cancerless

Cancer prevention and early detection among the **homeless** population in Europe: Co-adapting and implementing the Health Navigator model

Guidelines and materials for capacity building in the pilot sites

Alejandro Gil-Salmerón

International Foundation for Integrated Care (IFIC)

Project Officer: Ioannis Vouldis

WP3: Pilot implementation of the Health Navigator Model in real-life settings

Date: 28/02/2022

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965351

CANCERLESS has been funded by the European Union's Horizon 2020 Programme under the Grant Agreement GA 965351. The contents of this publication are the sole responsibility of the International Foundation for Integrated Care and do not necessarily reflect the opinion of the European Union.

- WP No.: 3
- Deliverable No.: 3.1
- Level of Dissemination: Public

Versions:

Version No.	**Person in charge**	**Partner (acronym)**	**Date**	**Specifications**
1	Alejandro Gil-Salmerón	IFIC	28.02.2022	First draft
2	Igor Grabovac	MUW	28.02.2022	Corrected version for submission
3	Alejandro Gil-Salmerón & Niamh Daly-Day	IFIC	06.03.2023	Changes after interim report evaluation. Included capacity building and training materials for pilots. Language review.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

This deliverable sets the strategy to develop Task 3.1 –Capacity building activities for the pilot implementation in the four pilot sites. Moreover, this deliverable develops the materials for the health navigator training as well as providing the means to implement the intervention. In this regard, this document is conceived as a “living document” allowing the project partners to support the development and strengthen the skills, abilities, processes, and resources that professionals and organisations need to adapt for the pilot implementation of the Health Navigator Model to thrive in their local context.

INTRODUCTION

Previous research has consistently demonstrated that people experiencing homelessness are at increased risk of experiencing poor health-related outcomes. Infectious diseases, mental health conditions and substance-related disorders are all over-represented within the homeless population (Fazel, Geddes & Kushal, 2014), while rates of premature mortality are significantly higher than in the general population with an average age of death being just 47 years old (Thomas, 2012). Critically in the context of this project, cancer-related mortality has been found to be twice as high when compared to the general adult population in high-income countries (Asgary, 2018).

These poor health-related outcomes may be explained both by behaviours known to increase risk of ill health, and also by the existence of barriers in accessing what are often highly complex and fragmented health and social care systems. In particular, it has been found that people experiencing homelessness often present with symptoms that are missed by primary and secondary prevention strategies and are therefore over-reliant on acute healthcare settings such as emergency hospital departments (Field, Hudson, Hewett & Khan, 2019). Issues with access to appropriate healthcare for this population are often compounded by lack of insurance, legal problems, risk of stigmatisation and experienced discrimination (Hwang et al., 2013; Lebrun-Harris et al., 2013). While it is essential that steps are taken to prevent homelessness, there is also a pressing need for interventions to guarantee timely access to healthcare for those who are currently homeless.

'CANCERLESS: Cancer prevention and early detection among the homeless population in Europe: Co-adapting and implementing the Health Navigator Model' is an EU Horizon 2020 project that aims to design and implement a person-centred and community-based intervention called the Health Navigator Model (HNM) with people experiencing homelessness to facilitate their access to cancer prevention and screening. The HNM will combine the principles of two existing frameworks, both of which have been shown to improve the health outcomes of marginalised and underserved populations: the Patient Navigation Model and Patient Empowerment.

The Patient Navigation Model (Freeman, 2012) is an intervention whereby a worker or team of workers (navigator(s)) promote and facilitate timely access to healthcare and take steps to reduce any identified barriers to care. While existing patient navigation programmes have targeted a wide range of population groups and health outcomes, they have most commonly been used to address the prevention, diagnosis, and treatment of cancer (Kokorelias et al., 2021).

Patient Empowerment is a process through which people gain greater control over decision-making and actions relating to their healthcare (WHO, 1996). In this regard, programmes which adopt Patient Empowerment principles are generally focused upon encouraging people to actively participate in their health, and often make use of education and awareness building as a key tool for empowerment.

While existing evidence strongly indicates that both the Patient Navigation Model and Patient Empowerment are promising approaches for overcoming health inequalities, there are currently limited examples of this sort of framework being used specifically with people experiencing homelessness outside of North America. Consequently, CANCERLESS project has focused on engaging and working collaboratively with stakeholders to ensure that the HNM is designed in a way that is suitable for and meets the needs of health and social care providers and the homeless population in the European context. However, many failures in the implementation of new interventions are due to the lack of adaptation or missing the capacities / capabilities needed for the implementation.

For that reason, this deliverable sets the strategy to develop Task 3.1 –Capacity building activities for the pilot implementation in the four pilot sites. These guidelines present the first deliverable of Work Package (WP) 3 – "Pilot Implementation of the Health Navigator Model in real-life settings" of the CANCERLESS project, the overarching aim of which is to set the capacity building strategy for the partners to implement the intervention.

This document is divided into four sections:

The first section of this document provides the framework for understanding the concept of capacity building as a shared starting point for the consortium.

The second section describes the benefits of the capacity building for the pilot sites and states the target groups of the capacity building.

The third section develops the Capacity Building Cycle and its five phases (preparation, needs analysis, planning and programming, implementation of the activities and evaluation), describing the methodology to prepare the adoption of the intervention into real-life settings.

The fourth and final section develops the capacity building materials (health navigator training and the different means for the intervention).

GENERAL DESCRIPTION OF THESE GUIDELINES

How do pilots benefit from Capacity Building?

The current structure of healthcare services should, in principle, be able to offer person-centred care. In the case of cancer care pathways, this also includes health promotion and prevention, early cancer diagnosis, and timely and appropriate cancer care. However, in reality, the current structure of healthcare services is fragmented with care providers working across different organisations. In this context, the homeless population is left completely outside of the healthcare system facing different barriers in the access of preventive and screening services. For this reason, health navigators, delivering effective, equitable and person-centred care across health and care systems, is also challenging.

CANCERLESS is testing this innovative approach for cancer prevention in four pilot sites requiring high levels of capacity planning for the successful implementation of the Health Navigator Model. Pilot capacity building in this context addresses the need to adopt, adjust and upgrade knowledge and competencies regarding this new intervention of the main actors (health navigators, shelters, primary healthcare services, cancer screening services and civil society groups) in the provision of cancer prevention services for the homeless population in the four pilot sites. This is necessary to make sure that the mentioned actors understand this new model and are able to fully accomplish their role for the implementation of the intervention, breaking silos and working collaboratively.

Who should use these Guidelines and materials?

These guidelines and materials can be used by project partners and other organizations willing to adopt the Health Navigator Model. For this reason, it is of importance that project partners gain full insight and a better understanding of the capacity building cycle to set what is needed for the successful implementation of the Health Navigator Model, so they are better placed to offer navigation services to the homeless population and accomplish WP3 objectives. The section 3 of this document is also important for project partners, but also for the organizations involved in the pilot implementation, as it will provide a guide for the capacity building assessment of needs in order to create the capacity building action plan. Finally, the section 4 of this deliverable provides materials and tools for the implementation organizations that will be used for the training of the health navigators and to homogeneously conduct the intervention.

Table 1. Suggested target groups.

Section	Suggested target group
Section 2. The concept of Capacity building	• Project partners
Section 3. The Capacity Building Cycle Phases	• Project partners • Implementation organizations
Section 4. Resources for Capacity Building	• Implementation organizations

THE CONCEPT OF CAPACITY BUILDING

Capacity building has become a popular term in different disciplines and policy sectors, from development policy to implementation research or health system reforms. Ultimately, it implies that human resource development is key to organizational improvement at all levels. In particular, in health and social care, contemporary challenges that push for continuous system transformations require the organisations and workforce the continuous ability to adapt and transform.

There is a multitude of concepts and definitions about what exactly "capacity" ought to refer to. Usually, most of the concepts refer to the abilities of individuals or organizations to perform functions and to achieve stated objectives. However, capacity may also mean more than purely technical competence, or the availability of sufficient financial or material resources. For the purpose of this deliverable, capacity is understood as dynamic and multidimensional, as the ability of an individual, an organization or a system to perform functions and to meet objectives effectively and efficiently.

In terms of the pilot implementation and deployment of the Health Navigator Model, capacity measurement is seen from the perspective on how the model is going to be adapted and the changes needed to be done or what usual procedures need to be more flexible for the successful implementation of the intervention.

In this regard, the CANCERLESS Consortium understands capacity building as a process that increases the ability of professionals and organizations to meet the pilot implementation's objectives. Furthermore, in the long-term, this activity is also understood as a key aspect to guarantee the sustainability of the Health Navigator Model by inducing, or setting in motion, multi-level change in professionals and organizations, as well as, systems seeking to strengthen their capabilities to answer the health needs of the homeless population through better coordination of provided services.

Capacity-building is defined by the United Nations as the process of developing and strengthening the skills, instincts, abilities, processes, and resources that organizations and communities need to survive, adapt, and thrive in a fast-changing world. Based on the definition provided by the United Nations, CANCERLESS Consortium is committed to generate and champion person-centered models for cancer prevention and care, going

beyond the pilot implementation to changing health and care systems and service delivery. For that reason, tailored strategies are needed for each pilot site and this deliverable comprises a common methodology and materials.

Capacity building consists of phases (needs assessment, formulation of strategies, implementation of actions, monitoring and evaluation, re-planning) which are closely linked, and not necessarily chronically sequenced. For this three-month capacity-building phase, the Consortium will focus on the needs assessment, formulation of strategies, implementation of actions and evaluation. The results of the evaluation of the capacity building will not only inform WP3 leader (PROLEPSIS) about the main strengths and weakness needing careful monitoring during the pilot implementation, but will also ensure that the piloting is going as planned, with problems being resolved on time. Moreover, the results of this evaluation will be used in the framework of WP5 – "Blueprint for a transformation of the cancer care for the homeless across health and social care systems in Europe", considering the valuable lessons learned into the recommendations at policy level.

For the successful implementation of the Health Navigator Model, capacity building is understood broader than mere training and CANCERLESS Consoritum understands that capacity building takes place on three levels in order to be effective and sustainable:

- the systems (or institutional) level, e.g., the regulatory framework, policies and frame conditions that support or hamper the achievement of certain policy objectives;
- the organizational (or entity) level, i.e., the structure of organizations, the decision-making processes within organizations, procedures and working mechanisms, management instruments, the relationships and networks between organizations;
- the individual level, i.e., individual skills and qualifications, knowledge, attitudes, work ethics and motivations of the people working in organizations.

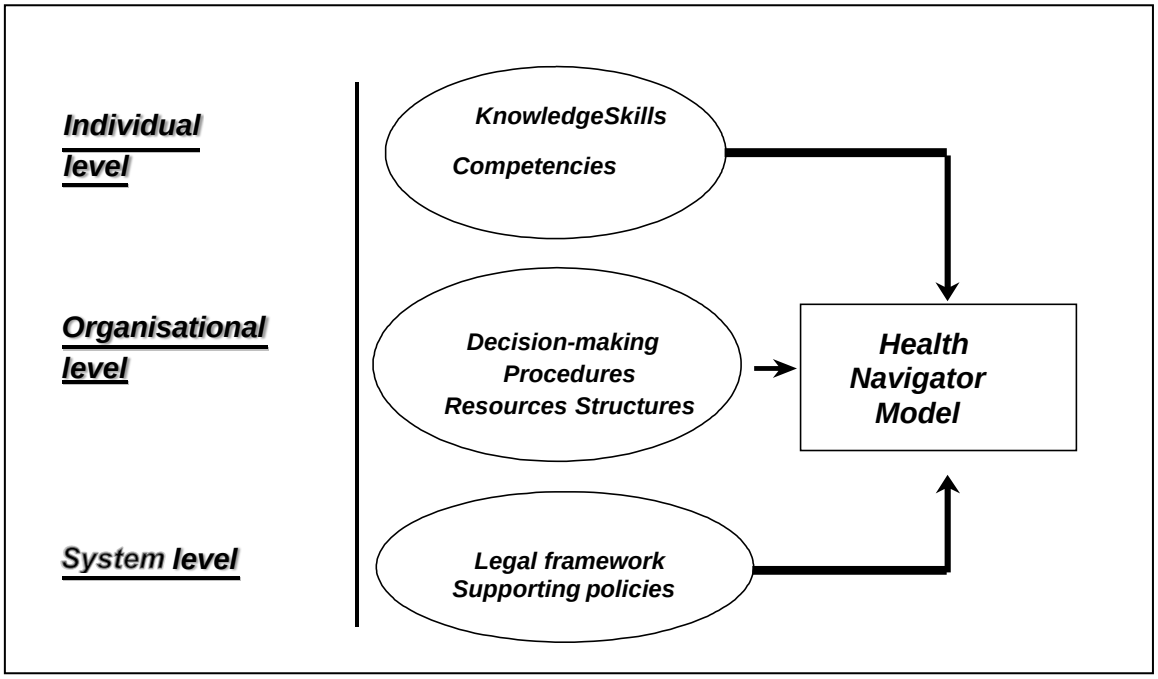


Figure 1: Levels of Capacity Building

These three levels are interdependent and changes on one level will have an impact on the other levels. The CANCERLESS Consortium will focus its capacity building at each of these levels, that will influence capacity of the other levels as well. Therefore, capacity building activities will have to address the needs for capacity building at all levels in the pilot sites in order to ensure sustainability far above mere pilot implementation success but also ensuring that person-centered principles remain in the care services delivery for the homeless population beyond the pilot implementation.

The common ground for the capacity building is developed as a cycle, being a continuing process, which consists of several interrelated elements:

- the assessment of capacity building *needs* through analytical activities
- the formulation of capacity building *action plans* involving main relevant stakeholders
- the implementation of capacity building *actions* by partners and other main stakeholders involved in the implementation of the intervention
- the evaluation of the *impact* of capacity building activities (the learnings during this last phase will inform about what needs special attention during the final stage)
- *implementation follow-up*, as well as the results of the evaluation will feed the policy recommendations.

Figure 2: CANCERLESS - Capacity Building Cycle

THE CAPACITY BUILDING CYCLE: PHASES, PROCESSES AND ACTORS

For the CANCERLESS Consortium, capacity building is understood as a cyclical process. Moreover, the Consortium acknowledges that there is no "one size fits all" capacity building cycle because the pilot implementation capacity building will take place in four different countries with different health and care systems and relevant actors. Therefore, the capacity building cycle will be different from one pilot to the other. Yet, in this deliverable we appraise a common methodology to be followed in all capacity building processes for the implementation of the Health Navigator Model. In this section, the 5 phases (preparation, need analysis, planning, implementation, and evaluation) will be outlined from the readiness evaluation to the evaluation of the impact, understanding that the phases are not always carried out in a sequential manner; rather they can take place simultaneously, in loops, and in a non-sequential way depending on local conditions and needs.

Phase A: Preparation

The preparatory phase of the capacity building cycle addresses the establishment of the work process at pilot level[1]. For this purpose, the formation of the pilot implementation team is needed so they will identify the need for capacity building. The decisions will be done collaboratively by all the members of the pilot implementation team.

Phase B: Analysis of Capacity Building Needs

In this phase, all the pilot sites will draft an initial pilot implementation plan, where all the steps for the intervention will be agreed and all the main stakeholders will be identified.

[1] See Annex 1. Capacity building materials

This preparation for the action will enable the project partners to envisage the operationalization of the pilot interventions in their sites by the first time.

Based on this initial draft, the pilot implementation teams will conduct an initial assessment process which will bring the pilot implementation team different results and insights, requiring different capacity building actions. Afterwards, using the drafts of the pilot plans, the main stakeholders in the health and social care services will be invited to participate in the implementation of the Health Navigator Model through telephone calls and emails where the project and the intervention will be explained. After accepting to participate in the intervention, a more concrete consultation will be conducted to collect and gather their input identifying key issues for the implementation of the pilot. The needs assessment will be conducted by the academic partners in each pilot site by providing support exploring the needs and/or facilitating the discussion. In this regard, the capacity building process will require close coordination between the academic partners and the implementation organizations. Furthermore, the analysis phase identifies existing capacity gaps pertaining to service delivery functions. Therefore, it is also important to keep the assessment process flexible.

The result of this phase will be a preliminary list of capacity building needs pertaining to the implementation of the Health Navigator Model in the four pilot sites and the main stakeholders involved.

Phase C: Planning and Programming

Based on the identified needs, the pilot implementation team will draft an internal capacity building plan to conduct clearly defined activities and actions. At the end of this phase, pilot sites will have a capacity building action plan which outlines capacity building strategies, time schedules, and institutional and operational arrangements for the pilot implementation. The draft plan will also identify the needs for external support (e.g., a hospital delivering screening services which is not part of the consortium), the cooperation mechanisms between the various main stakeholders, and a more definitive version of the pilot implementation plan including pilot management structures.

Furthermore, the plan and its capacity building actions should contain indicators to be used to assess progress achieved and impacts made on the pilot sites capacities.

Phase D: Implementation of Capacity Building Measures

In this phase of the cycle, project partners will put in place capacity building actions and activities based on their tailored planning to respond to their specific needs. Moreover, partners will provide continuous monitoring of the accomplishments of these actions and activities to ensure that the capacity building process stays on track and that improved capacity for the implementation of the Health Navigator Model is achieved.

Phase D: Evaluation of the Capacity Building Process

The final phase of the capacity building cycle deals with the evaluation of outcomes and impacts obtained from capacity building at the pilot site level. Performance indicators formulated as part of the Capacity Building Action Plan should facilitate the assessment on how the implementation organizations or individuals (including health navigators) have improved their performance for the implementation of the pilot. Based on this evaluation, special attention will be given to the different aspects during the follow-up and monitoring of the pilot implementation in each site.

MATERIALS FOR CAPACITY BUILDING

Health Navigator Training

The Health Navigator Training comprises the main features and contents of the training to be delivered to the professionals to become "Health Navigators".

Features of the Training

- Timing of the training (10 hours).
- Face-to-face.
- Translated materials into national languages.
- 5 modules.
- Participatory methodology.
- Evaluation (understanding of the core contents & satisfaction of the course).

Contents of the Training[2]

Based on the results of WP2, the training course is structured under the following **learning modules**:

- CANCERLESS, Health Navigator Model & Pilot Plan
  - CANCERLESS (general information of the project)
  - The Health Navigator Model (general information of the model, including role and responsibilities of the Health Navigator)
  - The Pilot Implementation Plan (specific information of the pilot scope and activities)
- Population-specific knowledge
  - Causes and impacts of homelessness
  - Different forms of homelessness

[2] See Annex 2. Training materials

- Safeguard
- Health issues and barriers faced:
    - Mental health
    - Substance use

- Communication and interpersonal skills
    - Simple language
    - Strategies for engaging this population.
        - Motivational interviewing
        - Psychosocial interviewing
    - Problem-solving skills
    - Cultural competence
    - Trauma-informed care and harm reduction
        - Trauma-sensitive conversation techniques
- Cancer/health education
    - Types and prevalence of cancer
    - Risk factors
    - Symptoms
    - Preventative strategies
- Local context and resources:
    - General information of health care system
        - Organization of the health care system
        - Access to the health care system
        - Assessing and overcoming barriers for accessing health care system for the homeless population
    - General information of social services for homeless population
        - Organization of social services
        - Social services available for homeless population
        - Community resources available for homeless population
    - Cancer screening programmes
        - Available screening programmes

- Existing cancer screening guidelines
- Assessing and overcoming barriers for accessing cancer screening

Means for Pilot Implementation

In this section, tools, documents, activities, and services required to support successful pilot implementation are presented:

- Identifying users: document to identify each user of the navigation services.
- Appropriateness for Screening assessment tool: tool to assess the accomplishment of screening criteria.
- Monitoring sheet: document to collect information regarding the different interventions carried out with the users.
- “Who can support you” - The multi-disciplinary team: document to fill in with the different contact persons to facilitate inter-agency collaboration.

REFERENCES

Asgary, R. (2018). Cancer screening in the homeless population. *Lancet Oncology, 19*(7), pp. 344-350. https://doi.org/10.1016/s1470-2045(18)30200-6

Fazel, S., Geddes, J. R., & Kushel, M. (2014). The health of homeless people in high income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. *Lancet, 384*(9953), pp. 1529–1540. https://dx.doi.org/10.1016%2FS0140-6736(14)61132-6

Field, H., Hudson, B., Hewett, N. & Khan, Z. (2019). Secondary care usage and characteristics of hospital inpatients referred to a UK homeless health team: a retrospective service evaluation. *BMC Health Services Research, 19*(857). https://doi.org/10.1186/s12913-019-4620-1

Freeman, H. (2012). The origin, evolution, and principles of patient navigation. *Cancer Epidemiology and Prevention Biomarkers, 21*(10), pp. 1614-1617. https:/doi.org/10.1158/1055-9965.EPI-12-0982

Hwang, S. W., Chambers, C., Chiu, S., Katic, M., Kiss, A., Redelmeier, D. A., & Levinson, W. (2013). A comprehensive assessment of health care utilization among homeless adults under a system of universal health insurance. *American Journal of Public Health, 103*(2), pp. 294-301. https://doi.org/10.2105/ajph.2013.301369

Kokorelias, K. M., Shiers-Hanley, J. E., Rios, J., Knoepfli, A., & Hitzig, S. L. (2021). Factors influencing the implementation of patient navigation programs for adults with complex needs: a scoping review of the literature. *Health Services Insights, 14*. pp. 1-17. https://doi.org/10.1177%2F11786329211033267

Thomas, B. (2012*). Homelessness kills: An analysis of the mortality of homeless people in early twenty-first century England*. London: The University of Sheffield for Crisis.

United Nations. n.d. "Capacity-building". UN. https://academicimpact.un.org/content/capacity-building. Accessed 26 February 2022

World Health Organisation (1996). *Health Promotion Glossary*. Geneva: WHO.

