Fertility Care Experiences of Omani Women with Poly Cystic Ovarian Syndrome (PCOS): A Qualitative Exploration

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Abstract

Objectives: This study aimed to explore the experiences of fertility healthcare services among Omani women with polycystic ovary syndrome (PCOS) and the extent and nature of emotional support received from healthcare providers (HCPs).

Methods: Twenty Omani women diagnosed with PCOS and infertility were purposively recruited from two fertility clinics in Muscat, Oman. Semi-structured interviews were conducted to elicit women's perspectives on fertility care and their interactions with HCPs. Interviews were audio-recorded, transcribed verbatim, and analysed using the framework approach.

Results: Participants had a mean age of 28 years (range: 19–35) and an average infertility duration of 4 years (range: 1–12). Three overarching themes were identified: (1) communication with HCPs, (2) provision of emotional support, and (3) experiences with fertility care services. Participants consistently reported inadequate information regarding the causes of infertility and limited explanations of treatment plans. Barriers to effective communication included brief consultation times, language differences, and discomfort interacting with male physicians. In contrast, Omani nurses were perceived as more empathetic and culturally attuned, although their clinical roles were restricted mainly to managing patients through appointment and testing schedules. Despite the psychological distress associated with infertility and its treatment, participants reported the absence of formal emotional support during consultations. Some attributed this to cultural sensitivities, such as one's privacy or stigma related to fertility in Omani culture, and beliefs that addressing emotional well-being was beyond the professional remit of physicians. Issues around lack of continuity of care, perceived provider inexperience, and inadequate facilities seemed to compound patient dissatisfaction further.

Conclusions: Omani women with PCOS and infertility express significant unmet needs in both informational and emotional aspects of fertility care. Communication barriers and a lack of integrated psychological support reflect systemic, professional, and sociocultural constraints. These findings underscore the importance of incorporating culturally sensitive, patient-centred emotional support as a standard component of fertility services in Oman.

Keywords: Infertility; Oman; Polycystic Ovary Syndrome; Management; Counselling; Qualitative.

Introduction

Infertility, irrespective of its underlying etiology, is widely recognized as a condition that extends beyond biological dysfunction, exerting significant psychosocial, emotional, and relational strain, particularly on women.[1] The pursuit of infertility treatment often exacerbates this emotional burden, with women consistently shown to experience greater psychological distress related to infertility and its treatment compared to men.[2,3] Polycystic ovary syndrome (PCOS), the most prevalent endocrine disorder affecting reproductive-aged women, is a leading cause of anovulatory infertility,[4] and thus a substantial proportion of women seeking fertility treatment are diagnosed with PCOS.[5]

Although advancements in assistive reproductive technologies have shifted the focus of fertility care toward clinical outcomes,[6] patient-centred care, encompassing emotional support, access, continuity, communication, and respect for individual preferences, remains underemphasized in clinical practice.[7] Research into patients' experiences with fertility services has highlighted the relevance of both system-level and interpersonal factors in shaping satisfaction with care.[6,8] System-level components include information provision, service accessibility, care coordination, and physical comfort. Interpersonal dimensions, which are often unmet patient needs, relate to provider attitudes, communication quality, privacy, and emotional support.[9]

A qualitative study using focus group discussions among 20 women in Ghana with infertility reported that women expect to receive holistic healthcare that will foster their well-being and treatment satisfaction. They expect health assessments to be done regularly and outline various healthcare expectations, which include psychological, educational, spiritual, social, and financial expectations.[10]

Other studies have shown that even among financially stable patients, the primary reasons for discontinuing infertility treatment are the physical and emotional burdens associated with it.[11,12] These findings reinforce the critical need for comprehensive, supportive fertility care that addresses the psychological dimensions of the treatment journey. In a qualitative study in Denmark, Schmid et al. reported widespread dissatisfaction among couples undergoing infertility treatment, largely due to the lack of psychological counselling and insufficient information about medical procedures.[13]

In Oman, Polycystic ovarian syndrome (PCOS) is the most common cause of infertility among women seeking fertility treatment.[14] Cultural expectations surrounding fertility and childbearing place immense pressure on women to conceive, contributing to the stigmatization of infertility.[15] This societal burden, coupled with the medical challenges of PCOS, suggests that Omani women may face unique psychological stressors that are not routinely acknowledged within the healthcare system. The extent to which their emotional needs are recognized or addressed during fertility care remains unclear.

