



Sexual health in cancer: the results of a survey exploring practices, attitudes, knowledge, communication, and professional interactions in oncology healthcare providers

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Abstract

Purpose To assess, focusing on population of healthcare professionals providing oncosexology care to men with cancer, clinical practice, attitudes, knowledge, communication, and professional interaction.

Methods We performed a descriptive cross-sectional study with an online self-administered e-questionnaire addressed to all medical, paramedical, or administrative professionals attending the 4th “Cancer, Sexuality and Fertility” Meeting in Toulouse, France. Their participation was voluntary and totally anonymous.

Results The 165 respondents comprised 44% of physicians, 47% of paramedics, and 9% of other health professionals in oncology, from all French regions. Paramedics were significantly younger than physicians ($p = .006$). One third of respondents were degreed in sexology, but 75.8% were in demand of oncosexology-specific trainings, particularly paramedics ($p = .029$). Regarding the oncosexology network, respondents declared being linked to organ specialists (56.8%), psychologists (49.5%), oncologists (47.4%), nurses (31.5%), radiation therapists (27.4%), and general practitioners (25.3%). Compared to paramedics, physicians were more likely to be engaged in oncosexology care ($p = .039$) and couple counseling ($p = .005$), but the proportions of counseled patients or couple were identical ($p = .430$ and $p = .252$, respectively). Overall, 90% of respondents reported discussing sexuality issues with patients. Regarding the time for discussion, physicians reported communicating more at cancer announcement ($p = .004$) or after treatments ($p = .015$), while more paramedics reported discussing at another time ($p = .005$). Regarding the place for discussion, paramedics more frequently reported talking about sexuality in the hospital room ($p = .001$) or during a specific consult ($p = .007$).

Conclusions Results emphasize various levels for improving existing oncosexology care, such as developing oncosexology-specific educational and practical training programs, particularly for paramedics; consolidating information, counseling, and therapeutic education with formal procedures like implementing medical and paramedical “oncosexology moments,” or strengthening the community-hospital networks, from diagnosis to survivorship.

Keywords Healthcare professionals · Oncosexology · Clinical practice · Communication · Attitudes · Training

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Introduction

Cancer patients can experience a range of significant persistent deterioration in their sexual quality of life, including body image, physiology, desire, emotion, psychology, relationships, and intimacy with partner [1, 2]. At least 40 up to 100% of cancer patients will experience these overall sexual functioning defects, as a consequence of cancer surgery, radio-/brachytherapy, and hormone treatments [2, 3], particularly those with pelvic or breast tumors [4, 5]. In France, a large-scale survey, involving 4349 cancer patients, observed that one in two participants at least reported sexual troubles 2 years after diagnosis [6].

Many studies, including cancer patients or oncology healthcare providers, have reported that treatment-related sexual consequences are not often addressed by professionals. The main reasons evoked by healthcare providers are the lack of time, the lack of knowledge, embarrassment or discomfort, and difficulties to refer patients to a specialist [1, 7–16].

Most of these studies concerned healthcare professionals regardless of their specialty and involvement/interest in sexual rehabilitation after cancer. However, in oncology teams, care management involves physicians and allied professionals (paramedics), as well as other non-medical professionals (estheticians, sophrologists, secretaries, etc.). Abdolrasulnia et al. compared 257 practicing primary care physicians (PCPs) versus 248 obstetricians/gynecologists (OB/GYNs) for practice patterns, perceptions, and barriers in diagnosing and treating women with cancer experiencing decreased desire. The authors concluded significant gaps and needs among practicing PCPs and OB/GYNs, such as personal attitudes and beliefs, time constraints, lack of effective therapies, and gender differences for instance [17]. In a qualitative study, Fitch et al. interviewed 34 cancer care professionals (nurses, physicians, social workers, and radiation therapists) assessing conversations about sexuality in ambulatory settings [11]. The results highlighted the need to clarify role expectations for all members of the cancer care team, about patient care regarding sexuality, and the provision of education to support the expected role.

To our knowledge, no quantitative study has assessed clinical practice, attitudes, knowledge, communication, and professional interaction focusing on a population of healthcare professionals already providing oncosexuality care. In that respect, we wanted to make a thorough evaluation of all the aforementioned parameters in the context of sexual troubles in men with cancer.

