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Review Article:

Assessing the Applicability of Fertility Decision Aids in Low- and Middle-Income Countries: An Ottawa Framework Review

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Abstract

Background: Fertility preservation (FP) is critical for reproductive-age cancer patients, yet the complexity of decision-making remains a significant clinical challenge. While patient decision aids (DAs) are standard evidence-based tools utilized in developed healthcare systems to mitigate decisional conflict, their implementation and efficacy remains understudied in Low- and Middle- Income countries (LMIC). **Aim:** This narrative review utilizes the Ottawa Decision Support Framework (ODSF) to critically evaluate the transferability of existing oncofertility decision support tools to LMIC. **Method:** A structured review identified 11 DAs, which were evaluated via thematic analysis. The ODSF was used to compare Western design elements with systemic realities in LMIC. **Conclusion:** Current DAs prioritize individual emotional conflict over the systemic barriers—financial, clinical, and cultural—prevalent in LMICs. Effective implementation may require a shift toward family-centered consensus models, active financial navigation, and low-literacy multimedia formats, and the proposed integration of trained clinical pharmacists to bridge crucial knowledge gaps in clinical utility in resource-poor settings.

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1. Introduction

The recent advances in cancer management have improved the overall survival rates (1). Fertility preservation (FP) is considered an important long-term consideration for young patients whose fertility may be compromised by cancer treatments such as chemotherapy, radiation, or surgery (2). The evolving field of oncofertility offers many FP options, including oocyte, sperm, embryo, and ovarian tissue cryopreservation (3). Major organizations—including the American Society of Clinical Oncology (ASCO), European Society for Medical Oncology (ESMO), European Society of Human Reproduction and Embryology (ESHRE), and the National Comprehensive Cancer Network (NCCN), have established formal clinical guidelines to standardize

Fertility care in cancer patients (2, 4-6). FP decision-making is complicated by the psychological trauma of cancer diagnosis, which can be overwhelming, potentially inducing a state of cognitive overload and impaired decision making (7). Traditional counseling without a systematic approach is not considered sufficient for patients facing the complex choices of FP options as they become more accessible.

Applying pressure on patients to undergo FP, while it may be intended to avoid potential regret later, can have negative consequences, as some individuals prefer starting the management as soon as possible (8). Furthermore, chemotherapy might not result in permanent infertility, but, the financial requirements of FP procedures can have negative long-term consequences, unrelated to the clinical outcome (9). Patient decision aids (DAs) are considered helpful for Shared decision-making, and can also be used to optimize patient and physician communication and discussion of complex clinical choices (10-13). DAs are evidence-based tools designed to support patients when choosing between options which have no clear advantages among them, this allows for values-oriented decision-making. In developed societies DAs are currently widely used in contrast, their implementation remains low in LMIC (10, 14-16). The current literature suggests that DAs are primarily designed to be applied within the Western cultural frameworks (17).

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The following research question can be raised to shed more light on the subject: Can the current systems for developing and evaluating FP decision aids be applied in low- and middle-income countries without major changes? This topic was addressed in the development of an FP tool in Portugal, researchers found that transcreation rather than translation was required for local adaptation (18-20). While the International Patient Decision Aid Standards (IPDAS) provide a basic framework for DAs design, most current adaptations focus mainly on Western nation's needs.

There is little evidence on the applicability of DA tools in LMIC (21-23). Applying the Ottawa Decision Support Framework (ODSF) to evaluate DAs may provide a systematic approach for identifying the decisional needs and outcomes for patients in LMIC. The ODSF has been applied for more than 20 years in DAs evaluation, and has been validated through multiple systemic reviews (21).

2. Methodology

2.1. Study design

A narrative synthesis approach was adopted in order to study the development, evaluation, and implementation of FP of DAs. The author examined DAs that were implemented in different cultures with different economic backgrounds. The reason behind the selection of this method over the formal systematic review was because we did not intend to quantify effect sizes. The author's primary objective was to explore the literature that included a range of randomized trials and implementation reports through the lens of ODSF.

