Preconception Fertility Optimization: Diet, Stress, Sleep, Lifestyle and the Role of Unani Medicine

A Complete Modern and Unani Guide to Preparing the Female and Male Reproductive System for Pregnancy

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

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

Introduction

When couples come to me because they want to achieve pregnancy, they often ask a very direct question:

“Doctor, which medicine should we take to improve fertility?”

My answer is that fertility cannot usually be reduced to one tablet, one herb, one hormone or one food.

Pregnancy depends on the coordinated health of several systems. In women, ovulation, ovarian function, fallopian-tube health, the uterus and endocrine balance all matter. In men, sperm production, sperm transport, sexual function and semen quality are important. Metabolic health, nutrition, tobacco exposure, chronic disease and age can influence both partners.

The material prepared for this article describes an integrative preconception model involving **nutrition, metabolic health, stress, sleep and traditional Unani principles such as Tanqiya and regulation of the body's essential lifestyle factors**.

These are useful areas to discuss, but modern fertility medicine requires an important distinction: **a healthy lifestyle can support reproductive health, but it cannot correct every cause of infertility**. Balanced food cannot reopen a severely scarred fallopian tube. Meditation cannot reverse severe testicular failure. Sleep improvement cannot restore an absent uterus or overcome every age-related reproductive change.

This is why the most effective approach is not “natural treatment versus modern treatment.” It is **correct diagnosis combined with sensible fertility optimization and appropriate treatment when a medical problem is identified**.

This principle has become even more important since the World Health Organization published its first global guideline on infertility in November 2025. WHO recommends fertility education, healthy diet, physical activity, tobacco cessation, psychosocial support and progressive treatment based on the identified cause of infertility.

At **Saira Health Care**, this diagnosis-based, patient-centred and integrative philosophy forms the foundation of my approach to sexual disorders and infertility.

What Is Preconception Fertility Optimization?

Preconception fertility optimization means improving the health of a woman and her partner **before pregnancy occurs**.

It includes much more than fertility medicine.

Good preconception care may involve:

- identifying ovulation or menstrual problems;
- addressing PCOS and metabolic abnormalities;
- evaluating significant male-factor concerns;
- improving diet and physical activity;
- stopping tobacco;
- reviewing alcohol and other substances;
- correcting important nutritional deficiencies;
- taking appropriate folic acid;
- controlling diabetes, thyroid disease and hypertension;
- reviewing medicines and herbal products;
- improving sleep;
- addressing severe psychological distress;
- screening for relevant reproductive infections;
- and determining whether formal infertility evaluation is already required.

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

Preconception care should therefore have two objectives:

support natural reproductive health where possible, and identify situations where lifestyle changes alone will not be sufficient.

Is the "Three-Month Fertility Preparation" Concept Scientific?

Patients often hear about a "90-day fertility plan" or a "three-month preconception program."

There is some biological logic behind planning ahead.

Sperm develop over a period of weeks before they appear in the ejaculate, and ovarian follicles also undergo a prolonged process of growth before ovulation. Therefore, lifestyle changes made before conception may influence the biological environment in which reproductive cells mature.

The supplied material uses the concept of a **three-to-six-month preconception window** for metabolic, nutritional and lifestyle preparation.

However, patients should understand that there is **no universal medical rule requiring every couple to complete three or six months of detoxification before trying for pregnancy**.

A woman approaching an age where fertility is declining should not unnecessarily postpone conception simply to complete a long supplement or cleansing programme.

Likewise, a couple with several years of infertility should not delay diagnostic evaluation for months because they have been told to "optimize the body first."

Preconception preparation is useful, but reproductive time also matters.

Fertility Is a Couple's Issue

Although women often receive most of the investigations and treatment, fertility is not exclusively a female issue.

Male factors contribute substantially to infertility, and WHO's current infertility framework includes separate diagnostic and treatment pathways for **male factors, ovulatory dysfunction, tubal disease, uterine disorders and unexplained infertility**.

Therefore, when a couple has genuine infertility, I prefer to consider both partners from the beginning.

A woman may have completely normal ovulation but her husband has severe oligospermia. A man may have excellent semen parameters while his wife has bilateral tubal disease.

Lifestyle advice should also apply to **both partners**, particularly regarding smoking, diet, physical activity and chronic disease.

Nutrition and Fertility: What Does the Evidence Really Show?

