Pre-Conception Counselling: Preparing the Biological "Soil" for a Healthy Pregnancy

A Complete Modern and Unani Guide to Fertility Preparation, Nutrition, Lifestyle, Environment, Emotional Health and Responsible Integrative Care

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Introduction

When a couple tells me, "Doctor, we are planning a baby—what should we do before trying?" I consider this one of the most valuable opportunities in reproductive medicine.

The best time to think about the health of a future pregnancy is **before the pregnancy test becomes positive**.

Modern medicine calls this **preconception or prepregnancy counselling**. Its purpose is not simply to increase the chance of conception. It is to prepare both partners for pregnancy by identifying health problems, reviewing medicines, improving modifiable lifestyle factors, addressing fertility risks, correcting nutritional deficiencies and determining whether any investigation is already necessary.

I often explain preconception health through a simple agricultural analogy.

The sperm and egg are like the **seed**. The uterus and reproductive tract provide part of the **soil**. Hormones, nutrition, metabolism, sleep, sexual health, general medical health and the emotional environment influence the wider conditions in which conception and pregnancy occur.

This metaphor is also compatible with the holistic philosophy of **Unani medicine**, which does not consider reproduction in isolation from the overall state of the body. Through concepts such as *Mizaj*, *Asbab-e-Sitta Zarooriya*, *Ilaj-bil-Ghiza*, *Hifz-e-Sehat* and individualized constitutional care, Unani medicine has traditionally emphasized preparing the whole person rather than focusing only on one reproductive organ.

However, I use the “soil” comparison as an educational analogy—not as a reason to replace reproductive diagnosis with vague concepts such as “toxins.”

The World Health Organization's first global infertility guideline, published in November 2025, emphasizes fertility education, healthy diet, physical activity, tobacco cessation, diagnosis of male and female fertility factors, progressive treatment and psychosocial support. These principles provide an excellent modern foundation for responsible integrative preconception care.

At **Saira Health Care**, my approach is therefore straightforward:

Prepare health before conception, identify genuine reproductive barriers early, use Unani principles where they can safely support the patient, and never allow complementary treatment to delay a necessary fertility intervention.

What Is Pre-Conception Counselling?

Pre-conception counselling is a clinical process that takes place before pregnancy.

ACOG describes the goal as reducing health risks for the woman, fetus and newborn by optimizing health, addressing modifiable risk factors and providing appropriate education before conception. Important areas include chronic disease, medications, nutritional supplements, herbal products, vaccinations, substance use, weight, genetic history and infection risk.

It is therefore much more than telling a couple to eat healthy food and remain positive.

A proper consultation may identify diabetes that needs better control, a medication unsafe for pregnancy, untreated thyroid disease, smoking, a previous pelvic infection, irregular ovulation, use of testosterone by the male partner, significant obesity, nutritional deficiency, genetic risk or a fertility problem that should not be left untreated.

Sometimes preconception counselling prevents complications.

Sometimes it improves the way a couple attempts natural conception.

And sometimes it reveals that the couple needs a fertility evaluation rather than another several months of trying blindly.

The “Soil” of Conception: A Useful Analogy With Important Limits

I like the idea of preparing the biological “soil,” but it should be understood correctly.

A healthy metabolic and nutritional environment can support reproduction.

Good sleep, appropriate exercise, freedom from tobacco exposure, control of diabetes, healthy sexual function and an adequate diet all matter.

But the analogy has limitations.

Good soil cannot replace a missing seed.

Likewise, lifestyle optimization cannot reopen every severely scarred fallopian tube, correct every genetic sperm-production disorder, restore an absent uterus or completely reverse age-related ovarian decline.

This is where modern reproductive diagnostics become essential.

Preconception optimization should improve health around fertility—not be used to deny the existence of structural infertility.

Pre-Conception Care Is for Both Partners

Although the woman carries the pregnancy, pregnancy planning should involve both partners.

Male reproductive health matters from the beginning.

Smoking, severe obesity, anabolic steroids, external testosterone, certain medicines, uncontrolled medical conditions, reproductive-tract disease and significant sexual dysfunction can affect the male contribution to conception.

ACOG specifically recommends asking male partners about androgen use because external testosterone can suppress sperm production and cause azoospermia.

When a couple already meets criteria for infertility, evaluating only the woman is incomplete care.

WHO recognizes abnormalities in both female and male reproductive systems as causes of infertility.

At Saira Health Care, I therefore counsel **the couple**, not only the woman.

When Does Normal Pregnancy Planning Become Infertility Evaluation?

WHO defines infertility as failure to achieve pregnancy after **12 months or more of regular unprotected intercourse**. Approximately **one in six people of reproductive age experience infertility during their lifetime**.

However, couples should not always wait exactly one year.

ASRM recommends considering investigation after approximately **six months when the woman is 35 years or older**, and earlier when age is more advanced or there is already a condition associated with infertility.

This distinction is essential.

A healthy 25-year-old couple who have been trying for two months generally do not need an aggressive fertility protocol.

A 39-year-old woman with irregular cycles should not spend a year on a “fertility cleanse” before being properly assessed.

Time itself is an important fertility factor.

A Pre-Conception Medical Review Should Come Before “Detox”

The internet increasingly promotes a three-month fertility detox before conception.

I do not consider routine detoxification a requirement for every couple.

The first step should be a **medical and reproductive review**.

A woman's history should include age, menstrual regularity, previous pregnancies, miscarriage or ectopic pregnancy, pelvic infection, endometriosis, reproductive surgery and relevant chronic disease.

