

REPORT

Disparities in psychosocial cancer care: a report from the International Federation of Psycho-oncology Societies

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Abstract

Background The aim of the study was to understand the characteristics of the International Federation of Psycho-oncology Societies (FPOS) and possible disparities in providing psychosocial care in countries where psycho-oncology societies exist.

Method A survey was conducted among 29 leaders of 28 countries represented within the FPOS by using a questionnaire covering (i) characteristics of the society; (ii) characteristics of the national health care system; (iii) level of implementation of psycho-oncology; and (iv) main problems of psycho-oncology in the country.

Results Twenty-six (90%) FPOS returned the questionnaires. One-third reported to have links with and support from their government, while almost all had links with other scientific societies. The FPOS varied in their composition of members' professions. Psychosocial care provision was covered by state-funded health services in a minority of countries. Disparities between countries arose from different causes and were problematic in some parts of the world (eg, Africa and SE Asia). Elsewhere (eg, Southern Europe and Eastern Europe), austerity policies were reportedly responsible for resource shortages with negative consequences on psychosocial cancer care. Half of FPOS rated themselves to be integrated into mainstream provision of care, although lack of funding was the most common complain.

Conclusions The development and implementation of psycho-oncology is fragmented and undeveloped, particularly in some parts of the world. More effort is needed at national level by strong coalitions with oncology societies, better national research initiatives, cancer plans, and patient advocacy, as well as by stronger partnership with international organizations (eg, World Health Organization and Union for International Cancer Control).

KEYWORDS

cancer, disparities, Federation Psycho-oncology Societies, oncology, psycho-oncology, psychosocial care

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1 | INTRODUCTION

Cancer is a worldwide problem, and global attention has been directed by national governmental organizations and health institutions to emphasize policies of prevention and screening, treatment, follow-up, and palliative care.¹⁻³ However, internationally, social inequalities persist in terms of cancer care, especially, but not only, in socioeconomically disadvantaged groups, underserved communities, and in developing countries.⁴ As regards psychosocial care, at least 30% of cancer patients report psychosocial distress and mental disorders⁵ and even a higher percentage report unrecognized psychosocial needs or untreated psychosocial disorders as a consequence of cancer at some point during the cancer trajectory.^{6,7} For example, while point prevalence rates of 40% are commonly reported, only in around 1-in-6⁸ to 1-in-12⁹ women with breast cancer do these problems persist, sometimes over many years, often linked to unresolved symptoms such as pain.¹⁰ The literature consistently indicates that persistent psychosocial conditions have extremely negative consequences for the patients, including poorer quality of life¹⁰ and shorter survival.^{11,12}

Consequently, there is an urgent need to ensure appropriate psychosocial care is available in cancer settings. However, as with other cancer services, inequalities exist. As reported by Koch,¹³ although a large number of evidence-based studies have demonstrated the benefit from structured psychosocial care services in oncology, with a growing consensus on the mandatory integration of psychosocial care into the routine care of cancer patients,¹⁴ there is an evident lack of precise and comprehensive information about psycho-oncology services within the national health care systems of different countries. This lack of information pertains to several aspects of care, such as if and where psychosocial services in different health care provision areas of cancer care are available (eg, inpatient and outpatient services, rehabilitation, and palliative care), what type of professionals of different disciplines (and their qualifications) work in psychosocial oncology services, and how much these services are integrated in the existent oncological services. According to Keller et al,¹⁵ some of the main indicators of psychosocial oncology are not followed by most of the countries where the objectives and the topics of psychosocial health care research for cancer patients, the study of structural conditions of psycho-oncology services and of psycho-oncology interventions under routine conditions, and quality assurance are lacking.

