Barriers to Early Fertility Consultation in Women with PMOS: A Questionnaire-Based Survey

Author: *Rudri Agrawal[1]

1. OASIS Fertility, Reproductive Medicine, Indore, India
*Correspondence to rudri28@gmail.com

Disclosure: The author has declared no conflicts of interest.

Keywords: Care-seeking behaviour, delayed fertility consultation, fertility counselling, infertility, polyendocrine metabolic ovarian syndrome (PMOS).

Citation: EMJ Repro Health. 2026;12[1]:38-39. https://doi.org/10.33590emjreprohealth/528406W1

BACKGROUND AND AIMS

Polyendocrine metabolic ovarian syndrome (PMOS) represents one of the most prevalent causes of anovulatory infertility worldwide; however, a substantial proportion of affected women initiate fertility evaluation only after prolonged delays.[1] Such delays may adversely influence cumulative reproductive potential, prolong exposure to anovulatory cycles, and exacerbate psychological distress.[2,3] Although fertility counselling is a central component of PMOS management, its timing, content, and effectiveness in facilitating appropriate care-seeking behaviour remain poorly defined. In particular, patient-perceived barriers, including misinformation, reassurance-related postponement, and lifestyle-driven delays, have not been systematically quantified, limiting the development of targeted interventions to promote timely fertility assessment.

This study aimed to identify patient-reported barriers contributing to delayed fertility consultation in women with PMOS and to evaluate the association between prior fertility counselling and help-seeking behaviour, psychological burden, and treatment readiness.[4]

MATERIALS AND METHODS

Women who are infertile with PMOS according to current international evidence-based diagnostic guidelines were enrolled following at least one fertility consultation. A structured, pilot-tested questionnaire assessed the interval from pregnancy intention to initial fertility consultation, patient-perceived barriers to early care, sources of fertility-related information, and prior exposure to fertility counselling. Counselling was categorised as structured (evidence-based and timeline-oriented) or non-structured. Delayed consultation (>12 months from pregnancy intent) was the primary outcome. Secondary outcomes included anxiety and treatment readiness. Independent predictors were identified using multivariable logistic regression.

RESULTS

A total of 548 women with PMOS were included in the final analysis. Delayed fertility consultation, defined as presentation more than 12 months after pregnancy intent, was reported by 56.8% of participants (n=311). The most frequently cited patient-perceived barriers to early consultation included reassurance of spontaneous conception despite persistent ovulatory dysfunction (44.9%), prolonged emphasis on weight loss prior to specialist referral (41.6%), misinformation regarding fertility timelines in PMOS (37.8%), and reliance on non-medical information sources such as social media or peer advice (34.1%). Women exposed to structured fertility counselling prior to specialist consultation demonstrated significantly lower odds of delayed care-seeking compared with those receiving non-structured or no counselling (adjusted odds ratio [OR]: 0.52; 95% CI: 0.38–0.71; p<0.001). After adjustment for age, BMI, education level, and duration of infertility, delayed consultation remained

independently associated with higher anxiety scores (adjusted OR: 1.89; 95% CI: 1.36–2.62) and reduced treatment readiness (adjusted OR: 1.67; 95% CI: 1.21–2.29). These associations persisted across sensitivity analyses, suggesting a low probability that the observed findings were attributable to chance alone.

LIMITATIONS

Barriers and counselling exposure were self-reported and subject to recall bias. The cross-sectional design precludes causal inference. Although the large sample size enhances statistical robustness, findings may not be fully generalisable across different healthcare settings.

CONCLUSION

These findings highlight delayed fertility consultation in PMOS as a modifiable health-system issue. Early, structured fertility counselling may reduce misinformation, improve timely care-seeking, alleviate psychological burden, and optimise patient-centred fertility management, with potential implications for guideline implementation and service delivery.

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