Human Conception and Achieving Pregnancy: Complete Modern and Unani Guide to Ovulation, Fertile Window, Intercourse Timing and Preconception Health

Understanding How Pregnancy Happens, the Best Time to Conceive, Fertility Awareness, Common Mistakes and the Supportive Role of Unani Medicine

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Introduction

One of the most frequent questions couples ask me is very simple:

“Doctor, what is the correct way to try for pregnancy?”

Sometimes the couple has no diagnosed infertility at all. They simply do not understand ovulation or the fertile period. Some are having intercourse only after an ovulation application says that ovulation has occurred. Others abstain for a week because they believe sperm must be “saved.” Some worry because semen comes out of the vagina after intercourse. Others perform complicated post-coital positions or take several fertility supplements even before understanding the normal menstrual cycle.

Human conception is an extraordinary biological process, but it is not an automatic one. Even in healthy young couples, pregnancy does not occur after every act of intercourse or in every menstrual cycle. Successful conception requires the correct timing of a viable egg, sufficiently functional sperm, an appropriate reproductive pathway and ultimately successful embryo implantation.

The detailed scientific material prepared for this article emphasizes the same principle: human conception depends on coordinated ovarian, hormonal, sperm and endometrial events, and misunderstanding the fertile window can create unnecessary delay and psychological distress.

This is why I believe couples should first understand **how pregnancy actually occurs** before assuming that medicines are required.

At Saira Health Care, my approach is to combine contemporary fertility science with selected principles of **Unani preventive and reproductive medicine**, especially attention to *Mizaj*, diet, sleep, physical activity, emotional wellbeing and general health.

Unani medicine can be particularly valuable in individualized preconception support, but it should not replace objective investigation when a couple has genuine infertility, blocked fallopian tubes, significant ovulatory disease, severe male-factor infertility or another established reproductive condition.

What Is Conception?

Conception is the biological process through which a sperm fertilizes an egg and the resulting early embryo progresses toward pregnancy.

For natural pregnancy to occur, several events must be coordinated.

A follicle must mature in the ovary. An egg must be released through ovulation. Sperm must be present within the female reproductive tract during the fertile period. The sperm must travel through the cervix and uterus toward the fallopian tube. Fertilization usually occurs within the tube. The resulting embryo subsequently travels toward the uterus and must implant successfully within a receptive endometrium.

Failure at any of these stages can prevent pregnancy.

This is why fertility cannot be judged simply by menstrual periods, semen appearance or sexual performance.

Pregnancy Is a Probability, Not a Guarantee in Every Cycle

This is important for reducing unnecessary anxiety.

Even healthy couples may require several menstrual cycles before pregnancy occurs.

The source material prepared for this article describes **fecundability** as the probability of achieving pregnancy during one menstrual cycle and emphasizes that human reproductive efficiency is naturally limited even under favourable circumstances.

Therefore, failure to conceive in the first, second or third month does not automatically indicate infertility.

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

However, age and medical history matter. Women aged 35 or above generally warrant earlier evaluation when pregnancy is delayed, and known fertility conditions may justify investigation without waiting a full year.

Understanding the Menstrual Cycle

Couples often think of menstruation as the entire menstrual cycle.

In reality, the menstrual period is only one part of a continuous hormonal process involving the brain, pituitary gland, ovaries and uterus.

A normal cycle is not necessarily exactly 28 days. In most ovulatory women, cycles are generally considered regular when they occur approximately every **21–35 days**.

The supplied reproductive background correctly emphasizes that the “28-day cycle” is a useful teaching model rather than a rule applying perfectly to every woman.

For practical understanding, the cycle can be divided into the menstrual phase, follicular phase, ovulation and luteal phase.

The Menstrual Phase: Day 1 Begins With Proper Menstrual Flow

Day 1 of the menstrual cycle is the first day of proper menstrual bleeding, not merely one small spot of premenstrual staining.

When pregnancy has not occurred in the previous cycle, levels of progesterone and estrogen fall.

This hormonal withdrawal causes the functional layer of the uterine lining to break down and shed as menstruation.

