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Public Literacy and Clinical Realities in Oncofertility: High Intent Meets Low Awareness among the Community of Eastern Province, Saudi Arabia

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Article

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Abstract

Purpose:

Several barriers prevent timely discussions of fertility preservation (FP) among childbearing cancer patients. This study aimed to evaluate baseline oncofertility knowledge and clinical attitudes in a localized cohort and to highlight the need for clinical referral pathways to enhance quality of life.

Methods:

A cross-sectional survey was administered to a cohort of 285 participants. Baseline oncofertility awareness was determined by scoring four knowledge items and classifying participants into Poor, Moderate, or Good Knowledge categories. Cross-tabulations were evaluated using Pearson's Chi-squared and Fisher's exact tests. Adjusted odds ratios (OR) and 95% confidence intervals (CI) for predictors of optimal awareness were determined using multivariable logistic regression modeling. Additionally, a clinical subgroup analysis was performed to assess staging and therapy profiles among cancer survivors (N=22).

Results:

Overall, 44% (n=125) of the cohort demonstrated Poor Knowledge, 28% (n=79) Moderate Knowledge, and 28% (n=81) Good Knowledge. Regression modeling showed advanced education was the strongest indicator of best awareness; postgraduates had nearly double the odds of achieving Good Knowledge relative to Bachelor's degree holders ("OR"=1.87, 95%" CI " [0.90,3.93], p=0.094). Higher baseline knowledge was strongly associated with positive attitudes: 80% of participants with Good Knowledge considered fertility preservation highly important, compared with 56% with Poor Knowledge (p=0.004). Within the survivor subgroup, 91% received gonadotoxic therapy, but only 64% recalled receiving pre-treatment counseling.

Conclusion:

Despite favorable attitudes toward FP, awareness and practice remain low in the Eastern Province. This gap highlights a critical need for structured public health outreach and systematized clinical referral pathways before toxic treatments.

1. Introduction

According to the Cancer incident report for Saudi Arabia (2022), 27.1% of cancer cases occur in the age group 15–44 years among females, and 48% occur between the ages 15–59 years among males. These ages are the normal childbearing period among the Saudi population(1). Cancer treatments, while often lifesaving, can cause various adverse effects. They are well-documented to compromise reproductive organs and permanently impair hormone production and germ cells (2, 3). Surgical interventions involving the reproductive system may also result in irreversible infertility. These fertility-compromising

effects are especially concerning for individuals of childbearing age who may desire to have children in the future. The psychological impact of potential infertility can add a further layer of stress, negatively affecting the overall quality of life and well-being of cancer patients.

The extent of fertility impairment depends on various factors, including the type and dose of treatment, age at the time of treatment, and baseline fertility status. Despite these risks, many patients are not adequately informed about the potential reproductive consequences of their cancer therapies (4–6). Therefore, early counseling and timely referral to fertility preservation services are critical components of comprehensive cancer care, ensuring that patients are empowered to make informed decisions about their reproductive future.

Advancements in reproductive medicine have introduced various fertility preservation (FP) methods. For men, options include sperm and testicular tissue freezing. For women, egg, embryo, and ovarian tissue cryopreservation are common methods, as well as ovarian transposition(7–10). However, these procedures are often complex, costly, and may require a delay in cancer treatment, which can complicate decision-making for both patients and healthcare providers. Studies show that fertility concerns are highly relevant to many cancer patients, yet discussions on fertility preservation are not always initiated by healthcare providers (11). Factors such as limited time before starting treatment and lack of awareness among patients and providers often inhibit these conversations. Consequently, many patients may miss the opportunity to make informed choices about preserving their fertility before starting cancer treatment. This highlights a crucial gap in cancer care where patients may be deprived of important information and choices that could impact their future.

In Saudi Arabia, studies examining knowledge and attitudes towards fertility preservation for cancer patients were conducted among medical students (12), healthcare workers (13), and oncologists (14). This study aims to explore the knowledge, attitude, and practice of fertility preservation for cancer patients among a wider range of the population to provide crucial insights into current gaps in patient education and support services. Understanding these variations is essential to developing effective patient awareness programs and ensuring that fertility preservation services are accessible and relevant to diverse patient populations.