The male partner's history should include previous fertility, testicular disease or surgery, sexual function, medications, anabolic steroids or testosterone, smoking and major medical conditions.

Both partners should have their current medicines and supplements reviewed.

ACOG specifically advises reviewing prescription drugs, over-the-counter medicines, vitamins, supplements and herbal products because all may influence reproduction or pregnancy.

This kind of assessment is more valuable than beginning a generic cleanse without knowing whether the couple has a biological fertility problem.

Chronic Diseases Should Be Optimized Before Pregnancy

Pregnancy places substantial physiological demands on the mother's body.

Diabetes, hypertension, thyroid disease, epilepsy, psychiatric illness, kidney disease, significant obesity and other chronic conditions may affect pregnancy or require changes in treatment.

ACOG recommends optimizing important chronic diseases before conception whenever possible.

This is one of the clearest examples of what preparing the “soil” should actually mean.

If a woman has poorly controlled diabetes, improving glycaemic control before conception is far more meaningful than a commercial detox drink.

If thyroid disease is genuinely present, it should be appropriately managed.

If a medicine has important pregnancy risks, an alternative may sometimes be planned before conception rather than after pregnancy occurs.

Folic Acid: One of the Most Important Pre-Conception Interventions

For most women planning pregnancy, **400 micrograms of folic acid daily** is recommended to reduce the risk of neural-tube defects in the future baby. ACOG recommends 400 micrograms for average-risk women, with larger prescribed doses in certain high-risk circumstances.

Folic acid is not a fertility medicine.

It does not stimulate ovulation or guarantee conception.

It prepares for healthier early fetal development if pregnancy occurs.

An important modern clarification concerns **MTHFR variants**.

Some fertility programmes tell women with common MTHFR variants that they cannot process folic acid and must use methylfolate instead. CDC's updated July 2026 guidance states that this is incorrect: people with common MTHFR variants can process folic acid, and 400 micrograms daily remains effective for increasing folate levels and preventing neural-tube defects.

This is a good example of why integrative medicine should follow current evidence rather than internet trends.

Nutrition Before Pregnancy: No Single “Fertility Diet”

Nutrition matters greatly for general health and metabolic wellbeing.

But there is no single scientifically established fertility diet that guarantees conception.

ASRM concludes that evidence is insufficient to show that one particular dietary pattern or macronutrient combination reliably improves natural fertility in otherwise healthy women. A

healthy lifestyle and nutritious diet are nevertheless recommended for their broader health benefits.

My approach is therefore not to prescribe one identical fertility menu to everyone.

A woman with insulin-resistant PCOS may need a different plan from an underweight woman with hypothalamic menstrual disturbance.

A vegetarian may require particular attention to certain nutrients.

Someone with diabetes needs a different nutritional strategy from someone without metabolic disease.

Food should be used to **correct nutritional and metabolic problems**, not as magical fertility treatment.

The Unani Concept of Ilaj-bil-Ghiza

Dietotherapy, or **Ilaj-bil-Ghiza**, is one of the formally recognized treatment approaches in Unani medicine.

CCRUM describes four major therapeutic approaches within Unani medicine: *Ilaj-bil-Tadbir* or regimenal therapy, *Ilaj-bil-Ghiza* or dietotherapy, *Ilaj-bil-Dawa* or pharmacotherapy, and *Ilaj-bil-Yad* or surgery.

This makes diet an authentic part of Unani clinical practice.

In preconception care, I consider this particularly useful because diet can be individualized according to the patient's nutritional status, metabolism, digestive tolerance and traditional *Mizaj* assessment.

But individualization should not become unnecessary restriction.

There is no evidence that every woman trying to conceive must stop yoghurt, cucumber, raw salad, lentils or other nutritious foods simply because they are considered “cold” in a traditional classification.

Likewise, warming spices are foods—not proven ovulation medicines.

The diet must remain **nutritionally complete and medically appropriate**.

Understanding the Unani Concept of Mizaj

Mizaj, or temperament, is central to Unani medicine.

Traditional Unani physiology describes variations through combinations of heat, coldness, moisture and dryness. Health reflects an appropriate individual equilibrium; disease may involve *Su-e-Mizaj*, or disturbance of temperament.

In reproductive medicine, these concepts have historically been applied to the uterus, testes and the patient's overall constitution.

I find the individualized philosophy valuable.

But I explain clearly to patients that traditional terms are **not laboratory diagnoses**.

A “cold” reproductive temperament is not scientifically identical to hypothyroidism.

A “moist” constitution is not the same diagnosis as PCOS.

A “dry uterus” is not a modern diagnosis of thin endometrium.

A *Balghami* temperament does not automatically prove insulin resistance.

Unani and biomedical medicine are different explanatory frameworks. Integration becomes more credible when we respect that distinction rather than pretending every traditional concept has a one-to-one modern laboratory equivalent.

The “Cold Uterus”: How Should We Understand It Today?

The concept of **Su-e-Mizaj Barid Raham**, often translated as a cold uterine temperament, is well recognized within traditional Unani gynecological thinking.

Historically, it may be associated with delayed cycles, reduced reproductive activity or symptoms interpreted as excessive coldness.

It can remain useful as a traditional constitutional description.

However, current evidence does not establish that air conditioning, drinking cold water, eating cucumber or consuming yoghurt causes infertility by literally cooling the uterus.

Nor should low progesterone, thin endometrium, hypothyroidism and poor pelvic blood flow all be labelled one disease called “cold uterus.”

Each of those modern conditions has its own physiology and diagnostic criteria.

If a woman has irregular menstruation, investigate the reason.