ANNEXES

Annex 1. Capacity building materials

CANCERLESS

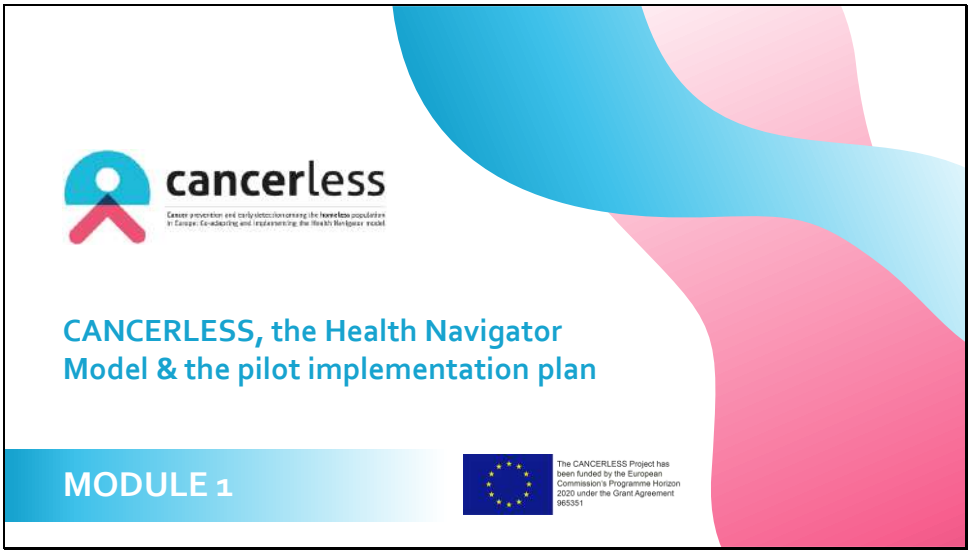
Capacity Building

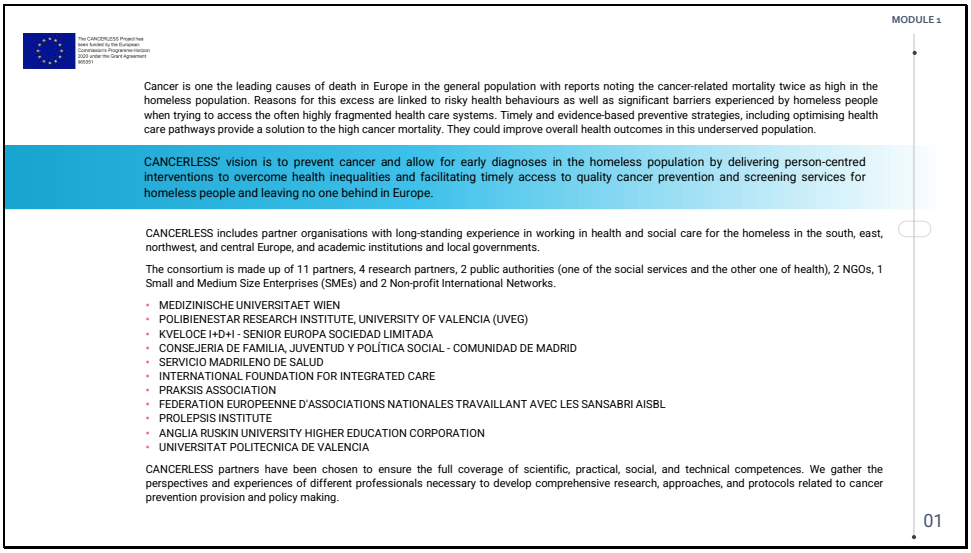
PREPARATION	
Identification of the "Pilot implementation team"	
ANALYSIS OF CAPACITY NEEDS	
Draft of initial implementation plan	
Identification of services and main stakeholders to present and motivate participation in the project.	
Consultation will be conducted to collect and gather care team's input identifying key issues for the implementation of the pilot.	
PLANNING AND PROGRAMMING	
Internal capacity building plan	

More definitive version of the pilot implementation plan including pilot management structures.	
IMPLEMENTATION	
Capacity building actions and activities to respond to the specific needs are put in place.	
EVALUATION	
Perform an evaluation using indicators in the capacity building plan	

STAKEHOLDER NAME	TYPE	STAKEHOLDER DESCRIPTION	MAIN CONTACT PERSON	NOTES

Annex 2. Training materials





MODULE 1

The CANCERLESS project aims to deliver an innovative solution as an aggregate intervention based on the combination of the tested Patient Navigator Model and Patient Empowerment Model to create the Health Navigator Model for Europe.

This care model serves to **virtually integrate the fragmented health care system eliminating the barriers for timely care across the health care continuum** (Freeman, 2012).

Patient Navigation is a proven effective patient-centred health care service delivery model aiming to **overcome health inequalities** and **facilitate timely access for the people, families and caregivers to quality health and psychosocial care through the cancer continuum of care** (Freeman, 2012; American Medical Association, 2015).

Patient Navigator is designed to provide a sustainable service to improve health outcomes, patient satisfaction, decreased no-show rates and reduced disparities in care (The Centre for Healthcare Affairs, 2012).

From a healthcare system approach, the Patient Navigator has shown benefits **reducing hospitals costs** avoiding revenue loss and even increasing revenue (The Centre for Health Affairs, 2013).

Patient Navigation, has shown to be potentially **applicable to a wide variety of populations affected by disparities** (including racial and ethnic minorities, residents of rural areas, or women for example), **across the cancer continuum** (prevention to survivorship) and to **different cancers** (breast, cervix, colorectal and prostate) (Paskett et al., 2011; Freeman, 2012).

However, even as the **Patient Navigator** programme has great transferability potential to international health care contexts (Fillion, 2012), there is still no evidence of its application among the homeless in Europe

02

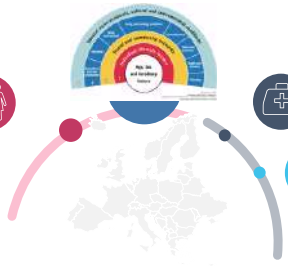
MODULE 1

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 945351

NEED FOR URGENT INNOVATIVE AND SUSTAINABLE MODELS OF CARE FOCUSED ON THE PATIENT AND THE CONTINUITY OF CARE

Patient Navigators Model (PN)

to overcome cancer health inequalities



to reduce health and social care systems costs by making the best use of finite resources

- provision of patient-centred care
- health promotion
- counselling and support to navigate the healthcare system

to improve health outcomes and satisfaction with care

through all phases of the cancer experience

03

MODULE 1

Patient empowerment is defined as '*a process through which people gain greater control over decisions and actions affecting their health*' (World Health Organization) is a key theme within global health and social care strategies.

Moreover, **Patient Empowerment** has also shown improvements in patients' outcomes (Tataw, Bazargan-Hejazi, James, 2011; Harrington, Noble & Newman, 2004; Post, Cegala & Miser, 2002). In this regard, interventions addressing gaining of control, which includes people taking the initiative, solving problems, and making decisions', have shown more **satisfaction with care** (Mullins, Shaya, Blatt & Saunders, 2012), **improved self-efficacy and self-management** (Tataw, Bazargan-Hejazi, James, 2011) and as well as **greater adherence to treatment and medical appointments** (Cegala, Marinelli & Post, 2000).

Implementation science shows the use of the empowerment strategies to be effective to prevent diseases and promote health by promoting health-related behaviours (Tol et al. 2015; Chatzimarkakis, 2010; Figueroa-Moseley, 2006). Yet, only a few small-scale studies to date have been conducted using the Patient Navigator to address cancer prevention and timely cancer detection for homeless world-wide, but results from North America show the value of these interventions by mitigating screening barriers at the systems, provider, and individual levels (Agary, Garland, Jakubowski & Sckell, 2014; Agary, Garland & Sckell, 2014; Lofters, Moineddin, Hwang & Glazier, 2013; Asgary, Sckell, Alcabes, Naderi, & Ogedegbe, 2015).

04

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement #101001

In 2017, FEANTSA stated that at least 700,000 people are homeless in Europe, with at least 60% of these being in emergency shelters or temporary accommodation there is an opportunity **to adapt the Patient Navigator and Patient Empowerment, and use the resulted Health Navigator Model in these non/semi-permanent housing to prevent, support and navigate with the homeless population the unfamiliar health services where routinely screening could be done.**

Such models are completely compatible with the EU Cancer Control Joint Action policy paper on tacking social inequality in cancer prevention and control in the European population, where embedding equity with cancer prevention policies in all EU member states with special emphasis on socially vulnerable groups is outlined.

Interventions to improve cancer screening in homeless population

Intervention...	Description
Tailored cancer health education and counselling (face-to-face, phone, printed materials, lay language, English and Spanish), and health navigators for cancer screening	Providing counselling and education on cancers and their risks and consequences, screening methods and their risks and benefits, screening barriers among homeless people, screening results and subsequent care, and the navigators' role and services
Patient perception and personal risks assessment	Understanding and addressing patient's perception, and targeted risk assessment and discussion
Establishing trust	Creating and reinforcing trust between homeless people and the staff at shelters, drop-in centres, and screening facilities
Scheduling appointments, reminders and follow-ups	Making screening appointments during clinical encounters or later, coordinating for screening with participants or caseworkers, reminder visits or calls for procedures, following up with patients if they have missed an appointment
Screening test preparation	Instructing on preparation for screening tests when needed, and addressing concerns during screening day
Transportation assistance and accompanying patients	Accompanying patients to and from procedures if needed, and helping with reaching and navigating screening sites
Obtaining and documenting screening results	Helping to obtain screening results, and communicating the results with patients and providers
Facilitating follow-up appointments with providers after screening	Following up to ensure continuation of medical care after tests and subsequent procedures if needed
Support and coordination	Reinforcing support system and coordinating with an individual's caseworker, social worker, or substance-abuse counsellor when needed
Partnership with service providers	Partnering with community organisations and screening facilities for flexibility in service processes

Source: Asgary, R. (2018). Cancer Screening in the homeless population, *The Lancet Oncology*, 19(7) E344-E350

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement #101001

This presents a missed opportunity to reduce the cancer burden in this marginalised population. Altogether combining the Patient Navigator with Patient Empowerment programme holds the promise to both overcome inequalities in cancer care and **create a comprehensive person-centred model for cancer prevention**: The **Health Navigator Model.**

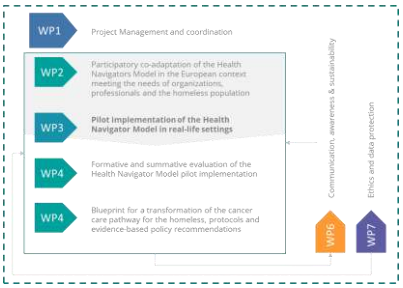
The Health Navigator Model is an evidence-based patient-centred intervention that develops patient empowerment through health education and social support, promoting timely access to primary and secondary prevention services.

In this regard, through the co-adaptation of the Patient Navigator & Empowerment programmes, the Health Navigator Model will deliver person-centred cancer care for the homeless population. In this regard, primary and secondary cancer prevention strategies will be facilitated by the Health Navigator, to improve health outcomes, to reduce risky behaviours, to increase patient satisfaction, to decrease no-show rates and to reduce disparities in care.

Using the Consolidated Framework for Implementation and the Research and the Reach, Effectiveness, Adoption, Implementation and Maintenance frameworks based on implementation science know-how, the CANCERLESS project aims to reduce the gap in health inequalities for the homeless population. So, CANCERLESS reduces the cancer burden, which will, in turn, reduce associated costs across health and social care systems in Europe.
Moreover, the CANCERLESS project aims to harness the transformative potential of the integrated care pathways in cancer as well as provide health and social care policy recommendations for the adoption and implementation of the Health Navigator Model across Europe.

The three-year project is structured as follow in 7 Work Packages (WP) (illustrated below). There are three overall WPs: project management and coordination (WP1); communication, awareness & sustainability (WP6); and ethics and data protection (WP7) the other four WPs aim to co-adapt, implement and evaluate the Health Navigator Model in Europe and inform policy and practices with its results.

Work stream structure



The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 945331

Five avenues

First one is targeting the co-adaptation of the Health Navigator Model through the foundation of the existing evidence on its application with the real-life needs of the homeless, professionals, managers, and policymakers through a participatory process.

The second avenue will aim to implement and test the Health Navigator Model in real-life settings. Before testing, capacity building activities for the pilot implementation will be carried out. Consequently, the piloting will be conducted with a longitudinal cohort study of homeless in 3 EU Member States (Austria, Greece & Spain; total n=1000) and UK (n=500) in a pre- vs. post-intervention, for 18 months, to assess whether this intervention can improve the delivery of evidence-based, community-based primary and secondary cancer preventive for homeless population.

The third avenue will assess the cost-effectiveness of the interventions from the healthcare perspective through empirical analysis and microsimulation modelling of patient service use and outcomes. The fourth avenue will focus on the CFIR framework to guide the implementation planning, organization, and conducting and use the RE-AIM framework to evaluate the impact and the optimum processes for implementing and disseminating the Health Navigators Model in health and social care practices, for the first time in Europe. CANCERLESS will use both frameworks of the science of implementation due to combining both results inform at two levels: the **process and the overall impact** of the implementation.

Evaluation

CFIR constructs are organized into five major domains focused on the process of implementation and, as applied to this study, are characteristics of the Health Navigator Model (e.g., evidence strength and quality, complexity); the outer setting (e.g., the homeless needs and resources); inner setting (e.g., compatibility of Health Navigator Model with existing programs, leadership engagement); the process used to implement the program (e.g., quality and extent of planning, engagement of key stakeholders); and the fifth domain, characteristics of individuals involved (e.g., knowledge and attitudes).

But in order to complement this and having a greater picture of the factors beyond effectiveness that can affect program impact, The **Reach, Effectiveness, Adoption, Implementation and Maintenance (RE-AIM)** framework provides a comprehensive approach to evaluating an intervention's overall public health impact. In the RE-AIM, Reach addresses the percentage and representativeness of participants, Effectiveness addresses the impact of the intervention on the targeted outcome, Adoption addresses the proportion and representativeness of settings that deliver the program, Implementation addresses the extent to which the program is delivered as intended, and Maintenance addresses both the individual and organizational (setting level) program delivery over time. Of these RE-AIM dimensions, Reach and Effectiveness are individual-level dimensions, Adoption and Implementation are Organizational/setting-level dimensions, and Maintenance has both individual-level and organizational/setting-level dimensions.

Based on CANCERLESS results, the fifth avenue will design the **blueprint** for a transformation of the cancer care pathway for the homeless population and evidence-based policy recommendations.

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement #101101

Health Navigator Model

Following the completion of a systematic scoping review and an exploratory qualitative study in WP2, the final stage of data collection was a series of focus group discussions conducted with key stakeholders and individuals with lived experience of homelessness.

The aim of these focus group discussions was to work collaboratively with stakeholders to co-adapt the HNM to ensure that it is suitable for and meets the needs of the homeless population and health and social care providers.

It was intended that the focus group discussions would inform decision making with regards to the 10 core components of the HNM, as defined by DeGroff et al. (2014).

These components cover all the various stages of the intervention, including the overall design, the remit of services provided, the profile of the navigator and the evaluation measures.

1. Identifying a theoretical framework and setting program goals
2. Specifying community characteristics;
3. Defining the point(s) of intervention within the cancer continuum focusing on primary and secondary prevention; Determining the setting in which navigation services are provided;
4. Identifying the range of services offered and health navigator responsibilities;
5. Determining the background and qualifications of the navigator.
6. Selecting the method of communications between users and navigator;
7. Designing the navigator training;
8. Defining oversight and supervision for the navigators;
9. Evaluating health navigation.

Results

Focus group discussions were held in field settings and/or online via videoconferencing platforms in four countries (Austria, Greece, Spain, and the U.K.) during December 2021 and January 2022, and were facilitated by a multidisciplinary team of researchers from partner organisations of the CANCERLESS project.

Results from the co-adaptation focus group discussions indicate a high level of consistency and cross-national agreement with regard what the core components of the HNM should be, and how the intervention should be designed and implemented.

it is proposed that the Health Navigator Model will be a longitudinal, person-centered and community-based intervention focused on addressing both primary and secondary cancer prevention, as well as reducing wider barriers to healthcare.

The Health Navigators will be professionals who have a background in providing social care and an understanding of the local user population and will be embedded in settings familiar and accessible to people experiencing homelessness.

The primary aspects of the Health Navigator role will be to identify the health needs and barriers of users, promote cancer awareness and education, facilitate timely access to healthcare services and cancer screening, and provide practical assistance, delivered through regular in-person meetings.

The Health Navigators will also utilise wider stakeholders, including healthcare professionals, to deliver the intervention, and will receive both clinical and administrative supervision.

A comprehensive training package will be delivered to the Health Navigators, covering population specific knowledge, interpersonal skills, cancer education and local resources.

The country specific findings were then cross-compared and integrated to form an overarching framework which defines the core components of the HNM, as follows:

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement #101101

Programme goals

- Deliver a person-centered intervention, responsive to user needs.
- Improve and build trusting relationships between users and health and social care providers, and between health and social care providers.
- Promote awareness and understanding of cancer (primary prevention).
- Increase rates and timeliness of cancer screening among homeless users (secondary prevention).
- Improve levels of self-care and overall wellbeing among homeless users.

Community characteristics

- Make intervention accessible to people experiencing and/or at risk of all forms of homelessness as defined by the ETHOS typology (FEANTSA, 2006).
- Prioritise those at most high risk of cancer, those not currently engaged with healthcare services and those with complex support needs.

Point of intervention

- Build trusting relationships and become embedded within the user population as the starting point for intervention.
- Implement intervention preventively, with continued care and follow-up for users where required.

Navigator services

- Identify health needs and barriers.
- Coordinate access to care.
- Offer practical assistance.
- Promote cancer awareness and self-management.

Setting

- Deliver main navigation activities in settings familiar and accessible to homeless users, and through mobile outreach.
- Facilitate access to formal clinical settings for full cancer screening and follow-up.

MODULE 1

Navigator background

- Select social or support worker, ideally experienced with user population and with local/community knowledge, to act as navigator.
- Establish and utilise local stakeholders (service managers, clinical professionals, and peers) to support implementation and delivery.

Communication channels

- Deliver navigation activities through in person meetings, with optional phone 'check ins'.
- Maintain a presence within spaces familiar and accessible to homeless users.
- Ensure navigator-user meetings take place at regular intervals, with exact frequency and timing to be decided by users.

Supervision

- Provide the navigator(s) with administrative and clinical supervision from appropriate professionals, either external or internal.
- Utilise a combination of formal observations, peer coaching and informal 'check-ins'..

Training

Develop and deliver a comprehensive package of training with input from local stakeholders, covering:

- Population-specific knowledge;
- Communication and interpersonal skills;
- Cancer education
- Local context and resources.

Evaluation

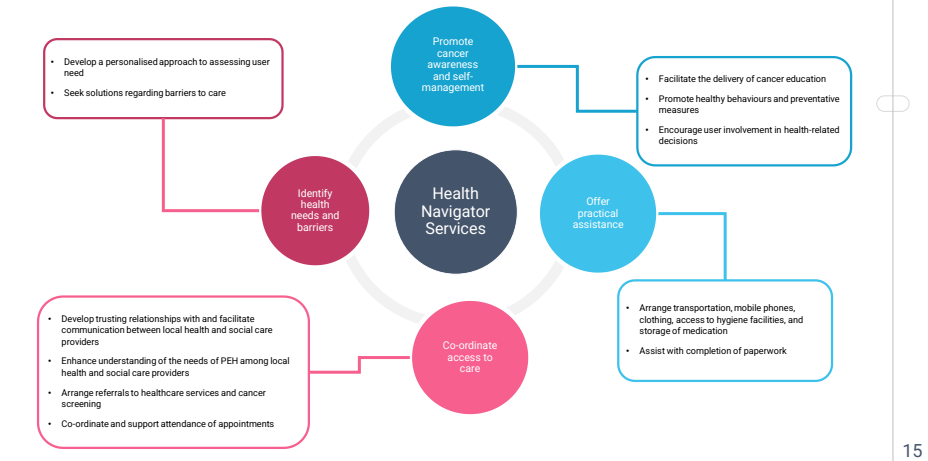
- Evaluate intervention using a combination of qualitative and quantitative measures, and include direct feedback from users, navigators, and service providers.
- Collect pre- and post- data on cancer screening rates; level of user engagement with the intervention; user health and quality of life; and the quality of relationships between users and health and social care providers, and between different health and social care providers.
- Formal 'check-ins'.

14

cancerless

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 945351

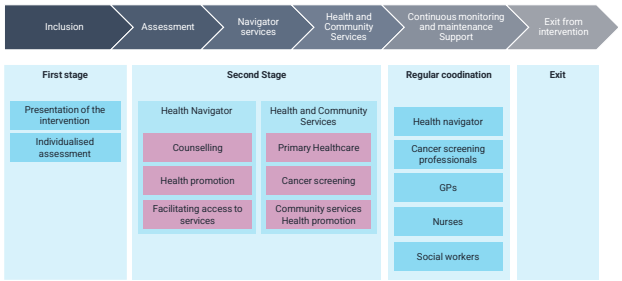
MODULE 1



15

MODULE 1

Intervention model



16

cancerless


cancerless.eu
cancerless
CANCERLESS, the Health Navigator
Model & the pilot implementation
MODULE 1

cancerless

Cancer prevention and early detection among the homeless population in Europe: Co-adapting and implementing the Health Navigator model

Population-specific knowledge

MODULE 2

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965351

Causes of homelessness

cancerless

Cross-sectional studies on the occurrence of homelessness have identified factors that distinguish homeless people from their housed counterparts. Research into the causes of homelessness suggests complex interactions between individual and structural factors:

- Individual factors associated with homelessness include physical health problems, substance abuse and poor coping skills
- Structural factors include the availability of affordable housing as well as educational and employment opportunities.

Several categories of risk factors have been associated with vulnerability to repeated homelessness, including criminal justice contact, mental illness, substance dependence, ethnicity, and social networks

The delineation of sub-groups within the homeless population is important for the identification of specific needs, and the delivery of indicated forms of intervention.