Methods

Study design and population

This is a descriptive cross-sectional study conducted with a self-questionnaire (Appendix 1) only available in electronic

format. The questionnaire was sent to all the participants of the 4th “Cancer, Sexuality and Fertility” Meeting. This meeting was organized by the Francophone Association for Supportive Care (AFSOS), the French Society of Andrology (SALF), the French Federative Group Against Cancer (UNICANCER), and the Federative Association of the French Cancer Networks (ACORESCA).

The targeted population were all medical, paramedical, or administrative professionals, who have an activity in oncosexuality. Their participation was voluntary and totally anonymous. The link was available for 2 months, with another sending of emails during the second month, to optimize response rates.

Survey questionnaire

Data from this study were collected using an online self-administered questionnaire (Appendix 1) on professionals' routine in dealing with sexual health care of men with cancer. To avoid missing data, the online version required an answer to most of the items for the validation of the questionnaire.

This survey questionnaire was created in collaboration with members of the pedagogical team of oncosexuality courses at the University of Toulouse and evaluated for the comprehension and validity of content by international experts and members of the steering committee of the UNICANCER-AFSOS Group.

The items of the questionnaire focused on social, demographic, and occupational characteristics (ten questions), clinical practice (eight questions), attitudes (five questions), communication on sexuality (four questions), and inter-professional relationships (one question under a 13 × 5 matrix form).

Statistical analysis

All variables were qualitative and the analyses performed were essentially descriptive. However, we constituted three groups of professionals (physicians, paramedics, and other professionals) and applied chi-square (χ^2) and Fisher exact tests for categorical comparisons between physicians and paramedics. Statistical analysis was performed using Stata version 14 (Stata Corp., College Station, TX, USA) with the significance level defined as 5%.

Results

Finally, 165 professionals answered the questionnaire (56 men and 109 women). For the completion of the questionnaire, 134 (81.2%) used a PC, 22 (13.3%) a smartphone, and 9 (5.5%) a tablet.

Respondents' characteristics

The professionals in our sample comprised 72 (44%) physicians (oncologists, other specialists, and general practitioners), 78 (47%) paramedics (nurses, psychologists, and physiotherapists), and 15 (9%) other health professionals in oncology (health managers, medical secretaries, onco-esthetician, and sophrologist, for instance).

The most represented professions were organ specialists (urologists, andrologists, gynecologists, etc. 20%), psychologists (16%), nurses (15%), and biologists from a French center of study and preservation of human eggs and sperm (CECOS, 12%).

Paramedics were significantly younger than physicians ($p = .006$).

Almost all respondents worked in urban areas (91.5%). Two thirds of respondents (66.1%) worked in the public sector, about a quarter (24.2%) as a freelance, and 16.4% in the private sector (Table 1).

Training in oncosexology

Overall, 32% percent of professionals was degreed in sexology, with 83% of them having a French national diploma in sexology. A similar proportion of paramedics and physicians were trained in sexology ($p = .574$).

More than two thirds of respondents (75.8%) would like to undergo additional training in oncosexuality,

particularly paramedics compared to physicians ($p = .029$) (Table 2).

Clinical practice regarding sexuality after cancer

Half of the physicians declared seeing more than one patient per week for sexuality issues, versus a third of paramedics ($p = .081$).

One fourth of the physicians reported discussing about the risk of sexual disorders with 100% of concerned patients, versus 10% of paramedics ($p = .014$). Two thirds of physicians said they participate in the management of sexual disorders, compared with 50% of paramedics ($p = .039$). No difference was observed for the amount of patients managed yearly between physicians and paramedics ($p = .430$) (Table 2).

Overall, 85% of physicians and 59% of paramedics ($p = .005$) reported they have an activity of couple counseling.

Regarding the oncosexology network, respondents declared being linked to organ specialists (56.8%), psychologists (49.5%), oncologists (47.4%), nurses (31.5%), radiation therapists (27.4%), and general practitioners (25.3%) (Table 3).

Attitudes while facing sexuality after cancer

More than half of the respondents estimated that their clinical agenda is not a hindrance to properly discuss sexuality after cancer, for both physicians and paramedics ($p = .368$).