If the endometrium appears persistently thin during fertility treatment, evaluate it properly.

If thyroid disease is suspected, test thyroid function.

Traditional terminology should guide individualized supportive care, not replace diagnosis.

Thyroid Function: Avoiding the "Perfect Fertility TSH" Myth

Another commonly repeated claim is that every woman trying to conceive must have TSH below 2.5 mIU/L.

The evidence is more nuanced.

ASRM's 2024 guideline concluded that TSH levels between approximately **2.5 and 4.0 mIU/L are not associated with increased miscarriage risk** and that routine levothyroxine treatment of subclinical hypothyroidism has not been proven to improve clinical pregnancy or live-birth outcomes.

This does not mean true thyroid disease should be ignored.

It means one laboratory number should not automatically become a universal fertility diagnosis.

Known overt hypothyroidism requires appropriate treatment.

But giving thyroid medicine to every woman with TSH above 2.5 in an attempt to "optimize fertility" is not supported by current evidence.

The Liver, Hormone Metabolism and the Myth of the Mandatory Liver Cleanse

Unani medicine traditionally places great importance on the **Kabid**, or liver, within nutrition, humoral formation and systemic health.

Modern physiology also confirms that the liver metabolizes many hormones and chemicals.

But these two observations should not be stretched into the claim that most infertility results from a "sluggish liver" requiring detoxification.

Terms such as "estrogen dominance," "blocked detox pathways" and "liver congestion" are commonly used in wellness marketing but are not specific diagnoses explaining most infertility.

There is no established evidence that a routine liver cleanse improves natural pregnancy or live-birth rates.

Supporting liver health means something much simpler and safer: avoid excessive alcohol, maintain healthy weight, manage metabolic disease, use medicines responsibly and evaluate genuine liver disease when indicated.

Istifragh and Tanqiya in Unani Medicine

Istifragh and **Tanqiya** are authentic classical Unani therapeutic principles involving evacuation or elimination according to the humoral diagnosis.

Unani medicine also contains the traditional concepts of *Munzij*—preparing abnormal humoral material—and *Mushil*—facilitating evacuation.

These concepts should be preserved accurately as **Unani theory**.

What they should not become is a biomedical claim that a purgative has removed endocrine-disrupting chemicals from ovarian follicles, cleared sperm DNA damage, detoxified the endometrium or reversed tubal fibrosis.

Those equivalences have not been scientifically demonstrated.

In my practice, I therefore distinguish traditional **Tanqiya** from commercial "detox" language.

Is Munzij-Mushil Therapy Necessary Before Pregnancy?

No—not for every couple.

Munzij-Mushil therapy is a recognized traditional concept, but a universal 10-day, 15-day or three-month preconception purgation programme is not a modern fertility guideline.

Purgative medicines can cause diarrhoea, dehydration and electrolyte disturbances and may be inappropriate in certain medical conditions.

More importantly, a woman actively attempting pregnancy could become pregnant before she knows it.

Therefore, strong purgatives should not be casually continued around conception.

If traditional Munzij-Mushil therapy is considered for an appropriate Unani diagnosis, it should be **physician-supervised and timed conservatively**, and it should never replace evaluation of infertility.

Hijama and Pre-Conception Fertility

Hijama or cupping is included among traditional regimenal approaches.

Some patients find cupping relaxing or seek it for musculoskeletal symptoms.

However, current high-quality evidence does not establish Hijama as a treatment that reliably improves ovarian reserve, sperm concentration, implantation or live-birth rates.

It cannot be promised to remove "fertility toxins."

Wet cupping also involves skin penetration and therefore requires proper infection control.

I regard Hijama, when appropriately selected, as a **traditional adjunctive therapy—not a substitute for fertility treatment**.

This distinction is especially important when patients have PCOS, severe male-factor infertility, blocked tubes or diminished ovarian reserve.

Dalk, Hammam and Other Regimenal Therapies

Traditional Unani regimenal therapy includes **Dalk**, or massage, and **Hammam**, or therapeutic bathing.

CCRUM documents these as established components of *Ilaj-bil-Tadbir*.

Massage can help relaxation and musculoskeletal comfort.

Bathing and other relaxation methods can support wellbeing.

However, abdominal massage cannot be promised to open scarred fallopian tubes or improve ovarian reserve.

Steam does not eliminate reproductive toxins through the skin.

The therapeutic claims should remain proportional to the evidence.

The Female Reproductive "Terrain" and Tubal Health

Preparing a woman's general health is useful, but fertility still depends on reproductive anatomy.

Fallopian-tube disease is an important cause of infertility.

ASRM considers **HSG a standard first-line test for tubal patency**. It can identify proximal or distal obstruction, although apparent proximal blockage may sometimes be due to spasm or technical factors and therefore require further interpretation.

This is especially important in integrative treatment.

If both fallopian tubes are severely damaged, a six-month nutritional or Unani strengthening programme does not create a new anatomical passage.

Selected proximal obstruction may sometimes be treated by tubal cannulation.

Some mild distal disease can be surgically approached in suitable women.

Severe hydrosalpinx may require surgical management and IVF planning.

This is the point where "preparing the soil" must give way to **treating the actual structural problem**.

HSG May Occasionally Have a Fertility-Flushing Effect

HSG is primarily a diagnostic test.

However, ASRM notes that tubal flushing, particularly with certain oil-based contrast media, has been associated with increased fecundity for several months after the procedure.

This does not mean HSG should be performed unnecessarily as a fertility treatment.

It also does not mean every blockage has been permanently "washed open."

The important message is that tubal evaluation should be interpreted properly and structural findings should determine management.