2. Materials and Methods

2.1 Study Design and Participant Selection

The current cross-sectional study was conducted over two months between November and December 2025. The sample size was calculated using the Sample Size Calculator by Raosoft, Inc., with a 95% confidence level and a 5% margin of error. The target sample size was 300. Utilizing a convenient sampling technique for data collection, the study targeted participants from the Eastern Province in Saudi Arabia, as well as cancer survivors and patients. Before data collection, all participants provided written informed consent, ensuring they were fully aware of the study's purpose, procedures, and

potential risks. The methods employed in this investigation comply with the principles of the Helsinki Declaration on human subject research. This study received approval from the Institutional Review Board at Mohammed Al-Mana College for Medical Sciences, approval no. SR/RP/224, ensuring ethical standards were met throughout the research process. Individuals under the age of 18 or those who chose not to provide consent were excluded from participation.

2.2 Data Collection Tool and Validation

The semi-structured survey instrument used was adapted from established literature with a similar clinical focus(12, 15). The questionnaire was modified and improved to form the final version. The questionnaire's face validity and content validity were assessed by two independent invited experts, who reported a content validity index (CVI) of 0.9. Additionally, a pilot questionnaire was field-tested by five respondents from the community to verify face validity and assess ease of comprehension. The experts confirmed that all items were fully comprehensible and estimated a participant's completion time of 5 to 10 minutes. The final questionnaire comprised 23 items divided into four sections: baseline sociodemographic characteristics, 6 items evaluating objective factual knowledge, 3 items focusing on participant attitudes, and 3 items assessing real-world clinical practices (Supplementary). The finalized tool was administered electronically as a Google Form survey link.

2.3 Data Cleaning, Variable Scoring, and Reliability

Raw data were exported into an R environment for programmatic filtering and cleaning utilizing the tidyverse packages (16). Multi-select survey responses (such as perceived barriers or decision-making drivers) were decoupled to capture distinct binary frequency counts for each sub-option.

Baseline Oncofertility Knowledge, was evaluated using the items located in Section Two. Correct responses were assigned a value of 1, while incorrect or "unsure" responses were assigned a value of 0. Individual item scores were aggregated to produce a knowledge score. Based on this score, participants were stratified into three levels: Poor Knowledge (Score of 0), Moderate Knowledge (Score of 1–2), and Good Knowledge (Score of 3).

The internal consistency of the 6-item objective knowledge component was evaluated using Cronbach's alpha. The analysis yielded a low raw alpha value ($\alpha = 0.11$). This low value is mathematically anticipated as the items evaluate an index of distinct factual awareness components (ranging from basic term recognition to practical usage) rather than a single, continuous psychological construct.

2.4 Statistical Analysis

All statistical analyses and demographic cross-tabulations were conducted in the R statistical computing environment (v4.3.1). Descriptive tables and bivariable comparisons were generated using the gtsummary package (17) to summarize the baseline sociodemographic profiles and clinical subgroup distributions. Variables were presented as absolute numbers and percentages (n, %). Tables were formatted and exported to Microsoft Word utilizing the flextable package (18). Bivariate associations between categorical variables—specifically testing how stratified knowledge levels drive

personal attitudes regarding fertility preservation—were evaluated using Pearson's Chi-squared test or Fisher's exact test where cell counts were sparse (n < 5).

To isolate independent sociodemographic determinants of high oncofertility awareness, a multivariable logistic regression model was constructed. Covariates, including age, gender, marital status, and education level, were entered simultaneously into the model. Adjusted Odds Ratios (OR) along with their corresponding 95% Confidence Intervals (95% CI) and p-values were computed. All data visualizations and charts were structured using the ggplot2 package(19).

3. Results

Of the 290 respondents who consented electronically, 285 participants completed the questionnaire (Table 1). Most respondents were within the common childbearing age, with the largest age group falling between 18 and 25 years (41%, n = 117), followed by 36 to 45 years (20%, n = 58) and 26 to 35 years (18%, n = 51). The vast majority of respondents were female (90%, n = 256), while males constituted (10%, n = 29) of the sample. The cohort exhibited a high level of educational attainment; over half of the participants held a Bachelor's degree (56%, n = 158), and 26% (n = 74) had completed postgraduate studies, whereas only 14% (n = 4) and 4.6% (n = 13) reported high school or diploma-level education, respectively.