Among 377 first time homeless adults admitted to shelters, Caton et al. (2005) found that older age and arrest history were the strongest predictors of duration of homelessness over 18 months.

McBride et al. (1998) within a sample of 215 participants found males were homeless for longer durations than females; and those with more severe psychiatric symptoms were more likely to be homeless for longer durations. Notably, no substance use variables were included in their analyses.

Studies of pathways into homelessness typically point to a series of ruptures involving important social bonds, often compounded by substance use

Johnson and Chamberlain (2008) identified three stages leading to homelessness:

1. separation from the mainstream labour market
2. erosion of support from family and friends
3. acquisition of new social networks in the context of homelessness

References

- Babayan, M., Futrell, M., Stover, B., & Hagopian, A. (2021). Advocates Make a Difference in Duration of Homelessness and Quality of Life. Social Work in Public Health, 36(3), 354-366.
- Caton, C.L.M., Hasin, D.S., Shrout, P.E., Opler, L.A., Hirshfield, S., Dominguez, B., &Felix, A. (2000). Risk factors for homelessness among indigent urban adults with nohistory of psychotic illness: A case-control study. American Journal of Public Health,90, 258–263
- Cronley, C. (2010). Unraveling the social construction of homelessness. Journal of HumanBehavior in the Social Environment, 20, 319–333.
- Johnson, G., & Chamberlain, C. (2008). Homelessness and substance abuse: Which comesfirst? Australian Social Work, 61, 342–256.
- Keys, D., Mallett, S., & Rosenthal, D. (2006). Giving up on drugs: Homeless young peopleand self-reported problematic drug use. Contemporary Drug Problems, 33(1), 63–98.
- Babayan, M., Futrell, M., Stover, B., & Hagopian, A. (2021). Advocates Make a Difference in Duration of Homelessness and Quality of Life. Social Work in Public Health, 36(3), 354-366.
- McBride, T.D., Calsyn, R.J., Morse, G.A., Klinkenberg, W.D., & Allen, G.A. (1998).Duration of homeless spells among severely mentally ill individuals: A survival analysis.Journal of Community Psychology, 26, 473–490
- Shinn, M. (2007). International homelessness: Policy, socio-cultural, and individualperspectives. Journal of Social Issues, 63, 657–677.

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965351

Risk Amplification Model

The Risk Amplification Model conceptualizes homelessness as the result of successive environmental disruptions, each of which places individuals at greater risk for homelessness and associated risk factors.

According to this model, in addition to the cumulative effects of progressive risk, risk may be multiplied at each stage because the environmental risks associated with later phases present increasingly greater challenges to development and adaptation (see Hser, Longshore & Anglin, 2007).

The first experience of homelessness may be a critical point in the process because duration of homelessness may predict the extent to which early risks are amplified.

References

- Babayan, M., Futrell, M., Stover, B., & Hagopian, A. (2021). Advocates Make a Difference in Duration of Homelessness and Quality of Life. Social Work in Public Health, 36(3), 354-366.
- Hser, Y.I., Longshore, D., & Anglin, M.D. (2007). The life course perspective on drug use – Aconceptual framework for understanding drug use trajectories. Evaluation Review, 31,515–547.
- Paradise, M., Cause, A.M., Ginzler, J., Wert, S., Wruck, K., & Brooker, M. (2001). The roleof relationships in developmental trajectories of homeless and runaway youth. In B.R.Sarason & S. Duck (Eds.), Personal relationships: Implications for clinical and communitypsychology (pp. 159–179). New York, NY: John Wiley & Sons Ltd.
- Whitbeck, L.B., Hoyt, D.R., & Yoder, K.A. (1999). A risk-amplification model ofvictimization and depressive symptoms among runaway and homeless adolescents.American Journal of Community Psychology, 27, 273–296.

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965351

Different forms of homelessness

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement #101001

Kuhn and Culhane (1998) described a **typology derived from their work with shelter users**, distinguishing between:

- **Chronic user**
- **Episodic user**
- **Transitional users**

Those who have been homeless for longer durations (usually defined as one year or more) have a greater impact on the public system of care and need the most assistance.

Individuals who are homeless for longer durations are more likely to have concurrent substance use and mental disorders which, complicates housing and the recovery needs of individuals

European Federation of National Organisations Working with the Homeless (FEANTSA) has developed a European Typology of Homelessness and housing exclusion (ETHOS) as a means of improving understanding and measurement of homelessness in Europe, and to provide a common "language" for transnational exchanges on homelessness.

This typology was launched in 2005 and is used for different purposes - as a framework for debate, for data collection purposes, for policy purposes, monitoring purposes, and in the media. It is important to note that this typology is an open exercise which makes abstraction of existing legal definitions in the EU members states.

In 2017, the English version of ETHOS and ETHOS Light were re-designed to reflect FEANTSA's new visual identity. Whilst ETHOS remains a comprehensive framework for experts and academics, ETHOS Light is intended as a harmonised definition of homelessness for statistical purposes,

Homelessness is perceived and tackled differently according to the country. ETHOS was developed through a review of existing definitions of homelessness and the realities of homelessness which service providers are faced with on a daily basis. ETHOS categories therefore attempt to cover all living situations which amount to forms of homelessness across Europe:

1. rooflessness (without a shelter of any kind, sleeping rough)
2. houselessness (with a place to sleep but temporary in institutions or shelter)
3. living in insecure housing (threatened with severe exclusion due to insecure tenancies, eviction, domestic violence)
4. living in inadequate housing (in caravans on illegal campsites, in unfit housing, in extreme overcrowding).

Resources

English: https://www.feantsa.org/download/ethospaper2006361859291413646324 9.pdf

Greek: https://www.feantsa.org/download/el___6311838887283173706.pdf

Spanish: https://www.feantsa.org/download/ethos_spain-24518105836657575492.pdf

German: https://www.feantsa.org/download/at___6864666519241181714.pdf

References

- Caton, C.L.M., Dominguez, B., Schanzer, B., Hasin, D.S., Shrout, P.E., Felix, A., . . . Hsu, E.(2005). Risk factors for long-term homelessness: Findings from a longitudinal study offirst-time homeless single adults. American Journal of Public Health, 95, 1753–1759.
- Edens, E.L., Mares, A.S., Tsai, J., & Rosenheck, R.A. (2011). Does active substance use athousing entry impair outcomes in supported housing for chronically homeless persons?Psychiatric Services, 62, 171–178
- Kuhn, R., & Culhane, D.P. (1998). Applying cluster analysis to test a typology ofhomelessness by pattern of shelter utilization: Results from the analysis of administrativedata. American Journal of Community Psychology, 26, 207–232

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement #101001

Safeguard

- Staff in homelessness services work with adults who have experienced or are at risk of abuse.
- It is the responsibility of all staff to recognise and respond to the signs of abuse.
- Organisations should have policies and procedures about Safeguarding Adults at Risk.
- Every country has their legislation defining what an adult at risk is.
- Being homeless may exacerbate physical and/or mental ill-health and impact negatively upon individuals' ability to care for and protect themselves.

Example of Guidance for frontline staff

Health issues

Individuals experiencing homelessness are often neglected by public health policies and their health and societal inequalities become an 'invisible burden' for many developed countries. In this regard, homeless people face intersecting physical, mental and social burdens that greatly increase morbidity and mortality relative to the general population.

There has been an increasing recognition of the public health importance of homeless persons, with many studies reporting high rates of acute hospitalization, chronic diseases, and mortality. Evidence has pointed out that people who are homeless are more likely to experience physical, mental and substance use disorders, often in combination, than people who are stably housed; these disorders may have precipitated or contributed to homelessness, or were instigated by or aggravated by it.

References

- Banerjee, D., & Bhattacharya, P. (2021). The hidden vulnerability of homelessness in the COVID-19 pandemic: Perspectives from India. International Journal of Social Psychiatry, 67(1), 3-6.
- Fazel S, Geddes JR, Kushel M. The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. Lancet 2014;384:1529–40.
- Hewett N, Halligan A, Boyce T. A general practitioner and nurse led approach to improving hospital care for homeless people. BMJ 2012;345:e5999.
- Homeless Link. The unhealthy state of homelessness. Health audit results 2014. London: Homeless Link, 2014. https://www.homeless. org.uk/sites/default/files/site-attachments/The unhealthy state of homelessness FINAL.pdf
- Liu, M., & Hwang, S. W. (2021). Health care for homeless people. Nature Reviews Disease Primers, 7(1), 1-2.

Mental health and drug use

A recent systematic and metanalysis study pointed out that alcohol use disorders had the highest absolute rate, at 37%, with substantially elevated proportional excesses compared to the general population for schizophrenia spectrum disorders and drug use disorders as well.

The high burden of substance use disorders and severe mental illness in homeless people represents a unique challenge to public health and policy.

Individuals with comorbid mental and substance use disorders may be at particular risk for prolonged episodes of homelessness as they have poor rates of treatment completion and higher rates of post-treatment relapse and re-hospitalization.

References

- Gutwinski, S., Schreiter, S., Deutscher, K., & Fazel, S. (2021). The prevalence of mental disorders among homeless people in high-income countries: An updated systematic review and meta-regression analysis. PLoS medicine, 18(8), e1003750.
- Weisner, C., Matzger, H., & Kaskutas, L.A. (2003). How important is treatment? One-year outcomes of treated and untreated alcohol-dependent individuals. Addiction, 98, 901–911

Mental health

Homelessness continues to be a pressing public health concern in many countries, and mental disorders in homeless persons contribute to their high rates of morbidity and mortality.

Mental illness in this population has been associated with:

- Elevated rates of criminal behavior and victimization
- Prolonged courses of homelessness [
- Perceived discrimination.

However, mental disorders among homeless individuals are mostly treatable and represent an important opportunity to address health inequalities.

References

- Babayan, M., Futrell, M., Stover, B., & Hagopian, A. (2021). Advocates Make a Difference in Duration of Homelessness and Quality of Life. Social Work in Public Health, 36(3), 354-366.
- Gutwinski, S., Schreiter, S., Deutscher, K., & Fazel, S. (2021). The prevalence of mental disorders among homeless people in high-income countries: An updated systematic review and meta-regression analysis. PLoS medicine, 18(8)
- Luong, L., Lachaud, J., Kouyoumdjian, F. G., Hwang, S. W., & Mejia-Lancheros, C. (2021). The impact of a Housing First intervention and health-related risk factors on incarceration among people with experiences of homelessness and mental illness in Canada. Canadian journal of public health, 112(2), 270-279.
- Park, G. R., Kim, S., & Kim, N. (2022). The association between crime victimization and depressive symptoms among homeless people in Korea: a gender stratified analysis. Journal of Social Distress and Homelessness, 31(1), 65-71.
- Vázquez, J. J., Cala-Montoya, C. A., & Berrios, A. (2021). The vulnerability of women living homeless in Nicaragua: A comparison between homeless women and men in a low-income country. Journal of community psychology.

Substance use

Substance use is strongly associated with prolonged and persistent homelessness among people with mental disorders, as is the early experience of first becoming homeless.

Johnson & Chamberlain (2008) observed that substance-related problems more commonly followed, rather than preceded, the onset of homelessness. Eighty-two percent of participants with substance abuse had been homeless for one year or more, compared to only 50% of those who had no substance abuse. In addition, two-thirds of those with substance use developed their problem after becoming homeless.

This finding emphasizes the importance of early intervention for substance use among individuals who are newly homeless.

References

- Babayan, M., Futrell, M., Stover, B., & Hagopian, A. (2021). Advocates Make a Difference in Duration of Homelessness and Quality of Life. Social Work in Public Health, 36(3), 354-366.
- Johnson, G., & Chamberlain, C. (2008). Homelessness and substance abuse: Which comesfirst? Australian Social Work, 61, 342–256

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 955321

Access to healthcare

Homeless individuals may face unique physiological hardships and emotional stressors compared to the general population, which results in distinct attributes surrounding health-seeking behaviours.

A recent analysis identified the following four critical attributes accessing healthcare:

(a) distrust in healthcare services, emerging from feelings of judgement or stigma from healthcare providers.
(b) prioritising physiological needs such as food, shelter, and clothing over the safety needs of health.
(c) delaying seeking care until physical symptoms are severe.
(d) having decreased access to healthcare because of being uninsured or having no money, requiring transportation, experiencing long wait times for appointments, or lacking knowledge of available healthcare services.

In addition to managing poor mental and physical health, uptake and access to health services is often restricted for people experiencing homelessness. A recent qualitative study (Cernadas & Ferández, 2021) highlighted different barriers when homeless individuals approach healthcare services:

1. Homeless individuals may sometimes be stigmatized by healthcare workers.
   a. First of all, by gatekeepers –security, administrative or reception staff.
   b. Reluctance of medical professionals. The lifestyle, appearance and supposed addictions of the homeless individuals can negatively influence the willingness of these professionals.
   c. Medical workers tend to do minimal interventions tend due to their knowledge of the lower levels of adherence to treatment of this population.
   d. Receiving lower quality medical attention compared to others, because it is understood that homeless individuals do not adequately follow prescribed treatments or have personal habits that are compatible with what has been prescribed for their pathologies.
2. Moreover, there can be found other structural challenges such as cost of transportation or services, navigating complicated booking systems.

Healthcare providers need to be aware of current barriers to care and perceived access to care in order to reduce the barriers to care that the homeless population faces.

Moreover, Cernadas and Fernández (2021) did different recommendations to reduce inequities of access to healthcare from a qualitative study

- adapting facilities to provide more adequate care for this population;
- increasing sensitivity/awareness among healthcare workers;
- developing in situ care systems in places where the homeless population is most concentrated;
- establishing healthcare collaboration agreements with entities that work with this population.

Resources and references

- Becker, J. N., & Foli, K. J. (2022). Health-seeking behaviours in the homeless population: A concept analysis. Health & Social Care in the Community, 30(2), e278-e286.
- Cernadas, A., & Fernández, Á. (2021). Healthcare inequities and barriers to access for homeless individuals: a qualitative study in Barcelona (Spain). International Journal for Equity in Health, 20(1), 1-17.
- Gunner E, Chandan SK, Marwick S, et al. Provision and accessibility of primary healthcare services for people who are homeless: a qualitative study of patient perspectives in the UK. Br J Gen Pract 2019;69:e526–36.
- Harris M. Normalised pain and severe health care delay among people who inject drugs in London: adapting cultural safety principles to promote care. Soc Sci Med 2020;260:113183.
- Rathod, S. D., Guise, A., Annand, P. J., Hosseini, P., Williamson, E., Miners, A., ... & Platt, L. (2021). Peer advocacy and access to healthcare for people who are homeless in London, UK: a mixed method impact, economic and process evaluation protocol. BMJ open, 11(6), e050717.

cancerless

Cancer prevention and early detection among the homeless population in Europe: Co-adapting and implementing the Health Navigator model

CANCER RELATED EDUCATION AND TRAINING FOR THE HEALTH NAVIGATORS

MODULE 3

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965351

CANCERLESS' vision is to prevent cancer and allow for early diagnoses in the homeless population by delivering person-centred interventions to overcome health inequalities and facilitating timely access to quality cancer prevention and screening services for homeless people and leaving no one behind in Europe.

In this section we will focus on the training and education of cancer prevention and screening for the health navigators. We will include the main types of preventable cancer types, identification of risk factors and exposure for cancer development, identification of people who should be included in existing screening programmes or referred to primary health care, and factors that may affect the engagement and capacity to make decisions that are specific for the homeless population and problems associated to the screening process itself.

CANCER IN THE HOMELESS POPULATION

cancerless

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 845351

Cancer burden is very high in the European countries and it is one of the most prevalent causes of death in Europe considering the whole population.(1) Excluding the non-melanoma skin cancer, the most prevalent cancer in the general population are female breast, colorectal, lung and prostate cancer.(1)

Cancer burden and its impact in the homeless population is not well known due to the lack of high-quality data and research of this population. However, there is evidence that homeless population are at a higher risk of exposure to risk factors, delayed diagnosis and treatment completion, and less opportunity to engage and sustain preventative measures. As a result homeless population are overburdened compared to the whole adult population and their risk of cancer related-death are at least two-fold higher.(2) (3)

The main types of cancer in the homeless population are related to higher exposure to risk factors to develop cancer as well as the lack of access to preventative measures. Those factors include smoking, unprotected sex, drug and alcohol, or lack of vaccination for human papillomavirus, for example.(4) (5) (6) (7) Homeless people have also a higher prevalence of some chronic infections such as HIV and hepatitis C which increase the risk of cancer.(8) (9) (10) (11) (12) (13) (14)

The existing data on the most prevalent types of cancer is not generalisable to the whole homeless population or the European region, as most of the research has been conducted in other countries such as the United States. Therefore, these results can be used as references to understand the context but personalised approach to individual risk factors need to be considered to assess individual cancer risk. In general terms, the following types of cancer need to be considered in the homeless population which are related or attributable to some of the risk factors they are exposed.

Some of the most prevalent cancers in the homeless population are

- Oral cavity and oropharyngeal cancer: this type of cancer refers to the cancer that appears in the mouth and throat.
- Bronchus and lung cancer: this cancer refers to lower respiratory system cancer which is below the thought and is the organ that allow us to breath.
- Oesophagus cancer: the oesophagus cancer refers to the muscular tube through which food passes from the throat to the stomach.
- Liver cancer: it refers to the cancer that occurs in the liver, which lies under your right ribs just beneath your right lung and it is part of the digestive system.
- Colorectal cancer: it refers to the cancers that starts in the colon or the rectum, which are the last parts of the gastrointestinal system.
- Breast cancer: it refers to the cancer that starts in the breast and it can affect on or both. "This type of cancer affects people who has breasts, due to either naturally-occurring oestrogen or oestrogen hormone therapy. This can include: trans men and non-binary people assigned female at birth who have not had an operation to remove the breasts (bilateral mastectomy); trans women and non-binary people assigned male at birth and who have taken feminising hormones; cisgender women". (Source: Cancer Research UK)(15)
- Cervical cancer: it refers to the cancer that starts in the cervix, which is the lower part od the uterus. "Cervix cancer can happen to anyone with a cervix which can include all the following people provided they have not had an operation to remove their uterus and cervix (full hysterectomy): people who are non-binary who were assigned female at birth and trans men, cisgender women". (Source: Cancer Research UK)(15)
- Melanoma: it refers to one type of skin cancer that affect the cells that give tan or brown colour to the skin. Melanoma can affect people with any skin colour even though lighter skin colours are at higher risk.(16)

Table 1: Most prevalent types of cancer in the homeless population

Cancer	Reference	Preventable or not	Main attributable risk factor in the homeless population
Oral cavity and pharynx, larynx,	(3) (5) (17) (18)	Yes	Smoking, alcohol
Bronchus, lung	(3) (5) (17)	Yes	Smoking
Oesophagus	(3)	Yes	Smoking, alcohol
Liver	(3) (17)	Yes	Alcohol, IV drugs, hepatitis C
Bowel or colon	(3)	Yes	Diet
Female genital cancer, cervical cancer	(5) (17) (19)	Yes	Exposure to unprotected sex, HPV
Anal and oral	(20) (6) (21)	Yes	Exposure to unprotected anal or oral sex, HPV, HIV
Breast cancer	(17) (22)	Not for all, but some preventative measures are possible (23) (24)	Relatively few lifestyle factors have been linked to the disease
Melanoma	(25) (26) (27)	Yes	Sun exposure