Ovarian Reserve: AMH Is Useful but Frequently Misunderstood

Preconception packages increasingly offer AMH testing to almost every woman.

AMH is useful for estimating ovarian reserve and predicting ovarian response during fertility treatment.

But AMH is not a pregnancy score.

A low value does not mean natural pregnancy is impossible.

A high value does not guarantee fertility.

Most importantly, no detox, spice, massage or supplement has been proven to restore the ovarian follicle pool to that of a younger woman.

A woman's **age and complete fertility context** remain more important than one AMH result.

This is another reason I caution against marketing that promises to "rejuvenate ovaries" during a 90-day programme.

Is a 90-Day Fertility Preparation Programme a "Gold Standard"?

A three-month preparation period is a useful **planning framework**, but it is not an international gold standard that every couple must complete.

Sperm development takes weeks, and reproductive health behaviours adopted before conception may reasonably influence the environment in which sperm and oocytes mature.

For this reason, couples can benefit from improving habits several months before pregnancy.

However, this should not become a rigid delay.

A 38-year-old woman with declining reproductive potential should not postpone appropriate treatment for three or six months solely to complete a fertility detox.

A woman with severe tubal disease should not delay IVF because a 90-day cleanse is unfinished.

A man with azoospermia needs diagnostic evaluation rather than three months of fertility foods before being investigated.

Use three months as an opportunity to improve health when time allows—not as a compulsory waiting period.

Fertility Foods: Nutrient-Dense Food Is Useful, "Superfoods" Are Not Magic

Traditional Unani nutrition frequently uses eggs, milk, chickpeas, nuts, dates and selected meats as nutrient-dense foods in individuals needing strengthening or reproductive support.

There is nothing inherently wrong with incorporating such foods when appropriate.

Eggs provide protein and micronutrients.

Nuts provide unsaturated fats and minerals.

Pulses provide protein and fibre.

But eating quail, lamb, ghee or chickpeas does not itself cure infertility.

Similarly, a woman does not need large amounts of sugar-rich halwa to improve fertility simply because it contains nuts and spices.

For someone with PCOS or insulin resistance, excessive sugar may be counterproductive.

Food should therefore be adapted to the patient's **metabolic condition, calorie requirements and nutritional needs**.

That is more consistent with genuine individualized medicine than following one "fertility superfood" recipe.

Ghee and Fertility: Moderation Matters

Ghee is a traditional food and may be included within a balanced diet in moderate amounts.

But there is no evidence that large amounts are required for testosterone synthesis, sperm membranes or steroid hormones.

The human body does not need excessive dietary saturated fat to manufacture reproductive hormones.

For couples with obesity, dyslipidaemia, diabetes or cardiovascular risk, large amounts of energy-dense fat may be inappropriate.

The principle is therefore moderation rather than either demonizing or medicalizing ghee.

Traditional Unani Formulations for Fertility

Unani pharmacology includes compound formulations historically used for reproductive support, uterine health, sexual weakness and semen-related complaints.

Such medicines are part of the Unani tradition and may be considered by appropriately trained physicians.

However, their **traditional indication should not be confused with proof of improved pregnancy or live-birth rates**.

This is particularly important for formulations containing animal-derived substances, minerals or potent herbs.

Ingredients require quality control, dose consideration, assessment of interactions and pregnancy-safety review.

A formulation historically described as *Muqawwi-e-Raham* should not be advertised as guaranteed to prevent miscarriage.

Miscarriage has many causes, including chromosomal abnormalities that cannot be prevented by a uterine tonic.

Coral, Pearl and Mineral Preparations Need Additional Caution

Traditional formulations may contain mineral or animal-derived ingredients such as coral or pearl preparations.

Pharmacopoeial processing and quality standards matter greatly.

A historical formulation should not be self-prepared from raw mineral materials or assumed to be safe because it is traditional.

In preconception and pregnancy-related medicine, I believe the safety threshold should be particularly high.

When the clinical benefit is uncertain, unnecessary mineral or complex herbo-mineral exposure should be avoided.

Asgandh, Mucuna, Gokhru and Other Male Fertility Herbs

Unani and related traditional systems use plants such as **Asgandh (*Withania somnifera*)**, *Mucuna pruriens* and *Tribulus terrestris* for male sexual and reproductive complaints.

These plants are biologically active and some small studies suggest effects on stress, semen parameters or sexual function.

But the evidence does not establish them as universal treatments for low sperm count, low motility or hormonal infertility.

A man with azoospermia needs to know whether the problem is obstruction or sperm production.

A man taking external testosterone needs correction of that exposure.

A man with a clinically significant varicocele may need specialist evaluation.

Herbs should support an individualized plan—not replace it.

Semen "Thickness" Is Not the Same as Fertility

Traditional Unani medicine places importance on characteristics of *Mani*, including consistency and quantity.

These observations can form part of traditional assessment.

But modern male fertility cannot be judged from semen thickness.

A watery-looking sample can contain an adequate number of sperm.

A thick sample can contain few or no sperm.

WHO's sixth-edition semen manual remains the international reference for standardized laboratory assessment of semen and provides the proper methods for evaluating male fertility parameters.

Therefore:

Do not treat visual semen appearance as a sperm test.

Should Men Abstain Before the Fertile Window?

Not for many days simply to "save sperm."

ASRM reports that the highest reproductive efficiency generally occurs with intercourse **every one to two days during the fertile window**, and frequent intercourse does not reduce fecundity. In men with normal semen quality, sperm concentration and motility may remain satisfactory even with daily ejaculation.