At the same time, the pituitary gland begins producing follicle-stimulating hormone, or **FSH**, which supports development of a new group of ovarian follicles.

The supplied source explains this early cycle process in detail.

The Follicular Phase: Preparing an Egg for Ovulation

After menstruation begins, several ovarian follicles may start developing under FSH stimulation.

Usually one becomes the **dominant follicle**.

As it grows, the follicle produces increasing amounts of estrogen, particularly estradiol.

Estrogen helps the uterine lining grow again after menstruation. It also changes cervical mucus in preparation for sperm.

The duration of the follicular phase can vary considerably, which is one reason ovulation does not occur on “day 14” in every woman.

This is one of the most important misconceptions I correct in patients.

Ovulation is related to the woman's individual cycle—not to a universal calendar date.

Ovulation: Release of the Egg

When the dominant follicle becomes sufficiently mature, rising estradiol triggers a surge in **luteinizing hormone, or LH**.

This LH surge initiates the final processes that lead to follicular rupture and release of the egg.

Ovulation generally follows the onset of the urinary LH surge within roughly the next one to two days, although the exact interval varies.

The released egg is captured by the fimbrial end of the fallopian tube.

From this point, the time available for fertilization is relatively short.

This is why intercourse **before ovulation** can actually be more important than intercourse after the egg has already been released.

The Luteal Phase: Preparing the Uterus for Implantation

After ovulation, the remaining follicular tissue forms a temporary endocrine structure called the **corpus luteum**.

The corpus luteum produces progesterone.

Progesterone changes the endometrium from a proliferative lining into a secretory lining capable of supporting an early embryo.

If pregnancy occurs, embryonic human chorionic gonadotropin—**hCG**—supports continued corpus luteum function during early pregnancy.

If conception does not occur, the corpus luteum eventually regresses, hormone levels fall and the next menstrual period begins.

The supplied scientific material describes these progesterone-dependent post-ovulatory changes and their importance for the endometrium.

What Is the Fertile Window?

This is perhaps the most useful concept for a couple trying naturally.

ASRM defines the **fertile window as the six-day interval ending on the day of ovulation**. The highest chance of conception generally occurs when intercourse takes place during the one to two days immediately before ovulation.

Why?

Because sperm can survive within favourable female reproductive-tract conditions for several days.

The egg, in contrast, remains fertilizable for a much shorter period after ovulation.

The supplied material similarly explains the fertile period as approximately the five days before ovulation plus the ovulation day.

This produces an important practical message:

Do not wait until ovulation has definitely finished before having intercourse. Ideally, sperm should already be present when the egg is released.

Is Day 14 Always the Best Day to Conceive?

No.

Day 14 is only a convenient example for some women with a 28-day cycle.

A woman with a 30-day cycle may ovulate later.

A woman with a shorter cycle may ovulate earlier.

Even a woman whose cycles are usually regular may occasionally ovulate earlier or later because of natural biological variation, illness, travel or other factors.

ASRM notes that the fertile window varies substantially even among women who describe their cycles as regular.

This is why relying exclusively on “day 14” can cause couples to miss fertile days.

What Is the Best Frequency of Intercourse for Pregnancy?

Couples often believe they must either have intercourse every day or abstain for several days to build up sperm.

Neither extreme is required for most couples.

ASRM concludes that reproductive efficiency is highest when intercourse occurs **every one to two days during the fertile window**. Importantly, having intercourse more frequently is not associated with lower fertility in men with normal semen quality.

For couples who find ovulation tracking stressful, intercourse approximately **two to three times per week throughout the cycle** can provide nearly comparable reproductive opportunity because it usually places sperm within the tract around the fertile period.

My practical advice is:

Do not allow pregnancy planning to turn intimacy into a compulsory laboratory schedule.

If tracking is helping, use it.

If tracking is creating severe anxiety or performance pressure, regular intercourse throughout the cycle may be psychologically healthier.

Does Daily Intercourse Reduce Sperm Count?

For men with normal semen quality, daily ejaculation does not generally cause a clinically important decline in fertility.

ASRM cites data showing that sperm concentration and motility can remain within satisfactory ranges even with daily ejaculation. Prolonged abstinence is therefore not routinely recommended simply to “save sperm.”