3.1. Baseline Oncofertility Knowledge

The baseline oncofertility knowledge of the participants was assessed across individual total scores (ranging from 0 to 3) and stratified into knowledge levels by gender. A higher proportion of male respondents scored 0 (34%) compared to female respondents (16%). Conversely, 29% of females achieved a perfect score of 3 compared to 21% of males, though this difference in point frequencies did not cross the threshold for overall statistical significance (Pearson's chi-squared, p = 0.073). When clustering total scores into categorical knowledge classifications, 44% (n = 125) of the overall cohort demonstrated Poor Knowledge (scores of 0 or 1), 28% (n = 79) demonstrated Moderate Knowledge (score of 2), and 28% (n = 81) demonstrated Good Knowledge (score of 3) (Table 2). Upon stratification by gender; a greater percentage of male participants fell into the Poor Knowledge category (62%, n = 18) relative to female participants (42%, n = 107). In contrast, a higher proportion of females attained Moderate Knowledge (29%, n = 74) and Good Knowledge (29%, n = 75) profiles compared to males (17%, n = 5 and 21%, n = 6, respectively). However, this overall distribution difference by gender category did not reach c statistical significance (p = 0.11).

Table 1
Sociodemographic Characteristics of the Study Cohort ($N = 285$).

Sociodemographic Characteristic	Study Cohort (N = 285)
	N = 285[1]
Age Group	
less than 18	0 (0%)
18–25	117 (41%)
26–35	51 (18%)
36–45	58 (20%)
46–55	37 (13%)
Older than 55	22 (7.7%)
Gender	
Female	256 (90%)
Male	29 (10%)
Education Level	
Bachelor	158 (55%)
Diploma	13 (4.6%)
High school	40 (14%)
Postgraduate	74 (26%)
Marital Status	
Divorced	3 (1.1%)
Married	156 (55%)
Single	124 (44%)
Widow	2 (0.7%)
[1]n (%)	

Table 2
Distribution of Baseline Oncofertility Knowledge Scores and Literacy Levels Categorized by Respondent Gender ($N = 285$).

Characteristic	**Female** **N = 256**[1]	**Male** **N = 29**[1]	**p-value**[2]
Total Knowledge Score			0.073
0	41 (16%)	10 (34%)	
1	66 (26%)	8 (28%)	
2	74 (29%)	5 (17%)	
3	75 (29%)	6 (21%)	
Knowledge Categories			0.11
Poor Knowledge	107 (42%)	18 (62%)	
Moderate Knowledge	74 (29%)	5 (17%)	
Good Knowledge	75 (29%)	6 (21%)	
[1]n (%)			
[2]Pearson's Chi-squared test			

3.2 Association Between Sociodemographic Characteristics and Oncofertility Knowledge Levels

Descriptive variations were observed when evaluating academic backgrounds across the knowledge levels (Table 3). While individuals holding a Bachelor’s degree represented the majority across every knowledge division, their proportional density was noticeably higher in the Poor Knowledge group 60% (n = 75) compared to the Moderate 52% (n = 41) and Good 52% (n = 42) knowledge cohorts. Conversely, a clear upward trend was observed for individuals with postgraduate qualifications: postgraduates made up only 17% (n = 21) of the Poor Knowledge cohort, but their representation nearly doubled to comprise 33% (n = 26) of the Moderate Knowledge cohort and 33% (n = 27) of the Good Knowledge cohort.

A highly significant positive association was observed between a participant's objective knowledge level and their attitude toward the necessity of oncofertility services (p = 0.004; Table 4). Among individuals classified as having poor baseline knowledge, only 56% (n = 70) agreed that fertility preservation was highly important, with a substantial portion (38%, n = 48) remaining unsure. Conversely, as literacy increased, positive attitudes rose dynamically: 68% (n = 54) of the moderate knowledge subgroup and 80% (n = 65) of the good knowledge subgroup independently affirmed the critical importance of integrating fertility preservation into standard cancer care.