NOTE: HIV infection increases the risk of non-AIDS defining malignancies, so a person with HIV infection would have an increased risk of cancer, with higher risk in people not receiving HIV treatment. (28) (29)

cancerless

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 845351

References

1. Ferlay J, Colombet M, Soerjomataram I, Dyba T, Randi G, Bettio M, et al. Cancer incidence and mortality patterns in Europe: Estimates for 40 countries and 25 major cancers in 2018. European Journal of Cancer. 2018 Nov 1;103:356–87.
2. Funk AM, Greene RN, Dill K, Valvassori P. The Impact of Homelessness on Mortality of Individuals Living in the United States: A Systematic Review of the Literature. J Health Care Poor Underserved. 2022;33(1):457–77.
3. Asgary R. Cancer screening in the homeless population. The Lancet Oncology. 2018 Jul 1;19(7):e344–50.
4. Smith-Grant J, Kilmer G, Brener N, Robin L, Underwood JM. Risk Behaviors and Experiences Among Youth Experiencing Homelessness-Youth Risk Behavior Survey, 23 U.S. States and 11 Local School Districts, 2019. J Community Health. 2022 Jan 11;
5. Holowatyj AN, Heath EI, Pappas LM, Ruterbusch JJ, Goraki DH, Triest JA, et al. The Epidemiology of Cancer Among Homeless Adults in Metropolitan Detroit. JNCI Cancer Spectr. 2019 Mar 25;3(1):pkz006.
6. Lazcano-Ponce E, Salmerón J, González A, Allen-Leigh B, León-Maldonado L, Magis C, et al. Prevention and control of neoplasms associated with HPV in high-risk groups in Mexico City: The Condesa Study. Salud Publica Mex. 2018 Nov;60(6):703–12.
7. Baggett TP, Hwang SW, O'Connell JJ, Porneala BC, Stringfellow EJ, Orav EJ, et al. Mortality among homeless adults in Boston: shifts in causes of death over a 15-year period. JAMA Intern Med. 2013 Feb 11;173(3):189–95.
8. zadeh AOT, SeyedAlinaghi S, Hassanzad FF, Hajizadeh M, Mohamadi S, Emamzadeh-Fard S, et al. Prevalence of HIV infection and the correlates among homeless in Tehran, Iran. Asian Pac J Trop Biomed. 2014 Jan;4(1):65–8.
9. Henny KD, Kidder DP, Stall R, Wolitski RJ. Physical and Sexual Abuse among Homeless and Unstably Housed Adults Living with HIV: Prevalence and Associated Risks. AIDS Behav. 2007 Nov;11(6):842–53.
10. Beijer U, Wolf A, Fazel S. Prevalence of tuberculosis, hepatitis C virus, and HIV in homeless people: a systematic review and meta-analysis. The Lancet Infectious Diseases. 2012 Nov 1;12(11):859–70.
11. Cheng R, Patel S, Mandel L. Oral manifestations in untreated HIV patient. N Y State Dent J. 2011 Sep;77(5):58–60.
12. Abu Khalaf S, Dandachi D, Granwehr BP, Rodriguez-Barradas MC. Cancer immunotherapy in adult patients with HIV. J Investig Med. 2022 Jan 27;jim-2021-002205.
13. González Grande R, Santaella Leiva I, López Ortega S, Jiménez Pérez M. Present and future management of viral hepatitis. World J Gastroenterol. 2021 Dec 21;27(47):8081–102.
14. Luna-Cuadros MA, Chen HW, Hanif H, Ali MJ, Khan MM, Lau DTY. Risk of hepatocellular carcinoma after hepatitis C virus cure. World J Gastroenterol. 2022 Jan 7;28(1):96–107.
15. I'm trans or non-binary, does this affect my cancer screening? [Internet]. Cancer Research UK. 2019 [cited 2022 Feb 24]. Available from: https://www.cancerresearchuk.org/about-cancer/cancer-symptoms/spot-cancer-early/screening/trans-and-non-binary-cancer-screening
16. Melanoma & Skin of Color [Internet]. Melanoma Research Alliance. [cited 2022 Feb 24]. Available from: https://www.curemelanoma.org/about-melanoma/people-of-color/
17. Baggett TP, Chang Y, Porneala BC, Bharel M, Singer DE, Rigotti NA. Disparities in Cancer Incidence, Stage, and Mortality at Boston Health Care for the Homeless Program. Am J Prev Med. 2015 Nov;49(5):694–702.
18. Moore CE, Durden F. Head and Neck Cancer Screening in Homeless Communities: HEAL (Health Education, Assessment, and Leadership). Journal of the National Medical Association. 2010 Sep 1;102(9):811–6.
19. Asgary R, Alcabes A, Feldman R, Garland V, Naderi R, Ogedegbe G, et al. HPV knowledge and attitude among homeless women of New York City shelters. Womens Health Issues. 2015;25(6):727–31.
20. Williams SP, Bryant KL. Sexually Transmitted Infection Prevalence among Homeless Adults in the United States: A Systematic Literature Review. Sex Transm Dis. 2018 Jul;45(7):494–504.
21. Colón-López V, Shiels MS, Machin M, Ortiz AP, Strickler H, Castle PE, et al. Anal Cancer Risk Among People With HIV Infection in the United States. J Clin Oncol. 2018 Jan 1;36(1):68–75.
22. 12 Preventable Cancers [Internet]. Siteman Cancer Center. [cited 2022 Feb 24]. Available from: https://siteman.wustl.edu/prevention/preventing-cancer/12-preventable-cancers/
23. Breast Cancer Risk Factors and Prevention Methods [Internet]. [cited 2022 Feb 24]. Available from: https://www.cancer.org/cancer/breast-cancer/risk-and-prevention.html
24. Colditz GA, Bohlke K. Preventing breast cancer now by acting on what we already know. npj Breast Cancer. 2015 Jul 22;1(1):1–4.
25. Joseph A, Kindratt T, Pagels P, Gimpel N. Knowledge, Attitudes, and Practices Regarding Skin Cancer and Sun Exposure among Homeless Men at a Shelter in Dallas, TX. J Cancer Educ. 2020 Aug;35(4):682–8.
26. Wilde M, Jones B, Lewis BK, Hull CM. Skin cancer screening in the homeless population. Dermatol Online J. 2013 Jan 15;19(1):14.
27. Gingras E. Reducing skin cancer risk factors in the homeless population. 2018 [cited 2022 Feb 24]. Available from: https://open.bu.edu/handle/2144/32964
28. Borges ÁH, Dubrow R, Silverberg MJ. Factors contributing to risk for cancer among HIV-infected individuals, and evidence that earlier cART will alter this risk. Curr Opin HIV AIDS. 2014 Jan;9(1):34–40.
29. Hernández-Ramírez RU, Shiels MS, Dubrow R, Engels EA. Spectrum of cancer risk among HIV-infected people in the United States during the modern antiretroviral therapy era: a population-based registry linkage study. Lancet HIV. 2017 Nov;4(11):e495–504.

PREVENTABLE CANCER AND RISK FACTORS

The risk of the most prevalent cancer in the homeless population can be decreased reducing the exposure to attributable risk factors or different lifestyle. Homeless population have specific characteristics and challenges to change their exposure to many risk factors that will be addressed in other modules. The explanation below refers to changes that can be introduced to reduce the risk of some preventable cancers.

Breast cancer

Breast cancer is less susceptible to environmental exposures compared to other cancers in the list. Even though some exposures have been identified as possible risk factors, their avoidance does not decrease the risk significantly and inclusion in screening programmes and information about the family history is very important.

Cervical cancer

Cervical cancer can be prevented with several preventative measures including decreasing exposure to HPV infection, HPV vaccine and cervical cancer screening programmes.

Source: Siteman Cancer Center (https://siteman.wustl.edu/prevention/preventing-cancer/12-preventable-cancers/)

Bowel or colon cancer

Excluding the type of colon cancer related to hereditary cancer, the risk of bowel and colon cancer can be reduced with several lifestyle changes, reducing exposure to toxic chemicals and participating in screening programmes.

Lung cancer

Most common lung cancer types are highly attributed to toxic chemical exposure. Avoidance of this exposure would decrease significantly the risk of developing lung cancer.

Skin cancer

Low exposure to UV rays and sun protection are key elements to reduce the risk of skin cancer. Childhood and young age prevention is specially relevant, even though sun protection should be considered always as sun damage is cumulative during the whole lifetime.

Source: Siteman Cancer Center (https://siteman.wustl.edu/prevention/preventing-cancer/12-preventable-cancers/)

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 955351

Liver cancer

The risk of liver cancer can be reduced by decreasing the exposure to the main risk factors such as toxic chemicals and hepatitis infections.

Ways to lower the liver cancer risk

- Avoid and treat hepatitis B and C infections
- Avoid alcohol and tobacco use
- Stay at healthy weight to avoid fatty liver disease and diabetes
- Avoid exposure to cancer-causing chemical (such as aflatoxins)
- Treat diseases that increase liver cancer risk such as inherited diseases, hemochromatosis or conditions with excess iron in the body

Oral cavity and Oropharyngeal Cancers

Some risk factors can be reduced or avoided to reduce the risk to develop oral cavity or oropharyngeal cancer.

Ways to lower the risk of oral cavity and oropharyngeal cancer

- Avoid tobacco and alcohol use
- Avoid other toxic chemicals use such as betel quid and gutka
- Avoid exposure to HPV through unprotected oral sex activities
- Avoid poor nutrition: staying at healthy weight and eating more plant-based diet may be beneficial, even though its impact is less relevant than the previous risk factors
- Protection to the sun and UV light may help preventing lip cancer

Source: American Cancer Society (https://www.cancer.org/cancer/liver-cancer/causes-risks-prevention/prevention.html)

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 955351

CANCER AND SCREENING PROGRAMMES

cancerless

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 955351

The European Union recommends three cancer screening programmes that include breast, cervical and colorectal cancer. There may be other potential screening programmes in the future for other types of cancer but they are still controversial and there is no enough evidence or consensus around them. This means that individual risks factors and symptoms must alert and guide individual screening for the majority of the cancer types.

Breast, colorectal and cervical cancer screening programmes may vary depending on the national contexts. The following information is based on the European guidelines of cancer screening but each site must revise the local programme to comply with local guidelines.

Breast cancer:

Breast cancer screening tests women with no symptoms to identify signs of a possible cancer development at early stages. Breast cancer screening uses non-invasive tests. The mostly available test and first stage test in most cases is a low-dose x-ray test called mammography. In women with high risk of breast cancer or abnormal mammography results, breast ultrasound or breast magnetic resonance imaging (MRI) can also be used.

In women without high risk factors of breast cancer and no symptoms, the European breast cancer guidelines recommends the following screening approach by age group:

- Younger than 45 years: no screening
- Age between 45-49: 2-3 yearly mammography
- Age between 50-69: 2 yearly mammography
- Age between 70-74: 3 yearly mammography
- Older than 74 years: no mammography

Some countries invite women actively between 50 and 70 years only. In general terms, the mammographies are more difficult to read younger women due to higher breast density and the evidence of the usability of the mammography is lower.

Women with high risk of developing breast cancer are recommended to have yearly mammography since they are usually 30 years-old. Women with higher risk of breast cancer can have a personal or family history that can make easier to identify them. The personal history that may increase the risk of breast cancer includes the exposure to some hormonal treatment, radiation therapy or breast cancer and other non-malignant breast diseases. The family history of breast cancer also increases the risk if women have first-degree relatives (mother, sister or daughter) or several family members with breast cancer.

See below a list of non-exhaustive risk factors to identify women with higher risk of breast cancer that have a recommendation to have a closer follow-up:

- Risk assessment tool estimation of a lifetime risk of breast cancer above 20%. This tools are usually based on family history of breast cancer.
- Genetic test positive to BRCA1 or BRCA2 gene mutation
- First-degree family members with a known BRCA1 or BRCA2 gene mutation, and have not had genetic testing themselves (if they are negative, and hence they do not have the gene mutation, the risk disappears)
- History of exposure to chest radiation therapy between the age of 10 and 30.
- Personal or first degree family relatives with a diagnosis of Li-Fraumeni, Cowden, or Bannayan-Riley-Ruvalcaba syndrome.

Based on current evidence, trans or non-binary people with no exposure to hormonal treatment do not have an increases risk of breast cancer compared to the general population. However, there is no enough evidence of the long-term impact or consequences of the exposure to the hormonal treatment from childhood or young age. Some studies suggest that transgender women exposed to hormone therapy for a long time may have an increased risk of breast cancer compared to the average risk in men but not as high as the average risk in women.

Resources and references

- https://www.ipaac.eu/res/file/outputs/wp5/new-openings-cancer-screening-europe.pdf
- https://www.ipaac.eu/res/file/outputs/wp5/new-openings-cancer-screening-europe.pdf
- https://www.cancerresearchuk.org/about-cancer/breast-cancer/getting-diagnosed/screening/breast-screening
- https://healthcare-quality.jrc.ec.europa.eu/european-breast-cancer-guidelines/screening-ages-and-frequencies
- https://www.cancerresearchuk.org/about-cancer/breast-cancer/getting-diagnosed/screening/breast-screening
- https://www.cdc.gov/cancer/breast/basic_info/risk_factors.htm#:~:text=A%20woman's%20risk%20for%20breast,also%20raises%20a%20woman's%20risk
- https://www.cancer.org/cancer/breast-cancer/screening-tests-and-early-detection/american-cancer-society-recommendations-for-the-early-detection-of-breast-cancer.html
- https://www.cancerresearchuk.org/about-cancer/cancer-symptoms/spot-cancer-early/screening/trans-and-non-binary-cancer-screening
- https://www.breastcancer.org/research-news/feminizing-hormones-increase-risk-in-trans-women
- https://cancer-network.org/wp-content/uploads/2017/02/Trans_people_and_cancer.pdf

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 955391

Cervical cancer:

Cervical cancer screening programmes are available in most of the European countries but eligibility, tests performed, and implementation level may vary. We strongly suggest to check the local programme to understand the local criteria and process.

In general terms, cervical cancer screening is performed during a gynaecological exploration either by a gynaecologist or nurse. During the exploration, they will take a small sample of cells of the cervix with a scraper or a brush. The test is not usually painful, but it can be uncomfortable.

Screening is usually offered to women between 25 and 64 and it is repeated every 3 to 5 years depending on the type of test performed in the laboratory and the age. The way the sample is collected does not vary for any of the tests performed afterwards.

Two types of tests are can be performed in the laboratory with the samples. Cytology-based tests identify abnormal or potentially abnormal cells that can develop cervical cancer in the future. The HPB test identify Human Papilloma Virus (HPV) infection in the sample which is known to increase the risk for cervical cancer. Cytology-based test has less sensitivity than HPV and the lesions may be in a more advanced stage. On the other hand, the HPV test identified the infection which occur before the development and has increased the referrals for colposcopy and invasive preventive treatments.

Some European countries are transitioning from cytology-based test to HPV-based tests but the implementation level and the performance of the population-wide programmes vary.

Even though the majority of the population is not still vaccinated with HPV vaccine in most countries and the vaccination policy is different between countries, future screening programmes may vary to adapt to the vaccination status.

In case of transgender men, the recommendation for cervical screening will depend on having or not a cervix. Transgender men who have had a total hysterectomy and therefore, removal of their cervix, do not have risk for cervical cancer and they do not require any screening. Transgender women who have not had any surgery and therefore, without a cervix, do not need screening as they cannot develop cervix cancer. There is no enough evidence about the cancer risk in cases of neo-cervix after vaginoplasty. The risk may depend on the type of surgery and the tissue used and the need of screening may need to be assessed individually. Beware that depending on the gender people are registered they may or may not receive an automatic invitation to the screening.

Resources and references

- https://www.cancer.gov/news-events/cancer-currents-blog/2020/cervical-cancer-screening-hpv-test-guideline#:~:text=ACS%20recommends%20cervical%20cancer%20screening,Pap%20test%20every%203%20years
- https://www.clinicalmicrobiologyandinfection.com/article/S1198-743X(19)30491-4/fulltext#:~:text=As%20of%20July%202019%2C%20the,at%20various%20stages%20of%20implementation
- https://www.nature.com/articles/s41416-020-0920-9
- https://www.nhs.uk/common-health-questions/sexual-health/should-trans-men-have-cervical-screening-tests/
- https://cancer.ca/en/cancer-information/find-cancer-early/screening-in-lgbtq-communities/as-a-trans-woman-do-i-need-to-get-screened-for-cervical-cancer#:~:text=If%20you're%20a%20trans%20woman%20and%20have%20not%20had,%2Dvagina%20or%20neo%2Dcervix

Colorectal cancer

Even though the Council of Health Ministers recommended in 2003 a colorectal screening for all people between 50 and 74 for all the European Member States, the implementation of this population-wide screening programme has been irregular among different countries in Europe .

Colo-rectal cancer risk is different among the European countries and therefore, the benefit of the screening programme also varies. Due to major disparities in this screening programme implementation, we strongly recommend checking national and regional programmes to understand the availability, process and eligibility criteria locally.

In general terms, the European Union recommends the faecal occult blood test (FOBT) as the main non-invasive test for people with low risk and no symptoms. Other test like flexible sigmoidoscopy, colonoscopy or computed tomographic colonography may be used for people with higher risk of colorectal cancer or symptoms.

In general terms, people with no symptoms and average risk of colorectal cancer will be offered a two-step screening approach, with FOBT as the initial non-invasive test. FOBT is usually done at home and the sample is sent or brought to the health centre. The FOBT test consist of taking a sample of faeces and testing if there is any presence of blood. If the test is positive, an invasive test with direct visualisation like the flexible sigmoidoscopy or colonoscopy is usually offered. People with high risk to perform a colonoscopy may be offered an imaging tests with computed tomographic colonography.

People with higher risk than average for colorectal cancer may need to start screening before the age of 45 or 50 with more frequent tests and usually with invasive test due to their higher capacity to detect and identify cancer or pre-cancer lesions.

People with higher risk for colorectal cancer may have one or several of the following risk factors:

- Family history of colorectal cancer, risk of high-risk polyps or some hereditary syndromes related to colorectal cancer (familial adenomatous polyposis or hereditary non-polyposis colon cancer)
- A personal history of colorectal cancer, high-risk polyps or inflammatory bowel disease
- A personal history of abdominal or pelvic radiation

The adequate tests and screening schedule for people with higher-than-average risk of colorectal cancer will be established after assessing individual risk factors.

Resources and references

- https://www.euro.who.int/en/health-topics/noncommunicable-diseases/cancer/news/news/2012/2/early-detection-of-common-cancers/colorectal-cancer#:~:text=The%20European%20Union%20recommends%20FOBT,of%20screening%20will%20also%20vary.
- https://journals.lww.com/ajg/fulltext/2021/03000/acg_clinical_guidelines__colorectal_cancer.14.aspx
- https://www.cancer.org/cancer/colon-rectal-cancer/detection-diagnosis-staging/acs-recommendations.html
- https://www.cancer.org/cancer/colon-rectal-cancer/detection-diagnosis-staging/acs-recommendations.html

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 955351

Cervical cancer:

Cervical cancer screening programmes are available in most of the European countries but eligibility, tests performed, and implementation level may vary. We strongly suggest to check the local programme to understand the local criteria and process.

In general terms, cervical cancer screening is performed during a gynaecological exploration either by a gynaecologist or nurse. During the exploration, they will take a small sample of cells of the cervix with a scraper or a brush. The test is not usually painful, but it can be uncomfortable.

Screening is usually offered to women between 25 and 64 and it is repeated every 3 to 5 years depending on the type of test performed in the laboratory and the age. The way the sample is collected does not vary for any of the tests performed afterwards.

Two types of tests are can be performed in the laboratory with the samples. Cytology-based tests identify abnormal or potentially abnormal cells that can develop cervical cancer in the future. The HPB test identify Human Papilloma Virus (HPV) infection in the sample which is known to increase the risk for cervical cancer. Cytology-based test has less sensitivity than HPV and the lesions may be in a more advanced stage. On the other hand, the HPV test identified the infection which occur before the development and has increased the referrals for colposcopy and invasive preventive treatments.

Some European countries are transitioning from cytology-based test to HPV-based tests but the implementation level and the performance of the population-wide programmes vary.

Even though the majority of the population is not still vaccinated with HPV vaccine in most countries and the vaccination policy is different between countries, future screening programmes may vary to adapt to the vaccination status.

In case of transgender men, the recommendation for cervical screening will depend on having or not a cervix. Transgender men who have had a total hysterectomy and therefore, removal of their cervix, do not have risk for cervical cancer and they do not require any screening.

Transgender women who have not had any surgery and therefore, without a cervix, do not need screening as they cannot develop cervix cancer. There is no enough evidence about the cancer risk in cases of neo-cervix after vaginoplasty. The risk may depend on the type of surgery and the tissue used and the need of screening may need to be assessed individually. Beware that depending on the gender people are registered they may or may not receive an automatic invitation to the screening.

Resources and references

- https://www.cancer.gov/news-events/cancer-currents-blog/2020/cervical-cancer-screening-hpv-test-guideline#:~:text=ACS%20recommends%20cervical%20cancer%20screening,Pap%20test%20every%203%20years
- https://www.clinicalmicrobiologyandinfection.com/article/S1198-743X(19)30491-4/fulltext#:~:text=As%20of%20July%202019%2C%20the,at%20various%20stages%20of%20implementation
- https://www.nature.com/articles/s41416-020-0920-9
- https://www.nhs.uk/common-health-questions/sexual-health/should-trans-men-have-cervical-screening-tests/
- https://cancer.ca/en/cancer-information/find-cancer-early/screening-in-lgbtq-communities/as-a-trans-woman-do-i-need-to-get-screened-for-cervical-cancer#:~:text=If%20you're%20a%20trans%20woman%20and%20have%20not%20had,%2Dvagina%20or%20neo%2Dcervix

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 955351

EARLY IDENTIFICATION AND SYMPTOMS

cancerless

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 955351

Symptom awareness campaigns and initiatives may help in the early identification of cancer. Even though symptom presence is usually associated to advance stages of cancer (stage IV), many symptoms appear in earlier stages and their identification can support earlier identification at treatable stages.

There are many times of cancer, and they produce many signs and symptoms. Many signs and symptoms are not specific for a specific type of cancer, and they can be very different from one person to another. However, some signs and symptoms can raise a red flag ad sign a problem, cancer-related or not, that need to be observed, explored or treated.

As a general rule, if there is a new sign or symptom that does not disappear in a short period, it is worth being checked. General cancer symptoms may include some of the following but they are not exclusive of cancer:

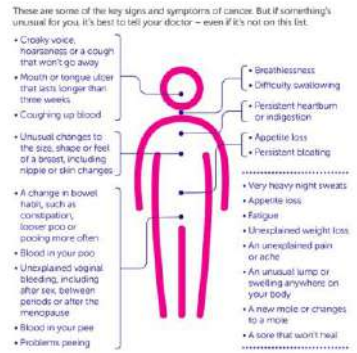
- Unexplained and/or chronic pain
- Severe sweating at night
- Unintentional and unexplained weight loss (more than 5% over the last 6 months)
- Persistent and growing lump, with special attention to flexures, neck, breast and groins
- Unexplained fatigue and weakness
- Persistent fever, even if it is not too high
- Skin changes

A bit more specific sign and symptoms can include:

- Skin changes: changes of the skin colour (jaundice), changes in a mole or any other relevant change.
- Affecting eating: difficulties or pain to swallow food or liquids, persistent heartburn or indigestion, feeling full-up easily, nausea and vomiting.
- Affecting the voice or breathing: unexplained and persistent change in the voice, persistent cough or breathlessness.
- Bowel and urine changes: changes in bowel habit such as persistent or increasing constipation, bloating, difficulties to pass urine, presence of blood or bleeding in the stools or urine, abdominal or pelvic.
- Bleeding or the presence or unexpected blood in all its forms, including postmenopausal vaginal bleeding
- Mouth, genital or anal ulcers that do not health or are persistent.
- Unexpected and unusual changes in breasts, testicles or genitalia, especially if they are persistent.

Resources and references

- https://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(19)30595-9/fulltext
- https://www.cancerresearchuk.org/about-cancer/cancer-symptoms
- https://www.hopkinsmedicine.org/health/wellness-and-prevention/early-cancer-warning-signs-5-symptoms-you-shouldnt-ignore
- https://www.cancer.org/treatment/understanding-your-diagnosis/signs-and-symptoms-of-cancer.html
- https://pubmed.ncbi.nlm.nih.gov/31704137/



Due to the specific characteristics of the homeless population, their awareness of unexpected or unusual symptoms may be different from the general population. Therefore, any relevant and persistent sign or symptoms should not be discarded, even if they can be explained with other exposures or conditions. Raising awareness of warning signs and symptoms in the homeless population and their support network may help identifying cancer and other severe conditions that are underdiagnosed and undertreated at the moment.