This study is an extension of other studies by the authors on PCOS in Oman.[16-18] This study to explore the experiences of Omani women with PCOS undergoing infertility treatment, focusing on their interactions with healthcare providers (HCPs), perceived communication barriers, and the extent of emotional support received. By situating these experiences within the broader sociocultural and health system context, this study seeks to inform culturally sensitive, patient-centred improvements in fertility care.

Methods

This qualitative study was conducted among Omani women of reproductive age (15–49 years) diagnosed with PCOS as the cause of primary or secondary infertility. In this study only women with secondary infertility with no live births were included. Participants were recruited from infertility clinics at two tertiary hospitals in Muscat, Oman, Sultan Qaboos University Hospital (SQUH) and the Royal Hospital (RH), from January to May 2018. Ethical approval was obtained from the Sultan Qaboos University Medical Ethics Committee for SQUH and from the Ministry of Health's Research and Ethical Review and Approval Committee for RH.

Purposive sampling was used to ensure diversity in age, infertility duration, and time since diagnosis. Eligible participants were identified from clinic appointment lists approximately one week in advance.[19] Potential participants were contacted via telephone, briefed on the study, and invited to participate. The study information sheet was either emailed in advance or provided in person on the day of the interview.

Twenty-three women were approached, three declined: two due to time constraints and one who was unwilling to participate. The obtained data reached saturation after completing 20 interviews, where no new themes were identified following preliminary analysis; therefore, recruitment of participants ceased.

A semi-structured interview guide was developed based on a review of relevant literature and study objectives to facilitate in-depth exploration of women's experiences. (20) The guide included open-ended questions covering satisfaction with fertility services, communication during consultations, and the presence or absence of emotional support. Basic demographic and clinical data were also collected.

The lead researcher conducted interviews, face-to-face in private rooms within the fertility clinics, either before or after participants' scheduled appointments. Written informed consent was obtained. Interviews were audio-recorded and guided by participants' responses to facilitate a participant-led approach.[20] All interviews were conducted by the lead researcher in Arabic.

Audio recordings were transcribed and translated into English by a professional translator. The lead researcher (HS) reviewed all transcripts for accuracy and removed identifying information. Data were analyzed using the framework approach.[21] and NVivo 11 was used to store data and manage analysis.

Initial open coding was applied inductively to identify patterns from the data. Codes were then refined into a working analytical framework. To ensure analytical rigor, a subset of transcripts was independently coded by a second researcher (MB), and discrepancies were resolved through discussion.[22] The framework was iteratively applied to all transcripts, with new codes added as necessary. Data were then charted into matrices by theme and subtheme, facilitating synthesis and cross-case comparison**.**

Results

The average age of participants was 28 years (range 19 to 35 years). Most women were from the region of Muscat (n=7, 35%). Half of the women were in employment, and most had a high school education or a higher educational degree (n=17, 85%). The average number of years participants reported trying to conceive was 4 years (range 1 to 12 years). Five (25%) participants had conceived previously, but these ended in miscarriage.

Analysis of participants' narratives yielded three overarching themes: (1) communication with healthcare providers (HCPs), (2) provision of emotional support, and (3) experiences with fertility care services. Subthemes illustrate the key challenges women faced during their fertility journey. (Table 1)

Table 1: Themes and sub-themes.