In Europe, a recent survey conducted under the European Partnership on Action Against Cancer and involving 27 representatives of European countries showed that only 8 (30%) reported having nationally recommended psychosocial oncology care (PSOC) clinical guidelines, with 10 (37%) having specific budgets for PSOC, and 6 (22%) having an official certification for PSOC education.¹⁶

The situation is even more fragmented and diverse when considered internationally. In one of the first surveys conducted by interviewing 45 psycho-oncology experts from 38 countries,¹⁷ it was shown that psychosocial oncology was not fully integrated into oncological care in the majority of the countries from which experts responded. In at least one-third of the countries, psychosocial oncology was not widely known or only accepted within educated and well-informed subgroups, and in the same percentage, there was a lack

of knowledge about the need or benefits psychosocial care. A series of different barriers were identified, including financial constraints, that were mentioned by almost all of the experts who responded, poor transfer of psychosocial research results into clinical practice, lack of knowledge and acceptance by medical professionals, stigmatization from being labeled as having a psychiatric problem or as being unable to cope with the disease, poor understanding of psychosocial support by cancer patients, and reticent trends towards disclosure of cancer diagnosis.

Where Psycho-oncology Societies (POS) have existed for many years, however, the situation of PSOC in those countries is expected to be and should be more structured and defined. The mission of POS in fact is usually not only to promote psychosocial care of cancer patients and their families through the development of standards, practice guidelines, and service integration strategies but also to foster interprofessional and political (eg, administrators, policy makers, and other stakeholders) collaboration in PSOC. When the International Psycho-oncology Society (IPOS) Federation of Psycho-oncology Societies (FPOS) was founded in 2008,¹⁸ the opportunity has been offered to begin to explore this specific area and to understand if the situation in the countries where a scientific society exists is more advanced in terms of care and integration within the national health system. In a preliminary study carried out within the FPOS, however, the impact of scientific societies was found to be not determining, with only a few countries (mainly in Europe), resulting to have national cancer plans (NCPs) underlining (or at least mentioning) the mandatory role of psychosocial care in oncology. In contrast, in many others, especially, but not exclusively, in developing nations, psychosocial oncology is either still not established or not completely established, or not an integral part of cancer care or not specifically offered except within the context of more, general psychological support, even if an established POS was operating.¹⁹

Given the need to better understand these data and the main problems causing possible disparities in PSOC in countries where POS are active, the present study, as part of a shared program within the FPOS, aimed at examining the characteristics of the POS represented within the federation, the possible differences in the health care system organization of the respective countries, and the main problems of the single POS in disseminating psychosocial care in cancer settings in their own countries.

2 | METHODS

At the time of the study, the federation consisted of 28 POS in 29 countries worldwide (Figure 1). For the aims of this survey, the methodology of other similar investigations¹⁷⁻¹⁹ was followed, by using a short questionnaire with mainly open questions. The questionnaire employed in this survey was developed on an agreement basis within the representatives of the FPOS members at a specific meeting held at the IPOS Congress in Rotterdam in 2012. At the meeting, the representative members of the FPOS unanimously decided to investigate, in this phase, some specific areas in a semistructured way, leaving for the future a further exploration with a more traditional multi-item Likert-scale questionnaire, according to the descriptive data that would