This corrects one of the most persistent myths among couples trying for pregnancy.

Sperm production is continuous.

A couple should not intentionally miss fertile days because someone advised the husband to abstain for one week.

How to Recognize the Fertile Period

There are several ways to estimate ovulation.

No method is perfect.

A useful approach should provide information without creating excessive anxiety.

Menstrual Calendar and Mobile Applications

Calendar methods estimate ovulation from previous cycle length.

They can be helpful for recognizing patterns, but they should not be treated as precise ovulation detectors.

ASRM reports that calendar-based applications can have limited accuracy when asked to predict the exact ovulation day because individual cycles vary.

Therefore, an app should be viewed as a **guide**, not as a laboratory test.

This is particularly important in women with PCOS or irregular cycles.

Cervical Mucus: A Useful Natural Fertility Sign

As estrogen rises before ovulation, cervical mucus typically changes.

It may progress from dry or sticky to wetter, clearer, more slippery and more stretchable.

Many women describe peak fertile mucus as resembling **raw egg white**.

ASRM notes that the probability of conception is highest when mucus is clear and slippery, although conception can still occur without a textbook mucus pattern.

The supplied source provides a detailed explanation of these estrogen-driven cervical mucus changes and their use in fertility-awareness systems.

For women comfortable monitoring their body, this can be a useful and inexpensive way to identify the approaching fertile period.

Ovulation Predictor Kits

Urinary ovulation predictor kits detect the **LH surge**.

ASRM states that urinary LH testing can identify the surge that precedes ovulation by approximately one to two days.

This makes an LH kit particularly useful because it provides prospective information.

If the test becomes positive, intercourse that day and over the following day or two can provide good timing.

However, false positive and false negative results occur.

Women with PCOS may sometimes have persistently elevated or irregular LH levels, which can make interpretation more difficult.

Therefore, an ovulation test should be interpreted in the context of the menstrual pattern.

Basal Body Temperature

Progesterone after ovulation slightly raises basal body temperature.

A sustained rise can therefore suggest that ovulation has already occurred.

The supplied document describes the physiological basis of BBT tracking.

However, BBT has an important limitation:

it is mainly retrospective.

By the time a temperature shift confirms ovulation, the most fertile days may already have passed.

ASRM also describes daily BBT tracking as relatively tedious and often unreliable and does not recommend it routinely when menstrual history already indicates regular ovulation.

It can therefore be useful for learning a cycle pattern, but it is not my preferred sole method for timing intercourse.

Which Ovulation Method Is Best?

For most couples, I prefer simplicity.

A woman with regular cycles can often use her menstrual pattern together with cervical mucus awareness.

An LH kit can be added when more precise timing is helpful.

A woman with irregular cycles may require medical assessment rather than increasingly complicated home tracking.

The purpose of fertility awareness should be to **reduce uncertainty**, not create obsessive monitoring.

How Does Fertilization Actually Occur?

During intercourse, semen is deposited in the vagina.

Sperm begin moving through cervical mucus toward the uterine cavity and fallopian tubes.

Only a very small fraction of ejaculated sperm ultimately reach the region where fertilization may occur.

Before a sperm can successfully fertilize an egg, it undergoes physiological changes collectively called **capacitation** within the female reproductive tract.

If a viable sperm encounters a viable egg in the fallopian tube and successfully penetrates it, fertilization occurs.

The genetic material of the egg and sperm then combines to create a new cell called a **zygote**.

From Fertilization to Implantation

Fertilization is not the end of the reproductive journey.

The fertilized egg begins dividing while travelling through the fallopian tube.

It develops through early embryonic stages before reaching the uterus.

The embryo eventually develops into a blastocyst capable of attaching to the endometrium.

Successful implantation requires coordination between embryo development and uterine receptivity.

This is why conception cannot be reduced simply to “egg meets sperm.” Pregnancy requires successful events both **before and after fertilization**.

Does Semen Coming Out After Intercourse Reduce the Chance of Pregnancy?

This is an extremely common concern.

Women frequently tell me:

“Doctor, most of the semen comes out when I stand up. How will I become pregnant?”