Nutrition is essential for health, but the phrase **"fertility diet"** is often misused.

Some websites promise that a particular combination of nuts, seeds, fruits, dairy foods or supplements will dramatically improve egg quality or sperm count.

Scientific evidence is more cautious.

The American Society for Reproductive Medicine states that there is **insufficient evidence that one particular diet or specific macronutrient pattern reliably increases natural fertility in otherwise healthy people**.

That does not mean diet is irrelevant.

A nutritionally poor diet can contribute to obesity, insulin resistance, nutrient deficiency and chronic disease, all of which may affect reproductive health. The aim should therefore be a **healthy metabolic environment**, not a magical fertility menu.

What Does a Sensible Fertility Diet Look Like?

For most couples, I favour a dietary pattern built mainly around minimally processed foods.

Vegetables, fruit, pulses, whole grains, nuts, seeds, adequate protein, appropriate dairy or alternatives, and healthy dietary fats can form the foundation.

Highly processed food, large amounts of refined sugar, excessive trans fats and an overall calorie intake far beyond metabolic needs should be reduced.

The supplied source emphasizes glycaemic control, healthy fats and antioxidant-rich whole foods in reproductive nutrition.

The modern interpretation should be practical rather than extreme.

There is no need to completely eliminate carbohydrates. There is no evidence that every infertile woman needs a ketogenic diet. Likewise, avoiding all dairy, gluten or animal protein does not have established fertility benefits in everyone.

Diet should be **appropriate for the patient's diagnosis**.

PCOS, Insulin Resistance and Dietary Counselling

Nutrition becomes particularly relevant in **polycystic ovary syndrome (PCOS)**.

Insulin resistance is an important biological feature in many women with PCOS. Elevated insulin can contribute to increased androgen production and disrupted ovulation.

The international evidence-based PCOS guideline recommends lifestyle intervention—including healthy eating, physical activity and behavioural strategies—for women with PCOS to improve metabolic health and overall wellbeing.

But an important point is often missed:

there is no one specific PCOS diet proven superior to all others.

A healthy eating pattern that can be sustained long term is generally more useful than a highly restrictive plan followed for two weeks.

For women who are overweight, appropriate weight management may improve metabolic and reproductive outcomes. For women who are not overweight, the goal is healthy nutrition and prevention of unnecessary weight gain—not forced weight loss.

High Sugar Intake and Fertility

The supplied research discusses high-glycaemic foods, insulin resistance and oxidative stress as potential reproductive problems.

This concept is especially relevant when a woman has PCOS, prediabetes, diabetes or significant metabolic dysfunction.

Repeated large glucose and insulin excursions are not desirable for overall health.

However, patients should not interpret this to mean that eating a sweet food once will prevent pregnancy.

What matters more is the **overall dietary pattern and metabolic condition over time**.

Good fertility counselling should prevent both unhealthy eating and unnecessary food fear.

Is the Mediterranean Diet the Best Fertility Diet?

The Mediterranean dietary pattern is often discussed in reproductive medicine because it emphasizes vegetables, legumes, fruits, whole grains, nuts, olive oil and fish.

Some observational studies have associated greater adherence with improved semen measures or reproductive outcomes.

However, a systematic review and meta-analysis concluded that evidence remains **insufficient to recommend Mediterranean-diet adherence as a specific fertility treatment**, despite some encouraging associations.

Therefore, I regard Mediterranean-style eating as a **healthy dietary model**, not a guaranteed fertility therapy.

The supplied material presents very large increases in IVF success associated with this diet. Those figures should be interpreted cautiously because dietary fertility studies are often observational and can be affected by many confounding factors.

Are There "Fertility Superfoods"?

There is no scientifically established fertility superfood.

Walnuts, vegetables, fruits, pomegranate, tomatoes, oily fish and other nutritious foods contain valuable fatty acids, vitamins, minerals or antioxidants.

The supplied material discusses foods such as walnuts, fish, pomegranate, tomatoes and leafy vegetables in relation to reproductive nutrition.

These foods can certainly form part of a healthy diet.

But a pomegranate does not unblock fallopian tubes.

Walnuts cannot correct severe azoospermia caused by genetic testicular failure.

Tomatoes cannot restore a severely diminished ovarian reserve.

Foods support physiology; they should not be promoted as treatments for structural or severe reproductive disease.