Table 3
Multivariable Logistic Regression Analysis of Sociodemographic Predictors Associated with Favorable Baseline Oncofertility Knowledge.

Characteristic	Poor Knowledge N = 125[1]	Moderate Knowledge N = 79[1]	Good Knowledge N = 81[1]	p-value[2]
Age Group				
18–25	52 (42%)	33 (42%)	32 (40%)	
26–35	21 (17%)	15 (19%)	15 (19%)	
36–45	22 (18%)	19 (24%)	17 (21%)	
46–55	16 (13%)	8 (10%)	13 (16%)	
Older than 55	14 (11.2%)	4 (5.1%)	4 (4.9%)	
Education Level				
Bachelor	75 (60%)	41 (52%)	42 (52%)	0.070
Diploma	7 (5.6%)	4 (5.1%)	2 (2.5%)	
High school	22 (18%)	8 (10%)	10 (12%)	
Postgraduate	21 (17%)	26 (33%)	27 (33%)	
Marital Status				
Divorced	2 (1.6%)	1 (1.3%)	0 (0%)	0.7
Married	63 (50%)	46 (58%)	47 (58%)	
Single	59 (47%)	31 (39%)	34 (42%)	
Widow	1 (0.8%)	1 (1.3%)	0 (0%)	
Gender				
Female	107 (86%)	74 (94%)	75 (93%)	0.11
Male	18 (14%)	5 (6.3%)	6 (7.4%)	

[1]n (%)

[2]NA; Fisher's exact test; Pearson's Chi-squared test

Table 4
Cross-Tabulation and Bivariable Comparison of Baseline Oncofertility Knowledge Tiers with Clinical Attitudes Toward Fertility Preservation ($N = 285$).

Characteristic	Poor Knowledge N = 125[1]	Moderate Knowledge N = 79[1]	Good Knowledge N = 81[1]	p-value[2]
Believes Fertility Preservation is Highly Important				0.004
No	7 (5.6%)	1 (1.3%)	1 (1.2%)	
Not sure	48 (38%)	24 (30%)	15 (19%)	
Yes	70 (56%)	54 (68%)	65 (80%)	

3.3 Ideological and Ethical Motivations Supporting Oncofertility Education

Among participants who advocated for oncofertility education, underlying motivations were deeply rooted in human rights and personal autonomy (Fig. 1). 87.4% (n = 249) of respondents declared that reproductive choice constitutes a basic human right. This ethical foundation was strongly supported by practical, long-term personal beliefs: 64.9% (n = 185) cited a definitive desire to preserve the option of having children in the future, while 43.9% (n = 125) emphasized the desire to avoid future psychological regret. Only a small minority (16.1%, n = 46) of the subset reported that they did not consider this health information fundamentally important.

3.4 Multivariable Logistic Regression Analysis of Factors Associated with Good Knowledge

To determine independent sociodemographic predictors of high oncofertility awareness, a multivariable logistic regression model was constructed using age, educational attainment, and marital status (Table 5).

Table 5

Characteristic	OR	95% CI	95% CI	p-value
age				
18–25	—	—	—	
26–35	0.87	0.32, 2.22	0.32, 2.22	0.8
36–45	0.83	0.27, 2.52	0.27, 2.52	0.7
46–55	1.29	0.42, 3.99	0.42, 3.99	0.7
Older than 55	0.53	0.12, 2.00	0.12, 2.00	0.4
education				
Bachelor	—	—	—	
Diploma	0.77	0.11, 3.63	0.11, 3.63	0.8
High school	0.90	0.38, 1.98	0.38, 1.98	0.8
Postgraduate	1.81	0.88, 3.79	0.88, 3.79	0.11
marital_status				
Divorced	—	—	—	
Married	1,598,203	0.00, NA	0.00, NA	> 0.9
Single	1,700,925	0.00, NA	0.00, NA	> 0.9
Widow	0.61	0.00, 802,693	0.00, 802,693	> 0.9
Abbreviations: CI = Confidence Interval, OR = Odds Ratio				