Table 1 Respondents' characteristics

	Total sample $N = 165$	Physicians $N = 72$	Paramedics $N = 78$	
	N (%)	N (%)	N (%)	p
Professions				
Oncologists	6 (4)	6 (8)	–	
Organ specialists	33 (20)	33 (46)	–	
Radiotherapists	12 (7)	12 (17)	–	
General practitioners	15 (9)	15 (21)	–	
Psychiatrists	2 (1)	2 (3)	–	
Other specialist physicians	4 (2)	4 (6)	–	
Biologists	20 (12)	–	20 (26)	
Nurses	27 (16)	–	27 (35)	
Physiotherapists	4 (2)	–	4 (5)	
Psychologists	26 (16)	–	26 (33)	
Midwives	1 (1)	–	1 (1)	
Non-medical/paramedical	15 (9)	–	–	
	N (%)	N (%)	N (%)	p
Age < 50 at diagnosis	109 (66)	40 (56)	60 (77)	.006*
Practicing in urban settings	151 (92)	66 (92)	70 (90)	.686
Working in public sector	109 (66)	47 (79)	53 (68)	.729
Working in private sector	27 (16)	6 (8)	16 (21)	.035*
Having a freelance activity	40 (24)	25 (35)	14 (18)	.019*

* $p \leq .05$

Table 2 Training, clinical practice, and attitudes facing sexuality

	Total sample <i>N</i> = 165	Physicians <i>N</i> = 72	Paramedics <i>N</i> = 78	
Training	<i>N</i> /total (%)	<i>N</i> /total (%)	<i>N</i> /total (%)	<i>p</i>
Degreed in sexology	53/165 (32)	24/72 (33)	26/78 (33)	1.000
Wish additional training	125/165 (76)	49/72 (68)	65/78 (83)	.029
Clinical practice and attitudes	<i>N</i> /total (%)	<i>N</i> /total (%)	<i>N</i> /total (%)	<i>p</i>
See more than 1 patient/week concerned by oncosexuality	69/165 (42)	36/72 (50)	28/78 (36)	.081
Discuss sexuality with 100% of patients concerned	30/165 (18)	18/72 (25)	9/78 (18)	.032
Discuss sexuality with more than 50% of patients concerned	64/165 (39)	38/72 (53)	22/78 (28)	.002
Patients have difficulty finding appropriate sex-based supportive care	122/145 (84)	49/61 (80)	61/71 (86)	.390
Provide sexology care	96/165 (58)	48/72 (67)	39/78 (50)	.039
To less than 10 patients/year	39/95 (41)	16/47 (34)	18/39 (46)	.430
To 10–50 patients/year	34/95 (36)	18/47 (38)	14/39 (36)	–
To more than 50 patients/year	22/95 (23)	13/47 (28)	7/39 (18)	–
Sexual care is at the initiative of partner	56/96 (58)	33/48 (69)	20/39 (51)	.097
Provide couple counseling	69/96 (72)	41/48 (85)	23/39 (59)	.005
Professional network for sexology care				
Organ specialists	54/95 (57)	30/48 (63)	22/38 (58)	.664
Psychologists	47/95 (49)	28/48 (58)	13/38 (34)	.026
Oncologists	45/95 (47)	19/48 (40)	22/38 (58)	.091
Nurses	25/95 (26)	14/48 (29)	8/38 (21)	.392
Radiation therapists	26/95 (27)	16/48 (33)	7/38 (18)	.121
General practitioners	24/95 (25)	14/48 (29)	10/38 (26)	.770

About 99% (physicians 98.4%, paramedics 98.6%, $p = .906$) considered that all patients with a treatment potentially impacting sexuality should be able to access sexual rehabilitation supportive care (Table 2).

Although at the limit of significance ($p = .052$), a larger proportion of paramedics felt they were not comfortable discussing sexuality with their patients (18.1% vs. 6.7%).

More than two thirds of respondents (83.3%), both physicians and paramedics ($p = .390$), felt that their cancer patients have difficulty finding appropriate sex-based supportive care (Table 2).

Finally, the large majority of surveyed professionals (95.5%) believed that communication about sexuality issues cannot be completed without a sufficient time of interview (paramedics vs. physicians, $p = .688$) (Table 3).

Communication about sexuality

More than 90% of both paramedics and physicians ($p = .647$) declared they usually discuss sexual issues with their patients.

Regarding the moment when sexuality is discussed, a similar proportion of physicians and paramedics declared they intervene a few days before starting treatment ($p = .555$) or during treatment ($p = .499$). A higher proportion of physicians said they discuss sexuality at the time of cancer announcement

($p = .005$) or after treatment ($p = .017$), while more paramedics reported discussing sexuality at another time ($p = .004$).