FIGURE 1 Psycho-oncology societies, currently (2015) members of the International Psycho-oncology Society (IPOS) Federation, by areas of the world: **Africa:** Psycho-oncology Society of Nigeria (POSON); **North America:** American Psychosocial Oncology Society (APOS), Canadian Association of Psychosocial Oncology (CAPO). **South America:** Brazilian Psycho-oncology Society (SBPO). **Europe:** Austrian Platform of Psycho-oncology (ÖPPO), British Psychosocial Oncology Society (BPOS), Bulgarian Society of Psycho-oncology (BAPO)*, Dutch Society of Psychosocial Oncology (NVPO), French Society of Psycho-oncology (SFPO), German Association of Psycho-social Oncology (DAPO), Hellenic Society of Psychosocial Oncology (HSPO, Greece), Hungarian Psycho-oncology Society (MPOT); Italian Society of Psycho-oncology (SIPO), Lithuania Association of Psychosocial Oncology (POA, Lithuania), Polish Psycho-oncology Society (PPOS), Portuguese Academy of Psycho-oncology (APPO), Portuguese Psycho-oncology Society (SPPO), Romanian Association of Psycho-oncology (ARPO), Slovenian Society of Psycho-oncology; Spanish Psycho-oncology Society (SEPO), Swedish Psycho-oncology Society (SWEDPOS), Swiss Society of Psycho-oncology (SGPO). **East Asia:** Chinese Psycho-oncology Society (CPOS), Japan Psycho-oncology Society (JPOS), Korean Society Psycho-oncology, Taiwanese Psycho-oncology Society (TPOS). **Australia/New Zealand:** Australian Psychosocial Oncology Society (OZPOS) and Psycho-oncology Co-operative Research Group (PoCoG, Australia), Psycho-social Oncology New Zealand (PONZ). **Middle East:** Israel Psycho-oncology Society (IPSO); Turkish Psychosocial Oncology Association (PSOD). *The Bulgarian Society of Psycho-oncology became part of the Federation in 2015. There are also countries that have societies in a developing phase, including the Irish Society of Psycho-oncology, the Russian Society of Psycho-oncology, the Psycho-oncology Society in Kenya and the Society of Psycho-oncology in South Africa, where, at the moment, the South African Oncology Social Work Association (SAOSWA)

emerge in this study. Because the main aim of the questionnaire was to assess the profile of each society, the criteria for the developmental level of palliative care service from the Global Atlas of Palliative Care²⁰ were adopted by replacing the word palliative care by PSOC. The major areas covered by the questionnaire are reported in Appendix A, in which 6 levels of psychosocial care organization is indicated, as reached on a consensus basis within the aforementioned FPOS meeting. The president (or a designated member) of each POS was then officially approached and the questionnaire emailed in January 2014.

By following what were done in similar studies,^{18,19} because the responses regarded qualitative data, only descriptive statistics were used to analyze the questionnaire.

3 | RESULTS

Of 29 POS belonging to the federation in 2014 and representing 28 countries (with Portugal having 2 national POS), data were available for 26 (89.6%) (corresponding to 25 countries, 89.3%).

3.1 | Members and type of profession

The total membership of the 26 POS was 7887 (minimum 15, Slovenia, founded in 2011, and maximum 1683, Japan, founded in 1986), of whom were 2907 in Europe, 2355 in East Asia (organized in the East Asian Psycho-oncology Network, now called Asian Pacific Psycho-oncology Network), 1275 in Australia/New Zealand, 750 in North America, 330 in South America, 162 in the Middle East, and 100 in Africa (Table 1).

Regarding the primary profession (Figure 2), 30% of the members were psychologists ($n = 2,317$), 28% physicians ($n = 788$ psychiatrists, $n = 1410$ other physicians), 12% nurses ($n = 947$, of whom 580 were specialized cancer or palliative care nurses, and 367 registered nurses), 7.5% social workers ($n = 590$), approximately 2% patient/family members ($n = 50$), pastoral care persons ($n = 40$), rehabilitators ($n = 40$), and 2% full-time researchers ($n = 146$). About 18% members belong to other professions (including physical, sex, or occupational therapists and pharmacists) or categories (including students, administrators, and other allied health groups).