Omega-3 Fatty Acids and Fertility

Omega-3 fatty acids are biologically important components of cell membranes and may influence inflammatory pathways.

Fish, particularly certain oily fish, provides EPA and DHA, while walnuts and several plant foods provide alpha-linolenic acid.

Studies have explored relationships between omega-3 intake and semen parameters or assisted-reproduction outcomes, but evidence is not strong enough to prescribe large doses of fish oil to every infertile couple.

A food-first approach is reasonable for most patients unless there is a specific clinical indication for supplementation.

Folic Acid Before Pregnancy

One supplement has a particularly strong evidence-based role before conception: **folic acid**.

WHO recommends that women take **400 micrograms of folic acid daily from the time they begin trying to conceive until 12 weeks of pregnancy** to reduce the risk of neural-tube defects.

This is a pregnancy-prevention measure rather than a medicine that makes a woman ovulate.

Patients should not confuse **preconception supplementation with fertility treatment**.

Certain women require different doses because of specific medical circumstances, so personalized medical advice may be necessary.

Supplements for "Egg Quality": A Cautious Approach

Women seeking fertility treatment are frequently offered CoQ10, melatonin, DHEA, inositol, NAC and multiple antioxidants.

The source provided for this article lists several of these supplements and specific proposed doses.

However, these should not be turned into a universal self-treatment protocol.

Evidence differs greatly among supplements and patient groups.

DHEA is a hormone precursor and is not an ordinary vitamin. It should not be taken indiscriminately.

Melatonin may influence sleep and biological rhythms, but using it as a routine fertility supplement is not established for every woman.

CoQ10 has attracted research interest, especially in assisted reproduction, but it cannot reverse biological age.

Inositol may have modest metabolic benefits in some women with PCOS, but the international PCOS guideline notes that its overall clinical benefits are limited compared with established approaches.

Supplements should therefore be selected according to diagnosis rather than internet popularity.

Tobacco: One of the Most Important Modifiable Fertility Risks

Tobacco deserves special emphasis because very recent evidence has strengthened the case for fertility counselling.

On **8 September 2026**, WHO published a new evidence summary on tobacco and infertility.

WHO reports that women who currently smoke have approximately a **40% higher risk of infertility than women who do not smoke**, based on evidence reviewed through 2026. It also reports associations in men with semen abnormalities and sexual dysfunction and warns that second-hand smoke may affect reproductive health.

This is one of the clearest lifestyle changes I can recommend to a couple trying to conceive:

stop tobacco rather than searching for a supplement to cancel out its effects.

WHO specifically recommends that healthcare professionals counsel individuals and couples planning pregnancy about tobacco-related reproductive risks and offer evidence-based cessation support.

Alcohol and Recreational Substances

Preconception counselling should also include alcohol, nicotine and recreational drugs.

ACOG recommends routinely discussing these exposures during prepregnancy care. It also recommends reviewing all prescription and non-prescription medicines, supplements and herbal products because they may affect reproduction or pregnancy.

A woman can become pregnant before recognizing that conception occurred, which is why pregnancy-safe behaviour is best discussed before the positive test.

Healthy Weight and Fertility

Body weight can influence fertility, but counselling must be respectful.

Both very low body weight and obesity may be associated with reproductive problems.

In women with PCOS and excess weight, modest weight reduction may improve metabolic health and sometimes ovulatory function.

In contrast, severe calorie restriction, excessive exercise and very low body fat can suppress hypothalamic reproductive signalling and cause absent or irregular menstruation.

The objective is therefore **metabolic health rather than an arbitrary appearance or number on the weighing scale**.

ACOG encourages achieving an appropriate preconception BMI where possible because very high or low BMI can be associated with infertility and pregnancy complications.

Physical Activity and Fertility

Regular physical activity is beneficial for cardiovascular health, metabolic function and weight management.

ACOG recommends approximately **150 minutes of moderate exercise per week** for most healthy adults, including during the preconception period.

More is not automatically better.

Extremely strenuous exercise combined with insufficient calorie intake can interfere with ovulation in some women.

For men, exercise can support metabolic and cardiovascular health, but anabolic steroids used for bodybuilding can suppress natural testosterone production and sperm production profoundly.

A fertility plan should therefore encourage **appropriate movement—not extremes**.

Stress and Infertility: What Is True and What Is Exaggerated?

One of the most harmful things a woman with infertility can be told is:

"Just stop stressing and you will become pregnant."