Normal leakage of seminal fluid after intercourse does not mean that all sperm have been lost.

Sperm begin entering cervical mucus very quickly after ejaculation.

ASRM notes that sperm can be found within the cervical canal within seconds and may reach the fallopian tubes rapidly.

Therefore, vaginal leakage afterward is normal and does not demonstrate failure of conception.

Should a Woman Lie Down After Intercourse?

There is no convincing evidence that lying with the legs raised, placing a pillow under the pelvis or remaining motionless for a prolonged period increases natural conception rates.

ASRM states that post-coital routines such as remaining supine do not have a scientific basis for improving natural fertility.

If a woman wants to rest comfortably for a few minutes, that is harmless.

But it is **not necessary for pregnancy**.

Is There a Best Sexual Position for Pregnancy?

No sexual position has been shown to produce higher pregnancy rates.

ASRM specifically reports that there is no evidence that coital position affects fecundability.

The important factors are appropriate timing, effective vaginal intercourse and deposition of sperm—not gravity.

Likewise, female orgasm may be an enjoyable and healthy part of sexual intimacy, but it is **not required for conception**.

This is important because fertility advice should not create unnecessary sexual performance pressure.

Lubricants When Trying to Conceive

Couples sometimes develop vaginal dryness because timed intercourse has become stressful.

Certain lubricants reduce sperm movement in laboratory studies, while hydroxyethylcellulose-based products have not demonstrated the same adverse effect on semen parameters. However, ASRM also notes that observational studies have not clearly demonstrated lower cycle fecundability among lubricant users overall.

For couples who require lubrication, choosing a product specifically designed for people trying to conceive is reasonable.

I would not recommend using saliva or arbitrary household substances as fertility lubricants.

Common Mistakes Couples Make While Trying for Pregnancy

One common mistake is assuming that ovulation always occurs on day 14.

Another is having intercourse only once in the entire fertile period.

Some couples wait until the ovulation test becomes negative, by which time the best opportunity may already have passed.

Others abstain unnecessarily for long periods to “increase sperm.”

Another group becomes so focused on ovulation charts and applications that intercourse turns into a stressful assignment rather than normal intimacy.

The supplied reproductive analysis identifies many of the same timing and behavioural problems and emphasizes that good fertility awareness should reduce rather than increase psychological burden.

Preconception Care: Pregnancy Planning Begins Before Conception

One of the most important improvements in reproductive medicine has been recognition that pregnancy care should begin **before the pregnancy test becomes positive**.

ACOG describes prepregnancy counselling as an opportunity to optimize health, identify modifiable risks, review medical and family history, assess medicines and supplements, review vaccination status and address chronic disease.

The source material likewise emphasizes preconception medical evaluation rather than viewing conception simply as repeated intercourse.

This is particularly important because major fetal development begins in the earliest weeks of pregnancy, often before a woman knows that she is pregnant.

Folic Acid Before Pregnancy

One of the strongest evidence-based preconception recommendations is folic acid.

The CDC's July 2026 guidance recommends **400 micrograms of folic acid every day** for women capable of becoming pregnant. Adequate folic acid before and during early pregnancy helps prevent serious neural-tube defects involving the baby's brain and spine.

Some women with particular medical histories may require a different dose under medical supervision.

Folic acid is not a fertility stimulant.

It does not make ovulation occur or guarantee pregnancy.

Its role is to **prepare for a safer early pregnancy if conception occurs**.

Review All Medicines and Supplements

Preconception counselling should include everything the woman and man are taking.

This includes prescription drugs, over-the-counter medicines, vitamins, gym supplements, herbal products and traditional medicines.

ACOG specifically recommends reviewing herbal products and nutritional supplements because patients may not consider them “medicines,” even though they can influence reproduction or pregnancy.

This is also relevant to Unani care.

A Unani medicine that may be considered before conception should not automatically be continued after pregnancy occurs.

Chronic Disease Should Be Controlled Before Pregnancy

Conditions such as diabetes, hypertension, thyroid disease and significant psychiatric illness may affect pregnancy.

ACOG recommends optimizing important chronic medical conditions before conception whenever possible.