Figure 1: Some of key signs and symptoms of cancer.

Source: https://www.cancerresearchuk.org/about-cancer/cancer-symptoms

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 955391

BARRIERS TO ENGAGE IN SCREENING

Population-wide screening programmes have many challenges and barriers to provide an effective programme and engage with the target population. The existing barriers have many elements that need to be taken into consideration:

- Person or target population barriers: fear, embarrassment, beliefs and values, mental health, health literacy, low awareness, lack of trust with the health system, opportunistic screening preferred to routine screening. Many of these factors are linked to inequity in health and care provision as well as social determinant of health.
- Healthcare provider barriers: poor coordination and communication, problems with the follow-up, poor training, work overload, insufficient infrastructure, lack of staff, poor quality of services, resistance to the screening programme, lack of interest, complex administrative procedures.
- Health system barriers: access problems, budget constraints, delays, ineffective response from primary screening to secondary screening or treatment, primary care not included in the programme, not joint information technology.

The homeless population may have a number of other specific barriers due to their context and past exposure. Some of the barriers may include:

- Issues with community or context safety that limits their capacity to access to the services
- Lack of trust and reluctance to use health services due to poor experience or of abuse with the health or administrative services
- Low of self-steem
- Lack of self-care
- Lack of power
- Mental health and substance abuse
- History of sexual abuse and trauma are identified has a significant barrier to breast, cervical, colorectal and prostate screening
- Social isolation and lack of social network
- Instability
- Cumulative trauma exposure and chronic stress

The Health Navigator and the health and care workforce need to be aware of the specific barriers of people experiencing homelessness to engage in early cancer identification and screening programmes. Specific approaches such as Trauma-Informed Care have been proposed to engage with people and communities exposed to chronic trauma or traumatic experiences like in the case of the homeless population. These approaches recognise the need to empower population exposed to trauma and build trust to facilitate engaging with health and care provider and participating in initiatives like cancer screening and symptoms awareness programmes.

Resources and references

- https://borgenproject.org/poverty-and-ptsd/
- https://comphc.org/coordination-of-care-is-trauma-informed-care/#:~:text=There%20are%20six%20core%20principles,cultural%2C%20historical%20and%20gender%20issues.
- https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1004-4
- https://evidence.nihr.ac.uk/alert/cancer-screening-across-the-world-is-failing-people-with-mental-illness/#:~:text=People%20with%20mental%20illness%20are,years%20earlier%20than%20other%20people.
- https://implementationsciencecomms.biomedcentral.com/articles/10.1186/s43058-020-00055-z/figures/1
- https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0226306
- https://nottssvss.org.uk/prostate-concerns-after-sexual-abuse/
- https://pubmed.ncbi.nlm.nih.gov/24454784/#:~:text=Conclusions%3A%20Sexual%20abuse%20is%20prevalent,colonoscopy%20may%20diminish%20this%20distress.
- https://pubmed.ncbi.nlm.nih.gov/30195444/
- https://pubmed.ncbi.nlm.nih.gov/32662141/
- https://www.digestivecancers.eu/wp-content/uploads/2020/02/466-Document-DiCEWhitePaper2019.pdf
- https://www.evolvehousing.org.uk/campaign/hurt-to-homeless/
- https://www.frontiersin.org/articles/10.3389/fpubh.2018.00030/full
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4157620/
- https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965351

RISKS OF SCREENING

The objective of cancer screening is to diagnose cancer in treatable earlier stages, to reduce the number of people developing and dying from cancer. However, screening programmes have several risks that need to be acknowledged:

- Overdiagnosis: people may be diagnosed with an early-stage cancer that would not grow or cause any problem during their lifetime. Because it is diagnosed, people may be exposed to potentially harmful, stressful and traumatic treatment that may not have been needed if they were not diagnosed.
- False positives: many primary screenings test have false positives and require an invasive secondary screening test that can increase the stress and risk related to the procedure.
- Increased testing: acknowledging the limitation of some test due to false positives, health care providers may do additional tests that are not usually part of the screening programme to avoid positive tests, increasing the cost and the risk for the user.
- False reassurance and over enthusiasm: screening test may increase a false safety perception in the population. In the case of false negative results, reassurance of the test results may delay seeking medical care.
- Risks associated to invasive screening tests: some screening tests are invasive and can cause severe complications.
- Early diagnosis may not improve individual survival or wellbeing: cancer diagnosis and treatment can be a traumatic experience. Early diagnosis is not always translated into a cure or improved life-quality compared to non-diagnosis.
- Too much confidence in screening programmes may decrease the compliance with preventive measures.

Cancer screening has benefits and risks and it is important people understand them to make the right choices. Shared decision-making and informed choices require to build trust and collaboration between the user and the care provider, which is especially important in the case of homeless population. The Health Navigator can support the user to get higher health literacy and empowerment to make the right decisions to take preventive measures and lifestyle habits, increase symptoms awareness and self-care, and make informed choices about screening programmes. Cancer prevention and screening programmes, and especially programme orientated to care for people experiencing homelessness, should include awareness of and planning to overcome the existing barriers to engage with the community. What is more, such programmes should ensure respecting individuals' rights, values and autonomy to make informed choices.

Resources and references

- https://www.cancer.net/navigating-cancer-care/prevention-and-healthy-living/cancer-screening
- https://pubmed.ncbi.nlm.nih.gov/30024212/
- https://www.cancer.gov/about-cancer/screening/patient-screening-overview-pdq
- https://pubmed.ncbi.nlm.nih.gov/34019164/#:~:text=The%20main%20intended%20benefit%20of,benefits%20accrue%20to%20distinct%20individuals.

cancerless

Cancer prevention and early detection among the homeless population in Europe: Co-adapting and implementing the Health Navigator model

COMMUNICATION AND INTERPERSONAL SKILLS

MODULE 4

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965351

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965351

Communication with homeless population

Communication is crucial for vulnerable adults to make sure that their most basic needs are met.
It is important for health navigators to communicate well and build a good rapport with these individuals to reduce their reluctance to access healthcare services.
Most individuals experiencing homelessness have suffered stigma and discrimination, increasing their feelings of untrust. This creates frustration and determines future access to care services.
Health Navigators can avoid this feeling of distress and support these individuals to see that they have influence over their own life.

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965351

Communication and empowerment

cancerless

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 845351

Four components have been reported as being fundamental to the process of patient empowerment:

- understanding by the patient of his/her role;
- acquisition by patients of sufficient knowledge to be able to engage with their healthcare provider;
- patient skills;
- the presence of a facilitating environment.

Based on these four components, WHO defines empowerment as "*a process through which people gain greater control over decisions and actions affecting their health" and should be seen as both an individual and a community process.*

FEANTSA (2009) describes empowerment as a process by which individuals and groups enhance their capacity to: ´

- Be informed,
- Make choices,
- Transform those choices into desired actions and outcomes.

Empowerment implies moving away from an approach that sees people as mere recipients of charity to an approach that emphasises the rights and autonomy of people.

Empowerment is linked to questioning existing power imbalances in a society (who has power, who doesn't, how is power obtained and how does power manifests itself) and ways to possibly redistribute power more equally.

Empowerment at individual level

CANCERLESS focuses on the individual level, here empowerment aims to strengthen a person's capacity to control his/her own life again. Empowerment includes:

- Rebuilding self-confidence
- Being aware of one's possibilities and resources and being able to use and mobilise these
- Being able to engage with others and participate in social networks
- Taking up responsibilities.

The health navigator aims to increase the empowerment of individuals through interviews with individuals experiencing homelessness.

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 845351

What it is an interview?

cancerless

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 845351

"An interview is a spoken meeting between two or more people who engage in verbal and non-verbal interactions, based on the differentiation of roles among the participants. Essential in the evaluation process by the amount of knowledge staff provided by the subject in a brief space of time, the interview is considered a vital source of privileged information in any environment" (Pope, 1979)

Interview functions:

- **Motivational function:** establishes a relationship that stimulates and enables change.
- **Clarifying function:** it allows the subject to clarify his/her own demand by telling his/her problems, analyzing them, ordering them...
- **Therapeutic function:** the very fact of verbalizing what worries him already exercises this function, and also because the health navigator offers alternatives to the current situation and a different point of view.

Pros and cons of interviews

Advantages of the interview

- Obtain abundant information
- Flexibility
- To be able to observe the interviewee to obtain more information on non-verbal and paralinguistic aspects.
- Interpersonal relationship
- The interview is the starting point of the therapist-person relationship, and it is through the interview that the form and quality of the intervention is defined.

Disadvantages

- High cost of time and effort
- Appearance of possible biases

Level of structure	1. Structured interview 2. Semi-structured interview 3. Non-structured interview
Directivity	1. Directed interview 2. Semi-directed interview 3. Non-directed interview

Planned objectives	1. Research or intervention interview 2. Diagnostic interview 3. Consulting interview 4. Therapeutic interview
Timing of the process	1. Initial interview 2. Complementary information interview 3. Anamnesis interview 4. Interview for providing feedback 5. Discharge interview

MOTIVATIONAL INTERVIEW

General information

- Motivational interviewing is a person-centered, directive therapeutic style to enhance readiness for change by helping individuals explore and resolve ambivalence.
- An evolution of Rogers's person-centered counseling approach, Motivational interviewing elicits the individual's own motivations for change.

Objectives of the interview

- The health navigator should facilitate the participant's verbalization of ambivalence regarding behavioral change and identify discrepancies between the participant's daily functioning and the pursuit of primary goods.
- To identify this ambivalence, health navigators should be attentive to inconsistencies that appear in the participant's discourse. These will be represented, for example, by the incompatibility between health risk behaviour and his or her desire for better health outcomes or access to health care.

Motivation for change

- Motivation for change must come from the participants and not be imposed. Therefore, coercion, confrontation, aggressive confrontation, use of contingencies, direct persuasion or giving advice are not effective methods of resolving ambivalence.
- It is tempting to try to "help" by convincing of the urgency of the problem, the need for change, or by expressing what "must" be done, but such tactics generally increase resistance and reduce the likelihood of successful intervention.
- The use of these strategies may lead to argument and denial by the participant, who may adopt a defensive and self-assertive position of personal freedom.

How does the change start?

- When the existence of a problem is not recognized or when the participant thinks that the problem is attendance to the intervention, the work should be oriented to strengthen the alliance and the use of motivational techniques. Similarly, the health navigator should ask, "What does the participant think of what I think is the problem? when can what I think is a problem be a problem for him/her? when does it cease to be a problem?
- Therefore, we must enhance the participant's self-motivation verbalizations. Expressions of recognition of the problem, of concern for the consequences of their behavior, of desire and intention to change or of self-efficacy in coping with their situation need to be reinforced by the coordinators.

Managing stigma

- Participants can expect to be met with hostility and rejection due to the stigma against homelessness.
- To neutralize this initial impression, health navigators should provide a warm, empathetic and emotionally connecting environment that promotes open and honest expression of their personal story. By actively listening to his story and the information gleaned from the first interview, coordinators can understand the participant's frame of reference and the context in which he/she is immersed.

Involving this population in the intervention

- Connecting emotionally with the participant is essential in order to get him/her involved in the intervention and to get him/her to collaborate in the proposal of the intervention objectives.
- Health navigators should connect emotionally with the participant but be careful that they do not distort the message and understand that acceptance neutralizes or minimizes the implications of their health risk behaviour.
- Therefore, the understanding of their personal situation should be linked to the rejection of any type of health risk behaviours by proposing, through solution-focused language, behavioral alternatives that are incompatible with health risk behaviors.

Framing the interview – tips for the first interview

- In order not to turn the interview into an interrogation, we suggest that the health navigator interject paraphrases, summaries or, empathetic and humorous comments.
- The conversation should promote open expression of thoughts and extended development of messages to encourage emotional connection and reflection on what is being said.
- The work of motivational interviewing is not aimed at "assessing" and obtaining information for the coordinators, but at generating useful information for the participant.
- The coordinators should help the participant to identify his or her intrinsic values and goals and to re-evaluate his or her personal history in order to stimulate motivation to change behaviors that will benefit him or her.

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 945351

Second interview

- The second session of the motivational interview is structured in two phases: awareness of the problem and empowerment of the intention to change.
- The following is an indicative protocol of questions that health navigators should adapt to each of the participants and to the pace and emotional tone of the interview.

Objectives of the second motivational interview:

- To promote awareness of the problem of the health risk behaviours by reflecting on its consequences.
- To strengthen the participant's intention to change through the presentation of alternative scenarios of improvement that allow the achievement of primary goods.
- To obtain minimum indicators that are accepted by the participant and help the health navigators in the design of the map of the change process.

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 945351

Fundamental interviewing skills

cancerless

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 945351

Empathy

Verbal means of conveying empathy:

- Showing a desire to understand (through questions about what you think and feel).
- Pointing out what is important to the participant (responding with brief statements that reflect his or her thoughts and feelings and capture his or her concerns)
- Reflection of feelings: "You feel discouraged because efforts to bring you to solve your situation are not succeeding."

Genuity

Consists of being "oneself" and serves to reduce emotional distance so that the participant perceives us as someone similar to him/her. How?

- By never emphasizing the role of the health navigator in order to reduce the distance with him/her.
- Showing congruence of words, actions, and feelings.
- Spontaneity: speaking naturally but tactfully.
- Self-revelations: Consists of providing information about ourselves.

Positive acceptance

How?

- By being committed to the participant.
- Trying to understand him/her.
- Having a non-judgmental attitude.
- Saying sincere, deserved and accurate phrases of praise.
- By being immediate with respect to us "I'm glad to see you...", "at this moment you seem upset and uncomfortable..." and with respect to the interaction "I'm glad you shared this with us today...".

Competence

Participant's perception that the health navigator will be helpful to them in solving their problems. How?

- Using relevant questions that stimulate their thinking.
- Direction and confidence in the presentation.
- Interpretations (possible explanation of the participant's behavior).
- Concreteness (ask clarifying questions, see what each term means for the subject "what specifically is it that depresses you?)

Attraction

Participants feel attraction to the health navigators through the friendliness, sympathy and similarity they perceive towards them.

Verbal behaviours that enhance attraction are:

- Self-disclosure.
- Structuring: Defining the framework and process for achieving objectives. It is very useful at the beginning of the intervention and consists of giving information about how the scope of the intervention, the potential available services, the work method and why, etc.
- Reliability or trust: It is the participant's idea that the health navigator does not deceive or harm them in any way.

Participants can test us by the following methods:

- They ask for information to find out if you can really help him/her, e.g. "How old are you?"
- They tease the health navigator to test him or her and see how he or she reacts.
- They exaggerate their problems or tell them in a very negative way expecting an overreaction from the health navigator.
- Ask for reasons why they are health navigator.
- They tell a secret, e.g., they tell us something embarrassing to them and watch our reaction; it should never be reactive or censorious.
- Ask for favors. Giving in if and when necessary.

Skills for dealing with relationship difficulties

- Redirecting the interview
- Assertive and discussion techniques

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965391

Active listening skills

- Observing to identify the content of their verbal experiences.
- Identifying feelings.
- Identifying when our interlocutor wants us to talk and ending the listening.
- Maintaining eye contact, with non-verbal language (moving the head), using appropriate tone and volume of voice.
- With words ("I see", "Um, um"), paraphrasing or using summary expressions ("if I didn't misunderstand you").
- Do not interrupt, do not judge, do not offer help or premature solutions, do not reject what he/she is feeling, do not tell your story while he/she needs to talk to you, avoid the expert syndrome, try as much as possible not to counter-argue but to encourage the participant's reflection.
- Show that we are aware of the impact of their problem, of the hardship they are going through and of the helplessness and sadness of their failures.
- Empathize with phrases such as: "I take charge", "I can understand that you feel this way".

Standards for active listening and positive Communication

Rules when speaking

1. Use the first person when expressing an opinion.
2. Give concrete examples of what is being stated, avoid "always" and "never".
3. Stay in the "here and now".
4. Formulate requests in a direct way, explaining the "when" and the "how".

Rules when listening

1. Give non-verbal signals of attention.
2. Make comments or gestures of assent
3. Use paraphrases
4. Ask open-ended questions, inviting the participant to continue speaking.
5. Give positive feedback about what is heard.

In addition:

1. Express criticism only if the other person asks for it.
2. Ask permission to express criticism
3. Express only constructive criticism, coupled with concrete suggestions for change.
4. Avoid sarcasm, irony and indifference as much as possible, especially if you think they may hurt the other person.
5. Maintain a relaxed tone of voice even in times of tension.

Summarize

How?

- With expressions such as: "So what you are telling me...", "Let me see if I have understood you correctly...", "You are telling me that...", "You are saying that...".
- Asking the participant to confirm or express disagreement.

Sending first person messages

This is the first person message that is respectful and expresses feelings, opinions and desires without evaluating or reproaching the behavior of others and facilitates the expression of differences and disagreements.

- By briefly describing the situation and/or behavior that bothers you or creates problems for you. It should be limited to a brief description of the facts and not evaluate or pass judgment on the subject.
- Describing the consequences or effects that such behavior usually has on you or on the participant. They must be tangible and concrete.
- Expressing feelings.
- Expressions such as, "I feel bad...", "I would like you to...".

Giving useful information and feedback.

- Start by giving positive information and then suggesting alternatives on how to improve the incorrectness of the executions.
- Carefully track in behavior and task performance anything that is an indicator of achievement and positive outcome, rather than error or failure. Remember that a positive element, when there are no others, is the very fact of executing the task and the effort invested in it.
- Express recognition and positive feedback with consistent messages; it should not be a mere verbal expression of affection.
- It is important that verbal recognition be accompanied by non-verbal expressions. Sometimes a smile or a nod of approval may be sufficient.
- Be specific. To be effective, feedback must guide action to improve or change. Specific actions that are done well should be reported. Instead of saying "you did very well," it may be more useful to be specific about what was done well.
- When there is a failure or mistake, in addition to pointing out any indicators of achievement, it is necessary to give positive hints or options on how to improve.
- Sentences used in the positive stimulate change to a greater extent.
- Feedback has to be timely in time and space, depending on the emotional state. Subjects are not always predisposed to receive feedback.

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 813391

Being positive and reinforcing

It is the ability to incentivize and motivate. The person who is rewarded tolerates setbacks better, is more receptive and is usually more willing to negotiate and change.

- It increases your ability to influence change and reduce resistance.
- If you are rewarding you will become an attractive role model whose behaviors will be closely observed and probably imitated.
- You arouse a sense of self-efficacy, self-control and raise their self-esteem.
- You counteract the tendency to focus on the negative aspects of their personality and behavior, and highlight their "strengths".
- You reduce the sense of demoralization and helplessness.
- You counteract the "self-fulfilling prophecy" effect of their failures.

How?

- Administer reinforcement after a desired behavior has occurred so that it is associated with a rewarding effect.
- Find the right time.
- Be specific and discriminating. It is important to know what you want to reward and what you do not want to reward.
- It must be immediate.

When?

- We want to help acquire and develop habits and customs that we consider worth learning.
- We want to generate positive emotions in the participants.
- We want to reward problem-solving behaviors: task accomplishment, verbalizations of problem-situations and confidence in coping with problems, appropriate attributions, requests for help, appropriate listening and appraisals.

Helping to think

This technique aims to facilitate self-reflection processes in the participant. It consists of facilitating reflections such as: "What am I doing here?", "What would happen if I do...? What would happen if I don't do...?, What worries me?, How does what I do influence others?

This skill is important because:

- Many so-called "impulsive" behaviors arise from a deficit of self-reflection processes.
- The problem-solving process is closely linked to the ability to think and wonder.
- Interpersonal error and failure is a source of learning, provided that it is reflected upon.

How?

- By using skills such as useful information, partial agreement or the broken record.
- With questions aimed at questioning oneself about the nature of the task or situation: "What happened?", "What did you do?", "What did the other do?", or about the consequences of one's own behavior "What happened when you...?", "Imagine that you actually do or say...", "What if you had done or said...? What if you had done or said...", "What are the advantages and disadvantages of a chosen alternative?", "What are the advantages and disadvantages of a chosen alternative?"
- With questions aimed at identifying objectives. "Why... what do you intend?", "What are you interested in", immediately, in the medium term and in the long term.
- With questions aimed at identifying the rules of a situation and assessing the validity of the objectives: "In your opinion, what should be done or said in...? What would be the most appropriate thing to do? Why do you think that in that situation should be done or said...? to achieve... What do you think should be done?"
- With questions that dismantle labels. "What does that mean, I would understand you better if you gave me an example."

When?

- We want the participant to reflect or rethink about a problem, situation or interpersonal conflict.
- We want to guide the problem-solving process.
- We want to teach an interpersonal skill.
- We intend to make the participant sensitive to the norms and rules of certain situations and to the consequences of his/her behavior on their health and wellbeing.
- We want the participant to identify objectives, contradictions between objectives and actions.

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 813391

Make people laugh

How?

- By provocatively exaggerating.
- Making paradoxical suggestions.
- Using humorous expressions and comments.

Partial agreement and broken record

- It consists of active listening and empathizing, accepting that the participants have desires and feelings that may be legitimate when making objections to us. It is used when we want the participant to be sensitive to our positions and come closer to the issues and objectives we intend and to reiterate an objective we consider important.
- Partial agreement is expressed: "It is possible that... but...", "I do not doubt that you will have reasons to..., but...", "I know that..., nevertheless and in spite of everything...", "It is true what you say, but I still wish...", "It is true that I was wrong, in spite of everything I still feel...".

Clarification

- Consists in the formulation of a clarifying question that we will ask behind an ambiguous message from the participant, e.g. "Sometimes I just want to get rid of everything", "What do you mean by everything?"
- Usually clarification is useful when the participant elaborates on the answer and adds missing details, aspects or images.

Paraphrasing

- Consists of selective repetition of words and thoughts. It involves giving attention to the cognitive part of the message, translating the participant's key ideas into his or her own words.
- Purposes of paraphrasing:
  - To demonstrate understanding of the message.
  - To expand or clarify your ideas.
  - To deepen key ideas or thoughts.
  - To help the participant focus on a particular situation, event or behavior.
  - To help make decisions.

