. Being able to talk frankly with others, to share experiences, fears and feelings and find out how others dealt with them helped Sonia cope with breast cancer and feel more in control of its management.

No doubt, Sonia was diagnosed with breast cancer at an early and very curable stage.

Today after 10-years, when we asked Sonia whether she would like to give a message to other women, she said "health is gift of God. Take care of yourself as you take care of your kids! Get more information, ask your family doctor for your personal risk of breast cancer and go for regular screening when recommended".

Reference

Ahmad, F., Cameron, J., & Stewart, D. (2005). A tailored intervention to promote breast cancer screening among South Asian immigrant women. *Social Science & Medicine* 60

CLASS 2. ALL ABOUT BREAST HEALTH

Class 2: Welcome & Icebreaker

30 Minutes

Materials:

- Name tags for everyone
- Sign-in sheet
- Pens (x 100)
- Printed color sheets of paper with the icebreaker questions, "What are you doing now to maintain good health?" "What's one major decision you'll make in the next 6 months to improve your health?"

Methods:

- Lecture
- Discussion

Learning Objectives:

- Identify and discuss personal barriers to and facilitators of preventive health

Staff members and peer educators welcome participants at a table, asks women to sign-in and create a name tag, invite participants to get their meal, and instruct participants to sit in groups and to answer and discuss the question on their table among the group. Chairs should be set-up in circles of 8-10.

Peer educators will moderate the discussion. There is no report back for this icebreaker.

Class 2: Cancer Care Videos & Debrief

30

Materials:

- LCD projector
- Laptop computer with MS PowerPoint and pair of portable speakers (for the video projection)
- Transcript of Dina and Vanita's story available for women who may not be able to follow the subtitles

Methods:

- Discussion

Learning Objectives:

- Identify and discuss beliefs related to mammography intention

1. **Peer educators** will introduce Cancer Care video and explain that they are going to watch a woman share her story about getting a mammogram and then discuss the points in the video.

2. **Peer educators** will lead a discussion in four groups about the videos by summarizing the story and then engaging in discussions based on the facilitator guide.

Dina's Story (Arabic)	Vanita's Story (Hindi/Urdu)
Barrier Beliefs Targeted: ✓ Physical Pain ✓ Comfort with Gender-Concordant Healthcare **Facilitator Beliefs Discussed**: ✓ Getting Screened for the Sake of Family	**Barrier Beliefs Targeted**: ✓ Physical Pain ✓ Fear of Mammogram Results **Facilitator Beliefs Discussed**: ✓ Positive Influence from Friends ✓ Positive influence from Family Members

Vanita's Breast Cancer Screening Story

https://www.youtube.com/watch?v=NUOOa7J9FFQ

Transcript

My name is Vanita. I am from India.
A mammogram was one of the tests I had when I first visited a doctor in Canada.
The doctor told me a mammogram checks for breast cancer.
I was scared!
But the doctor told me that if breast cancer is caught early, when it is the size of a corn kernel, it is easier to treat.
If it grows bigger, it is harder to treat.
For peace of mind, I decided to go for a mammogram.
I tried to manage the discomfort and I stayed calm when the nurse put my breasts between the two plates for a mammogram.
Since then, I have been getting tested regularly.
I encourage my friends and neighbours go for a mammogram.
I provide them with directions, interpretation, support and company.

Facilitator Guide

Summary of story:

Vanita came to Canada from India. One of the first medical tests she had in Canada was a mammogram. She remembers the doctor telling her that if breast cancer is caught early, when it is the size of a corn kernel, it is easier to treat. The doctor said that if it grows bigger, it is more difficult to treat. Vanita managed the discomfort and stayed calm while she had the mammogram. She gets tested regularly and encourages her friends to do the same. She even accompanies them to provide support and help with interpretation.