Age was not found to be a statistically significant predictor of oncofertility knowledge. Compared to the reference group (18–25 years), odds ratios for the remaining age brackets did not reach significance, including individuals aged 26–35 years (OR = 0.87, 95%CI [0.32, 2.22], p = 0.8) and those aged 36–45 years (OR = 0.83, 95% CI [0.27, 2.52], p = 0.7). Similarly, marital status markers exhibited broad confidence intervals and did not reveal a strong independent association with awareness levels (p > 0.9). In contrast, educational level emerged as a notable contributor to baseline awareness, displaying a strong descriptive trend. Using participants holding a Bachelor's degree as the reference category, individuals with postgraduate qualifications exhibited nearly double the odds of demonstrating high oncofertility knowledge (OR = 1.81, 95 CI [0.88, 3.79]). While this trend fell just short of statistical significance in the fully adjusted model (p = 0.11), it indicates that advanced academic training tracks closely with optimal baseline awareness. Lower educational milestones, such as a Diploma (OR = 0.77, 95% CI [0.11, 3.63], p = 0.8) or a High School certificate (OR = 0.90, 95%CI [0.38, 1.98], p = 0.8), did not significantly alter the odds of achieving high knowledge scores relative to a Bachelor's degree.

3.5 Structural Roadblocks and Decision-Making Realities

When evaluating the barriers that deter individuals from accessing oncofertility facilities, 30.5% (n = 87) of the community cohort felt that no personal barriers existed (Fig. 2). Among the remaining sample, financial burden was highlighted as a principal barrier by 28.8% (n = 82) of the cohort, while a lack of specialized regional fertility services in their immediate geographic area was cited by 23.5% (n = 67). Educational and clinical anxieties were also prevalent: 27.0% (n = 77) identified limited personal knowledge as a direct barrier to seeking care. Furthermore, medical misconceptions were documented as 26.0% (n = 74) feared that children born via these technologies would suffer from long-term medical concerns, and 10.2% (n = 29) worried that undergoing preservation procedures could trigger a cancer recurrence.

3.6 Evaluation of the Real-World Counseling Gap (Survivor Subgroup)

To evaluate how these community perceptions translate into real-world clinical practice, a specialized subgroup analysis was conducted among the 22 real-world cancer survivors captured within the study cohort (Table 6). Within this clinical subgroup, 27% (n = 6) had been diagnosed at Stage 1, 27% (n = 6) at Stage 2, 36% (n = 8) at Stage 3, and 4.5% (n = 1) at Stage 4. The vast majority (91%, n = 20) required active oncological intervention, including multi-modal regimens consisting of chemotherapy alone (41%, n = 9), combined chemo-radiotherapy (23%, n = 5), or regimens incorporating advanced hormonal or immunotherapies. Despite the highly gonadotoxic nature of these mandated cancer treatments, a major counseling gap was uncovered: 36% (n = 8) of these active cancer patients went through their entire oncological therapeutic experience without ever having a formal clinical discussion regarding fertility preservation with their medical team prior to the initiation of treatment.

Table 6

Clinical Variable (Cancer Survivor Subgroup)	N = 22[1]
Cancer Stage at Diagnosis	
I dont know	1 (4.5%)
Stage 1	6 (27%)
Stage 2	6 (27%)
Stage 3	8 (36%)
Stage 4	1 (4.5%)
Underwent Oncological Treatment	20 (91%)
Type of Therapy Received	
Chemotherapy	9 (41%)
Chemotherapy, Radiotherapy	5 (23%)
Chemotherapy, Radiotherapy, Hormonal therapy	2 (9.1%)
Chemotherapy Radiotherapy, Hormonal therapy, Immunotherapy	1 (4.5%)
Hormonal therapy	5 (23%)
Discussed Fertility Preservation with Doctor Before Treatment	14 (64%)

[1]n (%)

4. Discussion

The preservation of fertility is a critical element of holistic cancer care for reproductive-aged individuals, yet baseline public and patient awareness often remains a significant limiting barrier. This study intends to assess oncofertility knowledge levels, attitudes, and factors affecting consideration of fertility preservation for cancer patients among the Saudi community. Several studies assessed this among either practitioners, medical students, or even cancer patients. However, it is equally important to assess the community to be aware of, as they would be a source of education to those with cancer.