Reflection of feelings

- Used to repeat the affective part of the message and the emotional tone used by the participant. The purpose of the reflection is to help participants feel understood in order to encourage them to express their feelings.
- The keys to keep in mind in the reflection of feelings are:
  - Analyze which words related to feelings they have used.
  - Study what feelings are implicit in their tone of voice.
  - Select what may be a good choice of affect words that accurately describe their feelings at the same level of intensity.
  - Choose what is the context or situation surrounding the feelings I am going to paraphrase

Synthesis

- The purpose of the synthesis is to bring together the multiple elements that emerge in the participants' messages. Synthesis will serve as a good feedback tool because it extracts meaning from vague and ambiguous messages and makes it possible to identify a theme or message of the session.
- To do this, it is important to analyze what the participant has been telling me today and over time (key content and affect) and what is the recurring pattern or theme in his or her interventions.

Main mistakes when interviewing

- No reinforce enough or do it indiscriminately
- No specify the information
- Asking more closed questions (yes/no) rather than open questions
- Being passive
- Excessive directivity and control in the interview
- Avoiding personal topics
- Asking different things by once
- Not considering non-verbal communication
- Interrupting the individual
- Brining personal stories to the interview
- Not considering our non-verbal communication
- Distracting environment for the interview
- Short and sharp answers

cancerless

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965351

Questionnaires

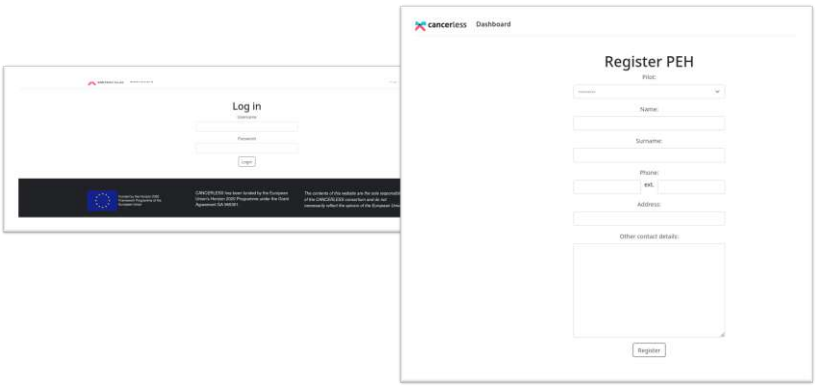
cancerless

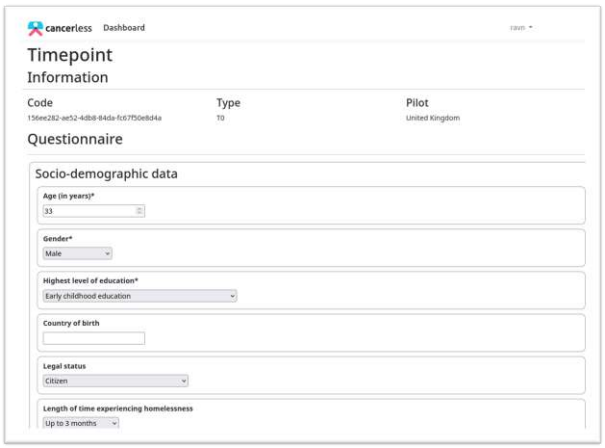
The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965351

- Socio-demographic data
- Health literacy
- Health data
- Risk behaviours and healthy lifestyles
- Psychological distress: Brief Symptom Inventory 18 (BSI-18)
- Quality of life: two items from the WHOQOL and the EQ-5D-5L
- Empowerment: Health Care Empowerment Questionnaire (HCEQ)
- Satisfaction
- Interpersonal Communication: Person-centred coordinated care experience questionnaire (P3CEQ)
- Use of health care services
- Adherence

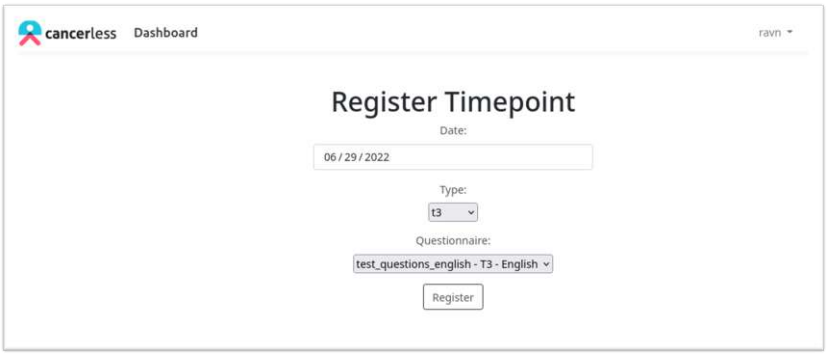
The Tool

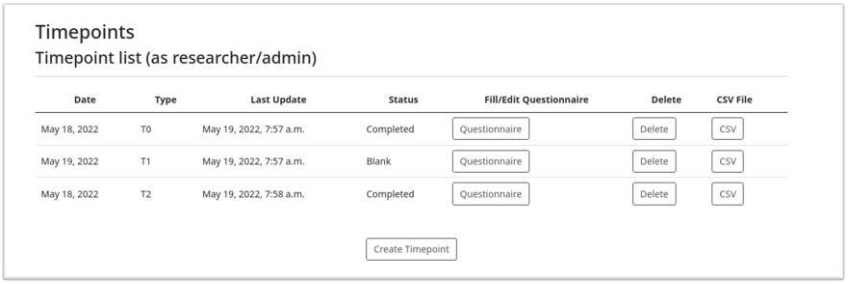
cancerless

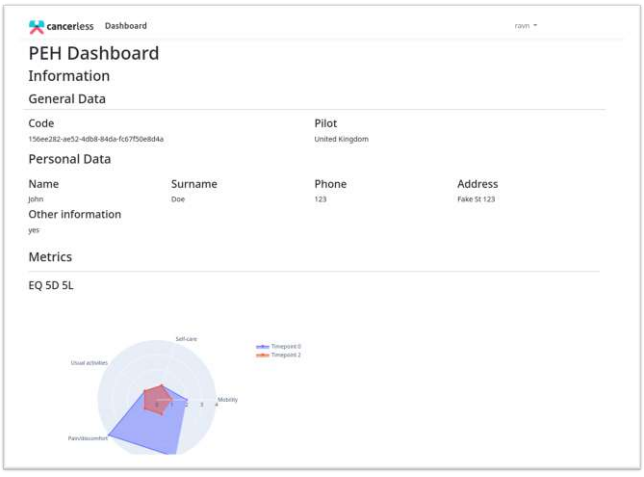




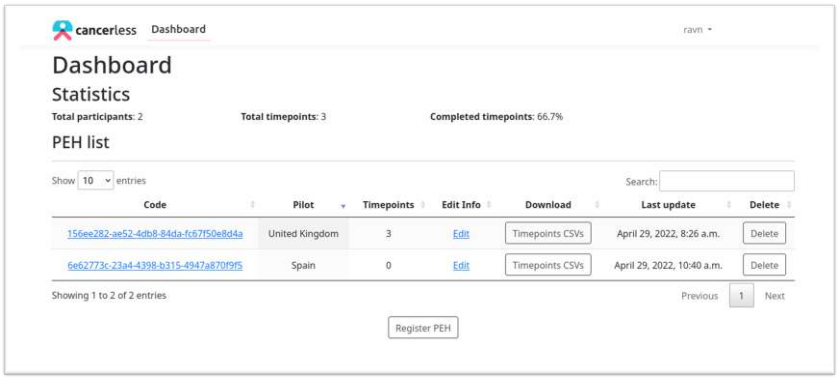
cancerless


cancerless
Dashboard
ravn
Register Timepoint
Date:
06 / 29 / 2022
Type:
t3
Questionnaire:
test_questions_english - T3 - English
Register


Timepoints
Timepoint list (as researcher/admin)
Date
Type
Last Update
Status
Fill/Edit Questionnaire
Delete
CSV File
May 18, 2022
T0
May 19, 2022, 7:57 a.m.
Completed
Questionnaire
Delete
CSV
May 19, 2022
T1
May 19, 2022, 7:57 a.m.
Blank
Questionnaire
Delete
CSV
May 18, 2022
T2
May 19, 2022, 7:58 a.m.
Completed
Questionnaire
Delete
CSV
Create Timepoint


cancerless
Dashboard
ravn
PEH Dashboard
Information
General Data
Code
156ee282-ae52-4db8-84da-fc67f50e8d4a
Pilot
United Kingdom
Personal Data
Name
John
Surname
Doe
Phone
123
Address
Fake St 123
Other information
yes
Metrics
EQ 5D 5L

MODULE 4



26

cancerless

cancerless

Cancer prevention and early detection among the homeless population in Europe: Co-adapting and implementing the Health Workplace model

Local context

MODULE 5

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965351

Local context and resources:

UK

cancerless

General overview of the health care system

Organisation of the health care system

The vast majority of health care in England (and the whole of the UK) is provided by the National Health Service, a taxpayer funded system free at the point of access to all permanent residents.

The NHS is very complex and made up of multiple regional and national organisations, each with different roles and responsibilities as explained in this short introductory video produced by the King's Fund.

Each local area has a Clinical Commissioning Group which is responsible for organising and funding hospital and community-based services – in this area, this is Norfolk and Waveney CCG.

Access to the health care system

Access to primary care, walk-in centres, Accident and Emergency (A&E) and diagnosis and treatment of infectious diseases are free for everybody.

For secondary care services, the UK's healthcare system is residence-based. This means that you must be living lawfully in the UK on a properly settled basis to be entitled to free healthcare.

- The measure of residence that used to determine whether someone is entitled to free NHS healthcare is known as 'ordinary residence'. To be ordinarily resident in the UK, people from countries outside the European Economic Area (EEA) who are subject to immigration control need to also have the immigration status of 'indefinite leave to remain'.
- Refugees, asylum seekers and victims of trafficking are exempt from these costs.

Some health services, namely dental care, eye care and prescription medicines, do also carry financial costs for residents, however those on low incomes (alongside other specified groups) are generally exempt from covering these costs. Certain medicines – such as contraceptives – are free for everybody.

GPs are not required to ask for proof of identity, address or immigration status from patients wishing to register. NHS guidance on how to register with a GP surgery clearly outlines that a practice cannot refuse a patient because they do not have proof of address or immigration status.

- If a patient applies to register with a GP practice and is turned down, the GP must still provide any immediately necessary treatment that is requested by the applicant, free of charge, for up to 14 days.

MODULE 5

Assessing and overcoming barriers in accessing the health care system for the homeless population

There are many known barriers to healthcare for people experiencing homelessness, and other socially excluded and vulnerable populations. These include:

- Instances of people experiencing homelessness being denied access when attempting to register with GPs, often incorrectly on the basis of a lack of fixed address or identification.
- Stigmatised attitudes and a lack of understanding around homelessness on the part of some health care professionals
- Practical difficulties in arranging and attending appointments (e.g., transport, phones, email, inflexible appointment times).
- Mistrust of healthcare professionals, often based on prior negative experiences.
- Poor health literacy, and limited understanding of when health care may be required among people experiencing homelessness.
- Health as lesser priority when compared with meeting other more immediate needs (e.g., accommodation, income, food).
- Limited knowledge regarding local services, and eligibility to access these.
- General scarcity of resources, particularly in the context of COVID-19 – long waiting times which serve to deter people experiencing homelessness from engaging in health care.

Existing evidence indicates that strategies/approaches that can help to overcome these barriers include:

- Tailored and individualised approaches to delivering health care, including the use of outreach.
- Health based education
- Building relationships between health care providers and homelessness services; sharing knowledge and examples of best practice.
- The active involvement of homelessness services in delivering/facilitating access to health care.
- Addressing immediate housing needs, for example through *Housing First* style approaches.

Useful links and resources

Healthy London Homelessness + Health Resource Pack
Department of Health and Social Care - Guide to the Healthcare System in England
Pathway Online Inclusion Health Course
Age UK Guide to Accessing Health Services
Healthwatch
Centre for Homelessness Impact: What Works in Improving access to H&SC services review

02

cancerless

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 945351

MODULE 5

General overview of support services for the homeless population

Organisation of support services

In the UK, there are two main avenues of support for people who are experiencing or at risk of homelessness:

- **Statutory homelessness**: local authorities (councils) have a responsibility to provide accommodation and support to certain 'priority need' groups (e.g., families, pregnant women, young people leaving care).
- Services for people who fall outside of this remit, often referred to as **single homelessness**, are predominantly delivered by third sector/charitable organisations, although these may still be government funded.
- There is a great deal of variety across the UK – particularly between the devolved nations - as to how effectively local authorities respond to homelessness, and the services that are available.

Support services and community resources available to the homeless population

There are a variety of services available to people experiencing homelessness including short and long-term accommodation (hostels, supported housing), day centres, soup kitchens and outreach services.

To identify local homelessness services, national charity Homeless Link provide an online directory of homelessness related services across England, organised according to postcode.

Useful links and resources

Shelter Overview of Homelessness Law/Legislation
Homelessness Services Search Engine (England)
Age UK Advice on Homelessness for Older People
Homelessness Monitor (Overview of Profile of Homelessness in UK)
Homeless Link – Guidance and Toolkits

03

MODULE 5

Cancer screening programmes

Available screening programmes

Across the UK, there are currently three national cancer screening programmes, delivered through the NHS: breast, bowel (colorectal) and cervical.

Invitations to all of the national screening programmes are sent automatically to all eligible adults who are registered with a GP, usually through letters and/or kits in the post.

Existing cancer screening guidelines

Cancer Research UK have a simple tool for assessing eligibility for each of the national programmes.

Breast cancer screening

- Mammogram completed by a female mammographer, usually every 3 years.
- This involves the breasts being placed on an X-ray machine four times (twice for each breast) which can help to identify signs of breast cancer that are too small to feel or see.
- Offered to all women, some trans men and non-binary people aged 50-70 and to women aged 40+ with a family history of breast cancer.
- Others who think they make be at increased risk of breast cancer can also speak to their GP about the potential for screening.
- NHS Breast Cancer Screening Information Leaflet

Bowel cancer screening

- Home-testing faecal immunochemical test, or 'FIT kit' sent out by post every 2 years via GP.
- This involves collecting a small sample yourself from three separate bowel movements and returning the kit by post to the laboratory for analysis.
- Routinely offered to all adults aged 60-74 and those over 75 by request; this is currently being extended to those over 50.
- NHS Bowel Cancer Screening Information Leaflet

04

cancerless

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965351

Cervical cancer screening

- HPV primary screening – also known as a 'smear test' or 'pap test' - completed by a nurse every 3 years (or every year if initial results are abnormal).
- This involves the nurse using a plastic instrument called a speculum into the vagina so that they can see the cervix clearly, and then using soft brush to take some samples of cells from the surface of the cervix.
- Offered to all women, some non-binary people and trans men aged 25-64
  - NHS Cervical Cancer Screening Information Leaflet

In some areas of the UK, Lung Health Checks are now also available for adults age 55-75 who have ever smoked and are registered with a GP, although this programme has not yet been extended to include the East of England.

HPV vaccination programme

- In addition to these screening programmes, there is a national HPV programme aimed at preventing cervical cancer, some mouth and throat (head and neck) cancers and some cancers of the anal and genital areas.
- The HPV vaccine is now routinely offered to both girls and boys in Year 8 of school (aged 12 or 13), in two doses administered 6 months apart.
- For those who missed this vaccination at school, it's available for free on the NHS up until the age of 25 for girls born after 1 September 1991 and boys born after 1 September 2006.
- Men who are bisexual, gay or have sex with other men up to the age of 45 are also eligible for free HPV vaccination on the NHS when they visit specialist sexual health services and HIV clinics in England.

Assessing and overcoming barriers in accessing cancer screening

Current cancer screening programmes in England rely on individuals being registered with a GP and receiving letters usually delivered through the post (or phone), meaning those who are disengaged from health care services, do not have a permanent address or living transiently are likely to be missed.

As well as the general barriers to healthcare already covered, other challenges for delivering cancer screening programmes to people experiencing homelessness include:

- Inadequate access to primary health care services; reliance on acute health care services.
- Poor health literacy and limited understanding around the importance of cancer prevention and early diagnosis.
- Fatalistic views about cancer.
- Fear of invasive screenings; embarrassment about the screening process – this is known in particular to be a barrier for cervical 'smear tests' (*Jo's Cervical Cancer Trust, 2022*).
- Practical difficulties associated with attending cancer screening appointments, such as lack of transport.
- Focus on addressing more immediate health concerns rather than preventative actions.
- Poor overall health among people experiencing homelessness serving to mask potential signs and symptoms of cancer.

As well as the general strategies for reducing barriers to healthcare already covered, actions which have been shown to improve access to and uptake of cancer screening in particular include:

- Tailored health education on cancer and cancer screening.
- Indivdiualised risk assessments.
- Building relationships between homelessness service providers and those delivering cancer screening programmes.
- Access to 'easy read' and translated versions of invitation letters and other documentation associated with cancer screening.
- Continuity in care – providing reminders and follow ups around appointments and outcomes.
- The offer of extra time in cancer screening appointments, to allow for questions and explanation of the procedure(s).

Useful links and resources

Cancer Research UK – Screening Overview
NHS England – Screening Overview
Macmillan – Worried About Cancer?
Healthy London Cancer Inequalities Toolkit
Healthwatch Norfolk Cancer Screening Report
Jo's Trust – Barriers to Cervical Screening

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965351

Local context and resources:

Austria

General overview of the health care system

1.1 Organization of the health care system

"The country Health Profile 2021 - Austria"

published by the OECD and the European Observatory is describing in the section "health system" Austrians organization of the health care system. Its informing about the actual status and the major reforms that had been done recently. It describes also the distribution of health spendings in Austria. In addition to that, the document "Das Österreichische Gesundheitssystem Zahlen-Daten-Fakten" from the Bundesministerium für Arbeit, Soziales und Gesundheit https://broschuerenservice.sozialministerium.at/Home/Download?publicationId=636

includes information about the principles of the Austrian social insurance, how it is divided and financed. It also describes the different responsibilities between the federal state, the regional states and the social insurance itself.

1.2 Access to the health care system

"The country Health Profile 2021 – Austria" released from the OECD and the European Observatory is informing about the gaps despite the nearly universal insurance coverage. Who has access to the Austrian health care system is also noted in the document.

1.3 Assessing and overcoming barriers for accessing health care system for the homeless population

The analysis of "The Public Health report in Austria"

from the European Observatory and the Hauptverband der Österreichischen Sozialversicherung is writing about the actual access to the health care system in Austria. It is mentioning who has no access to the health care system and what was done do overcome some barriers, like health insurance for asylum seekers or health insurance for people that have at least a 3-year residency in Austria.

There is a project called "Gesundheitslots:innen" from Volkshilfe Wien https://www.volkshilfe-wien.at/soziale-arbeit/integration/gesundheitslotsinnen/

that should guide and help people with migration background through the Austrian health care system.

General overview of support services for the homeless population

Organization of social services

The sites listed below are providing consultation and are contact points for the homeless population. The "Fonds Soziales Wien" is the head organization for homeless people and is financed trough the public sector and a small part from the contributions of the beneficiary.

The advisory center „Wohnungslosenhilfe" is organized from the FSW (Fonds Soziales Wien) and is a contact point where homeless people get information about services available, fundings and they are also organizing subsidized flats. This organization is also helping with night shelters and day-care centers.

This is a link to the website from "Wohnunglosenhilfe" of the FSW https://www.fsw.at/p/wohnungslosigkeit

The "P7- Wiener Service für Wohnunglose" organised from Caritas Wien is informing about available places at the shelters in Vienna, are doing crisis intervention, are helping with financial support und with legal advice.

This is a link to the website from "P7" https://www.caritas-wien.at/hilfe-angebote/obdach-wohnen/beratung/p7-wiener-service-fuer-wohnungslose/

The "Wohnungslosenhilfe" from Volkshilfe Wien is offering night shelters and a day-care center. Furthermore, they are helping with the apartment search and support clients who are in danger of loosing their housing.

This is the link to the website of "Wohnunglosenhilfe" https://www.volkshilfe-wien.at/soziale-arbeit/wohnungslosenhilfe/

The "Wohnunglosenhilfe" from the Rotes Kreuz Wien are also offering night shelters, day care centers and warm rooms for homeless people. This is the link to the website

https://www.roteskreuz.at/wien/ich-brauche-hilfe/hilfe-fuer-wohnungslose-menschen

The "Wohnberatung" from Diakonie is a site where refugees can get information about housing and regal advice on studio rental.

This is the link to their website: https://www.diakonie.at/unsere-angebote-und-einrichtungen/wohnberatungsstelle-wiwa

Social services available for homeless population

Food aid:

There is a list of places where homeless people can get access to free meals or groceries. Often also hygiene articles are distributed.
https://www.wien.gv.atsozialinfo/content/de/10/SearchResults.do?keyword=Lebensmittelhilfe

Medical care:

There is a list of medical centers specialized in working with homeless people.
https://www.wien.gv.at/sozialinfo/content/de/10/SearchResults.do?keyword=Medizinische+Betreuung+f%C3%BCr+wohnungslose+Menschen

There they get medical treatment for free. There are also physiotherapists, translators and psychotherapists working there. Additionally, at one medical center there is also a veterinarian present.

Clothes/donations:

There is a list of services offering free clothes and other donations. Some of them have special conditions and others are free for everyone. "Kost-nix" (no costs) stores a listed below.

https://www.wien.gv.at/sozialinfo/content/de/10/SearchResults.do?keyword=Kleidung&liid=10

German lessons/EDV courses:

The social service "ADRA" is offering German lesson and computer lesson for free. Here is the link to the website:
https://www.adra.at/project/sozialzentrum-wien/?neues-spendenformular-5015/spende

Community resources available for homeless population

Night shelters: This is a link
https://www.wien.gv.at/sozialinfo/content/en/10/SearchResults.do?keyword=Emergency+accommodation+for+homeless+persons

to a list of night shelters for men, women, families and underaged children. Each of them has different facilities and conditions to stay. Some of them are also especially for people in need for special protection.