2.2. Search strategy and eligibility

Author conducted a systematic literature search in two main databases platforms: PubMed and Cochrane Library. An additional Google Scholar search was performed to ensure a comprehensive capturing of the relevant papers. The results were capped to the first 200 records in total, sorted by relevance. The search included studies published until January 15, 2026, to include the most recent publications regarding Decision Aids utilization in fertility preservation in cancer patients. The databases search was restricted to studies on human subjects and publications in English language only. Manual screening on the reference lists of the included articles was performed to identify additional relevant publications. The exact search wording used are detailed in the appendix. Title and abstract screening were conducted by two independent reviewers with subsequent whole text screening to establish eligibility. The disagreements that happened during the selection of the studies were resolved through consultation of a third reviewer after thorough discussion.

2.3. Inclusion criteria

The studies were selected for inclusion based on the following criteria:

1. Papers on DAs designed for fertility preservation in cancer patients that studies the development, pilot testing, evaluation or randomized clinical trials on the mentioned DAs implementation.

2. Interventions that met the definition of DA by providing clinical information in combination with value clarification exercises or other decision aid techniques.

2.4. Exclusion criteria

1. Studies that do not contain a clear decision-making tool regarding fertility preservation in cancer patients.
2. Studies with DAs in cancer patients that is not specifically designed for fertility preservation decision-making.
3. Studies with observational design that did not implement or test a specific DA for fertility preservation in cancer patient (such studies were excluded in the screening phase and were classified under wrong study design).
4. Studies published in languages other than English.

Although this is a narrative synthesis, The study adopted PRISMA flow diagram, which is usually reserved for systemic reviews only, for the purpose of enhancing search transparency (Figure 1).

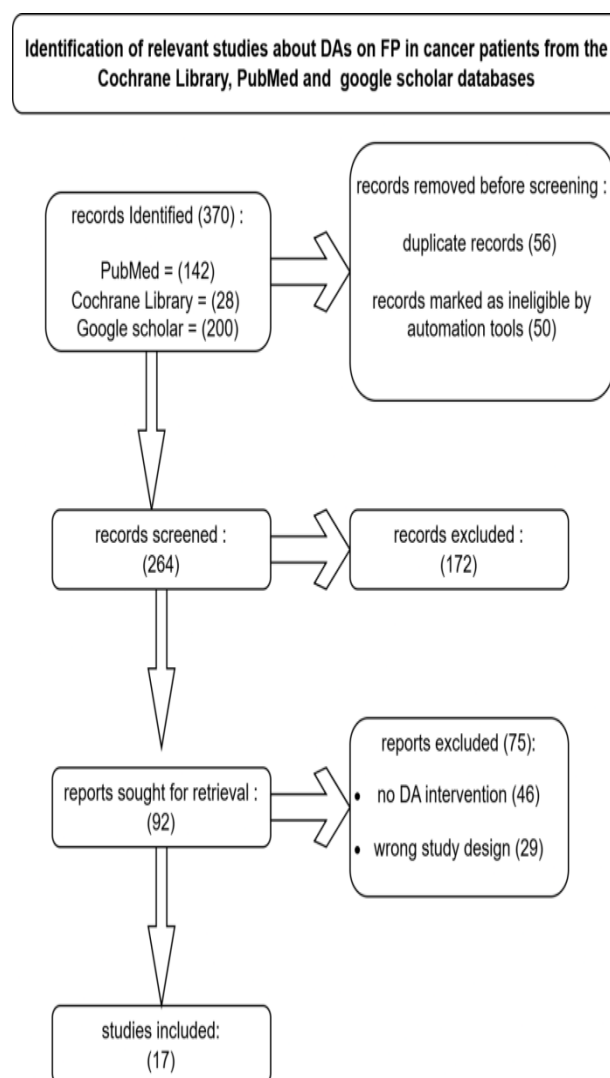


Figure 1. PRISMA flow diagram detailing the identification, screening, and inclusion phases for records retrieved from PubMed, Cochrane Library, and Google Scholar databases

2.5. Data analysis and extraction

Author analyzed the included studies thematically and not statistically, examined, and tested the DAs in relation to the ODSF elements, focusing on health literacy, socioeconomic barriers, and cultural factors. The ODSF was selected over other tools (such as IPDAS) because it specifically addresses the interaction between the decisional needs and the systemic support structures (21). Author chosen to disaggregate the three primary ODSF elements into seven themes (Table S1), using a deductive thematic mapping technique. This disaggregation allowed for a more dynamic approach to the evaluation of each DA against systemic barriers. Data were extracted into an evidence table (Table S2). The table highlighted the study design, sampling, DA format, and key outcomes. Synthesis was performed by deductive thematic analysis using seven ODSF themes as an a priori coding framework. This systematic process allowed us to conduct a comparative analysis between established Western DA structures and the systemic realities of LMIC.