That statement is medically simplistic and emotionally insensitive.

Infertility itself can cause tremendous stress.

WHO's 2025 infertility guideline recognizes that infertility can lead to anxiety, depression, stigma and social isolation and recommends ongoing access to **psychosocial support**.

Severe stress, major calorie restriction, excessive exercise and other physiological stressors can contribute to **functional hypothalamic amenorrhoea** in some women. But common emotional stress does not explain every case of infertility.

Stress management should improve wellbeing—not blame the patient for failing to conceive.

The HPA and Reproductive Axes

The supplied material describes an interaction between the body's stress-response system—the **hypothalamic-pituitary-adrenal axis**—and reproductive hormonal signalling.

There is genuine biological communication between these systems.

High physiological stress states can alter hypothalamic signalling and reproductive function.

However, concepts such as the popular **"pregnenolone steal" or "cortisol steal" theory** should not be presented as an established mechanism explaining ordinary infertility. The endocrine system does not simply run out of one common hormone precursor because a person feels stressed.

For textbook-quality fertility information, it is better to say:

chronic physiological stress can alter neuroendocrine signalling in certain circumstances, but infertility is usually multifactorial and should not be attributed to cortisol without appropriate investigation.

Mindfulness, Counselling and Fertility

Mindfulness-based therapies have been studied in women experiencing infertility.

A systematic review and meta-analysis found meaningful improvements in **anxiety, depression and several measures of quality of life** among women receiving mindfulness-based interventions.

A later meta-analysis likewise reported improvements in anxiety, depression, perceived stress and wellbeing, while noting limitations in study quality.

This makes psychological support valuable.

But I would not tell a patient:

"Meditation will make you pregnant."

The strongest evidence is for improving emotional wellbeing and coping. Effects on live birth or pregnancy rates remain much less certain.

Yoga and Fertility

Yoga may contribute to physical activity, relaxation, flexibility and stress reduction.

These are reasonable health benefits.

However, no specific yoga posture has been proven to "increase blood flow to the ovary," unblock a tube or guarantee improved sperm production.

The supplied source discusses particular yoga postures and claims reproductive effects through autonomic and oxidative mechanisms.

Such mechanisms remain areas of research.

Yoga can therefore be recommended as a **wellbeing practice**, provided the patient does not use it instead of necessary infertility investigation or treatment.

Sleep and Fertility

Sleep has received increasing attention in reproductive medicine.

A 2024 systematic review found that women experiencing infertility frequently report poorer sleep and that poor sleep, unusual sleep duration and certain sleep disorders are associated with less favourable fertility-related outcomes. However, the authors emphasized that mechanisms and causality remain incompletely understood.

A 2026 systematic review of women undergoing IVF/ICSI similarly found associations between some sleep disturbances and poorer treatment outcomes, but concluded that causal relationships and optimal sleep interventions remain uncertain.

Therefore:

good sleep is a sensible component of reproductive health, but sleep improvement should not be sold as a proven infertility cure.

How Much Sleep Is Best?

The source supplied for this article describes seven to nine hours of sleep as an ideal fertility range.

Seven to nine hours is a common general recommendation for many adults, but there is no universally validated “fertility sleep prescription” guaranteeing better conception.

The practical advice is to maintain:

- reasonably consistent sleep and waking times;
- sufficient duration to feel rested;
- treatment of chronic insomnia when significant;
- assessment of possible obstructive sleep apnoea where relevant;
- and avoidance of unnecessary sleep deprivation.

This is particularly important in women with PCOS and obesity, in whom sleep apnoea may occur more frequently.

Shift Work and Circadian Rhythm

Human physiology follows daily biological rhythms.

The reproductive system is influenced by these rhythms, and sleep disruption or shift work may be associated with menstrual irregularity and reproductive disturbances.

The supplied research discusses reproductive “clock genes,” melatonin and circadian disruption in this context.

These are legitimate areas of reproductive research.

However, the claim that avoiding screens for exactly two hours or sleeping in complete darkness will directly improve egg quality or pregnancy rates is stronger than current clinical evidence allows.

Reducing excessive late-night light exposure may support sleep hygiene, but it should not be presented as a fertility treatment equivalent to ovulation induction or IVF.

Male Fertility and Sleep

A 2025 comprehensive review concluded that sleep disturbance is increasingly associated with hormonal and reproductive abnormalities in men, although many questions regarding causality remain unresolved.