For men, diabetes and metabolic disease may also affect erections, ejaculation and reproductive health.

Preconception care therefore concerns the **health of both partners**, not merely fertility organs.

Smoking: One of the Most Important Fertility Risks

This area has especially important new evidence.

On **8 September 2026**, WHO published an updated knowledge summary on tobacco and infertility.

WHO reports that tobacco is associated with infertility in women, harmful effects on sperm and male sexual function, and potentially poorer outcomes from fertility treatment. The evidence summary reports that women who currently smoke have approximately a **40% higher risk of infertility than women who do not smoke**. Second-hand smoke may also adversely affect fertility.

I therefore tell couples that stopping tobacco deserves much greater priority than searching for another fertility supplement.

This applies to cigarettes and other tobacco exposure.

Alcohol and Recreational Substances

Heavy alcohol consumption and recreational drug use can adversely affect reproductive and general health.

WHO recognizes smoking, excessive alcohol consumption and obesity among lifestyle factors associated with higher infertility risk.

Couples trying for pregnancy should discuss substance use honestly with their healthcare professional.

The purpose is not judgment.

The purpose is to identify modifiable risks before pregnancy occurs.

Healthy Weight and Fertility

Both very low body weight and obesity may affect reproduction.

In women, obesity and insulin resistance can interfere with ovulation, particularly in PCOS.

Very low energy availability can suppress normal hypothalamic reproductive signalling and produce irregular or absent menstruation.

ACOG recommends working toward an appropriate weight before pregnancy when feasible because both high and low BMI may be associated with infertility and pregnancy complications.

Weight counselling should be clinical and respectful.

It should never become criticism of appearance.

Male Health Is Part of Preconception Care

The male partner should not be ignored simply because pregnancy occurs inside the woman's body.

If infertility is present, male evaluation should occur alongside female evaluation.

Important male factors include sperm concentration, motility and morphology; varicocele; hormonal disease; previous testicular injury; undescended testes; reproductive-tract infection; obstruction; use of anabolic steroids or testosterone; and sexual dysfunction.

ACOG specifically notes that men using **androgens such as testosterone** should be identified during preconception counselling because external testosterone can cause azoospermia and infertility.

This is one of the most important warnings I give men planning fatherhood.

Stress and Conception

Couples are often told:

“Stop worrying and pregnancy will happen.”

I do not consider this an appropriate way to counsel an infertile couple.

Stress can affect sleep, sexual relationships and general wellbeing. Severe physiological stress may also interfere with ovulation in selected women.

But blocked fallopian tubes are not caused simply by worrying.

Azoospermia is not cured by relaxation.

Infertility should therefore be investigated appropriately rather than blaming the patient for being anxious.

At the same time, emotional wellbeing matters because excessive fertility pressure can make intercourse difficult, create relationship tension and reduce quality of life.

When Fertility Tracking Becomes Harmful

Tracking should provide information.

It should not control the couple's life.

If a woman is checking several applications, cervical mucus, temperature, LH several times daily and multiple other signs and this is creating anxiety, the plan may need simplification.

For many couples, regular intercourse every two or three days is sufficient without identifying one exact ovulation hour.

Fertility awareness is valuable when it gives a couple confidence.

It becomes counterproductive when intimacy becomes a compulsory procedure.

Understanding Conception From the Unani Perspective

Unani medicine takes a whole-body approach to reproductive health.

Rather than considering conception only as sperm meeting an egg, the traditional system evaluates the reproductive organs together with **Mizaj**, nutritional health, the quality of bodily functions, psychological state, physical activity, sleep and broader constitutional wellbeing.

This holistic perspective can be useful during preconception care when interpreted responsibly.

Modern reproductive science explains conception using hormones, follicles, sperm, fallopian tubes, embryology and endometrial receptivity.

Traditional Unani medicine explains health using its own classical physiological framework.

These should be understood as **different explanatory systems rather than forced into artificial one-to-one equivalence**.

Mizaj and Individualized Reproductive Care

Mizaj, or temperament, is one of the fundamental concepts of Unani medicine.

CCRUM's scientific programme continues to study Unani temperaments and their relationship with physiological and biochemical characteristics.