TABLE 1 Federated Psycho-oncology societies and main characteristics

Area of the World and Country	Year of Foundation and Website	Number of Members	Support from the Government	Link with Academic Institutions	Link with Other Professional Societies(eg, nursing, oncology, and palliative care)	Coverage of PO by NHS or Insurance	Level of Development of PO in the Country (See Appendix A for Legend)
Africa							
Nigeria	2009 www.posonline.com	100	N	Y	N	NR	3a
Asia							
China	2006	425	Y	Y	Y	Y	3b
Japan	1986 http://www.jpos-society.org/	1683	Y	N	Y	Y	4b
Korea	2005	80	N	N	N	N	3a
Taiwan	2009 www.tpos-society.org/	167	Y	Y	Y	Y	4a
Australia							
Australia	2005 www.pocog.org.au	1240	Y	Y	Y	Y	4b
New Zealand	2001 www.ponz.org.nz	35	Y	Y	N	N	3b
Europe							
Austria	2003 www.oeppe.com	80	N	Y	Y	Y	4a
France	1982 www.sfpo.fr	100	N	N	Y	Y	4a
Germany	1983 www.dapo-ev.de	529	Y	Y	Y	NR	4b
Italy	1985 www.siponazionale.it	732	N	Y	Y	Y	4a
Lithuania	2007 www.POA.lt	40	N	Y	Y	Y/N	3b
Netherlands	1993 www.nvpo.nl	450	N	Y	Y	Y	4a
Poland	1993 www.ptpo.org.pl	200	Y	NR	Y	Y	4a
Portugal	1995 1999 www.appo.pt	71 100	N N	Y N	Y N	Y	3b/4a
Romania	2002 www.arpo.org	80	N	Y	Y	Y/N	3a
Slovenia	2011	15	Y	Y	Y	Y	3a
Spain	2002 www.sepo.es	100	N	N	N		3a
Sweden	2007 www.swedpos.se	130	N	N	Y	Y	3b
Switzerland	2003 www.psychoonkologie.ch	220	N	Y	Y	Y	4a
UK	1983 http://www.bpos.org	60	N	N	N	Y	4a
Middle East							
Israel	1992	170	N	Y	Y	NR	4a
North America							
Canada	1987 www.capo.ca	300	Y	Y	N	Y	4a
USA	1986 www.apos-society.org	450	Y	Y	Y	Y/N	4a
South America							
Brazil	1994 www.sbp.org.br	330	N	N	Y	Y	3a

N, no; NR, not reported; Y, yes; Y/N, not completely covered by the national health system or partially covered.

There were differences by continents, with a higher ratio of physicians (including psychiatrists) (45%-70%) with respect to psychologists (13%-28%) and nurses (15%-18%) in Eastern Asian POS; a higher ratio of psychologists (35%-40%) and social workers (25%-30%) with respect to physicians (including psychiatrists) (20%) in

North America and in Australia/New Zealand; and a higher ratio of psychologists (30%-90%) in comparison with physicians (including psychiatrists) (30%-40%) in European POS, with the highest percentage of psychologists being in the Polish and Spanish (80%), and South American POS (90%).

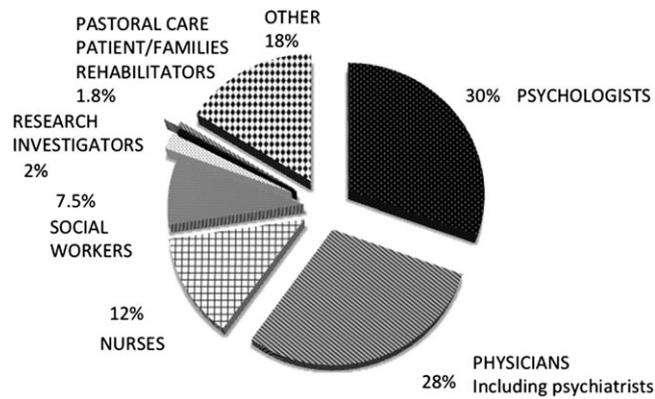


FIGURE 2 Roles and professions of the members of the 25 Psycho-oncology Societies of the Federation

3.2 | Health organization system

There were major differences among countries regarding the structure and organization of health systems and provision of psychosocial care. In some Northern American and Asian countries, including Canada, Japan, and Taiwan, universal-coverage national health systems fund cancer care, including psychosocial aspects; in others, including the USA and China when government-funded health system or private insurance does not completely cover all citizens, or copayment is required, patient advocacy organizations and professional organizations in some instances provide psychosocial care having incorporated these services as part of comprehensive cancer care. Otherwise, access may be lacking.