3. Results

3.1. Overview of identified interventions

The literature search identified 17 publications representing 11 DAs (Table S3). The difference between the number of publications and the number of DA tools is due to many papers report on different developmental phases for the same DA, such as protocol design, pilot testing, and randomized controlled trials. All 11 identified DAs were developed and evaluated in high-income countries; There was no DA that was developed or even adapted for low- or middle-income countries (LMICs).

3.2. Thematic analysis

Author thematically organized the 11 DAs according to the presence or absence of the seven ODSF themes previously detailed in (Table S3) (25-27, 30, 33-36, 38-40). Our thematic analysis revealed a strong structural tendency to manage internal cognitive factors over addressing system barriers. There is a dominant focus on Knowledge and information exchange (theme 2), and Decision Uncertainty (theme 4) across all the evaluated DA tools. This was achieved through the application of VCEs and risk weighing tasks. The studied DAs adequately incorporated the complex medical probabilities into easily understandable forms (e.g., pictographs). This helps to reduce the psychological impact on the patient, and at the same time helps the patients to match the choices to their personal values around family building (Theme 1).

When analyzed in the lens of Needs assessment (Theme 5), all eleven DAs addressed those themes. A more unique pattern emerged when analyzed for emotional preparedness (theme 3), and External support (Theme 6). In each case only nine of eleven DAs provided some form of a framework for this purpose (37-39), (35, 40). All the studied DAs assumed a good basic level of healthcare infrastructure. This is clearly visible through the literature, by mentioning Multidisciplinary teams and basic health coverage that are properties of adequately functioning healthcare infrastructure.

The studied DAs demonstrated notable efficacy in improving cognitive outcomes and established a clearly visible reduction in post treatment regret in their well-

equipped healthcare systems for which they were developed (theme 7). However, they clearly rely on a well-established individual autonomy, this is a recognized limitation for their implementation in environments where external influences affect personal values.

3.3. Cross-cutting insights and gaps

Cross-cutting analysis produced two key gaps in the current DA design: the absence of socioeconomic considerations and the absence of different implementation requirements.

3.4. Socioeconomic and financial omissions

A primary gap that was identified in the literature is the absence of financial transparency. For example, DAs developed in the Netherlands do not address costs because FP is covered under national health insurance. Such tool design is considered specific to its original local environment and may restrict its transferability to LMICs where out-of-pocket costs are the main barrier to receiving care.

3.5. Workflow and implementation

Although DAs are very effective in studying conditions, their adoption in clinical practice is not ideal. Time constraints on oncologists and the need for a quick initiation of cancer treatment often slow the integration of such DAs (41). These challenges highlight the importance of considering the various implementation barriers when designing DA tools that may be effective in theory but not in practice, especially in resource-poor settings and busy clinics.

4. Discussion

Analyzed through the lens of ODSF, most of the FP DAs in high-income countries have integrated the seven thematic components of ODSF (Table S3), to improve patient understanding and clinical decision quality. In high-resource settings, using structured DAs as interventions, reduce decisional conflict, reduce post-treatment regret, and align medical choices with patients' family-building FP goals (42).

However, many unmet needs, gaps, and systematic barriers are exposed when applying the developed countries' DAs designed according to ODSF parameters, to low and middle-income countries (43, 44). While decision aids in developed nations focus mainly on emotional aspects of the decision-making process and the various complex clinical probabilities (45), patients and their healthcare providers in LMIC face fundamentally different problems. While each LMIC may have its own unique circumstances, they mostly share the same problems on basic themes such as the lack of organized institutional referral protocols and the lack of multidisciplinary teams that deal with oncofertility (46, 47).

