The ROSA experience: lessons from a health professional network to reduce the inequality of access to oncosexological care.

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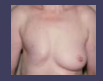
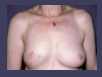
2nd Rotterdam Symposium on cancer and sexuality 4/6/2010

Why ROSA ?
Findings in 2005 (1)

- **Unquestionable progress**

1. Scientific
   - cancer : 50% of cure ⟶ increasing chronic disease = problem of quality of life
   - sexual health
     - pertinent parameter of both global health and quality of life
     - new treatments (Viagra R, oncoplasty….)

2. Socio-cultural
   - new patients rights (WHO 2000)
   - increasing demand of better "well-being" (quality of life)

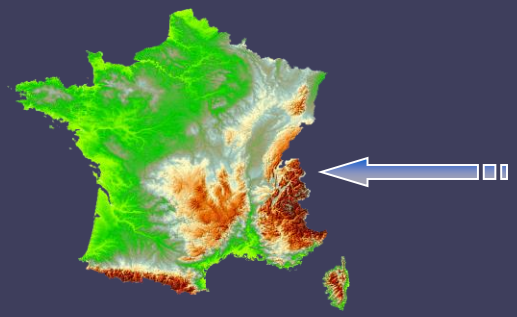
Why ROSA ?
Findings in 2005 (2)

- Oncosexological request = reality but… major problem of care offer
  - non visible and non organized
  - exclusively physician or centre dependant and mono-organ (breast, prostate…)
  - real inequality of care access ++

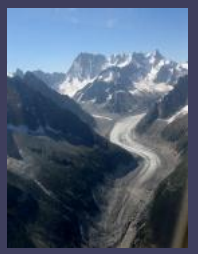
- Major brakes
  - health professional attitudes = little active and too partitioned off
  - oncosexology = not at all a priority

Objective

- As sexual health troubles should be taken into account **without any problem of health care access**, we have set up the pilot plan ROSA (Réponse Onco-Sexologique des Alpes).
- Our objective was to analyze the different problems observed during the **period of setting up** for drawing the lessons distinguishing the <u>inventory</u> phase (2006-2007) then <u>operative</u> phase (2008-2010)



ROSA



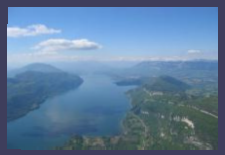
Material and method

- ROSA process included successively

- 1) a proximity care response whatever the stage, treatment or topography of cancer, thanks to a dedicated (patient / couple) consultations SAICSSO

- 2) a regional response by structuring first, our health care territory (400 000 inhabitants) then our Alpine Arc cancer network (3 millions inhabitants) including several health care territories.

- General hospital of Chambery: role of pilot center (territorial referent in oncology and regional in sexoandrology)



Lessons 2006-2007 (1)

Awareness and aptitudes to oncosexological supportive care
preliminary survey among health professional of our hospital 2006

1. excellent awareness to oncosexological dimension
2. large approval to the setting-up of dedicated consultation
3. strong gaps (knowledge's / skills)
4. strong demand for a better visibility of health care offer
5. same results +++ for additional surveys (junior urologist and radiotherapist + senior urologist + national LCC patient association) 2008-2009-2010

Presentations AFU 2007-2009, Strasbourg 2007 ESSM 2007,ISSM 2008, ESSM 2009

Lessons 2006-2007 (2)
awareness of health professionals

- Mandatory but not sufficient parameter requiring a daily work at all levels
  - cancer = motivating because « serious » for all the actors but… sexology appears as not serious
  - institutional support = necessary condition but… not sufficient
  - shared project but in daily practice, it mainly relays on individual engagement of few persons owing to a real problem of lack of time (specialists = mainly "rapid medicine" and sexual health appears as time consuming)

Lessons 2006-2007 (3)
major problem of knowledge's

« oncosexological GPS² » = double need of information / formation

- geographical GPS: to know where to orientate = to recognize the human / institutional resources = regional directory

- competences GPS: to know how to do = strong needs of standards of clinical practice / guidelines (under way in 2010)

- how to detect / talk about sexual health and its troubles = proved positive factor of resilience but…health professional dependent +++