The traditional idea that a man must conserve semen for several days before ovulation therefore should not be presented as a general fertility rule.

Laboratory semen analysis has its own abstinence instructions, but trying for pregnancy is different.

For natural conception, the goal is to ensure sperm are present during the fertile window.

The Fertile Window

ASRM defines the fertile window as the **six-day interval ending on the day of ovulation**.

The highest probability of conception is generally during the days immediately before ovulation.

For most couples, intercourse every one to two days during this period is a sensible approach.

Couples who do not wish to track ovulation intensively can have intercourse several times each week, which usually provides good fertile-window coverage.

The objective is to improve timing without turning sexual intimacy into a stressful medical procedure.

Lying Down After Intercourse Does Not Improve Natural Fertility

Another traditional or popular recommendation is for a woman to lie on her back with her hips elevated so that semen does not escape.

ASRM states that specific post-coital routines have **no scientific foundation for improving fertility**. Sperm can reach the cervical canal and upper reproductive tract rapidly after intercourse.

Some seminal fluid leaking afterward is normal.

A woman may rest if she finds it comfortable, but she does not need to remain supine to become pregnant.

Stress and Fertility: A Balanced Understanding

Emotional wellbeing is an important part of preconception care.

Infertility can produce anxiety, depression, sexual pressure and relationship stress. WHO's 2025 guideline specifically emphasizes ongoing psychosocial support for people affected by infertility.

However, I strongly avoid telling a woman:

“Stress is stopping you from becoming pregnant.”

That can be both inaccurate and cruel.

Severe physiological stress can interfere with hypothalamic reproductive signalling in selected women, particularly when accompanied by undernutrition or excessive exercise.

But common emotional stress is not a reliable explanation for blocked tubes, severe male infertility or many other reproductive conditions.

Relaxation should help patients **cope better**, not make them feel responsible for infertility.

Unani Harkat-wa-Sukoon-e-Nafsani

Unani medicine traditionally recognizes the relationship between emotional states and physical health through concepts involving psychological movement and repose.

This is a valuable aspect of the system.

In contemporary fertility practice, it can support counselling, relationship communication, stress-management techniques and attention to sleep and emotional wellbeing.

What I would avoid is claiming that a specific emotional state directly “burns” an egg or that depression literally creates a particular humour responsible for infertility.

Traditional descriptions can remain traditional descriptions without being turned into unsupported molecular claims.

Sleep and Circadian Health

Sleep is another area where traditional and modern health principles overlap.

Unani medicine considers **Naum-wa-Yaqzah**, sleep and wakefulness, one of the important determinants of health.

Modern research also increasingly links sleep disturbance with reproductive health.

A 2024 systematic review found that women with infertility commonly report poorer sleep and that poor sleep quality, extreme sleep duration and certain sleep disturbances are associated with less favourable fertility and fertility-treatment outcomes. However, the authors emphasized that mechanisms and causality remain incompletely understood.

Therefore, adequate sleep is sensible preconception advice.

But there is no proven rule that precisely seven or eight hours of sleep will increase egg quality.

Do Couples Need a "Digital Sunset"?

Reducing late-night screen use can be a useful **sleep-hygiene strategy** when phones and computers are delaying bedtime or interfering with relaxation.

But it is not a fertility treatment in itself.

There is interesting biological research involving circadian rhythms and melatonin in reproduction, but evidence does not justify saying that switching off a phone exactly 90 minutes before bed will improve egg quality or implantation.

The useful clinical advice is simpler:

Maintain a consistent sleep schedule, aim for adequate restorative sleep and seek evaluation when chronic insomnia or suspected sleep apnoea is present.

Physical Activity and Fertility

Regular physical activity improves metabolic and cardiovascular health and can be particularly valuable in PCOS, insulin resistance and obesity.

WHO's current infertility guidance recommends physical activity as part of fertility promotion for people planning or attempting pregnancy.

But the relationship is not "the more exercise, the better."

Very intense exercise combined with inadequate energy intake can suppress normal reproductive signalling and disturb menstrual cycles in some women.

For most patients I favour **sustainable moderate exercise** rather than either a sedentary lifestyle or extreme training.

This aligns well with the Unani principle of *Riyazat-e-Motadil*—balanced physical activity.

Is Sitting a "Contraceptive"?

No.

Calling a chair a contraceptive exaggerates the evidence.

Prolonged sedentary behaviour is undesirable for overall metabolic and cardiovascular health, and people who sit at work benefit from regular movement.

In men, repeated substantial scrotal heat exposure may adversely affect semen parameters, but evidence for individual everyday exposures varies.

I advise desk workers to stand and move regularly because it is good health practice—not because sitting at a desk directly causes infertility.

Tobacco: One of the Most Important Modifiable Risks

Here the evidence is much stronger than for most fertility "detox" interventions.

WHO issued an updated **Tobacco and Infertility** knowledge summary on 8 September 2026.

The evidence indicates that women who currently smoke have an approximately **40% higher risk of infertility** compared with women who do not smoke. WHO also reports harmful associations between smoking and male semen parameters, sexual function and fertility-treatment outcomes. Second-hand smoke may also affect reproductive health.

This is a priority.

If a couple spends significant money on antioxidants while continuing to smoke, the treatment plan is focusing on the wrong thing.

Stopping tobacco is one of the most evidence-supported preconception interventions available.

Alcohol and Other Substances

Preconception counselling should also review alcohol, nicotine, recreational drugs and nonmedical use of prescription medicines.

ACOG recommends routine discussion of these exposures during prepregnancy care.