In several European countries, government-based insurance systems, the National Health Service (UK) or the national universal health care insurance coverage, (for example, France and Germany) includes psychosocial care, with widespread acknowledgment of the importance of psychosocial care throughout the cancer continuum and psycho-oncologists integrated in supportive care teams or with strong links with supportive care professionals. In other European countries, insufficient insurance coverage for psychological treatment and psychosocial care is reported, in part because of the nature of the health care system. In a growing number of European countries, economic austerity policies are reducing health care spending, forcing cuts to all but most basic services, impacting psycho-oncology and mental health in general.

Elsewhere, for example in African and some SE Asian countries, the availability of appropriate primary cancer treatment itself is a problem,

with limited access to first-line therapies, such as surgery, radiotherapy, and chemotherapy, significant urban-rural inequalities and economic and geographic barriers and rudimentary national health insurance schemes. These problems mean access is mostly only available to a small, often urban-based elite portion of the population. This has been reported to contribute to delayed cancer diagnosis in numerous patients with negative consequences in terms of prognosis and outcome, particularly where chronic disease care has to compete with other care demands such as maternal and neonatal care, communicable diseases, and violence. Understandably, this creates problems in screening, early diagnosis, and treatment of cancers. In some places, disruption of and even targeting of health services by political instability, war, or insurgency prohibits even the most basic care.

3.3 | National variation in psycho-oncology service development

The situation of psychosocial care in oncology, according to the 6 possible levels of organization (Appendix A), as represented in the country, is detailed in Table 1. Overall, 23% of the POS indicated in their own country embodied isolated care provision of psychosocial oncology (level 3a); about 20% indicated a generalized care provision (level 3b); 46% were in a more advanced state (level 4a), having preliminary integration into mainstream service; only 11% indicated an advanced integration into mainstream service provision (level 4b). Globally, 40% of POS in Europe referred to their psycho-oncology situation as level 3 and 60% as level 4, in Asia and Australia/New Zealand 50% rated it as level 4 and 50% as level 3, while 100% in North America rated it as level 4. More problems were found in South America and Africa where the only societies existing there rated psycho-oncology as isolated (level 3a). In Africa, 1 country (that had not formally a society, but in the process of doing that at the time of the study) rated the situation as in progress with possible capacity of building activities, although no service has yet been established (level 2).

3.4 | Main reported problems

Several types of problems were however reported by the POS participating in the survey (Table 2). All POS underlined a lack of financial support for psycho-oncology services. Some societies (mainly in Eastern and Southern Europe, Africa, and South America) also indicated

TABLE 2 Main problems to cope with as reported by the Federated POS

1. Lack of resources and funding (including no government support)
2. Problems with the national health care system (eg, PO either not taken into account in NCPs, or when part of NCP, not considered within the specialties that are part of the essential level of care)
3. Difficult implementation of national homogenous guidelines in the area of psycho-oncology
4. PO not recognized as a speciality (ministerial level)
5. Lack of psychosocial oncology services for cancer patients and families in small towns or rural and remote areas (psycho-oncology mostly active in highly specialized cancer centers or university centers)
6. Problems of dissemination of psycho-oncology in a multiethnic and multicultural country with some ethnic minorities have their own language and culture
7. Small number of mental health professionals (eg, psychologists and psychiatrists) trained in psycho-oncology and no contract for them within the health care system
8. Stigma about mental health issues

Abbreviations: NCP, national cancer plan; PO, psycho-oncology; POS, psycho-oncology societies.

that the austerity had worsened the situation with several negative effects, on, for example, stalling the implementation of NCPs (psychosocial care integrated into cancer care) and not being considered essential to service implementation (eg, Italy). Several societies (eg, the Netherlands) reported the need for more scientific evidence for the cost-effectiveness of various psychosocial interventions for the patient and for society in order to increase the willingness of medical specialists to refer, of health insurance companies to reimburse, and of the political world to put psychosocial care high on the agenda.