Main Theme	**Sub-Themes**
1. Communication with HCPs	1.1 Lack of Information and Clarity on Treatment
	1.1.1 Language barrier
	1.1.2 Short consultation time
	1.2 Role of Nurses in Communication
2. The provision of emotional support	2.1 Absence of Formal Psychological Support
	2.2 The need for emotional support
	2.2.1 Social Pressure and the Desire to Vent
	2.2.2 Emotional Burden of Treatment
	2.2.3 Positive Impacts of Emotional Support
3. Experiences with Fertility Care Services	3.1 Discontinuity of Care
	3.2 Perceived Inexperience of Staff
	3.3 Structural and Logistical Constraints

Theme 1: Communication with Healthcare Providers

1.1 Lack of Information and Clarity on Treatment

Participants frequently described inadequate explanations from HCPs regarding their medical condition, diagnosis, and treatment procedures. Women reported confusion about the nature of PCOS and its relevance to their infertility.

"It was all about asking me some questions and I will answer, but they didn't show any further response... they only gave me the plan and they will start telling me to come and go, come and go... they didn't explain the reasons behind the pregnancy delay nor they gave you any models to show me." (31 yrs, 10 years of infertility)

As a result, many resorted to external sources such as the internet or peers, which sometimes led to misinformation. The lack of printed educational materials compounded this concern:

“It is the physician who tells me about it and explains to me orally, which is difficult to understand at times, and she doesn't give me any leaflet for further information.” (27 yrs, 4 years of infertility)

1.1.1 Language Barriers

Several participants highlighted difficulties in understanding physicians who did not speak Arabic, noting reliance on nurses for translation. However, nurses were not always available, and their presence was not always comfortable for patients due to privacy issues. This language gap limited patients’ ability to fully understand medical information, ask questions freely, and engage in shared decision-making. As a result, some participants reported feeling less informed, more anxious, and less confident in their care, potentially impacting adherence to treatment plans and satisfaction with services.

“I was going to talk to the physician about many things but I felt she will not understand me well because she is a non-Arabic speaker and my English is not that good, so I didn't speak to her and she was in a hurry and didn't tell me about the treatment I use....she only wrote my medications on the computer and told me to take them again.” (31 yrs. 10 years of infertility)

1.1.2 Short Consultation Time

Time constraints during consultations were noted as a barrier to thorough communication and relationship-building with physicians. Participants attributed this to clinic overcrowding and the high patient load. They were also disappointed that they were not given enough time during the consultation, especially given the long wait to obtain an appointment in the clinic in the first place.

“I think because they are very busy and has a load of patients...so there is no time to discuss anything else, I think they might feel that it is not important to ask about the feelings and it doesn’t cross their mind.” (28 yrs. 3 years of infertility)

1.2 Role of Nurses in Communication

Participants generally reported feeling more at ease communicating with Omani nurses, whom they perceived as culturally sensitive, respectful of local norms, emotionally supportive, and more frequently encountered compared to physicians. Their frequent presence during routine procedures made them more accessible than physicians, fostering familiarity and trust. This accessibility encouraged patients to seek clarification on certain topics, discuss non-clinical concerns, and share sensitive personal information that they might withhold from other HCPs.

However, participants also noted that nurses’ involvement in clinical decision-making and provision of medical information was limited. As a result, while nurses served as a valued emotional and cultural bridge, their restricted authority meant that important medical questions and decisions still required physician input. This often led to delays in receiving comprehensive answers, increased dependence on physicians for critical discussions, and occasional frustration when physicians were not readily available.

“The physician is the one who gave me the appointment and called me on the phone... the physician is the one who does everything.” (27 yrs, 5 years of infertility)

Theme 2: The Provision of Emotional Support

2.1 Absence of Formal Psychological Support

While participants acknowledged the kindness, politeness, and occasional words of encouragement offered by HCPs, they overwhelmingly reported that their emotional well-being was neither explicitly assessed nor systematically addressed during consultations. Supportive gestures were often perceived as incidental rather than an integral part of care. Most participants viewed physicians’ roles as narrowly focused on diagnosing and treating the biological causes of infertility, with little engagement in discussing the psychological or social dimensions of the experience.

This biomedical emphasis left many participants feeling that an important aspect of their care was overlooked, particularly given the emotional distress, anxiety, and social pressures commonly associated with infertility in their cultural context.