The central argument is that applying FP DAs developed in high-income settings to LMIC faces the reality of the need for substantial changes in the priorities of structuring such DAs, taking into account the shift from prioritizing individual informational and emotional support to managing systemic, economic, and infrastructural barriers that limit access to FP care (48). To produce the findings, the author grouped the results into three thematic clusters:

Cluster 1: Cognitive & Decisional Foundations (combines Theme 1: Personal Values with Theme 2: Knowledge and Theme 4: Decision Context).

Cluster 2: Psychosocial Dynamics & Support Systems (combines Theme 3: Emotional Readiness with Theme 6: External Support/Deliberation).

Cluster 3: Implementation, Assessment, & Outcomes (combines Theme 5: Needs Assessment with Theme 7: Evaluation/Outcomes).

4.1. Cognitive and decisional foundations

In high income countries, DAs provide structured evidence-based frameworks that help manage patient uncertainty about FP after diagnosis and before the start of treatment (49). DAs sometimes are used to address poor knowledge and information (50), for example, through incorporation of accurate data regarding fertility preservation, such as success rates using easy-to-understand visual formats like pictographs; this will ensure better understanding across every health literacy level (32, 34). The DAs also suggest that they use values clarification exercises to guide patients to weigh potential risks that may affect their reproductive future, thereby alleviating future decisional regret (33, 40). While verbal translation of developed countries' DA (including pictographs, true-false checks, and risk weighing) can be relatively easy, the translated DA might not function ideally in LMICs. Systemic barriers might hinder effective implementation of the cognitive and decisional aspects in low- and middle-income countries, especially regarding the baseline health literacy (51). Baseline education determines a patient's ability to comprehend FP information; for instance, knowledge about the gonadotoxic effects of chemotherapy is significantly less among patients with low education or socioeconomic status, which keeps them from participating in values clarification exercises (VCEs) (52, 53).

The translation of risks by healthcare providers adds to the complexity of knowledge levels and realities in LMICs. Oncologists practicing in Mexico and Lebanon, for example, often feel uncomfortable discussing fertility risks with a life-threatening prognosis (54-56). Discussions regarding FP options, sometimes are not initiated by physicians, based on their own assumptions about a patient's education level, or their own judgment to focus on cancer survival rather than long-term quality of life (57, 58).

This breakdown in information exchange limits shared decision-making so that patients remain uninformed and unable to participate in the choice about their future reproductiveity. DAs are designed to provide alternative options for the patient to choose from; however, advanced FP technologies such as ovarian tissue cryopreservation or in vitro maturation are either nonexistent or only available at private centers (54, 57).

This issue is manifested even among developed countries. For example, the female FP decision tree in the USA is limited in terms of its applicability in Japan. The US tree includes donor eggs and gestational carriers, those options are not allowed or socially accessible in Japan. This creates a gap in which the DA may not be applicable, demonstrating a failure of cultural and structural transcreation (32). Thus, structural gaps in DAs can emerge when localized restrictions limit clinical applicability for value clarification tasks (32, 37).

4.2. Psycho-social dynamics and systemic support

In Western countries, emotional readiness and communication using DAs are heavily focused on individual autonomy and transparency (59); such models often clash with the family-centered and different privacy and transparency expectations in LMIC as was found in south Asia for example (60). Decision-making about medical conditions in most low- and middle-income countries is a family affair rather than an individual one. For example, caregivers in India may prefer immediate cancer treatment and may actively exclude the adolescent patient from the discussions about fertility (61).

Furthermore, there are cultural taboos surrounding sexual health and reproduction that can restrict open communication on the subject of FP. Young females may be reluctant to talk about fertility or menstrual matters in oncology clinics, particularly when older male family members are present (61). In addition, adolescent patients' parents usually experience emotional shock that prevents them from thinking about anything other than their child's survival. Their choices may create an ethical dilemma by sealing the fate of the reproductive health of the patient who was excluded from the decision (57, 62).