In reproductive counselling, Mizaj can be used within the traditional framework to individualize advice regarding diet, activity, sleep and general health.

However, a Mizaj assessment cannot tell us whether a fallopian tube is blocked.

It cannot measure sperm concentration.

It cannot replace thyroid testing when thyroid disease is suspected.

The strongest contemporary approach is therefore to **combine individualized traditional assessment with modern diagnostic methods when necessary**.

Asbab-e-Sitta Zarooriya and Preconception Health

Unani medicine places great emphasis on six essential lifestyle factors—**Asbab-e-Sitta Zarooriya**.

These traditionally involve air and environment, food and drink, movement and rest, psychological activity and repose, sleep and wakefulness, and retention and elimination.

For modern preconception counselling, this framework can be extremely practical.

Food and drink correspond naturally with nutritional preparation.

Movement and rest remind patients to remain physically active without extremes.

Sleep and wakefulness emphasize adequate sleep.

Psychological balance is highly relevant when couples are under fertility stress.

Environmental health includes avoiding tobacco and unnecessary toxic exposures.

In this sense, traditional Unani preventive medicine can complement modern preconception care very naturally.

Ilaj-bil-Ghiza: Dietotherapy for Couples Trying to Conceive

Dietotherapy, or **Ilaj-bil-Ghiza**, is an established part of Unani medicine.

I consider it especially relevant when there is poor nutrition, obesity, metabolic disease, insulin resistance or general weakness.

The aim should not be to create a rigid “fertility diet.”

ASRM concludes that evidence is insufficient to prove that one specific diet or macronutrient pattern universally improves natural fertility.

Therefore, I recommend a balanced, nutritionally adequate dietary pattern appropriate for the individual rather than promising pregnancy from one food.

Dates, milk, almonds, walnuts, fruits, vegetables, whole grains, pulses and healthy dietary fats may all contribute to good nutrition where suitable.

But no single food can guarantee conception.

Unani Pharmacotherapy Before Conception

The Unani pharmacopoeia contains many medicines traditionally used for reproductive health, menstrual disorders, general debility, male sexual weakness and semen-related complaints.

I believe these medicines should be selected only after understanding the patient's actual condition.

A man with azoospermia should not automatically receive a general semen tonic without determining why sperm are absent.

A woman with bilateral tubal obstruction should not lose several years taking medicines in the hope that every structural blockage will dissolve.

A woman with irregular ovulation requires a different treatment strategy from a woman who already ovulates normally.

This is the true meaning of **individualized Unani medicine**.

What Unani Medicine Can Realistically Contribute

Unani medicine can be especially valuable in preconception care through **diet, lifestyle regulation, digestive health, sleep, emotional balance, general metabolic wellbeing and appropriately selected supportive medicines**.

It may also be helpful in managing associated sexual-health problems in selected patients.

But Unani care should not be marketed as a guaranteed method for conceiving within a particular number of days or cycles.

No responsible fertility system should promise “100% pregnancy.”

The outcome depends on age, egg availability, sperm function, reproductive anatomy and many other factors.

Sexual Health and Conception

Some couples have apparently normal fertility investigations but intercourse itself is difficult.

A man may have erectile dysfunction or severe ejaculatory problems.

A woman may have vaginismus, vaginal dryness or painful intercourse.

One partner may have very low sexual desire.

In such circumstances, conception may not occur simply because regular effective vaginal intercourse is not taking place.

Because my clinical practice focuses on **sexual disorders as well as infertility**, I consider these issues an essential part of preconception counselling.

They should be discussed privately and without embarrassment.

When Should a Couple Stop Simply Trying and Seek Investigation?

A couple should not continue unassisted attempts indefinitely when there are clear fertility concerns.

ASRM recommends initiating infertility evaluation after approximately **12 months in women younger than 35**, after approximately **six months in women aged 35 years or older**, and

potentially sooner in women over 40. Investigation should begin without delay when there is a known condition associated with infertility.

Examples include very irregular menstruation, absent periods, known tubal disease, endometriosis, suspected male-factor infertility, sexual dysfunction or previous treatment that may have damaged reproductive function.