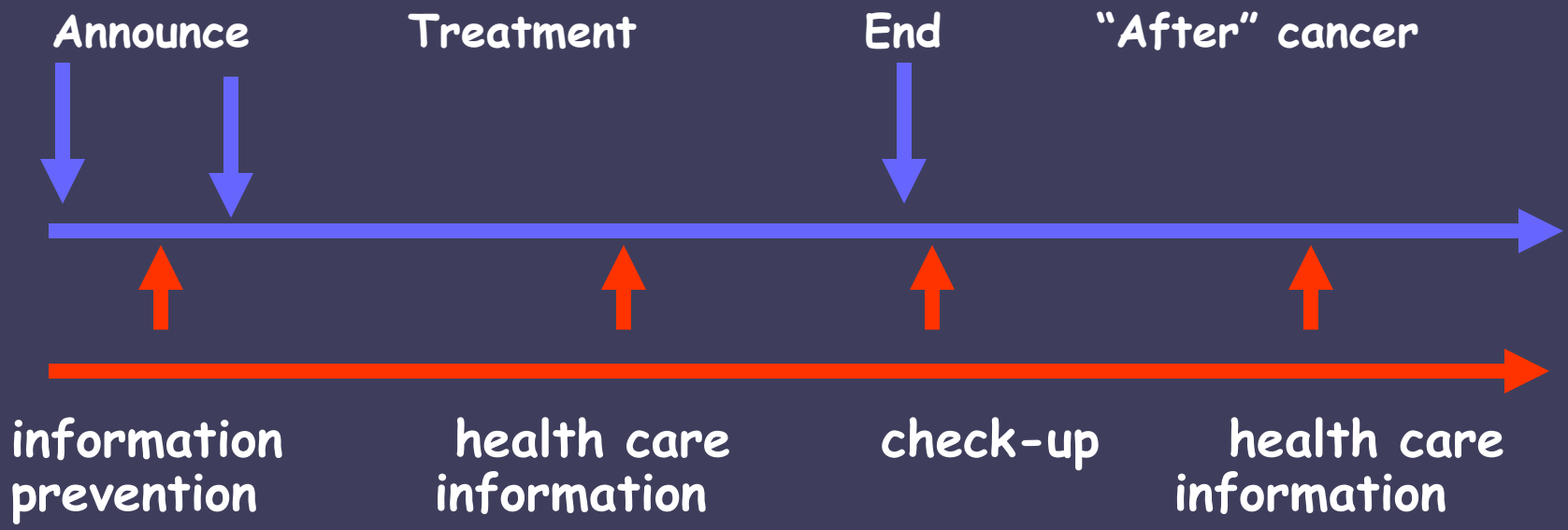
Lessons 2008-2010 (1)
problematic of better efficacy

- Identify
  - Adequate structures
    - center of supportive care = more legitimate and efficient (multidisciplinary by definition)
    - to relay on another existing structures
      - territorial / regional oncological network
      - associations of patients
  - Optimal targets
    - all health professional (directly or not) involved in oncology
    - GP and nurse (key role)
    - associations of patients ++
  - Optimal moment ++

Lessons 2008-2009 (2)

when and how ?

Personalized patient circuit in oncosexological health care (PPC)



Usual evolution of hierarchy of values underlines the needs

- to stay listening and available = humanistic medicine
- to detect vulnerabilities
- to anticipate and prevent difficulties

Lessons 2008-2009 (3)
Authorize and legitimate

- **Break the silence**
  - talk sexual health (and no sex) = usually **very easy** and natural
  - correct the false ideas (contagious, price to pay, not important…)
  - be careful with "Dr Internet" (referent sites, controlled web.2)
- **To not go beyond the demand** (respect of individual liberty / dignity)
  - information = **100 %** patients / partner / health professionals
  - no request of treatment = **1/3 patients**
  - request of sexual health care = 2/3 patients
    - simple = 1/3
    - **complex = only 1/3 +++**

Conclusions

- Our 5 years ROSA experience show 3 main points :

1. the oncosexology must integrate into the health care course (PPC) as a **new health care offer** within the territorial supportive health care

2. the structuring of the offer must be preferentially **progressive** by creating first, locally dedicated consultations, then by **informing / educating** all the concerned both health professional and structures

3. For being a success, the approach must be **pragmatic** and **transversal** using the numerous human / institutional resources of their own health territory and region.