Over half of professionals (57%) reported usually discussing sexuality in a routine practice with patients during a standard consult, 22% during an oncology consult, 20% at a specific consult, 17% in the hospital room, 8% in another place (when preserving fertility or during a home care opportunity for example), and 3% in speaking groups or workshops.

Paramedics more frequently reported talking about sexuality with their patients in the hospital room ($p = .001$) or during a specific consult ($p = .005$), compared to physicians.

No professional declared they change for the subject when a patient appears sorry by the announcement of the possible impact of cancer treatments on their sexuality. Two thirds reported showing empathy and the ability to find support in them, 55% proposing patients to meet a specialist to talk to, 30% reminding patients of the importance of treatment and the vital issue, and 5% reacting differently (particularly by deepening the discussion with patients). Paramedics are more likely to refer patients to a specialist ($p = .002$) (Table 3).

The majority of professionals (61%) declared they have no communication experience addressing sexuality issues with adolescents. Among those who treat adolescent patients, 35% address sexuality issues with the patient in a one-on-one conversation, 2% in the presence of parents, and 2% in the presence of the partner. No difference was observed

Table 3 Communication about sexuality issues

	Total sample <i>N</i> = 165	Physicians <i>N</i> = 72	Paramedics <i>N</i> = 78	<i>p</i>
Communication about sexuality	<i>N</i> /total (%)	<i>N</i> /total (%)	<i>N</i> /total (%)	
Agenda is a barrier to discussion	62/145 (43)	28/60 (47)	28/72 (39)	.368
Comfortable to talk about sexuality with patients	128/145 (88)	56/60 (93)	59/72 (82)	.052
Think that discussing sexuality requires a sufficient time	139/145 (96)	58/60 (97)	68/72 (94)	.688
Talk about sexuality issues with patients	150/165 (91)	67/72 (93)	71/78 (91)	.647
Moment when discussion occurs				
At time of cancer announcement	43/150 (29)	28/67 (42)	14/71 (20)	.005**
Before starting treatments	41/150 (27)	19/67 (28)	17/71 (24)	.555
During treatments	76/150 (51)	32/67 (48)	38/71 (54)	.499
After treatments	73/150 (49)	41/67 (61)	29/71 (41)	.017*
At another time	28/150 (19)	6/67 (9)	20/71 (28)	.006*
Place where discussion occurs				
During announcement of cancer	33/150 (22)	17/67 (25)	11/71 (15)	.149
During a standard consult	86/150 (57)	46/67 (69)	39/71 (55)	.098
During a specific consult	30/150 (20)	17/67 (25)	10/71 (14)	.095
In the hospital room	25/150 (17)	4/67 (6)	19/71 (27)	.001**
In another place	13/150 (9)	2/67 (3)	8/71 (11)	.005**
In speaking groups or workshops	4/150 (3)	2/67 (3)	2/71 (3)	1.000
When a patient appears sorry about potential sexual impairments				
I change for subject	0/165 (0)	0/72 (0)	0/78 (0)	–
I show empathy and support	110/165 (67)	51/72 (71)	53/78 (68)	.702
I refer the patient to a specialist	91/165 (55)	30/72 (42)	52/78 (67)	.002**
I remind the patient the importance of treatments and the vital issue	49/165 (30)	22/72 (31)	23/78 (29)	.887
Other reactions	9/165 (5)	1/72 (1)	7/78 (9)	.065
I preferably address sexuality issues with adolescent patients				
In a one-on-one conversation	58/165 (35)	24/72 (33)	32/78 (41)	.331
In the presence of parents	4/165 (2)	3/72 (4)	0/78 (0)	.108
In the presence of the partner	3/165 (2)	2/72 (3)	1/78 (1)	.608
I have no such experience with adolescent patients	100/165 (61)	43/72 (60)	45/78 (58)	.801

p* ≤ .05, *p* ≤ .005

between physicians and paramedics in the way to address sexuality issues with adolescents (Table 3).

Discussion

A strong demand for training in oncosexology

It is encouraging to note that among the oncology professionals surveyed, one third were degreed in sexology, with 83% of them having the French national diploma in sexology. This French diploma consists of a 200-h, 3-year, face-to-face training that addresses the physiology of sexual reactions and sexual disorders in men and women with their etiology, the different existing therapies, and the management of sexual disorders (in men, women, and couples). In addition to addressing the medical aspects, this diploma also addresses aspects of human and social sciences related to human sexuality.