Do not lose valuable reproductive time trying increasingly complicated home remedies when the next appropriate step is investigation.

What Does a Basic Infertility Evaluation Include?

For a woman, evaluation generally considers **ovulatory function and the structure and patency of the reproductive tract**.

For the male partner, semen evaluation is essential when infertility is being investigated.

ASRM specifically recommends parallel evaluation of the male partner when applicable.

Additional hormonal, imaging or genetic investigations depend on clinical findings.

The purpose is not to perform every test available.

It is to answer the question:

Where in the reproductive process is the difficulty occurring?

Dr. Nizamuddin Qasmi's Specialized Approach to Conception and Fertility

When a couple consults me at **Saira Health Care**, my first objective is to understand whether they truly have infertility or simply need better guidance about conception.

I review the woman's cycle pattern and whether ovulation appears to be occurring.

I explain the fertile window in practical terms rather than simply saying “try on day 14.”

I ask how frequently intercourse occurs and whether there are sexual difficulties.

I consider the ages of both partners, previous pregnancies, previous miscarriage or ectopic pregnancy, pelvic infections, surgery, medications and relevant illnesses.

When infertility criteria are met—or there is an obvious risk factor—I prefer proper investigation rather than continuing empirical treatment indefinitely.

At the same time, I use my Unani training to assess the patient's broader health: **Mizaj, diet, digestion, sleep, physical activity, emotional state and general constitutional condition**.

The treatment is then individualized.

This is what I consider a rational integration of Unani and modern reproductive care.

What "Special Treatment" Means at Saira Health Care

For me, special treatment does not mean giving every couple a secret fertility formulation.

It means identifying the **specific barrier to pregnancy**.

A couple who are simply mistiming intercourse need education rather than heavy medication.

A woman with PCOS and anovulation requires different care.

A woman with tubal obstruction requires evaluation of the tubes.

A man with severely reduced sperm production requires a proper male infertility work-up.

A couple with erectile dysfunction or vaginismus may require sexual-health treatment before fertility medicines.

Once the main problem is understood, individualized Unani supportive treatment can be integrated where it is clinically suitable.

The objective is to avoid both **undertreatment and unnecessary treatment**.

Contribution of Saira Health Care in Sexual Disorders and Infertility

At **Saira Health Care**, we work with many couples who arrive after months or years of confusion.

Some have been told that the woman is responsible without examining the man.

Some have taken numerous fertility medicines without ever having intercourse correctly timed.

Some men believe sexual potency proves fertility.

Others become frightened by one semen report.

Some women believe a mobile application tells them the exact moment of ovulation.

Our role is therefore not limited to prescribing medication.

We aim to provide **fertility education, sexual-health counselling, interpretation of reports, appropriate investigation and individualized integrative management**.

Where a modern reproductive intervention is needed, the patient should understand why.

Where no major abnormality exists, unnecessary treatment should be avoided.

This is how fertility care becomes more scientific, more economical and less stressful for couples.

Frequently Asked Questions

What is the best day to become pregnant?

There is no universal best cycle day. The fertile window spans approximately the six days ending with ovulation, and conception is generally most likely when intercourse occurs during the one to two days before ovulation.

Is ovulation always on day 14?

No. Day 14 is only an example for some 28-day cycles. Ovulation varies among women and among cycles.

How many times should we have intercourse?

Intercourse every **one to two days during the fertile window** gives the highest reproductive efficiency. Two or three times per week throughout the cycle is also a reasonable strategy for many couples.

Does daily intercourse reduce sperm?

Usually not in men with normal semen parameters. Couples do not need to intentionally limit intercourse to “save” sperm.

How long can sperm live?

Sperm may survive for several days in favourable cervical mucus, which is why intercourse before ovulation can result in pregnancy.

How long does the egg survive?

The egg remains capable of fertilization for a much shorter period after ovulation, generally around a day. This is why pre-ovulation intercourse is particularly important.

Is an ovulation kit useful?

Yes. Urinary LH testing can detect the surge preceding ovulation by approximately one to two days, although false results can occur and PCOS can complicate interpretation.

Can a mobile app tell the exact day of ovulation?