For women actively trying for pregnancy, the possibility of conception before pregnancy is recognized is another reason to minimize avoidable exposures.

For men, heavy alcohol use and drug use can also influence general and reproductive health.

Again, counselling should be non-judgmental.

People are more likely to disclose an exposure when they understand that the purpose is to make pregnancy safer—not to criticize them.

Environmental Endocrine-Disrupting Chemicals

Environmental exposures deserve attention without creating fear.

Research has associated endocrine-disrupting chemicals such as BPA, phthalates, PFAS and several persistent pollutants with reproductive outcomes. A recent review of human studies found associations with semen quality, ovarian reserve, hormone levels, infertility and some ART outcomes, although studies remain heterogeneous.

ACOG also recommends identifying potentially important occupational and environmental exposures during preconception counselling, including some plastics, pesticides, lead, solvents and other workplace hazards.

This supports **reasonable exposure reduction**.

It does not support an extreme belief that every plastic item has caused infertility.

Practical Environmental Precautions Without Fear

I advise couples to make sensible changes rather than attempt impossible chemical purity.

Avoid tobacco smoke.

Do not routinely heat food in unsuitable plastic containers.

Follow workplace safety precautions around solvents, pesticides, heavy metals and radiation.

Wash produce appropriately.

Use medicines and cosmetics sensibly.

If there is a genuine occupational or heavy-metal exposure, obtain proper medical evaluation.

What I do **not** advise is taking cilantro, chlorella or other products as self-directed “heavy-metal chelation.”

True heavy-metal toxicity requires medical diagnosis and specific treatment. Unsupervised chelation or detoxification can itself cause harm.

“Organic Food” Is Not a Fertility Requirement

Eating more vegetables and fruit is beneficial.

But couples do not need to feel that pregnancy depends on purchasing an entirely organic diet.

Washing produce and maintaining a nutritious overall diet is more important than creating anxiety about every conventional food.

A healthy fertility plan should be **realistic and sustainable**, particularly for families with limited resources.

Fertility care should not become a luxury wellness programme available only to wealthy couples.

PCOS: An Important Area for Responsible Integration

Women with PCOS can particularly benefit from good preconception counselling because metabolic health, physical activity, weight, ovulation and psychological wellbeing may all need attention.

Lifestyle intervention is a major component of modern PCOS care.

This creates a genuine area of overlap with Unani principles relating to diet, physical activity, sleep and individual constitution.

But Unani treatment should not delay effective ovulation treatment when persistent anovulation is preventing conception.

Likewise, the presence of PCOS should not be diagnosed merely from a traditional *Balghami* temperament or an ultrasound showing multiple follicles.

Objective diagnostic criteria remain necessary.

The Uterine Lining and "Uterine Strength"

Unani medicine contains the traditional concept of *Muqawwi-e-Raham*, or uterine-strengthening approaches.

This can provide a useful framework for general reproductive support.

However, the endometrium is not simply a muscle that can be "strengthened" like a biceps.

Implantation depends on embryo competence, endometrial biology, hormonal timing and many other factors.

Likewise, recurrent miscarriage should not automatically be attributed to a weak uterus.

Chromosomal abnormalities, uterine abnormalities, endocrine conditions, antiphospholipid syndrome and other factors may be relevant depending on the clinical situation.

Therefore, a woman with repeated pregnancy losses deserves proper evaluation rather than only a uterine tonic.

Progesterone and the "Cold Uterus" Comparison

Progesterone raises basal body temperature slightly after ovulation, which may make the traditional comparison with "warmth" intuitively attractive.

But low progesterone should not be assumed merely because a woman has cold hands or describes herself as cold-natured.

ASRM states that isolated **luteal-phase deficiency has not been proven as an independent cause of infertility or recurrent pregnancy loss**, and available diagnostic tests are imperfect.

If progesterone is clinically indicated—for example within certain ART protocols—it should be used according to evidence-based fertility practice.

Warming herbs should not be described as biological substitutes for progesterone.

Do Herbal Sitz Baths Change Vaginal pH or Fertility?

A warm sitz bath may be soothing for some external symptoms.

But routinely using herbal baths to alter vaginal pH or make the vagina "more sperm-friendly" is not evidence-based fertility treatment.

The vagina contains a complex microbiological environment.

Unnecessary internal cleansing, douching or introduction of herbal preparations can irritate tissues or disturb normal flora.

Therefore, preconception care should generally avoid unnecessary vaginal manipulation unless there is a specific medical indication.

Herbal Medicine During IVF Requires Particular Caution

Couples undergoing IVF often ask whether they can continue all their herbs and supplements.

My answer is that every product should be reviewed individually.

Ovarian stimulation and embryo-transfer protocols involve carefully controlled hormones.

Some herbs may influence metabolism, blood clotting, uterine activity or the handling of prescription medicines.

Therefore, I do **not** advise automatically continuing strong Unani formulations, purgatives or poorly characterized herbal products during ovarian stimulation, egg retrieval, embryo transfer or early pregnancy.

Integrative treatment during IVF should usually focus on **nutrition, sleep, appropriate physical activity, psychological support and clinically reviewed medicines**.

Safety comes before theoretical benefit.

Unexplained Infertility Does Not Mean "Hidden Toxins"

A couple may undergo appropriate testing and still have no clear explanation for infertility.

This is termed **unexplained infertility**.

It is a diagnosis of exclusion.

It does not mean the couple is completely normal at every microscopic or molecular level.

But it also does not prove that toxins, uterine coldness, gut dysbiosis or hidden humoral imbalance are the cause.