Day care centers: This is a link
https://www.wien.gv.at/sozialinfo/content/de/10/SearchResults.do?keyword=Tageszentren+f%C3%BCr+wohnungslose+Menschen

To a list of day-care centers where homeless people can have a shower, wash their clothes and find some calm in a quiet room. There are often events and social workers are going there to support people where they can. In some day-care centers medical treatment is also offered. There is also the possibility that clients can have a personal mailbox there to receive important papers.

Cancer screening programmes

Early detection of cancer in woman:

HPV:

This brochure https://www.krebshilfe.net/fileadmin/user_upload/Dachverband/Brosch%C3%BCren/2022_HPV_01.pdf

from the "Österreischische Krebshilfe" is informing about the risks of a HPV infection and how a vaccination can prevent an infection. There is information about the vaccine itself, the program in schools, the costs and the screening prevention program. This brochure can be handed out to patients.

Cervical smear test (PAP)

- Age > 20
- Frequency: annually
- Gynecologist

HPV test

- Age > 30
- Frequency: triennially
- Regardless of whether HPV vaccinated or non-vaccinated
- Double testing should be avoided → smear test and HPV test should be performed alternately
- Is not free

Gynecologist

- HPV vaccination
- Girls: between the ages of 9 and 15
- Women: between the ages of 15 and 45

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 945351

Breast cancer:

This brochure from the "Österreichische Krebshilfe"
https://www.krebshilfe.net/fileadmin/user_upload/Dachverband/Brosch%C3%BCren/2021_Frauen___Pink_Ribbon.pdf

is about cancer prevention for woman in general and specifically informing about breast cancer prevention. It consists of information about risk factors, how individuals can examine their breasts themselves and how and when patients can get access to a mammography. This is a website https://www.frueh-erkennen.at/ueber

where clients can apply to the screenings and they can find a list of doctors with a certificate for carrying out mammographies in Vienna. This links can also be handed out to patients.

Palpation of the breast by the doctor

- Age > 20
- Part of the gynecological examination
- Does not replace mammography, as it cannot detect small changes in the breast

Breast self-examination/self-palpation

- Age > 20
- Frequency: monthly (after menstrual period ends)
- Breast self-scanning is not a substitute for mammography

Mammography

- X-ray examination of the breast
- Can detect small tumors that are not yet palpable
- Age > 40
- Frequency: biennially

Colonic cancer:

This brochure from the "Österreichische Krebshilfe"
https://www.krebshilfe.net/fileadmin/user_upload/Dachverband/Brosch%C3%BCren/Darmkrebsvorsorge_2022.pdf

Is about nutrition, digestion, when and where to get a colonoscopy and also suggestions for certified sites for colonoscopy

Haemoccult test

- Examines hidden blood in the stool
- Age > 40
- Frequency: annually

Colonoscopy

- Prevention of colorectal cancer
- Additional to colorectal cancer screening
- At an examination center that holds the "Preventive Colonoscopy" quality certificate
- Age > 50
- Frequency: every 7 – 10 years

Skin cancer:

This brochure from "Österreichische Krebshilfe"
https://www.krebshilfe.net/fileadmin/user_upload/Dachverband/Brosch%C3%BCren/2021_Sonne_ohne_Reue___Web.pdf

consits of information about skin types, what individuals can do to protect their skin and recommendations for regular checkups with the dermatologist.

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement #101101

Early detection of cancer in men

Prostate cancer/testicle cancer/bladder cancer:

This brochure from the "Österreichische Krebshilfe" is about a program that is called "loose tie" and should inform men about the importance to have regular prostate, bladder and testicle checkups.

https://www.loosetie.at/fileadmin/user_upload/Downloads/Broschueren/2021_Maenner__Prostata-Vorsorge____Web.pdf

There patients can find information about screenings and recommendations concerning prostate, testicle and bladder cancer.

Self-examination of the testicles

- Age > 20
- Frequency: monthly

Prostate examination by the doctor

- Palpation by the doctor
- PSA test
- Age > 45

Urine examination

- Prevention of bladder cancer
- Strip test → examines for traces of blood
- Urinalysis
- Age > 40

Colonic cancer:

This brochure from the "Österreichische Krebshilfe" is informing about risk factors of colonic cancer, how to avoid them, nutrition and the endoscopy and haemoccult test as a cancer screening program. It is also containing a list of certified doctors for colonoscopy.

Haemoccult test

https://www.krebshilfe.net/fileadmin/user_upload/Dachverband/Brosch%C3%BCren/Darmkrebsvorsorge_2022.pdf

- Examines hidden blood in the stool
- Age > 40
- Frequency: annually

Colonoscopy

- Prevention of colorectal cancer
- Additional to colorectal cancer screening
- At an examination center that holds the "Preventive Colonoscopy" quality certificate
- Age > 50
- Frequency: every 7 – 10 years

Skin cancer

This brochure from "Österreichische Krebshilfe" consits of information about skin types, what individuals can do to protect their skin and recommendations for regular checkups with the dermatologist

Skin self-examination

https://www.krebshilfe.net/fileadmin/user_upload/Dachverband/Brosch%C3%BCren/2021_Sonne_ohne_Reue___Web.pdf

- Examination of skin for changes
- Frequency: 2 times a year → before and after summer

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement #101101

For people without insurance:

Skin cancer: self-checking of suspicious birthmarks, then maybe referral to a dermatologist at AmberMed

- Breast cancer: people without insurance get a "Ersatzkrankenschein" at ÖGK Kundenservice. With this Ersatzkrankenschein, they have to call the "früh-erkennen.at" Hotline where they activate their status. There is a list of verified doctors at the "früh-erkennen" website.
- Material: https://www.frueh-erkennen.at/

This link https://www.gesundheitskasse.at/cdscontent/?contentid=10007.878943&portal=oegkportal

https://www.loosetie.at/fileadmin/user_upload/Downloads/Broschueren/2021_Maenner__Prostata-Vorsorge____Web.pdf

- Informs about the option to do a screening without insurance.
- Prostate cancer: PSA check in the laboratory, also with the "Ersatzkrankenschein"

Existing cancer screening guidelines

Guidelines breast cancer:

- S3 Guidelines for screening, diagnostics and therapy from AWMF
- Material: https://www.awmf.org/uploads/tx_szleitlinien/032-045OLl_S3_Mammakarzinom_2021-07.pdf

Guideline cervical carcinoma:

- S3 Guidelines for screening
- Material: https://www.awmf.org/uploads/tx_szleitlinien/015-027OLl_Praevention_Zervixkarzinom_2020-03-verlaengert.pdf

Guideline skin cancer:

- S3 guidelines prevention of skin cancer
- Material: https://www.awmf.org/uploads/tx_szleitlinien/032-052Olk_S3_Praevention-Hautkrebs_2021-09.pdf

Guideline colonic cancer:

- S3 guidelines: prevention, diagnostics, therapy
- Material: https://www.awmf.org/uploads/tx_szleitlinien/021-007OLl_S3_Kolorektales-Karzinom-KRK_2019-01.pdf

MODULE 5

Assessing and overcoming barriers for accessing cancer screening

Promote cancer awareness and self-management

- Cancer education
- Promotion of healthy behaviours and preventative measures

User involvement in health-related decisions

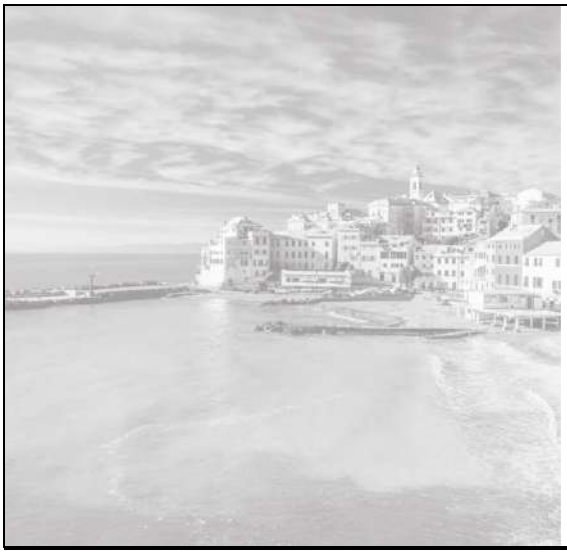
- Identify health needs and barriers
- Personalized approach to assessment of user needs
- Adapted solutions regard barriers to care

Coordinate access to care

- Trusting relationships and facilitated communication between local health and social care providers
- Enhanced understanding of needs of homeless people among local health and social care providers
- Referrals to healthcare services and cancer screening
- Attendance of appointments
- Offer practical assistance
- Transportation, mobile phones, clothing, access to hygiene facilities, storage of medication

18

cancerless



Local context and resources:

Greece

cancerless

General overview of the health care system

MODULE 5

Organisation of the health care system

Mixed universal health care system

- National health insurance (EFKA-EOPYY)
- Public Healthcare System
- Private health service providers

https://ec.europa.eu/health/system/files/2017-12/chp_gr_greece_0.pdf (greek)

National health insurance

- Responsible institute: **Single Social Security Entity** (EFKA)
- To whom addresses: working force and their family members
- How: social security card (known as AMKA)
- Provider: National Organisation for Healthcare Provision (EOPYY)

Public Healthcare system (provided by EOPYY)

- National Hospitals (National Healthcare System-ESY)
- ESY Healthcare Centers
- Local Healthcare Units (TOMY)
- EOPYY-contracted freelance physicians

How to be eligible for cost-free and accessible public health care system?

- Uninsured people (vulnerable groups) have to issue the **Health Booklet of the Financially Weak or Uninsured (BYA)**

https://www.moh.gov.gr/articles/health/anaptyksh-monadwn-ygeias/3999-prosbash-twn-anasfalistwn-sto-dhmosio-systhma-ygeias

21

Access to the health care system

Access to the health care system is FREE when provided by public healthcare institutions

For: Anyone owning AMKA card can access public health care system (regardless their social security status)

When: Arrange an appointment or **When**: Visit Emergency Departments (when concerning an emergency).

FREE means covering of:

- Primary and secondary health facilities
- Mental health facilities
- Detoxification facilities
- Nursing and diagnostic procedures
- Laboratory tests
- Scheduled surgeries
- Prevention and promotion of health
- Maternity care
- Dental care
- Medical-related appliances or devices
- Emergency transportation

Medicines prescription is free when prescribed by a physician of a public health institution.

- Fee for medicines prescription when prescribed by a freelance physician (contracted or not under EOPYY)
- No fee for medicines prescription when prescribed by a freelance physician (contracted or not under EOPYY) for vulnerable groups of people
- You have to co-pay for prescribed medicines
- You do not have to pay anything when excluded from the co-payment due to special provisions

Who is vulnerable concerning the cost-free and accessible public health care system?

- Uninsured people who:
- Lost their insurance due to the crisis, even if they have debts to their insurance companies
- Reside legally in the country
- Do not have legal residence documents, but need immediate health care as members of vulnerable social groups (e.g. minors, pregnant women, people with disabilities, drug addicts, homeless, etc.)

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 945351

General overview of support services for the homeless population

Barriers for accessing health care system for the homeless population

- The term "homeless" wasn't mentioned in the law till recently
- Bureaucracy limitations for issuing ΒΥΑ (need to declare residential address and a document from the Public Power Corporation as proof that they have paid the electricity bill)
- Unawareness of their rights on public health care system
- Unawareness of social structures providing help
- Perception of their own health status
- Poor health
- Fear of homeless people of rejection by professionals
- Self-stigmatization
- Negative attitudes by the staff of services
- Travel costs

Drivers and solutions for accessing health care system for the homeless population

- The conditions of living play a positive role on the encouragement of homeless individuals to seek help
- Social structures for food distribution and temporary accommodation also work as agents for provision of medical care

General information of social services for homeless population

Organization of social services

Civil society organisations and the public sector (local and central) have specific interventions and programs to meet the needs of the beneficiaries:

- Outreach services / street work.
- Social services:
- Housing services via specific projects.
- Job consultancy and promotion.
- Open Day Centres for homeless people where somebody could clean their clothes, take new clothes, have their bath, take food.

However, although according to the law, the State has the obligation to provide housing to people who cannot provide their own housing for financial and other reasons, still, the percentage of people living in precarious conditions and deprived of the right to housing is increasing every day. In practice there are many obstacles. There are mainly some dormitories, which are basically complete. This means that only civil society organizations make sure that temporary, transitional accommodation is set up. For this reason, there are long delays because, again, there are not enough places. In addition, there are several documents (legal, medical, tax) that are needed to stay in a shelter, which the beneficiaries find it difficult to provide, so that they are sometimes excluded from access to these shelters.

In Greece, there are two official networks that are working in the advocacy these areas:

- Greek antipoverty network;

- Greek network for the right to housing.

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement #101001

KEY ASPECTS OF THE WORK

Holistic approach model of intervention

- Via one-stop shops and/ or
- Network

Key Management plan agreed

Key approaches for engaging the population

- Outreach work
- On a standard basis contact
- Peers training
- Multi - disciplinary approach

Key areas of the work

- A conceptual framework
- Planning and stakeholders
- Strengthening Communication
- Values, norms and boundaries
- Management plan agreed

Guiding principles to use in psychosocial support

- **Safety -** It is essential to ensure the safety of the person at all times.
- **Confidentiality -** Respect the confidentiality at all times by not disclosing any information, at any time, to any party without the informed consent of the person concerned. Ensure trust and empowerment.
- **Respect -** All actions or decisions should be guided by respect for the person's choices, wishes, rights, and dignity.
- **Non-Discrimination -** Ensure fair and equal treatment, regardless of their age, sex, race, marital status, sexual orientation, or any other characteristic.
- **Honesty -** Provide honest and complete information about possible referrals for service, be made aware of any risks or implications of sharing information, and have the right to limit the types of information shared and whom it is shared with.

COMMUNICATION

Main principles in communication

- Respect
- Active listening
- Friendliness
- Confidence
- Feed back
- Empathy
- Confidentiallity

Practical rules for the communication

- Use appropriate language, i.e., language that is readily understood and accepted.
- It is important to know/ learn the jargon, the (sub-)cultural codes of the target group(s).
- Provide consistent, complete and neutral information, offering the chance for a well-considered choice.
- Informing people is not only telling but also listening.
- Especially when asking personal questions state clearly that people don't have to answer, that you do not want to be offensive.
- Explain the reason why you are asking this question, e.g., to get a picture what information someone needs.
- Provide relevant information, i.e., information people need.
- Support (positive) change in behavior and attitude to reinforce these changes. This support of changes towards safer behavior is important to foster self-esteem and self-efficacy, and, thus, is the basis for ongoing change.
- Do not judge or reject a person in case of negative change of behavior.
- Encourage and support snowballing
- by simply asking the target group to pass on the information to their peers;
- by discussing how this can be done;
- by involving the target group in the making and handing out of information material, etc..
- Stop a dialogue in time, do not force people to go on.

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement #101001

Basic principles of a professional

An active approach to

- Make contacts actively
- Not a wait and see attitude
- Self- moves to the community
- Intentionally coming in contact with the person

Promoting wellness

- Ensuring social rights and promoting quality of life
- Starting from emancipatory process to working with and on strengths people
- Striving for independence
- Contribute to the plan that the person himself makes

Participatory basic attitude

- Being real, Involvement
- Equivalence
- Openness
- Unconditionally
- Positive attitude
- Professional proximity
- Reliability aspect
- Both verbal and non-verbal

People in disadvantaged situations

Not or inadequate reached

- Contact- then consider what support is needed
- Ensure streamlined current service and assistance
- To optimize support to suit the needs of the target group
- Building bridges between the world of the target group and the relevant departments/organizations

Working In their environment

- Leave the familiar surroundings of their own organization
- Work in the environment of the target

Aknowledging the prevailing values

- Respect and openness to the current values in the environment
- Flexibility and creativity of the worker is required

Mutual reconciliation

- Restore or enhance connections between community and services
- Connecting link

Target group and social vulnerability

- Explicit choice for working with this target group

The role of peers in THE work

- Persons who use their own life expierence to help others.
- Life experience workers can – based on their experience – act as a guide or translater.
- Life experience workers can close the "US-THEM" split, can act as a bridge.
- Being/becomming a life experienced worker means more than having a personal experience.
- They can reach out the target groups in different ways.
- Peers can relate to the target groups; messages from peers are more likely to be heard
- Can give an extra dimension, different point of view.
- Offer real life expierence

Characteristics of key target groups

- Homeless people with health issues
- Patients/ former patients
- Former homeless
- Persons living in shelters
- LGBTQI+ people living in difficult conditions
- People with mental health issues
- People using drugs

➢ ***Key point: Multiple vulnerabilities***

Multiple vulnerabilities

- Persons who use drugs (PWUD)
- HIV seropositive
- People / PLWA, Hepatitis B and C patients
- Mental health issues
- Dermatological issues and other health issues
- Persons from the LGBTQI community
- Persons who have lost their jobs, houses, and/ or victims of economic crisis

People in vulnerable situations

- Socially vulnerable
- Missing being connected to the broader society
- Often socially excluded/ isolated
- Complexity of their needs

Key barriers

- Lack of **knowledge** concerning services from NGOs, prevention
- Lack of **access** to the health care system and as a result of lack of legal documents and/ or health insurance
- Lack of **understanding** of health problems
- **Language** barriers concerning homeless asylum seekers, refugees and migrants

Social services and community resources available for homeless population

Social support is being offered by the public as well as the Civil Society Sector.

The Social Services in each Municipality run specific programs for supporting beneficiaries. How active one Social Service is differing a lot within the different areas in Greece. In general, the social welfare system in Greece has been very problematic in many areas. In general, each Social Service must work locally and focus also on social vulnerable groups withing the Community. However, this is not always possible. There are specific programs that exist in the community and this change according to the changes in the funding procedure as well.

In general, these are two main ways: the support via the Social Services of the public sector and the Civil Society Sector. There are also programs that are by the community organizations as well. Most of the organizations support in access to housing; health support; outreach work; provision of hygienne kits; psychosocial support; legal support; food; emergency shelters etc. It should be pointed out though, that the interventions cannot cover all needs and specifically the housing ones and mostly the emergency housing support.

Some bodies in the area of supporting homeless populations are: Unesco; Municipality of Piraeus; Doctors of the World; KYADA; KLIMAKA; STEPS; ITHACA LAUNDRY; Hellenic Red Cross; The National Centre for Social Solidarity (EKKA); Homeless Shelter of the Municipality of Thessaloniki; PRAKSIS; ARSIS; KYADA, Equal Society, Caritas, Social Kitchen "The Other Man" ("O Allos Anthropos") etc..

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 945351

Cancer screening programmes

Available screening programmes

- National Screening program (ΕΠΠΕ)
- Local actions by municipalities (especially during the period of cancer-related world days) (e.g. Municipality of Agioi Anargyroi)
- Social associations (e.g. Alma Zois)
- Private hospitals (e.g. free only for registered vulnerable groups)

Existing cancer screening guidelines

- Europe's Beating Cancer Plan for breast cancer, cervical cancer and colorectal cancer
- https://ec.europa.eu/transparency/documents-register/api/files/COM(2021)44_0/de00000000960621?rendition=false (greek translation)

Recommendations for breast cancer:

- Mammography every year for all women over 40 years old without symptoms but of medium risk (medical history, heredity)

Recommendations for cervical cancer:

- Vaccination against HPV for teenage girls (over 11 years old)
- Cervical screening for women over 21 years old (Pap test)
  - Every 3 years until the age of 30
  - Every 3 years for women aged 30-65 together with HPV DNA test
  - No test over 65 years old (when no positive record during the last decade)

Recommendations for colorectal cancer:

- Stool hemoglobin test
- Orthosigmoidoscopy
- Stool hemoglobin test and orthosigmoidoscopy
- Radiological examination with barium enema
- Colonoscopy
- New examinations (under evaluation like stool test for genetic abnormalities associated with colon cancer, and a type of computed tomography called a virtual colonoscopy)

For people running:

- medium risk (men and women aged over 50, method chosen according to the physicians instructions, for colonoscopy only: every 10 years if negative)
- high risk (earlier than 50, depends on family medical history, heredity and colon inflammative diseases)

Assessing and overcoming barriers for accessing cancer screening

- Not enough information about
  1. Availability of screening methods
  2. Cost of screening methods
  3. When they should be performed
  4. Where they are performed
- Health care system is dedicated to treatment and not to prediction
- Only private doctors occasionally suggest cancer screening
- Perception of not being affordable

USEFUL LINKS :

- https://ec.europa.eu/health/system/files/2017-12/chp_gr_greece_0.pdf (greek)
- https://www.moh.gov.gr/articles/health/anaptyksh-monadwn-ygeias/3999-prosbash-twn-anasfalistwn-sto-dhmosio-systhma-ygeias
- Europe's Beating Cancer Plan for breast cancer, cervical cancer and colorectal cancer
- https://ec.europa.eu/transparency/documents-register/api/files/COM(2021)44_0/de00000000960621?rendition=false
- Project "Peer2Peer: Reinforcing Peers' Involvement in Outreach Work"; https://peer2peerproject.com/
- Project "Eployment4Inclusion"; Counselling zone 5: Social participation; https://www.employment4inclusion.eu/wp-content/uploads/2021/05/Counselling-Zone-5_English.pdf
- Project: " Come Forward: Empowering and supporting victims of anti-lgbtqi hate crimes"; Working with Victims of Anti-LGBT Hate Crimes: A Practical Handbook; http://www.lgbthatecrime.eu/handbook/pdf/Working%20with%20Victims%20of%20Anti%E2%80%93LGBT%20Hate%20Crimes_gr_2.pdf
- Project: "PARADISO - Participatory approach for raising awareness and fighting discrimination against sexual and gender orientation in the health care sector"; www.paradiso.gr

Local context and resources:

Spain

The National Health System (NHS) and the Social Services System (SSS) in Spain is made up of all the services of the 17 Autonomous Communities, which share basic characteristics, but with differences in their management and provision:

All the Autonomous Communities there are two levels of care:

National Health System (NHS)

Primary care, which forms the first level, characterized because it is the first contact that the patient has with the NHS.