Deliberation techniques in current DAs are further complicated by deep cultural stigmas related to infertility and to FP procedures. In many African cultures, for example, fertility is considered a symbol of strength; infertility might be considered as a stigma which can produce psychosocial consequences such as social rejection, marital problems, or even divorce (58). Therefore, the psychological effects of a cancer diagnosis might be complicated by the pressure of societal norms about the ability to have children, making the emotional readiness assessment difficult and incomplete (58). Moreover, cultural, religious, and legal frameworks usually prohibit third-party options, including egg, sperm, or embryo donation and surrogacy, which eliminates these alternative options from the patient's decision options (46, 57, 63). Access to local FP options may be limited to married heterosexual couples, which excludes single individuals and adolescents (46).

Lastly, the discussion about FP is often constrained by conservative religious and cultural norms that view some reproductive technologies as morally unacceptable (57, 58). For example, some interventions, such as transvaginal oocyte retrieval, in conservative societies, can provoke fears related to loss of virginity, thus adding yet another ethical barrier for young unmarried women as well as their parents (64). DAs designed to support independent evaluation of FP options may not be suitable to handle situations when FP interventions threaten a patient's marriage, religious adherence, or social status (Figure 2) (60).

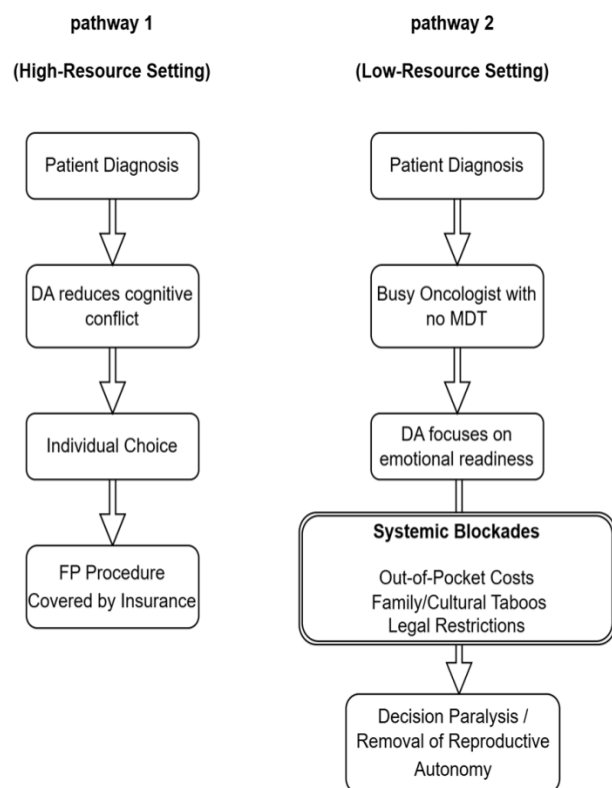


Figure 2. Conceptual pathway comparing the implementation and outcomes of FP of DAs in high-resource versus low-resource healthcare settings

4.3. Implementation, assessment, & outcomes

Needs assessment tools that are integrated within DAs ideally should allow for the systematic identification of baseline psychological distress, safety fears, and specific knowledge gaps before the beginning of cancer treatment (24, 25, 30). In LMIC, the implementation of such assessments is compromised by the pressure on oncology-related institutions and physicians' workloads. Oncologists in resource-limited settings often face high daily patient numbers, and they are under pressure to start lifesaving therapies as soon as possible, especially in cases of patients who usually present with advanced stage malignancies (56, 57).

Oncologists, in consequence, face time constraints during consultations. This will leave them with no sufficient time to perform the required needs assessments or for defining a patient's fertility risks (54, 65). This pressure is worsened by the lack of fertility specialists or multidisciplinary cancer teams (MDT); without these MDTs to do fertility evaluations, the responsibility is often entirely placed on already busy oncologists who might not have the training required to assess a patient's reproductive needs (46, 64). Thus, structured needs assessments are often ignored in favor of immediate initiation of cancer treatment.

To fill this knowledge gap and take some pressure off busy oncologists, the author propose a model that integrates clinical pharmacists into the FP decision-making process. This integration should follow a proper oncofertility training. Being medication experts, clinical pharmacists can give advice to patients about the gonadotoxic risks that come with different chemotherapeutic regimens. With

specific information about how drugs can lead to fertility decline, pharmacists can participate in validation of the decision-making process (66). This changes the role of the pharmacist from a passive dispensing to an active engagement by helping patients use decision aids before they arrive at oncology consultation (66).