According to the Patient Bill of Rights and Responsibilities by the Saudi Ministry of Health (MOH), patients have the right to be informed about fertility consequences and options before treatment and to be referred to a specialist (20). Research in different healthcare settings and populations has found a wide range of knowledge, attitudes, and practices regarding fertility preservation. Some studies indicate that patients are largely unaware of their options, while others show varying degrees of interest and willingness to undergo fertility preservation (15, 21). Attitudes towards FP can be influenced by factors such as cultural beliefs, marital status, family planning goals, and perceived urgency of cancer

treatment. Understanding these variations is essential for developing effective patient education programs and ensuring that fertility preservation services are accessible and relevant to diverse patient populations.

A key finding of this study is that nearly half of the overall cohort (44%) demonstrated "Poor Knowledge" regarding oncofertility options, scoring 0 or 1 out of a maximum of 3 correct parameters. This high prevalence of baseline awareness deficits matches global trends reported in similar survey-based frameworks, where public awareness of specialized cryopreservation options remains low until precise clinical counseling is initiated (14, 22).

Interestingly, our multivariable logistic regression model highlighted that while age and marital status did not independently dictate awareness scores, higher educational attainment served as a strong descriptive protective factor. Participants holding postgraduate qualifications exhibited nearly double the odds of demonstrating optimal "Good Knowledge" compared to those holding Bachelor's degrees. This suggests that advanced education fundamentally fosters a greater proficiency for medical contexts. The fact that high school or diploma-level training is tracked with even lower baseline familiarity underlines the pressing need for plain-language public health outreach campaigns that do not assume prior specialized biological literacy.

The limited public knowledge about fertility preservation may largely stem from the scarcity of fertility awareness initiatives and educational campaigns. Moreover, the national and private healthcare system in Saudi Arabia has focused only limited attention on fertility preservation. This highlights the need to enhance awareness and education on this topic.

Moreover, our bivariable analysis revealed a statistically significant correlation between strong baseline knowledge and positive patient attitudes towards fertility preservation. Where individuals classified in the "Good Knowledge" group believed fertility preservation to be of high clinical importance. However, even among the lowest knowledge group, more than half of the respondents descriptively support the concept of fertility preservation despite not knowing the specific local options or clinical issues involved. The study highlights that the population is highly receptive to oncofertility initiatives; their primary barrier is not personal or structural resistance, but simply a lack of clear information.

This research also highlights the need for systematic changes, such as incorporating fertility counseling into standard cancer care protocols, training oncologists on FP options, or increasing access to financial assistance for FP procedures. Evidence-based studies have set guidelines and recommendations for male and female fertility preservation options that the treatment team should be acquainted with in order to educate patients and their families (6, 23, 24). This counseling should not only be before treatment, but also after when there is a reproductive window that can appear one year after treatment(25). By identifying areas where there is a lack knowledge or misconceptions, healthcare providers and educators can better address these gaps through targeted interventions. Furthermore, understanding patients' attitudes can help in designing counseling services that are sensitive to their needs, values, and priorities. Evaluating current practices can shed light on whether patients are

receiving timely and adequate information and if they are taking steps to preserve their fertility when appropriate.

5. Clinical Implications

The findings of this study highlight a clinically important gap between positive attitudes toward fertility preservation and the limited awareness and counseling received by patients of reproductive age. Routine fertility risk assessment and pre-treatment counseling should be integrated into standard oncology care, with timely referral to fertility specialists before gonadotoxic therapy. Strengthening clinician education, implementing standardized referral pathways, and increasing public awareness may improve access to fertility preservation services and enhance long-term survivorship outcomes in Saudi Arabia.

6. Study Limitations

This study holds certain limitations that should be noted. First, the cross-sectional survey design captures a single snapshot of baseline awareness therefore we cannot evaluate longitudinal changes in behavior or true long-term decision-making. Second, our cohort was characterized by a gender imbalance (90% female vs. 10% male), which reduced the statistical power needed to identify true significance within the male sub-cohort during adjusted regression processing.