However, training in sexology does not seem sufficient for oncology professionals to take charge of oncosexological pathologies, since 75.8% of respondents would be interested to take specific training in oncosexology. This illustrates the fact that oncosexology is an emerging specific field of sexology, which probably has also specific educational objectives, different from those of the national sexology training.

Oncosexology trainings adapted to paramedics

It is interesting to note that a greater proportion of paramedics are in demand for training (*p* = .029), maybe due to their younger age. An American study performed by Julien et al., including 576 nurses from a comprehensive cancer, showed that younger and less experienced nurses had more difficulties to discuss sexuality with patients [14].

Paramedics are ground actors who seem essential in oncosexology care. Actually, on the one hand, paramedics

have moments during hospitalizations, when they can come into the rooms and establish contact with patients ($p = .001$). As a result, these caregivers will more easily be confidantes for the patients and will have easier access to their intimacy. This facility could be related to the fact that (1) in daily routine care, paramedics have more occasions than physicians to address these issues; (2) patients do not wish to disappoint their doctors by telling them that the treatment they give them for their healing has an impact on their sexuality; or that (3) patients would confide more easily to a more neutral person, such as a nurse, than the doctor.

On the other hand, paramedics, especially nurses, have a growing importance in therapeutic education. Therapeutic education is also developing in oncosexuality in both men and women, with, for example, post-prostatectomy rehabilitation or the implementation of vaginal dilators in women treated with radiotherapy and brachytherapy.

For all these reasons, caregivers seem to be ideal ground actors for a first level of identification of vulnerabilities, information, and counseling [18]. In Julien's study, nurses also reported they discussed sex with their patients without taboo. In order to inform their patients, nurses claimed for trainings for their better understanding of the mechanisms leading to sexual impairments. However, they preferred to defer to the physicians for any sexually related questions [14]. As a result, it would be interesting to develop short-term training for these first-level actors to meet awareness, information, and counseling objectives. In that respect, short courses seem better indicated than long courses that are part of a specific career project.

A higher level of training for a better organization of oncosexuality

In our sample, the management of oncosexuality seems to face organizational constraints, since 83.3% of professionals believe that their patients have difficulties in finding appropriate oncosexuality care. A study including 119 radiation oncologists emphasized the need for educational and practical training, as well as a list of specialized referrals [19].

Professionals attending the “Cancer, Sexuality and Fertility” Meeting is a selected public, presumably aiming to become referrals for managing oncosexuality issues in their workplace.

To answer their training needs in oncosexuality, we created a French nationwide University Diploma in oncosexuality consisting of a 2-year e-learning course program.

Structuring oncosexuality care management

It is reassuring to note that 99% of surveyed professionals recognize that any patient with a treatment that potentially impacts their sexuality has the possibility to access

sexological rehabilitation care. In that respect, 58.2% consider participating to the care of concerned patients, with 71.9% of them also providing couple therapy. In our sample, oncosexuality care is provided more often by physicians. This would reflect the fact that individual care and sexual function is put forward in oncosexuality care, before psycho- or couple therapy. Actually, other studies showed that, in France, patients with sexual disorders would be more likely to consult a physician [20]. This result could be explained by the fact that the French health system (1) reimburses medical consultations, (2) restricts the prescription of pharmacological treatments to physicians, and (3) some of these treatments are also reimbursed in the context of oncosexuality care. Surprisingly, general practitioners (GPs) are the last health professionals with whom the oncology professionals interviewed are in touch with for sexual care of their patients, limiting supportive care to the oncology team. This result illustrates the interest of developing relationships with GPs, who could be city relays, particularly during survivorship. This would make it possible to (1) decompartmentalize oncosexuality care, (2) free time for the cancer care of the new incident cases, and (3) strengthen the community-hospital networks, for an optimal follow-up of patients.

Communication about sexuality

We can be satisfied with the fact that 96% of the professionals interviewed considered that addressing sexuality issues with patients is not feasible without a sufficient time, and 43% of them still consider their agenda as a barrier to discussing sexuality with patients. Oncosexuality is part of supportive care, defined as “The total medical, nursing and psychosocial help which the patients need besides the specific treatment” [21]. Thus, healthcare professionals providing sexology care do so in parallel of their core activities. One of the major challenges of oncosexuality care is that it becomes a stand-alone medical activity, preventing agenda from being a barrier.

Another interesting observation is that more than 90% of the respondents communicate about sexuality after cancer with their patients.