While the current evidence for specific pharmacist role in FP counselling is limited to developed countries setting only like Japan (66), Their efficacy in LMIC is not tested. There is a lack of literature that studies the specific role of clinical pharmacist in oncofertility in such settings.

Moreover, DAs may include standardized monitoring tools such as the Decisional Conflict Scale to follow decisional stability and post-treatment regret (26, 27, 46, 64). The evaluation of such DAs in LMIC is highly likely to fail in capturing true patient outcomes, because of structural data gaps.

An important systemic failure is the lack of centralized national registries that follow FP utilization or long-term reproductive outcomes, so that a continuous objective evaluation is considered impossible (46, 64). However, clinically, oncologists at tertiary centers who routinely monitor patients for oncologic survival, rarely have the time or the systemic infrastructure to monitor post-therapy pregnancies, regret, or fertility outcomes (61).

Standardized psychological and decisional monitoring techniques do not apply to the realities of LMIC because they are structurally designed to measure a patient's cognitive conflict when choosing between viable medical options. DAs that measured decisional conflict in LMIC, cannot reflect clinical realities; due to that fact that advanced fertility technologies are either unavailable or inaccessible in a fragmented healthcare system limitations. Patients do not hesitate about which option to choose but rather are deprived of choices altogether (57, 67).

Finally, crowded outpatient departments struggle with the absence of privacy and safe clinical spaces required for patients to talk about their emotional status or about their decisional regret. This leads to underreporting of the psychosocial burden faced by patients (61). Consequently, standardized evaluation scales are likely to fail in capturing the patient's regret when the healthcare infrastructure itself prevents accurate reporting and follow-up.

While DAs represent a clinical efficacy in controlled conditions, they have to be assessed for their real-world use through implementation frameworks. Using the implementation outcomes defined by Proctor et al. (54), like acceptability, adoption, feasibility, and penetration, it is clear that Western DAs may have high acceptability among highly educated groups but limited efficiency in LMIC healthcare systems. The absence of multidisciplinary oncofertility teams is negatively affecting the adoption of these tools; future DAs should be designed with implementation potential as a primary goal instead of just cognitive outcomes.

4.4. Structural redesign of DAs for low-resource settings to address systemic unmet needs

The primary unmet need that is identified in the literature is that current DAs assume a baseline of healthcare infrastructure, and the existence of a supporting financial system, with full access to a range of reproductive technologies (67). In low- and middle-income countries, this foundation does not exist practically. Patients face severe financial troubles due to dependence on out-of-pocket costs and the absence of insurance coverage for FP choices (46,57).

Furthermore, the FP options are often limited to basic cryopreservation with the absence of fertility specialists, while legal, cultural, and religious factors further restrict the available options (46,64,68). Developed countries' DAs, if taken at face value, may present to patients either unaffordable, or legally/religiously prohibited, or simply nonexistent option. For future DAs to be effective in LMIC, they must be structurally redesigned across three main lenses (Figure 3).

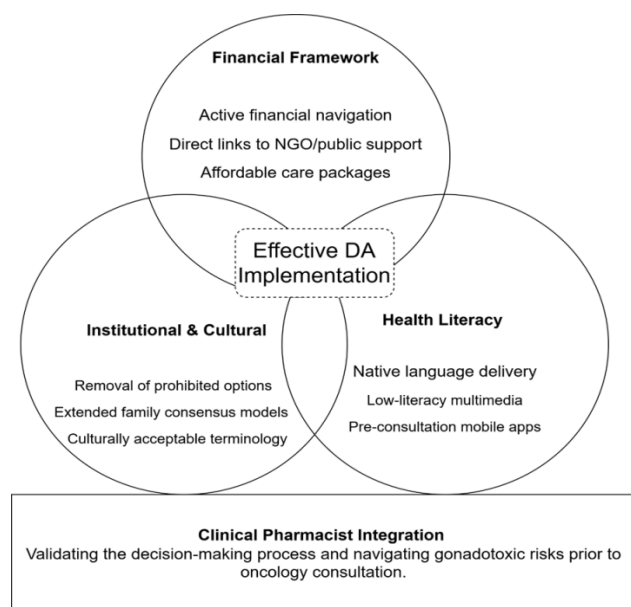


Figure 3. A structural redesign framework for fertility preservation decision aids in LMIC, illustrating the required integration of financial, institutional/cultural, and health literacy lenses supported by clinical pharmacist integration