7. Conclusions

In conclusion, while baseline oncofertility knowledge is limited within the study cohort, attitudes toward the value of fertility preservation are considerably positive. Bridging this gap requires the development of accessible, standardized public health toolkits and mandatory clinical referral systems. This ensures that every cancer patient facing a gonadotoxic treatment is empowered with actionable information, regardless of their demographic or educational background. Future multi-center initiatives should focus on recruiting a more balanced cohort across sexes and implementing longitudinal tracking to see if targeted educational interventions directly translate into higher utilization rates for fertility preservation services.

Abbreviations

The following abbreviations are used in this manuscript:

FP	Fertility Preservation

Declarations

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Institutional Review Board Statement: This study received approval from the Institutional Review Board at Mohammed Al-Mana College for Medical Sciences, approval no. SR/RP/224, ensuring ethical standards were met throughout the research process.

Informed Consent Statement: “Informed consent was obtained from all subjects involved in the study.”

Conflicts of Interest: The author declares no conflicts of interest.

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Figures

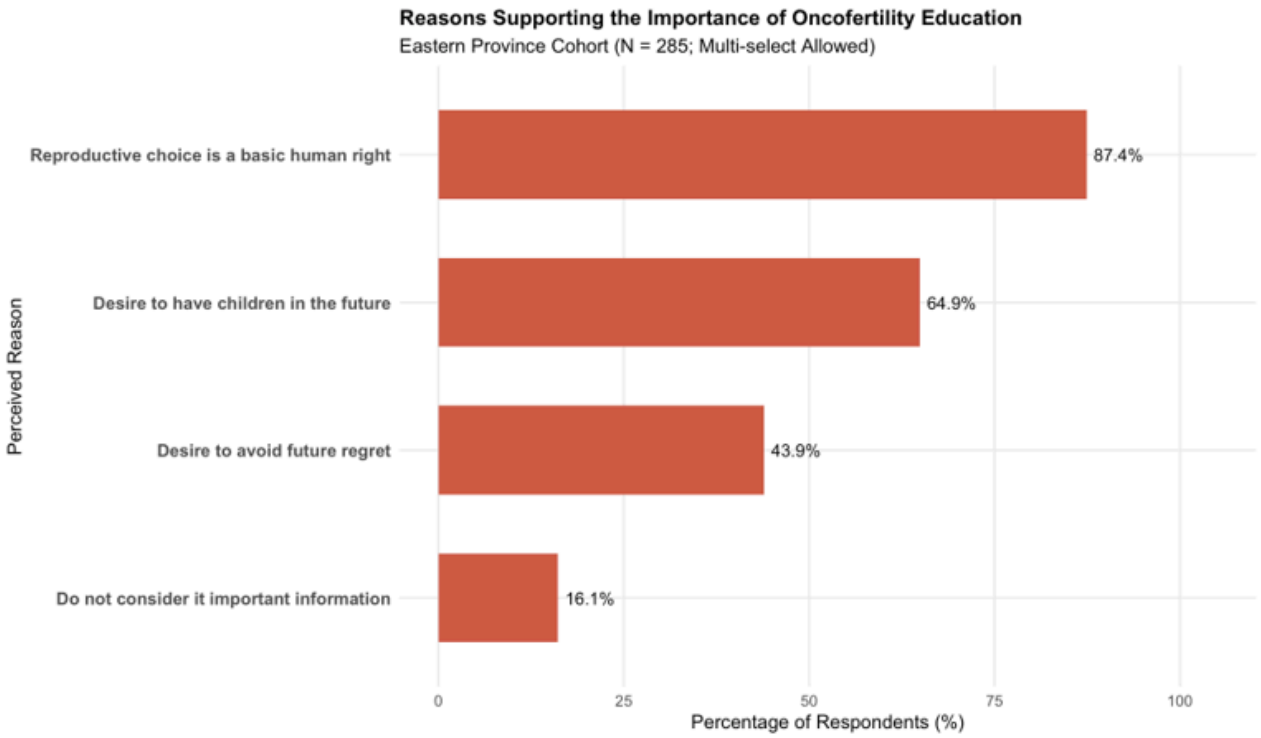


Figure 1

Perceived reasons supporting the necessity and clinical importance of oncofertility education (N = 285). Bars represent the total percentage of the cohort that selected each respective ethical, personal, or practical motivation. Percentages do not sum to 100% as participants were permitted to select multiple responses (multi-select survey item).