This is another reason fertility counselling should include both partners.

A man who sleeps four hours every night, smokes heavily, has uncontrolled diabetes and is significantly overweight may benefit substantially from general health optimization even while formal male-factor investigation proceeds.

The Unani Concept of Health Before Conception

One of the important strengths of Unani medicine is that it has always placed considerable emphasis on **Hifz-e-Sehat**, or preservation of health.

Rather than waiting for disease to become severe, the system considers daily living conditions important to maintaining physiological balance.

Central to this approach are the **Asbab Sitta Daruriyya**, or Six Essential Factors.

CCRUM, under India's Ministry of Ayush, defines these as:

air; food and drink; bodily movement and rest; mental activity and peace; sleep and wakefulness; and retention and evacuation.

In fertility counselling, this provides a useful traditional framework for reviewing diet, physical activity, psychological health, sleep and general lifestyle.

Mizaj and Individualized Fertility Care

The Unani concept of **Mizaj**, or temperament, emphasizes that individuals do not respond identically to diet, environment or treatment.

Within traditional Unani medicine, disease is often considered in relation to altered temperament or **Su-e-Mizaj** and disturbances of the four humours—*Dam, Balgham, Safra and Sauda*.

CCRUM describes normalization of altered temperament and individualized lifestyle as formal principles of Unani treatment.

I consider the individualized philosophy useful, particularly when combined with objective reproductive medicine.

But a Mizaj assessment cannot replace semen analysis, ultrasound, HSG, hormonal testing or genetic investigation where those tests are indicated.

Tanqiya: The Unani Concept of Cleansing

The supplied research places considerable emphasis on **Tanqiya**, traditionally referring to evacuation or removal of abnormal humoral material before strengthening therapy.

CCRUM also recognizes **Tanqiya** as a traditional Unani principle, which may involve methods such as Munzij-Mushil therapy, cupping, venesection, diuresis or diaphoresis depending on the classical diagnosis.

This establishes Tanqiya as an authentic concept within Unani medicine.

However, an important scientific clarification is necessary.

Traditional terms such as “morbid matter” or “bad humours” should not be directly translated into modern claims that Tanqiya **removes reactive oxygen species, clears toxins from reproductive organs, resets hormones or improves egg and sperm DNA**.

Those biological equivalences have not been established.

Munzij-Mushil Therapy

Munzij-Mushil is a classical two-stage Unani approach.

In traditional theory, **Munzij** medicines are used to prepare or “concoct” abnormal humours, while **Mushil** medicines are used for their evacuation.

The source supplied for this article describes this traditional process in considerable detail.

It is an authentic part of Unani therapeutics.

But strong purgatives are not harmless.

They may cause diarrhoea, dehydration, electrolyte disturbances or interactions with other treatments. Certain traditional ingredients can also be inappropriate for pregnancy or particular medical conditions.

Therefore, **Munzij-Mushil therapy should never be used casually as an internet "fertility detox."**

It requires qualified clinical judgment and should not delay established fertility investigation.

Does a Fertility "Detox" Improve Pregnancy Chances?

There is no high-quality evidence that commercial detox drinks, repeated purgation, colon cleansing or similar procedures increase natural conception or live-birth rates.

The word **detox** is frequently used in marketing without identifying which toxin is supposedly being removed or how its removal has been measured.

Unani Tanqiya is a specific traditional concept and should not simply be equated with fashionable commercial detoxification.

In my view, responsible Unani practice should preserve its authentic terminology while avoiding unsupported biomedical claims.

Hijama and Fertility

Hijama, or cupping therapy, is included within traditional Unani regimenal medicine.

The supplied material discusses dry and wet cupping in relation to pelvic blood flow and fertility.

Current evidence does **not** establish Hijama as a treatment that unblocks fallopian tubes, improves ovarian reserve or reliably increases sperm count or live-birth rates.

It may be used by appropriately trained professionals for selected traditional indications, but claims of direct fertility restoration should be avoided until better clinical evidence exists.

Wet cupping also involves skin penetration and therefore requires strict hygiene and infection-control procedures.

Fasd or Venesection

Fasd, or therapeutic venesection, is another classical Unani regimenal therapy.

Historically, it has been used in particular humoral states.

However, bloodletting should not be promoted as routine preconception care.