"No... no one asked me that question... no one asked me about any feelings regarding the pregnancy delay... it might be because of the sensitivity of the topic itself, some women don't like to be asked such questions." (27 yrs, 2 years of infertility)

Some participants referred to certain HCPs who routinely checked on a patient's emotional well-being. This led to the conclusion that offering emotional support to patients in fertility clinics is a HCP's personal choice, and it depends largely on their personality and their style in treating their patients.

"I think it is up to the physician...and their personality to check on patients feelings." (31 yrs. 10 years of infertility)

A participant shared her experience with a physician who she felt always showed care for her and asked about her emotions each time they met:

"I like her communication style and I felt she knows my situation and understands my feelings and trying to reassure me...it is very rare to meet a physician with this style that cares about your feelings." (24 yrs. 4 years of infertility).

2.2 Need for Emotional Support

Several participants believed that HCPs avoided starting discussions about their emotional well-being as it may be considered disrespectful to them. These women thought it was embarrassing to be asked about their feelings towards pregnancy delay by their treating doctors because it is a sensitive issue culturally.

"No...no one asked me that question...no one asked me about any feelings regarding the pregnancy delay...it might be because of the sensitivity of the topic itself, some women don't like to be asked such questions." (27 yrs. 2 years of infertility)

2.2.1 Social Pressure and the Desire to Vent

Participants expressed a need for psychological support to help them cope with the social pressure, stigma, and emotional distress arising from infertility itself, the repeated cycles of treatment, and the uncertainty of outcomes. Several described feeling burdened by community expectations to conceive soon after marriage, the implicit or explicit blame directed at women in cases of childlessness, and the emotional strain of discussing their situation with relatives or peers.

Many participants indicated they would be willing to share their feelings and personal struggles, but only if the physician initiated the conversation. As a result, opportunities for early identification of psychological distress were often missed, leaving some to navigate their emotional challenges in isolation or rely on informal support from family or friends, which was reported to be varied in quality and understanding.

"I don't like to engage in such discussions, but if the physician you are dealing with will give you time and attention and talk to you, I will feel that I will be more encouraged to talk with her about my daily struggles and treatment stress and discuss my emotions." (22 yrs, 7 years of infertility)

2.2.2 Emotional Burden of Treatment

Several participants expressed the tremendous burden they felt due to the extensive fertility treatment they received, and reported feeling psychologically drained. These participants went on to discuss that they struggled to accept the large numbers of medications, injections, and medical tests needed to follow their ovulation response. Moreover, the frequent hospital trips and experiencing strong side effects from hormonal treatments affected their mood, which was compounded by failed treatment cycles.

"They gave a chance to use some stimulators such as clomid and I continued to use it for several months and of course, nothing happened. Then they took a step higher and told us that they want to start the IUI and for the IUI it was the same thing, in the beginning, we have entirely refused but oh God, the situation we had pushed us to start this experience and I have done the IUI. I have tried 3 times, and this was, of course, after the failed attempts using pills and injections, and they all were failed attempts. Then, I mean, I had an upset and frustrated feeling and was thinking seriously about quitting." (31 yrs. 10 years of infertility)

2.2.3 Positive Impacts of Emotional Support

Participants who had access to psychological support within fertility clinics consistently described feelings of comfort, satisfaction, and renewed motivation in their treatment journeys. Many emphasized that emotional support was not merely helpful but essential in helping them cope with the immense psychological, social, and treatment toll of infertility. Women who received this support reported feeling more emotionally stable, resilient, and optimistic about continuing treatment, even in the face of setbacks.

“I can feel that Dr. X is more understanding of my feelings; she allows me to speak to her about certain issues when I’m frustrated, she will encourage me and motivate me, and she spends enough time with me for me to overcome my stress about the treatment.” (24 yrs, 4 years of infertility)

Participants consistently emphasized how seemingly small gestures of emotional support, particularly verbal encouragement during clinical consultations, had a disproportionately positive impact on their psychological well-being and treatment perseverance. Many described how brief but intentional affirmations from healthcare providers served as emotional lifelines during moments of despair.