Evidence-based management depends on the woman's age, duration of infertility and previous treatment. ASRM does not recommend simply using ovulation medicines with timed intercourse for unexplained infertility; appropriate ovarian stimulation combined with IUI and, when needed, IVF may be considered according to the couple's situation.

The role of Unani medicine here can be supportive—but the diagnosis should not be replaced by an unproven explanation.

A Responsible Integrated Pre-Conception Roadmap

Rather than a compulsory "cleanse–nourish–conceive" protocol, I prefer a flexible clinical roadmap.

Stage	Modern medical focus	Responsible Unani / lifestyle contribution
1. Assessment	Reproductive history, age, menstrual pattern, semen when indicated, medical conditions, medicines, risk factors	Mizaj and lifestyle assessment as complementary information
2. Risk reduction	Control diabetes/thyroid disease, review medicines and vaccines, folic acid, stop tobacco, treat relevant infection	Hifz-e-Sehat, Ilaj-bil-Ghiza, sleep, activity, digestion and emotional wellbeing

Stage	Modern medical focus	Responsible Unani / lifestyle contribution
3. Fertility optimization	Fertile-window education, targeted treatment of ovulation or sexual dysfunction	Individualized supportive Unani care where clinically suitable
4. Infertility treatment	IUI, surgery, IVF/ICSI or other diagnosis-specific treatment where indicated	Nutrition, counselling and carefully reviewed supportive care without delaying treatment
5. Early pregnancy	Appropriate obstetric follow-up and medication review	Stop unnecessary or potentially unsafe preconception medicines; supportive care only when pregnancy-safe

This is what I consider genuine integration.

It is not “half modern medicine and half Unani medicine.”

It is **the right intervention for the right problem at the right time**.

Dr. Nizamuddin Qasmi's Approach to Pre-Conception Counselling

When a couple consults me before pregnancy, I begin by listening.

I want to know whether they are only preparing for pregnancy or whether pregnancy has already been delayed.

I review the woman's age, menstrual pattern, previous pregnancies, miscarriage or ectopic pregnancy, reproductive infections, operations, PCOS, thyroid history and current medicines.

I consider whether she is likely to be ovulating.

I review the male partner's health, sexual function, previous fertility, medication history, smoking, testosterone or anabolic-steroid use and whether semen analysis is already necessary.

I also ask about sleep, food habits, body weight, physical activity, psychological strain and occupational or environmental exposures.

This is where my Unani background is particularly valuable.

I assess the broader person rather than limiting the consultation to one laboratory value.

But when an objective fertility question needs an objective answer, I use modern investigation.

Mizaj does not replace semen analysis.
A traditional uterine assessment does not replace HSG when the tubes need evaluation.
Diet does not replace treatment of an endocrine disorder.
And a tonic does not replace IVF when the reproductive barrier requires IVF.

This is the balance I try to maintain.

What "Special Treatment" Means at Saira Health Care

At **Saira Health Care**, special treatment does not mean one secret fertility medicine for every couple.

It means individualized treatment.

A couple who are simply mistiming intercourse need fertility education.

A woman with PCOS and anovulation requires metabolic and ovulatory management.

A woman with severe tubal damage requires structural fertility planning.

A man with severely abnormal semen requires proper male fertility assessment.

A couple unable to have intercourse because of erectile dysfunction or vaginismus may first require sexual-health treatment.

A woman approaching advanced reproductive age may need faster progression to assisted reproduction rather than prolonged supportive therapy.

Where Unani medicine can genuinely contribute—through diet, lifestyle, constitution-focused care, general wellbeing and selected supervised pharmacotherapy—I use it within appropriate limits.

This is what I consider **patient-centred integrative reproductive medicine**.

Contribution of Saira Health Care in Sexual Disorders and Infertility

At Saira Health Care, our work in fertility is closely connected with our work in sexual health.

Some couples struggle because of PCOS or tubal disease.

Others face low sperm count or poor sperm motility.

Others have erectile dysfunction, premature ejaculation, vaginismus, painful intercourse or difficulty consummating marriage.

Some couples have no single severe problem but several smaller factors affecting their chance of conception.

Our contribution is therefore broader than prescribing medicine.

We aim to help patients understand fertility, identify when investigation is necessary, interpret reproductive reports in simple language, address sexual barriers to conception, improve modifiable health factors and use Unani medicine responsibly where it can add genuine supportive value.

We also believe in timely referral or collaboration when reproductive imaging, surgery, IUI, IVF, ICSI, genetics, obstetric care or another specialized service is required.

The objective should always be the patient's **best reproductive outcome**, not keeping the patient within one system of medicine indefinitely.

Frequently Asked Questions

How long before pregnancy should we start preparing?

There is no compulsory duration. Starting healthy preconception habits several months in advance is useful, but a fixed 90-day fertility programme is not required for every couple. Women with age-related urgency or known fertility problems should not postpone evaluation simply to complete a programme.

Should every couple complete a fertility detox?

No. There is no evidence that every couple needs purgation, liver cleansing or commercial detoxification before pregnancy.

Is Munzij-Mushil useful?

Munzij-Mushil is an authentic traditional Unani therapeutic concept. It may be considered for an appropriate Unani indication under qualified supervision, but it is not a universal infertility treatment and should not delay reproductive diagnosis.

Can Hijama improve pregnancy chances?

There is currently insufficient high-quality evidence that Hijama reliably increases natural pregnancy or live-birth rates. It should not be used as a substitute for infertility investigation or treatment.

Does a “cold uterus” cause infertility?