Not reliably. Apps can help identify patterns, but ASRM notes limited accuracy in predicting an individual's exact ovulation day.

Is egg-white cervical mucus a fertile sign?

Yes. Clear, slippery cervical mucus generally occurs around the most fertile part of the cycle.

Should I raise my legs after intercourse?

No evidence demonstrates that this increases pregnancy rates.

Which sexual position is best?

No specific intercourse position has been shown to improve natural conception.

Why does semen come out after intercourse?

Some leakage of seminal fluid is normal. Sperm begin entering the cervical canal rapidly, so leakage does not mean conception is impossible.

Do women have to orgasm to become pregnant?

No. Female orgasm is not required for conception.

Should we take fertility medicines before trying naturally?

Not automatically. Healthy couples may only need correct timing and preconception care. Medicines should be selected when there is a specific diagnosis or indication.

Should women take folic acid?

Yes. CDC recommends **400 micrograms daily** for women capable of becoming pregnant to help prevent neural-tube defects.

Does smoking affect fertility?

Yes. WHO's September 2026 evidence summary links tobacco exposure with female infertility and adverse effects on male sperm and sexual function.

Can Unani medicine help couples trying to conceive?

Yes, particularly through **individualized preconception support involving diet, lifestyle, sleep, general health, Mizaj and selected physician-supervised medicines**. It should not replace necessary fertility investigation or established treatment for structural, endocrine or severe male-factor infertility.

My Final Message to Couples Trying for Pregnancy

Whenever a couple asks me how to achieve pregnancy, I first want them to understand their own reproductive biology.

You do not need to treat every menstrual cycle like an illness.

You do not need to wait for one perfect “day 14.”

You do not need to keep the husband abstinent for a week.

You do not need to raise the woman's legs after intercourse.

And you do not need to begin several fertility medicines simply because pregnancy did not occur in the first month.

Understand the fertile window.

Have intercourse regularly.

Prepare both partners' health.

Stop tobacco.

Review important medicines.

Take appropriate folic acid before pregnancy.

Pay attention to menstrual irregularity or significant sexual problems.

And when the time for fertility investigation has arrived, do not unnecessarily postpone it.

My Unani training teaches me to consider the patient more broadly through **Mizaj, Ilaj-bil-Ghiza, sleep, activity, emotional wellbeing and the wider principles of Hifz-e-Sehat**. Modern reproductive medicine gives us objective tools for understanding ovulation, sperm, tubes, hormones and reproductive anatomy.

I believe couples benefit most when these strengths are used responsibly.

At **Saira Health Care**, my aim is not simply to give a “pregnancy medicine.” My aim is to determine whether the couple requires better timing, healthier preconception preparation, treatment of a sexual-health problem, an infertility investigation, individualized Unani supportive care or a modern fertility intervention.

The pathway to pregnancy should be **scientific, understandable, patient-centred and realistic**.

And perhaps the most reassuring message is this:

Pregnancy does not have to happen in the first cycle for a couple to be healthy. But when pregnancy is delayed beyond the appropriate time, there is also no reason to remain in uncertainty. Proper counselling and timely investigation can provide a clear way forward.

About Dr. Nizamuddin Qasmi

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Integrated Sexual and Reproductive Health – ISRH, UNFPA

Dr. Nizamuddin Qasmi's work at **Saira Health Care** focuses on sexual disorders and infertility, with particular attention to couple-based fertility counselling, sexual-function problems, male and female reproductive assessment and individualized integrative care.

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Medical Disclaimer

This article is intended for **general education and public awareness**. It does not constitute individual medical advice, a fertility prescription or a guarantee of pregnancy.

The timing of ovulation and probability of conception vary between individuals and cycles. Couples with prolonged difficulty conceiving, significant menstrual irregularity, known tubal disease, recurrent pregnancy loss, azoospermia, markedly abnormal semen parameters or sexual dysfunction should seek individualized professional evaluation.

Unani medicines, herbs, supplements and fertility remedies should not be self-prescribed as substitutes for appropriate investigation. Women who may have conceived require particular caution because a medicine suitable before conception may not necessarily be suitable during pregnancy.