4 | DISCUSSION

In this study, coordinated under the aegis of IPOS, we reported data from 26 POS, representing 25 countries in the world, that are members of the international Federation of POS, representing several countries in the world, with additional input from Asian Pacific Psycho-oncology Network members.

As an initial finding, significant differences were found between the organization of the POS, in part reflecting the differences in the health organizational systems of the countries that were part of the survey. It is in fact difficult to compare POS that have a huge number of members and seem extremely well developed with more limited societies struggling with needs for recognition within their country and health systems or where the numbers of active psycho-oncology workers amount to only a handful. Also, the role of professionals is quite different, with some societies consisting almost completely of psychologists, others having a high percentage of physicians, mainly but not only psychiatrists, and others involving also nurses and social workers. A general trend was apparent confirming what was reported in a previous federation survey,¹⁹ specifically that of POS are formally linked to institutional bodies (eg, ministry of health and central governmental institutions) with psycho-oncology recognized in NCPs.

In terms of implementation of psycho-oncology and self-evaluation of their status, however, only a minority of POS representatives (1 in Europe, 1 in Asia, 1 in Australia) reported in their own country an advanced integration into mainstream service provision, with PSOC available in a wide range of locations, a comprehensive provision of care by multiple service providers, a substantial impact of PSOC upon policy, an unrestricted availability of multiple aspects of PSOC, a broad awareness of PSOC on the part of health professionals, local communities and society in general as well as a development of recognized education centers and academic links forged with universities, in particular upon public health policy. The situation in Europe, in particular, seemed to be fragmented in countries where POS have been long established, with more problems in Southern and Eastern European than Northern European countries. In those countries, because of restriction of investments and irrespective of the recognition or not of psychosocial oncology within the NCPs, policy-making bodies seemed to have gradually transformed a human right, as it is for psychosocial care, to a luxury not constituting an essential component of care. These findings confirm what is reported by a recent European study that, although it did not take into account if POS were or were not active,¹⁸ showed that only 30% of the countries reported as having nationally recommended PSOC clinical guidelines and 37% as having

specific budgets for these guidelines. Significant disparities were also reported in the only 2 countries in Africa, one of which has a formalized POS and the other which is in the process.

Several challenges and problems were identified by the participating POS in this survey; again, these varied according to local circumstances. A number of POS identified the paucity of funding for clinical care as a major problem. Governments and insurers almost everywhere are attempting to reduce health care expenditures using austerity policies, economic exigencies, and privatization to justify this, in some cases for purely ideological reasons. These factors have seemingly limited the growth and development of psycho-oncology care for cancer patients or reduced their capacity where they exist. Where disposable incomes are limited and out-of-pocket or copayment is required, many patients are unwilling to seek or cannot afford professional help that does not directly serve curative functions. There has also been an overall decline in research funding awarded to psycho-oncology, with only small, often declining percentage of the budgets of cancer societies or national programs allocated to psychosocial oncology research. One POS cited the need for stronger research evidence to clarify the benefits of some psycho-oncology interventions in cost-effectiveness terms as well as outcomes (eg, Travado et al²¹), something that will prove increasingly difficult with financial restrictions.