“Cold uterus” is a traditional Unani constitutional concept rather than a modern biomedical diagnosis. Symptoms suggesting thyroid disease, anovulation, endometrial abnormalities or another condition should be investigated on their own merits.

Should women avoid cold foods when trying to conceive?

There is no modern evidence that normal consumption of foods such as yoghurt, cucumber or salads causes infertility by cooling the uterus. Dietary recommendations can be individualized within Unani practice, but the overall diet should remain nutritious and balanced.

Is a hot/warming diet necessary for fertility?

No universal warming diet has been proven to increase pregnancy rates. Spices and warm cooked foods can be included according to preference and digestive tolerance, but they are not substitutes for fertility treatment.

Do I need to stop all raw food?

No. Properly washed vegetables and fruits can be nutritious parts of a preconception diet. Restrictions should be based on a genuine medical or dietary reason.

Should I use methylfolate instead of folic acid because of MTHFR?

Common MTHFR variants do not prevent the body from processing folic acid. CDC continues to recommend 400 micrograms of folic acid daily for most people capable of becoming pregnant.

Does stress prevent pregnancy?

Stress can affect wellbeing, sleep, relationships and in selected severe circumstances reproductive physiology, but infertility should not automatically be blamed on stress. WHO recommends psychosocial support because infertility itself can be emotionally difficult.

How often should we have intercourse?

For natural conception, intercourse every **one to two days during the fertile window** provides the highest reproductive efficiency. Couples do not need long abstinence periods to conserve sperm.

Should the woman lie down after intercourse?

No special position has been proven to improve natural conception. Normal semen leakage after intercourse does not mean sperm have been lost.

Is smoking really important for fertility?

Yes. WHO's September 2026 review found substantial reproductive risks from smoking in both women and men and recommends tobacco-cessation support for people planning pregnancy.

Do we have to remove every plastic product from our house?

No. Certain endocrine-disrupting chemicals are legitimate reproductive-health concerns, but reasonable exposure reduction is more appropriate than fear-based detoxification.

Should I take chlorella or cilantro for heavy metals?

Not routinely. Suspected significant heavy-metal exposure should be medically investigated. Unsupervised detoxification or chelation is not appropriate preconception care.

Can Unani medicine be helpful before pregnancy?

Yes. Its strongest role is in **individualized lifestyle and health support**, including diet, sleep, physical activity, digestive health, emotional wellbeing, sexual health and selected physician-supervised traditional treatment.

Can Unani treatment replace IVF?

No. When IVF is indicated because of severe tubal disease, severe male-factor infertility, age-related urgency or failure of appropriate simpler treatment, complementary care should not indefinitely delay it.

My Final Message to Couples Preparing for Pregnancy

When couples ask me how to prepare their bodies before pregnancy, I tell them that the answer is both simpler and more sophisticated than a detox programme.

Prepare your **health**, not merely your reproductive organs.

Stop tobacco.

Review medicines.

Take appropriate folic acid.

Control diabetes, thyroid disease and other genuine medical problems.

Eat nutritious food.

Remain physically active.

Sleep adequately.

Protect emotional wellbeing.

Discuss sexual problems openly.

Understand the fertile period.

And when pregnancy does not occur within the appropriate time, investigate both partners.

My training in Unani medicine teaches me that health is influenced by the entire pattern of life—**Mizaj, food, activity, rest, sleep, emotional state, environment and the body's overall functional balance**.

These concepts can make preconception care more individualized and more humane.

But I also believe strongly that Unani medicine is best served by being medically honest.

We do not need to call every metabolic problem a toxin.

We do not need to promise that purgation opens tubes.

We should not tell a woman that yoghurt has cooled her uterus.

We should not tell a man to abstain for a week when the fertile window is passing.

And we should never allow a woman approaching advanced reproductive age to lose precious time while completing an arbitrary detox protocol.

At **Saira Health Care**, my approach is therefore:

Assess first.
Optimize what can genuinely be improved.
Use Unani care where it can safely support the whole person.
Treat identifiable reproductive disease appropriately.
And escalate to modern fertility treatment when the biological situation requires it.

That, in my view, is the real meaning of **pre-conception counselling and preparing the biological soil for pregnancy**.

The purpose is not to create the longest treatment plan.

The purpose is to help the couple enter conception and pregnancy **healthier, better informed and with the clearest possible understanding of their reproductive situation**.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi
Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility

BUMS – Hamdard University, Delhi
MD
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Certificate in Infertility – MGBIMS, Delhi
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Masters in Male Infertility – MasterHealthPro (HealthPro)
Integrated Sexual and Reproductive Health – ISRH, UNFPA

Dr. Nizamuddin Qasmi's clinical work at **Saira Health Care** focuses on sexual disorders and infertility, including male and female fertility problems, reproductive counselling, sexual-

function concerns and individualized integration of Unani supportive care with appropriate modern fertility assessment.

Website: www.sairahealthcare.com

Medical Disclaimer

This article is intended for **general health education and public awareness**. It does not constitute an individualized diagnosis, prescription or guarantee of pregnancy.

Preconception requirements vary according to age, medical history, reproductive diagnosis and the health of both partners. Unani medicines, herbal products, purgatives, Hijama, supplements and other complementary therapies should not be self-prescribed as substitutes for medically indicated fertility investigation or treatment.

Women actively trying for pregnancy should be particularly cautious with strong herbs, purgatives and unreviewed traditional formulations because conception may occur before pregnancy is recognized. Couples with prolonged infertility, severe menstrual irregularity, known tubal disease, azoospermia, markedly abnormal semen parameters, recurrent pregnancy loss or significant sexual dysfunction should receive individualized professional assessment.