“One day I came to take some injections and one of the nurses said "all the best" when she injected me with the dose, I felt very happy when she said it...I mean that they are very simple words, but they gave me so much hope.”(34 yrs. 4 years of infertility)

Theme 3: Experiences with Fertility Care Services

3.1 Discontinuity of Care

Participants expressed frustration with frequent physician turnover during their treatment journeys, describing how disrupted continuity of care compounded their emotional and logistical burdens. This systemic issue forced patients to repeatedly mention medical histories with unfamiliar providers, exacerbating their distress and diminishing available time for actual treatment discussions.

“You know the main problem here is that every time I attend the clinic, I see a different doctor, and I don't see the same one from my first appointment, and each one of them will ask me about my story and my medical history. It annoys me that I see a different doctor each time... It’s a waste of time.” (25 yrs, 2 years of infertility)

Participants expressed safety concerns regarding inconsistent physician follow-up, noting that frequent provider changes increased the risk of medical errors**.** Furthermore, Participants identified inconsistent healthcare providers as a significant relational barrier hindering patient-doctor bonding.

3.2 Perceived Inexperience of Staff

Participants expressed concern about the limited expertise of junior doctors, particularly when considering a critical structural barrier identified in the current fertility care model is the insufficient number of qualified specialists relative to patient volume, compounded by variable competency levels among treating staff. Participants reported concerns about the limited clinical experience of many frontline providers, particularly junior doctors who often lacked the expertise to independently manage complex fertility cases without consulting senior colleagues. They deferred decisions to senior colleagues, which affected patient confidence.

“Most of them don't have the proper experience to the point that she asked for some help from a senior physician, and this disturbs the consultation and our confidence in them.” (35 yrs, 10 years of infertility)

Several participants voiced significant concerns regarding the suboptimal dietary guidance provided within fertility clinics, particularly for women managing PCOS-related weight challenges. These accounts revealed a troubling pattern of generic, non-individualized nutritional advice that failed to address their specific metabolic needs, ultimately undermining both clinical outcomes and patient motivation.

3.3 Structural and Logistical Constraints

Many participants mentioned limited access to clinic services, such as scan rooms and finding slots for intra-uterine insemination (IUI) procedures and other radiological procedures, due to the high volume of patients attending the clinic. Doctors usually get rushed to empty the scan room for the next patient because the same rooms are used for both pregnant women and those with infertility.

“They can add more scan rooms and devices because you need to wait too long for your turn, and when it is your turn, you will feel like she is rushing the procedure, and I feel they want to finish it quickly.” (24 yrs, 4 years of infertility)

Several participants raised significant concerns regarding the lack of appropriate facilities for semen collection, highlighting a critical gap in patient-centered care for male partners. The current infrastructure forces men to provide samples under suboptimal conditions that fail to meet basic privacy and hygiene standards, creating unnecessary psychological and practical barriers to treatment.

A few participants mentioned there was a need to separate pregnant women from those with infertility in the waiting area of the clinic. In their opinion, it is not suitable to mix them up as it hurts their feelings and makes them irritated to sit there and watch and hear pregnant women talking to each other about their pregnancy while they are following up for infertility.

Discussion

This qualitative study reveals a pronounced gap in the emotional and psychosocial support provided to Omani women undergoing infertility treatment, highlighting that these dimensions of care are frequently overshadowed by biomedical priorities. Participants described limited attention to their emotional well-being during consultations, with little assessment or discussion of psychological needs despite evident distress. Key unmet needs included emotional validation, coping support for treatment-related stress, guidance in navigating societal pressures, and consistent, clear communication to aid decision-making. Barriers to holistic care were attributed to time constraints, high patient volumes, predominant clinical focus on organic infertility causes, and cultural sensitivities surrounding emotional expression. Nonetheless, women expressed a strong desire to be heard, understood, and supported throughout their fertility journey. When emotional care was offered - typically by nurses- it occurred informally rather than as part of a structured service. Women with polycystic ovary syndrome (PCOS) reported particular vulnerability due to weight-related stigma, reinforcing the need for a more integrated, empathetic, and culturally sensitive model of infertility care.