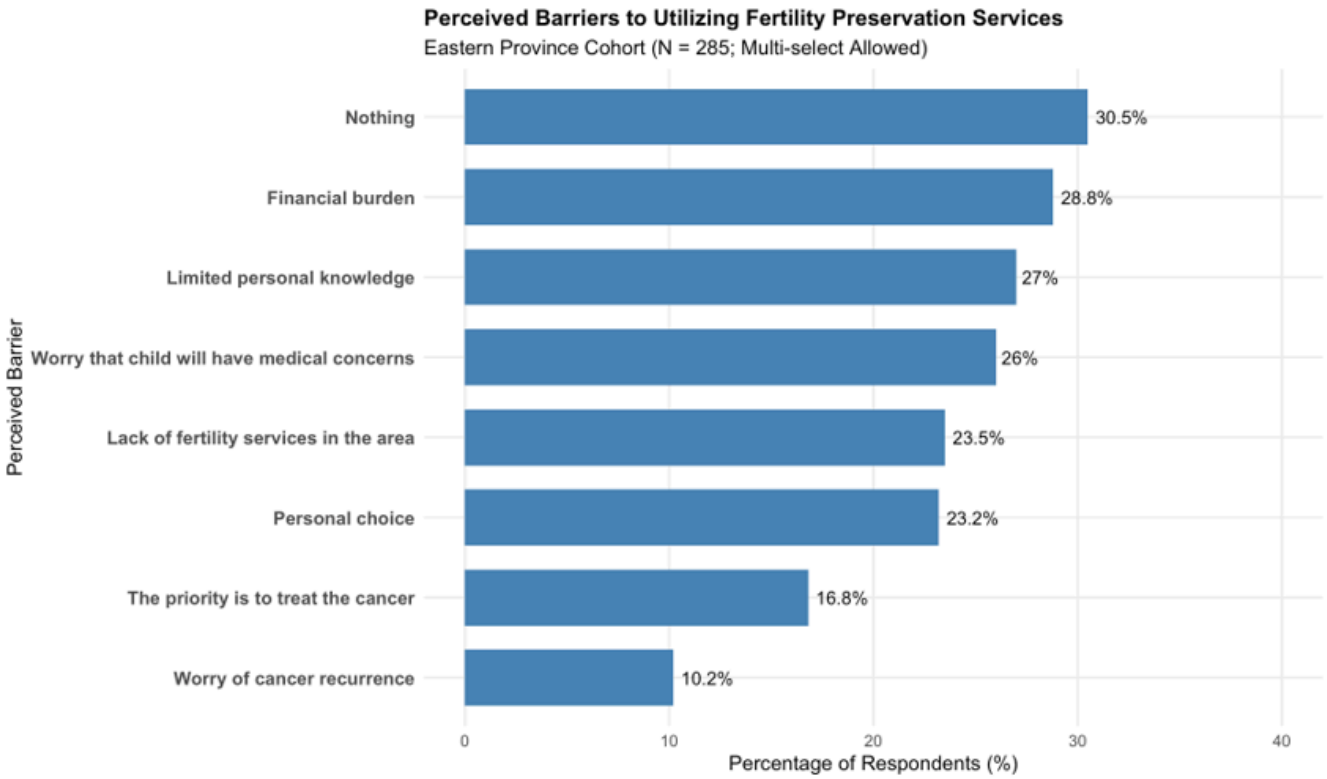


Figure 2

Perceived Barriers to Utilizing Fertility Preservation Services. This horizontal bar chart illustrates the self-reported obstacles to access oncofertility care within the Eastern Province cohort (N=285). Because a multi-select questionnaire format was utilized, cumulative percentages exceed 100%.

Supplementary Files

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- supplementaryfile.xls