Our sample being a particular population of professionals sensitized to oncosexuality and oncofertility and involved for the majority in the oncosexuality care, this result is not representative of all French care professionals. It illustrates the fact that professionals, when sensitized to the theme, communicate more with patients about sexuality after cancer. In fact, our result is to be compared with numerous studies [6, 20, 22], including the French national survey (VICAN), which showed that throughout France, information on sexuality is poorly provided by health professionals, especially to women, even for cancer sites with a high risk of sexual dysfunction [6]. In France, the Cancer Plan I (2003–2007) introduced the mandatory

Announcement Intervention (Dispositif d'Annonce) which is part of the personalized care plan. This specific intervention consists of different times of announcement (related to cancer and treatments) with a medical consultation (generally provided by oncologists or organ specialists), and a paramedical consultation (generally provided by nurses). One could imagine that specific “oncosexuality announcement” could be planned during these consultations to improve information, but also its precocity.

Actually, prevention and early diagnosis are known to improve sexual prognosis [23–25]. So, in its professional guidelines on the oncosexological management of cancer patients, the Francophone Association for Supportive Care (AFSOS) recommends delivering information right from diagnosis. This first phase of announcement is about legitimizing the patient's questions about sexual disorders. In addition, AFSOS recommends continuous information, for systematic prevention and management (when necessary), at each phase of patient follow-up. In addition to legitimization, different purposes of information delivery have been identified for each phase:

- Prevention of sexual disorders, during the cancer treatment phase;
- Allowing and encouraging patients to communicate on their sexual difficulties at the end of treatments;
- Rehabilitating patients' sexual functioning during survivorship. Other actors are identified at this step, such as associations of patients.

In addition to the various training courses for professionals mentioned above and the recommendations on how to deliver information, media can be developed (website, directories of professionals in sexology, brochure, CDs, mobile applications, etc.) to optimize the time of information, but also to allow access to information to everyone, at any time.

Finally, regarding the place where discussion occurs, “Hospital room” is cited by 1/10 of physicians and by almost 1/3 of paramedics. The difference observed ($p = .001$) is legitimized by the fact that paramedics generally provide routine care in hospital rooms more often than physicians. Hospital rooms can be places lacking privacy due to proximity of patients to one another, open bed wards, presence of the patients' parents or family members, and presence of other several providers at a time, which were factors reported in previous to limit discussion [26]. However, since our item “Discussion occurs in hospital rooms” also includes situations when the patient can be alone (single room, neighbor patients, or family members out of the hospital room during discussion, etc.), one can imagine that our highly sensitized professionals degreed in Sexology who declared discussing sexuality in hospital rooms could do so in a private fashion.

Study strengths and limitations

The major limit of this study is the fact that the sample was composed of professionals engaged in oncosexuality care. This limits the generalizability of the findings to French healthcare professionals. We also are aware of the ensuing self-selection bias. However, as we wanted to select professionals involved in oncosexuality care and engaged in providing information about their clinical practice and sources of improving oncosexuality care management, we consider this a bias of low importance.

Another limit is the use of a self-report instrument which can lead to inaccurate recall and questionable comprehension or interpretation of the items. However, these potential biases were limited, as the questions focused on respondents' daily professional activity and not on specific past events.

Moreover, the major strength of our design is that our sample, composed of professionals from different regions and of multiple specialties, gives an idea of how French healthcare professionals are aware of cancer-related sexuality issues.

Conclusion

Results emphasize various levels for improving existing oncosexuality care, such as developing oncosexuality-specific educational and practical training programs, particularly for paramedics; consolidating information, counseling, and therapeutic education with formal procedures like implementing medical and paramedical “oncosexuality moments,” or strengthening the community-hospital networks, from diagnosis to survivorship.

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Compliance with ethical standards

The targeted population were all medical, paramedical, or administrative professionals, who have an activity in oncosexuality. Their participation was voluntary and totally anonymous. The link was available for 2 months, with another sending of emails during the second month, to optimize response rates.

Conflict of interest The study was methodologically supported by the University Cancer Center of Toulouse (University Hospital of Rangueil), the Cancer Network of Midi-Pyrénées (ONCOMIP), the Association of Coordinators of the French Cancer Networks (ACORESCA), the joint group of the Federative Group of French Cancer Centers (UNICANCER), the French Association for Supportive Care (AFSOS), and the French Education and Research Group of Andrology, Urology, and Sexology (GEFRAUS).

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