The psychological burden of infertility, intensified by repeated treatment failures and social pressures, was consistently voiced by participants. The distress experienced by these women aligns with previous research that equates the psychological toll of infertility with that of life-threatening illnesses such as cancer.[23-25] Despite established evidence on the mental health impact of infertility and the benefits of psychological support,[26-28] such support was noticeably absent in clinical encounters for these participants. Participants attributed this to time limitations, a focus on biomedical management, and cultural discomfort with discussing emotional issues; findings echoed in other international qualitative studies,[9,29,30] suggesting experiences of women are not too dissimilar but that provision of support may be related to cultural and societal factors, for the Omani and Middle Eastern context. Consistent with global findings,[31-33] participants believed psychological support could mitigate emotional distress and potentially improve treatment outcomes. For women with PCOS, the dual burden of infertility and weight challenges further underscores the need for multidisciplinary care, including dietary and psychological services.

Nonetheless, there is an urgent need to integrate mental health services into fertility care in the Omani context, to screen and assess these common disorders among this sample and offer timely intervention. The nature and means to address this gap needs careful consideration in relation to the cultural context.

Participants trusted physicians for medical expertise but felt a stronger emotional connection with nurses, particularly Omani nationals, due to more frequent interactions and perceived cultural familiarity. However, nurses were perceived to have limited roles, often confined to procedural tasks. Similar findings have been reported among Kuwaiti women undergoing IVF, where limited counselling roles accompanied a stronger rapport with nurses.[34] Literature supports enhanced patient satisfaction and engagement when fertility nurses play a more active role in education and support.[35,36] This suggests that the nursing profession should consider establishing fertility nursing as a sub-specialty, incorporating insights from psychology to better equip nurses in these settings to deliver more structured psychological care. Unfortunately, nurses in fertility clinics in Oman perform their basic nursing tasks like checking and recording vital signs and weight, giving injections and preparing them for examination or investigations. These were similar to the primary roles of direct patient care reported by 73% of infertility nurses reported in the literature review.[35].

Participants also expressed dissatisfaction with fragmented physician care, language barriers with expatriate doctors, and poor communication, issues that hinder treatment continuity and increase the risk of error.[37–39] Recommendations included having a lead physician assigned for each case and improving clinic infrastructure to enhance privacy, such as providing dedicated spaces for semen collection and separating waiting areas for pregnant and infertile patients. These issues have been similarly noted in other qualitative studies.[8].

Alongside medical and fertility interventions, patients voiced the need for incorporating tailored dietary guidance to help manage insulin resistance and support hormonal balance, both of which are crucial in improving reproductive outcomes. An integrated care model that combines medical, nutritional, and mental health support can significantly enhance both physical and emotional well-being, ultimately improving quality of life and fertility outcomes for these patients especially for women with PCOS who struggle with weight loss issues as an additional risk factor to fertility journey.[40]

This is the first qualitative study in Oman to explore women's lived experiences of fertility care, including their emotional and psychosocial needs. The use of semi-structured face-to-face interviews and purposive sampling across two government fertility centers allowed for a diverse representation of perspectives.[41,42] However, limiting participants to those with PCOS and attending specialized centers may restrict the transferability of the findings, though our data reached saturation. Finally, despite the study being conducted in 2018/2019, the findings are still believed to be invaluable and fill a gap that still exists around this topic in the literature, especially given that the current services in these centres have been unchanged since then, with findings reflecting similarities to regional and international perceptions of fertility care. Future studies could expand to include a broader range of infertility etiologies among women and male factor infertility and employ mixed-methods approaches with validated psychological measures to complement qualitative findings.

Conclusion

Omani women undergoing infertility treatment face considerable emotional strain, yet their psychological needs are not adequately addressed in current fertility care settings. While they value the publicly funded services, they advocate for the integration of emotional support as a formal component of care. Delegating this responsibility to trained psychologists could overcome existing barriers faced by overburdened physicians and culturally constrained consultations. Tailored, multidisciplinary care, particularly for women with PCOS, can foster better treatment adherence, emotional resilience, and satisfaction with fertility services. Future research should examine the cost-effectiveness and acceptability of embedding psychological support into standard fertility care pathways in Oman.

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