The most common health problems are treated through basic services, by means of the **Health Centres.**

Specialized care, which constitutes the second level, and has the concentration of more complex technology for the resolution of problems that could not be solved in primary care

Within the NHS and SSS in Spain we find universality.
Universal access coverage imply that all people have access without any discrimination to comprehensive services according to their needs, being adequate and of high quality.

Social Services System (SSS)

Primary Social Care is the structure set up for citizens access to the social services system and its benefits.

It has a polyvalent character, receiving the whole variety of demands for social care and developing diverse responses to the problems posed.

The basic equipment at the Primary Social Care level will be the municipal social services centres.

Specialized Social Care is the structure designed to respond to situations and needs that require specific situations and needs that require a specific technical specialisation or the provision of specific resources.

The NHS is also characterized as a system whose management of health resources has been decentralized with the aim of guaranteeing greater responses of services and professionals to the needs of citizens.

The NATIONAL health system retains responsibility for:

The SSS has been decentralized to the autonomous communities, and is the exclusive competence of these, unlike the health system.

STATE ORGANISATION

↓

CENTRAL GOVERNMENT (1)

↓

AUTONOMOUS GOVERNMENT (17)

↓

LOCAL GOVERNMENT (8.112)

↓

SERVICE PROVIDER

General overview of the health care system

The Health System of the Community of Madrid was structured in a deconcentrated way through the Health Areas, whose function was to carry out activities related to public health in terms of: prevention, health promotion and rehabilitation and health care.

These health areas were governed under the model of integrated health care, understanding health care and public health as an indissoluble union (Ley de Ordenación Sanitaria de la Comunidad de Madrid, 2001).

With the entry into force of Law 6/2009 on freedom of choice in the health system of Madrid, this is modified and the organisation of the health system is reduced to a single health area, establishing through Decree 52/2010 that the single health area will be integrated by the basic health areas, where primary care will act, developing health activity through health centres (Ministerio de Sanidad, Política Social e Igualdad, 2008).

Basic Health Areas: this is the basic geographical delimitation that the professionals (health and non-health professionals) belonging to the Primary Health Care Teams (EAP) use as a reference to organize and plan their work, as they are responsible for attending to the population belonging to that area:

- Each Basic Health Area has its own Primary Health Centre, in which the different local clinics that depend on that Health Centre are integrated.
- In the Community of Madrid, we can find 286 Basic Health Areas that are grouped in the Single Health Area of the Community of Madrid.
- The organizational structure of the Regional Ministry of Health in Madrid is formed as follows: firstly, by the Vice-Ministry of Health Humanization, to which is attached the General Directorate of: Humanization and Patient Care; Health Inspection and Management; Research, Teaching and Documentation; and finally, Social and Health Coordination.

Access to the health care system

All persons duly accredited by means of the individual health card are entitled to public health care from the Health System of the Region of Madrid. According to this Law, those persons who are in any of the following situations shall have the status of insured persons:

Workers affiliated to the Social Security and in a situation of registration or assimilated to that of registration.
Social Security pensioners.
Recipients of any periodic Social Security benefit, including unemployment benefit and subsidy.
Persons who, having exhausted their unemployment benefits or subsidies, are registered in the corresponding office as job seekers.
Persons who, without meeting any of the above requirements, are Spanish nationals, nationals of a Member State of the European Union, the European Economic Area or Switzerland who reside in Spain (registered in the Register of Citizens of the European Union and foreigners holding an authorization to reside in Spanish territory (residence permit).

Groups that hold the status of beneficiary of the policyholder:

The person may benefit from the insured, provided that he/she resides in Spain and is: the spouse or person with analogous relationship of affectivity, the dependent ex-spouse of the insured, the descendants and assimilated dependents of the insured, who are under 26 years of age or who have a disability equal to or greater than 65%.
Community foreigners who have exported the Social Security rights they have in their countries of origin, and non-EU foreigners from countries with Bilateral Social Security Agreements with Spain covered by such agreements.
The Spaniards of origin, not insured with residence abroad, will be able to obtain the health card according to the Law 40/2006, of the statute of the Spanish citizenship abroad, both if they refer to temporary stays, as if they return definitively. To do so, they must apply for their right to health care at the National Institute of Social Security. Then, they must apply for the card at the corresponding Health Centre.

They are also entitled to health care without a health card:

1. Citizens covered by another country under international regulations: holders of the European Health Insurance Card or other legal documents issued by a Member State of the European Union, the European Economic Area, Switzerland, or other countries that have signed bilateral Social Security agreements with Spain (Andorra and Chile).
2. Foreigners who are not registered or authorized as residents in Spain will receive the health care included in the Portfolio of Services of the National Health System.
3. Citizens applying for international protection (ASYLUM) will have access to the National Health System's health care.

SOCIAL POLICY: "Inclusion Plan for Homeless People of the Community of Madrid 2016-2021.

The Community of Madrid has developed the "Inclusion Plan for Homeless People of the Community of Madrid 2016-2021.
The objectives so that this group can effectively exercise their rights as citizens:

1. Prevention and awareness.
2. Establishment of measures to prevent homeless people from sleeping on the street or in inadequate places.
3. Increase access to public services and increase the number of people who are integrated into society.

Focusing on the healthcare system, the measures to be adopted under the Plan towards people experiencing homelessness include the following:

- Specialized training for health, social and security professionals on the care that should be offered to them.
- Social work professionals, as well as other social professionals, must carry out social street work.
- Registration of homeless people in their municipality.
- Awareness campaigns aimed at health and social professionals.
- The need for specialized emergency services with a health component as well as a social and security component, (hospitals, street, shelters, etc.).
- Creation of specialized housing services that offer an intervention focused on the individual needs of each person, increasing 24-hour shelters.
- In the case of convalescent persons, health care will be extended to the social centres where they live.
- Comprehensive database to improve coordination between social and health services.

The Social Inclusion Strategy of the Community of Madrid 2016-2021 has been developed, which aims to design and implement a strategy to address poverty and social exclusion. The 2016-2020 Strategy aims to follow the objectives of the National Action Plan for Social Inclusion (PNAIN), to achieve the European objective, of reducing poverty and promoting social inclusion of groups at risk of exclusion, of the European 2020 Strategy.
The main objective of the Strategy is the development of inclusive policies in employment, education, housing and the health system.
In the field of health, it aims to create a model that guarantees access to affordable and quality health care, improving the health of the most disadvantaged people, such as the homeless, by means of:

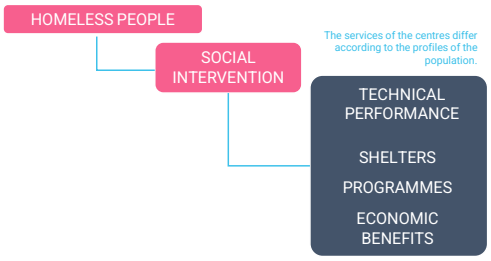
- Improvement of public resources for Mental Health care with greater emphasis on people with Severe Mental Disorders.
- Implementation of an Oral Health Plan.
- Implementation of the Health Prevention Program for vulnerable groups.
- Improvement of the mobile team for intervention with the population in a situation of social exclusion.

General information of social services for homeless population

Public network and centres:
For homeless people in the Community of Madrid, the Primary Social Care network is currently made up of 36 Social Services Centres and 2 Social Care Points, present in each of the 21 municipal districts of the autonomous community and attached to the Social Services Councils (Madrid City Council, 2021a).

Public network and services:
The Samur Social is responsible, on the one hand, for street detection, both through the Street Teams and the Mobile Units, carrying out functions of detection, location, intervention and referral or request for support to the Primary Care Network or to specialised centres for the homeless (Madrid City Council, 2012).Translated with www.DeepL.com/Translator (free version).

Private network with or without partial public funding. Other types of social intervention.



Prevention

There is an European Code against Cancer that focuses on measures that every citizen can take to help prevent cancer. Successful cancer prevention requires that government policies and actions support these individual actions.

1. Do not smoke. Do not use any type of tobacco.
2. Make your home a smoke-free. Support smoke-free policies in the workplace.
3. Maintain a healthy weight.
4. Be physically active in everyday life. Limit the time you spend sitting. 30 min./day of moderate intensity exercise (walking at a good pace, dancing, climbing stairs...) are enough.
5. Have a healthy diet:
   - Eat plenty of whole grains, pulses, vegetables and fruits.
   - Limit high-calorie foods (foods high in sugar or fat) and avoid sugary drinks.
   - Avoid processed meat; limit red meat and foods high in salt
6. If you drink alcohol of any type, limit your intake. Not drinking alcohol is better for cancer prevention.
7. Avoid too much sun, especially for children. Use sun protection. Do not use sunbeds.
8. In the workplace, protect yourself against cancer-causing substances by following health and safety instructions.
9. Find out if you are exposed to radiation from naturally high radon levels in your home.
   Take action to reduce high radon levels.
10. For women:
    - Breastfeeding reduces the mother's cancer risk. If you can, breastfeed your baby.
    - Hormone replacement therapy (HRT) increases the risk of certain cancers. Limit use of HRT.
11. Ensure your children take part in vaccination programmes for:
    - Hepatitis B (newborns)
    - Human papillomavirus (HPV) (for girls).
12. Take part in organised cancer screening programmes for:
    - Bowel cancer (men and women)
    - Breast cancer (women)
    - Cervical cancer (women)

Cancer Screening Programmes

Colorectal Cancer Screening (Men and Women)
"Prevecolon" is the Early Detection Program for Colon and Rectal Cancer of the Community of Madrid. It is aimed at the entire population aged between 50 and 69 years without symptoms or added risk factors for Colorectal Cancer (CRC). Its objective is to detect CRC or lesions early in their pre-malignancy phases to apply less aggressive treatments and maximize the chances of cure.

Breast cancer screening (women)
The breast cancer early detection program (DEPRECAM) is aimed at women between the ages of 50 and 69, asymptomatic and who meet the established inclusion criteria. Its goal is to prevent the development of breast cancer, one of the main health problems in women, through early diagnosis.
The Program consists of a screening mammogram every two years, which allows detecting cancer in very early stages, thus increasing the chances of cure. The DEPRECAM program will be accessible to all asymptomatic women aged between 50 and 69 years.

Cervical cancer screening (women)
Cervical cancer screening has shown a decrease in mortality in women. This program has been carried out in Spain by cytology by midwife or nurse in the health center and opportunistic during the last 50 years.
In 2019, this national program is modified within the common portfolio of services of the National Health System in the field of public health (Order SCB/480/2019) becoming an organized program of a population nature and incorporating the human papillomavirus (HPV) detection test as a primary screening test in a part of the target population.
This new program is carried out according to the following criteria:
Target population: women aged between 25 and 65 years.
Primary screening test and interval between scans:
25-34 years: cytology every 3 years.
35-65 years: High-risk HPV (HPV-AR) determination.
If HPV-AR Negative: repeat HPV-AR test at 5 years.
If HPV-AR positive: triage with cytology. If HPV-AR positive and cytology negative: repeat HPV-AR at one year.

Prostate cancer screening (men)
Prostate carcinoma is predominantly a tumor that occurs in older men, often responds to treatment even when it is widespread and can be cured when it is located in a significant percentage. Tumor growth varies from very slow to moderately fast and some patients have a very long survival after having metastasized at a distance, such as to bone. Since the average age for diagnosis is 72 years, many patients, especially those with localized tumor, can die from other diseases without ever having suffered any problems related to their tumor.

The CANCERLESS Project has been funded by the European Commission Programme Health under the Grant Agreement 945357

Available cancer screening guidelines:

- Guide Community action to gain health Ministry of Health.
- https://www.sanidad.gob.es/profesionales/saludPublica/prevPromocion/Estrategia/Accion_Comunitaria_Ganar_Salud.htm
- Strategy for health promotion and prevention in the national health system https://www.sanidad.gob.es/profesionales/saludPublica/prevPromocion/Estrategia/estrategiaPromocionyPrevencion.htm
- Community of Madrid. PREVECOLON Colon and Rectal Cancer Program
- https://www.comunidad.madrid/servicios/salud/prevecolon-prevencion-cancer-colon-recto
- Community of Madrid. DEPRECAM Program -Breast Cancer
- https://www.comunidad.madrid/servicios/salud/deteccion-precoz-cancer-mama
- Ministry of Health. Cervical cancer:
- https://www.mscbs.gob.es/profesionales/saludPublica/prevPromocion/Cribado/CribadoCancerCervix.htm
- Community of Madrid. prostate cancer program https://www.comunidad.madrid/servicios/salud/cancer-prostata

Assess and overcome barriers to access cancer screenings

Social Determinants in health.

We can say that health depends on the circumstances in which people are born, grow up in, live in, work in and lastly, age in. These circumstances are called SOCIAL DETERMINANTS OF HEALTH.
Social determinants of health (SDH) are understood as "those factors and mechanisms by which social conditions affect the level of health". The SDH includes specific characteristics of the social context by which social conditions are impacted and condition the health of the individual.
The SDGs establish large differences in health statuses that are inequities. The concept of inequality implies that "inequalities are unfair and avoidable, i.e. they can be prevented and remedied".
Equity in health means that every person has an equal opportunity to achieve their full health potential and that no one is disadvantaged in achieving it. Achieving health equity requires equity of access to care, which is achieved when all people have access to health and social services according to their needs and regardless of their ability to pay.

Andersen and Davidson identify four dimensions on which access depends on:
1. Contextual characteristics (health system, family and community).
2. Individual characteristics.
3. Health behaviours.
4. Results.

Tanahashi's model considers four stages in the access process to obtain effective coverage:
A. **AVAILABILITY**, understood as the availability of programme or care centre services, human resources, equipment, supplies, infrastructure and information;
B. **ACCESSIBILITY,** associated with physical accessibility such as distance, connectivity, and availability and timing of transport; organisational/administrative, related to administrative requirements for care, and the mode of obtaining hours and schedules of care; and financial, related to the cost of transport, out-of-pocket expenses and loss of earnings at work;
C. **ACCEPTABILITY OF SERVICES,** which depends on the perception of benefits, influenced by social, cultural and religious factors, beliefs, norms and values, treatment and privacy, among others;
D. **SERVICE CONTACT**, understood as the continuity of care given by the adaptation of health services to the patient and the quality of care;
E. **EFFECTIVE COVERAGE**. Access or abandonment of health services can be explained by identifiable facilitators and barriers in the different phases of the model, where there are social groups - generally the most vulnerable populations- that face various barriers and have no contact with the services. Several studies have examined barriers and facilitators to accessing health services in specific populations, programmes and pathologies, identifying personal, geographic, economic and health system barriers among the main ones.

The CANCERLESS Project has been funded by the European Commission Programme Health under the Grant Agreement 945357

Bronfenbrenner developed his theory of the ecology of human development, identifying levels ranging from the individual to the macrosystem through the close relational microsystem and the mesosystem as a space for available resources in the social structure.
- **MICROSYSTEM**: PERSON
- **MESOSYSTEM**: Family, neighbourhood, peers, school, health and social services and other social services and community resources.
- **EXOSYSTEM**: Policies, local governments, public services, media.
- **MACROSYSTEM**: Laws, beliefs, norms, practices and customs.

SDH, therefore, are systematic differences in one or more dimensions of health between population groups or subgroups (socially, economically, demographically or geographically defined) that meet these two conditions:
a) are considered socially UNJUST;
b) are potentially AVOIDABLE,

Social inequalities in health, both because of their impact and because they are unfair and avoidable, are one of the fields of action that need to be taken into account and addressed as a priority in health and social intervention.

Health inequities affect different individuals and groups along different axes of inequality and their component variables:
- Age
- Gender
- Class
- Ethnicity
- Migration
- Sexual diversity
- Functional diversity
- Territory

In turn, these different axes intersect with each other, the so-called INTERSECTIONALITY, understood as different categories that overlap and generate from discrimination to processes of social exclusion.

The EQUITY FOCUS at the intervention level:

1. The "maximum" criterion (maximising the health of the worst-off);
2. Equal treatments for equal needs (same care for the same disease);
3. Equal access for equal needs (all people bear the same costs to access the service);
4. Equal opportunities (reduction of differences between actual and potential access through positive discrimination measures);
5. Equality of basic capabilities (which does not deny the existence of personal factors and responsibilities with respect to health but understands that those factors that inequality in access to well-being must be addressed)

One of the groups that most harshly faces social exclusion are the homeless. In the case of the Homeless, we are in the inclusion zone of the following table:

DIFFERENTIATING FEATURES	POVERTY	SOCIAL EXCLUSION
SITUATION	It is a state	It is a process
BASIC CHARACTER	Personal	Structural
SUBJECTS AFFECTED	Individuals	Social group
DIMENSIONS	Básically unidimensional (economic deprivation)	Multidimensional (labour, economic, social, cultural aspects)
CORE VARIABLES	Cultural and economic	Labour
ASSOCIATED SOCIAL TRENDS	Pauperisation	Social dualisation
ADDED RISKS	Social marginalisation	Crisis of social connections
PERSONAL DIMENSIONS	Failure, passivity	Disaffiliation, resentment
EVOLUTION	Residual. Static	Expanding.
SOCIAL DISTANCES	Top - bottom	Dynamics inside - outside

cancerless

cancerless.eu

The CANCERLESS Project has received funding from the European Commission's Programme Horizon 2020 under the Grant Agreement 965351

Local context and resources
MODULE 5

Evaluation: Health Navigator Training

EVALUATION

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965351

The purpose of this evaluation exercise is to engage with the trainee in a process of **reflective learning** after the **Health Navigator (HN) Training Programme** has been completed.

The **HN Training Programme** has sought to grant the selected HN candidates with the right competences or abilities to properly perform such role role. A person is competent when he or she has the required knowledge, skills and practical abilities to perform effectively within a certain work environment. Through the 5 different modules of the Training Programme, the Health Navigator candidates are expected to have acquired the right combination of skills, knowledge and practical abilities to deliver a complex person-centred intervention such as the HN model.

However, as the Training Programme has not sought to simply acquire *knowledge* but to acquire *competence*, the purpose of the evaluation is not to test whether candidates know specific contents of knowledge (e.g. to ask them to list all evidence-based interventions to improve cancer screening in homeless population; or to name the 10 core components of the Health Navigator Model, as defined by DeGroff et al. 2014, etc.) but to ensure that candidates are (and feel) ready for the challenging job ahead.

Hence, we suggest the **Reflective Learning approach** as the most suitable way for this purpose. Reflective learning involves students thinking about what they have read, done, or learned, relating the lesson at hand to their own lives and making meaning out of the presentations heard and material read. It's more than just memorizing some facts, formulas, or dates. This learning approach has been emphasized in many professions in recent years, particularly in professions such as teaching, nursing and social work where field experience and academic course work need to be closely integrated. Reflective learning should "allow you to recognize your own strengths and weakness, and use this to guide on-going learning. By reflection you will develop your skills in self-directed learning, improve motivation, and improve the quality of care you are able to provide".

References

Gould, N., & Taylor, I. (1996). Reflective Learning for Social Work: Research, Theory and Practice (1st ed.). Routledge. https://doi.org/10.4324/9781315245058 ; White, Fook, Jan, Gardner, Fiona, Ebook Library, & ProQuest. (2006). *Critical reflection in health and social care*. Open University Press.
Koshy, K., Limb, C., Gundogan, B., Whitehurst, K., & Jafree, D. J. (2017). Reflective practice in health care and how to reflect effectively. *International journal of surgery. Oncology*, *2*(6), e20. https://doi.org/10.1097/IJ9.0000000000000020

Methodology

Either at the end of the whole Training Programme or at the completion of each module, candidate and tutor would hold a 15-30 minute reflective conversation about the key learnings, concerns, feelings and suggestions on how to apply the information received.

You could use the structure and questions below to help the conversation, or you could keep it unstructured. There are numerous structures and models for reflections, but, in a nutshell, they all seek to reflect on what happened, why does this matter and what are the next steps.

References

Roger Greenaway (2018) The four F's of active reviewing, https://www.ed.ac.uk/reflection/reflectors-toolkit/reflecting-on-experience/four-f

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965351

Possible Questions for Reflective Thinking

Level of satisfaction	• Overall, are you satisfied with Training Programme? Why? • What would you propose to improve the Training Programme?
How did the Training Programme make you feel—your emotional state	• What are some of the feelings you have experienced during the training (or during a particular module)? (e.g. were you afraid, confused, angry or scared?) • What were your personal highs and lows? (e.g. did you feel overwhelmed at some point about the different roles and tasks that the HN should perform? Do you feel there are too high/low expectations placed on you as HN?)
Concrete learning	• What was the most memorable/different/interesting thing that you heard or can recall from the presentation(s)? • What was the most/least valuable? • Which modules or parts of the presentations that you were already familiar with? • Which modules or parts of the presentations were totally new to you? How did you find them? • Having learned about the project, the HN model, your tasks and roles, the target population, the intervention and its methodology, etc., which knowledge, skills and abilities will be most necessary in order to deliver the role of Health Navigator? (e.g. Detailed knowledge of existing cancer screening programmes in your area; ability to listen to people; to be proactive all the time; etc.)
Applying to the HN role in the future	• How do you imaging using what you have learned? • Which strengths (including your own strengths) do you feel will be the most valuable to bring into your role? • Which potential obstacles or problems you may encounter? • Do you feel you still need additional knowledge, skills or abilities to acquire in order to fulfil the role of Health Navigator? • If so, what plan can you make for the future?

cancerless

Cancer prevention and early detection among the **homeless** population in Europe: Co-adapting and implementing the Health Navigator model

The CANCERLESS Project has been funded by the European Commission's Programme Horizon 2020 under the Grant Agreement 965351

Picture by Carola68 Die Welt ist bunt / Pixabay