Discussion

These topics are based on Vanita's comments. You are not expected to cover all of the topics in 30 minutes, however we require you to address at least the following list of selected concepts:

Barrier Beliefs Targeted:

- ✓ Physical Pain (can be addressed through question 3a)
- ✓ Fear of Mammogram Results (can be addressed through questions 2a, 2b)

Facilitator Beliefs Discussed:

- ✓ Positive Influence from Friends (can be addressed through questions 4a, 4b)

- ✓ Positive Influence from Family Members (can be addressed through question 4a, 4b)

<u>Discussion Topics</u>:

1. Finding the cancer when it is the size of a corn kernel

a. Why is cancer easier to treat when it is small?

2. Having peace of mind about her health

a. Vanita wanted to have peace of mind, so she decided to go for a mammogram. Do you agree with Vanita? What does peace of mind mean to you?
b. Have you been worried about your health, had a test and then had peace of mind? Give an example.

3. Feeling discomfort during a mammogram

a. Vanita says that she managed the discomfort as the nurse put her breast between two plates for the mammogram. Does pain of a mammogram scare you? How do you think we should manage the pain aspect?

4. Going to a mammogram appointment with a friend or family member

a. Vanita helps friends and family members by going with them to their mammogram appointments. Would going with someone help you? Who would you bring if so and why?
b. What would you say to friends or family members to encourage them to go with you?

Class 2: Survivorship Story

20 Minutes

The survivorship story session is intended to provide a personal narrative from a survivor of breast cancer that is understandable and relatable to group education participants. Stories may highlight detection of disease, experience with mammography, treatment of the disease, and other experiences. Participants will have opportunities to ask questions to the survivor in a candid fashion. A concordant survivor from the community is recommended for this session.

Materials:

- LCD projector
- Laptop computer with MS PowerPoint and pair of portable speakers (for the video projection)

Methods:

- Lecture
- Discussion

Peer educators introduce the cancer survivor to the group. **Cancer survivor** gives her speech.

Class 2: Breast Cancer Screening Guidelines & Procedures

60

Minutes

Materials:

- LCD projector
- Laptop computer with MS PowerPoint

Methods:

- Lecture

Learning Objectives:

- Distinguish myths and facts of breast cancer
- Understand the benefits and process of mammography

Peer educators introduce the healthcare professional to the group.

Healthcare professional should address the following beliefs during their presentation as well as current cancer screening guidelines and data about the importance of screening.

Facilitator Beliefs Discussed:

- ✓ Family History Leads to an Increased Risk of Breast Cancer
- ✓ Prevention Actions
- ✓ Perceived Duty to Care for One's Health

Class 2: Closing Ceremony

30 Minutes

Materials:

- Certificates of completion (x 100)
- Decorations (i.e. balloons)
- Calendars for the year
- Cake

Learning Objectives:

- Recap underlying motivations for the project and goals of the training program in improving women's health knowledge and mammography intention
- Feel empowered to overcome barriers to preventive health practices

1. **Peer educators** thank participants for their commitment to the classes, give a recap of the purpose of the study and group education classes, and post the following questions on a PowerPoint slide and invite discussion from the group:
    - ✓ What is it you would like to see in your mosque integrating religion & health?
    - ✓ How was your experience participating in this curriculum?

2. **Peer educators** will begin the distribution of certificates and explain the importance of each item the women will receive:
    - ✓ Certificate: Marks the end of their participation in a ground-breaking health program.
    - ✓ Pink Rose: Breast cancer awareness
    - ✓ Calendar: A tool to help participants put themselves first so that they can take good care of their loved ones.
    - ✓ Candle: For next activity

Peer educators will call each participant to the front, one at a time, to receive a certificate of completion and calendar.

4. Once women are seated, **a peer educator** will give a small talk calling women to action around their health. Talk should include the idea that one cannot unlearn something and the responsibility to spread knowledge and become a beacon of light for others.

5. Participants are instructed to light their candle and reflect on their experience in the program. **Peer educators** will remind the group that the lit candle illustrates internalized knowledge gained and the importance of sharing knowledge and lighting someone else's candle.

6. Participants and staff enjoy the cake.

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