4.4.1. Financial framework lens

DAs for LMIC should structurally reshape the external support concept by integrating active financial options rather than passive cost breakdown, like developed world DAs. Since out-of-pocket expenses have emerged as a main barrier to FP in LMIC, DAs must directly link patients to localized public sector choices and possibly nongovernmental organization (NGOs) support, and affordable charity care packages (46, 69). If adequate financial frameworks were made actionable within the DAs, they could help close the main gap in patients' decision paralysis and the impractical execution of their reproductive goals due to lack of funds (58,65).

4.4.2. Institutional, legal, and cultural lenses

The specific clinical, legal, and cultural realities of a patient's region must be appropriately reflected in DAs. These tools should be customized to exclude legally/religiously prohibited options such as surrogacy or third-party gamete donation (46,70). Also, they have to take cultural sensitivities of the FP subject into account by using acceptable terminology and allowing extended family members' involvement in collective decision-making processes so that the DAs operate in a way that respects the local culture (55, 58).

4.4.3. Health literacy lens

DAs need to be redesigned using the native language, possibly in a low-literacy multimedia format, to overcome the time constraints during busy oncology consultations and the varying health literacy levels. Outside the clinic, oncofertility information can be delivered by mobile-based applications, pictographs, and culturally adapted educational videos to supply patients with the required information before they see their busy oncologist. (56,65, 68) Successful translation into native languages of platforms like the "Save My Fertility" toolkit has already proven that digital multimedia that are culturally sensitive can enhance patient understanding and reduce physician time pressure while promoting independent thinking in low-resource settings (46).

4.5. Critical appraisal of ODSF applicability in low-resource settings

The Ottawa Decision Support Framework has greatly enhanced FP DAs development, but is profoundly limited for Western-centric models applied to low-resource settings. The ODSF relies mainly on individual autonomy principles that often clash with structural and economic realities in LMIC. In non-Western contexts, extended family involvement represents the norm in decision-making. Thus, ODSF's elements of values clarity should be extended to consensus clarity, where medical decisions must align with family values for quality standards. Also, ODSF's Values Clarification Exercises may become not applicable when structural constraints, such as legal restrictions on surrogacy or local religious norms, restricts certain medical options. The external limitations become the most important variables instead of patients' preferences. Existing DAs might be limited in their implementation potential to the general patient population due to the required advanced health Literacy levels. Linguistic translation is not enough; instead, cultural transcreation is required.

Familial financial stewardship in low-resource settings is the most important determinant of medical viability. The ODSF presumes a baseline of healthcare access; however, fertility preservation requires a long-term familial financial commitment. If the family income cannot support out-of-pocket and storage costs, the medical option is automatically removed from consideration without regards to the individual preference. This economic reality is further complicated by the absent connection between oncology and reproductive endocrinology which result in phantom referrals. In such case actual consultations do not follow referrals because there are no standard pathways. Framework adaptation for DAs must focus on structure practicality over direct translation for DAs to be used effectively in LMIC such as Iraq.

4.6. Limitations

By design, a narrative review, unlike a systematic review, do not use any formal risk-of-bias appraisal tools (71). The review may have some selection bias. Deductive thematic analysis is based on interpretive synthesis rather than quantitative effect sizes; therefore, subjectivity by default is present in data categorization. Another limitation is geographically biased data sources. All the analyzed 11 DAs were developed and evaluated in high-income countries. Therefore, the conclusions about their limited applicability in resource-limited settings is based on

theoretical deduction and comparative analysis against known systemic barriers; there is no empirical evidence that these DA tools have failed in real-world clinical trials. The ODSF used as a priori coding framework is largely based on Western principles of individual autonomy; one limitation of this lens is that it may miss non-Western decision-making paradigms by default.