On these figures, in the future of the IPOS Federation, new significant obligations should be added in its mission, as repeatedly stressed elsewhere.^{22–24} It is necessary to help those countries which, although active within their national POS, are still not able to liaise with governmental institutions in order to have psychosocial oncology standards of care in NCPs. Also, besides creating opportunities for training and the provision of support in drafting and implementation of POS where they do not exist, it seems to be mandatory the development of more effective policies. The role of IPOS and other organization supporting IPOS, such as the World Health Organization (WHO) and the Union for International Cancer Control (UICC), should be considered strategic in this. The WHO, for example, has strongly supported palliative care as a fundamental area to health and a basic human right, by clearly and unambiguously recognizing the obligation of all countries to make sure no one needlessly suffers from pain and other debilitating symptoms.^{25,26} It is mandatory to apply and to extend these aims to the whole trajectory of cancer care, where debilitating symptoms, including psychosocial distress and the manifold forms of spiritual suffering and mental disorders should be also recognized as a human right.^{23,27} This could be partnered with what the United Nations High Commissioner for Human Rights and the WHO Human Right Declaration on Mental Health states, that “there is a right to be treated with dignity as a human being, that there is the right of everyone to enjoy the highest attainable standard of physical and mental health and the right to have access to psychosocial services and psychosocial intervention in the event of sickness.”²⁸ A WHO Resource Book on Mental Health, Human Rights, and Legislation and a number of tools (eg, checklist and training exercises) have been developed, in order to assist countries in reviewing and assessing the comprehensiveness and adequacy of their existing law, to increase people's skills in the area of mental health, human rights, and legislation and to help them in the process of drafting new laws, when necessary.^{29–31} These strategies could be extended to psycho-oncology, moving forward from declaration to

action in a more structured way. Similar arguments can be performed with respect to the UICC that has endorsed the IPOS standards and recognizing distress as the sixth vital sign; added a specific aim (target 8) of effective pain control and distress management services to be universally available; and claimed that it is necessary to promote and support national capacity in order to “increase investment in basic, clinical and implementation research across fields and disciplines including psycho-oncology, behavioural medicine and survivorship, and make specific efforts to accelerate the translation of research findings into clinical practice.”³² Finally, it is increasingly incumbent on POS to challenge the prevailing political discourse of neoliberal rhetoric that is used so often to justify cuts to health services funding and care provision. All too often this is more ideological than it is an economic necessity. Advocacy for sustaining and improving care needs to be part of the POS skills set.

However, if this can be important at an international level, more effort is needed at national level. Without strong coalitions with oncology societies, better national research initiatives, cancer plans, and patient advocacy movements, it is difficult that initiatives planned just at an international level can have an impact on national governments, with the risk of leaving the situation of psycho-oncology fragmented in many countries. For example, the European Union (EU) Council Conclusions on reducing the burden of cancer³³ has produced in 2008 a document that was signed by the 27 EU member states recognizing the important role of psychosocial oncology in cancer stating that “to attain optimal results, a patient-centred comprehensive interdisciplinary approach and optimal psychosocial care should be implemented in routine cancer care, rehabilitation and post-treatment follow-up for all cancers” (par. 5), with an open invitation to all EU member states “to take into account the psychosocial needs of patients and improve the quality of life for cancer patients through support, rehabilitation and palliative care” (par. 19). From our results, however, it seems that these indications have not been respected in the same way in the single countries, and that, in spite of the efforts of the national POS, many countries in Europe are struggling with significant problems.

There are significant limitations in this survey. Because of its descriptive nature, more specific information about the single characteristic of psychosocial oncology in the single countries and more sophisticated statistical analysis are not allowed. Also, the participating societies of the federation reached an agreement in creating a general questionnaire, while more questions and topics could have been better operationalized by using a more structured (eg, Likert scales) questionnaire. This has been considered, however, as a further step for the future. The results reported are also based on information provided by the country POS referents, and whilst we have endeavoured to be accurate in the description derived from the survey, possible inaccuracies may be present. Also, changes can be determined in the last years after the survey was conducted.

In conclusion, although the survey contains non-negligible limitations, the results depict some important aspects on current status of psycho-social service in countries around the world where established POS exist. Likewise, what is described in several papers relative to cancer care in general (eg, access to public health and medical services, shortages of specialist staff, and increased demand for services and lack of knowledge about cancer patients' problems),^{34–38} the data

regarding psychosocial care indicate the need to work more closely together at national and international levels to defend and to make mandatory a true patient-centered comprehensive interdisciplinary approach and optimal and routine psychosocial care in cancer settings.