The review is limited by the primary studies included. Most evaluations of DAs focused on short-term cognitive and psychological outcomes, such as knowledge scores and decisional conflict, because primary literature does not track long-term rates of actual FP use or metrics for real-world clinical implementation, the review cannot assess their true behavioral impact very well.

5. Conclusion

This narrative synthesis was designed to evaluate the qualitative, cultural, and structural challenges that standard statistical metrics and meta-analyses often miss. The literature evaluated through this lens highlights the disparity in an important aspect of oncofertility care, which is the utilization of DAs in developed countries to manage cognitive uncertainty and knowledge deficits. The DAs likely requires adaptation to LMIC due to fundamental differences. Baseline health literacy levels and provider communication barriers in LMIC may restrict the relevance of standard values clarification exercises in FP discussions. Psychosocially, developed countries' tools highlight individual autonomy and emotional transparency, but these concepts are contradicted by the family-oriented, culturally sensitive realities in LMIC, with the added complexity presented by the stigma attached to the individual reproductive status. In terms of implementation and outcomes, typical assessment tools such as the Decisional Conflict Scale do not reflect the real patient experience, where extreme out-of-pocket costs may severely limit access, potentially overriding the cognitive process of choice.

To meet the global quest for equitable access to FP support, DAs must be structurally redesigned from tools of clinical education into comprehensive support systems that provide realistic financial frameworks and respect local legal/religious and cultural boundaries, and operate efficiently within overwhelmed healthcare infrastructures. This review contributes to the discourse on contextual adaptation of DAs by highlighting the structural, rather than only the cognitive, elements of decision-making in low-resource settings.

Conflict of interest

The authors declare that there are no conflicts of interest regarding the publication of this manuscript

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تقييم مدى ملائمة أدوات دعم اتخاذ القرارات المتعلقة بالخصوبة في البلدان ذات الدخل المنخفض والمتوسط: مراجعة إطار عمل أوتاوا

الخلاصة

المقدمة: يُعد الحفاظ على الخصوبة أمرًا بالغ الأهمية لمرضى السرطان في سن الإنجاب، إلا أن تعقيد عملية اتخاذ القرار لا يزال يُمثل تحديًا سريريًا كبيرًا. في حين أن أدوات دعم اتخاذ القرارات للمرضى تُعد أدوات قياسية قائمة على الأدلة تُستخدم في أنظمة الرعاية الصحية المتقدمة للتخفيف من حدة التردد في اتخاذ القرار، إلا أن تطبيقها وفعاليتها لا يزالان غير مدروسين بشكل كافٍ في البلدان ذات الدخل المنخفض والمتوسط. **الهدف:** تستخدم هذه المراجعة السردية إطار عمل أوتاوا لدعم اتخاذ القرارات لتقييم مدى إمكانية تطبيق أدوات دعم اتخاذ القرارات الحالية المتعلقة بالخصوبة في مجال الأورام في البلدان ذات الدخل المنخفض والمتوسط. **المنهجية:** حددت مراجعة منظمة 11 أداة لدعم اتخاذ القرارات، والتي تم تقييمها من خلال التحليل الموضوعي. استُخدم إطار عمل أوتاوا لدعم اتخاذ القرارات لمقارنة عناصر التصميم الغربية بالواقع النظامي في البلدان ذات الدخل المنخفض والمتوسط. **الاستنتاج:** تُعطي برامج دعم القرار الحالية الأولوية للصراع العاطفي الفردي على حساب العوائق النظامية - المالية والسريرية والثقافية - السائدة في البلدان المنخفضة والمتوسطة الدخل. قد يتطلب التنفيذ الفعال تحولًا نحو نماذج توافقية تركز على الأسرة، وتوجيهًا ماليًا فعالًا، ووسائل متعددة مبسطة، بالإضافة إلى دمج الصيادلة السريريين المدربين لسد فجوات معرفية حاسمة في التطبيق السريري في البيئات ذات الموارد المحدودة.

الكلمات المفتاحية: النجاة من السرطان؛ الصيدلة السريرية؛ التفاوتات في الرعاية الصحية؛ الحفاظ على الخصوبة لدى مرضى السرطان.