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APPENDIX A

Summary of the main area investigated by the questionnaire

A) Society information

- Name of the society:
- Year of foundation:
- Number of Members regularly registered (approximately):
- Society Website URL (if existent):
- Name of the current President: (appointed year: -)
- Is there a regular conference? – how often?:
- What are the existing communication methods among members? (check what applies)
 - Journal (Please provide name and website link:)
 - Newsletter
 - Email list
 - Social network service (e.g. Facebook) (specify:)
 - Others (specify:)
- Composition of members of your society
 - 1). Advanced practice nurse: %
 - 2). Registered nurse : %
 - 3). Patients and family : %

- 4). Physician (other than psychiatrist): %
 5). Psychiatrist : %
 6). Psychologist : %
 7). Social worker : %
 8). Others (please specify) : % ()
 Others (please specify) : % ()

B) Society information

Organization

1. Committees / Subgroups (Please list all committees, special interest groups, and other subgroups of the society; e.g. executive board, publication committee, pediatric workgroup, etc...)
2. Is there any support from (or link to) the government? If yes, please describe.
Yes/No
3. Is there any link to academic institutions? If yes, please describe.
Yes/No
4. Is there any partnership with other professional societies (e.g. nursing, oncology, palliative care...)? If yes, please describe.
Yes/No
5. Please describe if there is any other information (characteristics of your society) you want to add.

Activities

1. Please list a few major ongoing projects/activities of the society
2. What are the facing problems/challenges of the society?
3. Are there any internationally collaborative projects?
4. Is your society willing to mentor, to be mentored, or to be partnered with other federation societies? If so, please describe possible area of collaboration.
5. Is there anything your society wants IPOS or IPOS Federation to do to help promoting the activities of your society?

Health care information

Describe if there is any characteristic of your community (health care system, culture, etc.) that may influence (benefit or impede) psycho-social care of cancer patients? (e.g. National universal health insurance coverage, lack of resources, etc) Please include comments on whether psycho-oncology care is reimbursed (covered) in your health-care system.

Situation of Psycho-social oncology in the country

Please circle the level (number) that best describes the situation of psychosocial oncology in your country.

Level	Description
1	No known psycho-social oncology care activityUnable to identify any psycho-social care activity in the country, although there may be chances that current work has been unrecognized.
2	Capacity building activityThere is evidence of wide-ranging initiatives designed to create the organizational, workforce and policy capacity for psychosocial oncology care services to develop, though no service has yet been established. The developmental activities include: attendance at, or organization of, key conferences; personnel undertaking external training in psycho-social oncology care; lobbying of policy-makers and ministries of health; and incipient service development.
3a	Isolated care provisionThe country is characterized by: the development of psychosocial oncology care activism that is patchy in scope and not well supported; sourcing of funding that is often heavily donor-dependent; limited availability of care.
3b	Generalized care provisionThe countries is characterized by: the development of psychosocial oncology care activism in a number of locations with the growth of local support in those areas; multiple sources of funding; the availability of care; a number of psychosocial oncology care services from a community of providers that are independent of the healthcare system; and the provision of some training and education initiatives.
4a	Preliminary integration into mainstream service provisionThe countries is characterized by: the development of a critical mass of psychosocial oncology care activism in a number of locations; a variety of psychosocial oncology care providers and types of services; awareness on the part of health professionals and local communities; the

(Continues)

TABLE (Continued)

Level	Description
4b	availability of psychosocial oncology service; limited impact of psychosocial oncology service care upon policy; the provision of a substantial number of training and education initiatives by a range of organizations. The country is characterized by: the development of a critical mass of psychosocial oncology care activism in a wide range of locations; comprehensive provision of care by multiple service providers; broad awareness of psychosocial oncology care on the part of health professionals, local communities and society in general; unrestricted availability of multiple aspects of psychosocial oncology care; substantial impact of psychosocial oncology care upon policy, in particular upon public health policy; the development of recognized education centers; academic links forged with universities.