A woman with iron deficiency or anaemia could potentially be harmed by unnecessary blood removal.

Women attempting pregnancy frequently need adequate iron stores rather than therapeutic depletion.

Therefore, any consideration of Fasd must be highly individualized and should not be used simply because a patient has infertility.

Hammam and Dalk

Hammam, therapeutic bathing, and **Dalk**, massage, form part of Unani regimenal therapy.

CCRUM formally recognizes **Ilaj-bil-Tadbir**, dietotherapy, pharmacotherapy and surgery as modes of Unani treatment.

In fertility care, gentle massage or bathing may support relaxation and general wellbeing.

However, I do not regard massage or steam as methods for mechanically opening the fallopian tubes or increasing ovarian reserve.

Their role is **supportive rather than curative for structural infertility**.

Unani Pharmacotherapy Before Conception

The Unani pharmacopoeia contains many formulations historically used for reproductive health, uterine strength, sexual weakness and semen-related disorders.

The supplied source mentions formulations including **Majoon-e-Hamal Ambari Alwi Khani, Majoon Arad Khurma, Hab-e-Hamal and Jawarish Jalinoos**.

Historical indication, however, is not equivalent to modern proof of improved pregnancy or live-birth rates.

I do not recommend that patients select these formulations themselves merely because they are planning pregnancy.

The appropriate formulation—if any—should depend on the patient's diagnosis, Mizaj, other medicines, nutritional state and whether pregnancy may already have occurred.

This last point is particularly important because **a medicine considered before conception may not necessarily be appropriate once pregnancy begins**.

Quality Control of Unani Medicines

Responsible Unani practice requires attention to medicine quality.

CCRUM's drug-standardization programme includes development of pharmacopoeial standards and assessment of factors such as heavy metals, microbial load, aflatoxins and pesticide residues.

Patients trying to conceive should therefore avoid unidentified powders, secret mixtures or products without clear ingredients and reliable manufacturing standards.

If the contents of a medicine are unknown, its reproductive and pregnancy safety are also unknown.

The Six Essential Factors as a Practical Fertility Framework

One way I find the **Asbab Sitta Daruriyya** particularly useful is to translate them into practical preconception counselling.

Food and drink: maintain adequate nutrition and good metabolic health.

Movement and rest: remain physically active without overtraining.

Mental activity and peace: address anxiety, relationship stress and emotional burden.

Sleep and wakefulness: maintain a stable, adequate sleep routine.

Environment and air: reduce tobacco smoke and avoid unnecessary harmful exposures.

Retention and evacuation: maintain normal digestive, urinary and physiological function rather than pursuing extreme cleansing.

This is an example of using traditional Unani philosophy in a way that can complement modern preventive medicine safely.

Preconception Care Is More Than Fertility Treatment

A woman preparing for pregnancy should also consider general medical health.

ACOG recommends reviewing chronic conditions, vaccination status, medications, nutritional supplements, herbal products, tobacco, alcohol and other exposures during prepregnancy counselling.

Conditions such as diabetes, hypertension and thyroid disease should ideally be appropriately controlled before pregnancy.

STI screening should also be considered according to individual risk.

The objective is not simply getting pregnant.

The goal is entering pregnancy **as healthy and prepared as reasonably possible**.

Age and Fertility: Lifestyle Cannot Stop the Biological Clock

A healthy lifestyle is valuable, but it cannot completely overcome reproductive ageing.

Female fertility decreases progressively with age, especially after the mid-thirties.

No diet, detoxification procedure, antioxidant or Unani formulation has been proven to make the ovaries biologically younger.

This is why women should not lose valuable reproductive time pursuing repeated “egg rejuvenation” programmes when appropriate fertility evaluation or assisted reproductive treatment is indicated.

Lifestyle can support health.

It cannot stop time.

PCOS: Where Lifestyle and Unani Care May Integrate Well

PCOS is one condition where an integrative approach may be particularly practical.

The international guideline strongly recommends healthy lifestyle behaviours for all women with PCOS and recognizes the importance of weight, smoking, alcohol, nutrition, physical activity, sleep and emotional health when pregnancy is planned.

Within Unani medicine, the same patient can also be considered according to Mizaj, diet, exercise, sleep and other essential factors.

This creates a reasonable point of integration.

However, if the woman has persistent anovulatory infertility, letrozole is currently recommended as first-line pharmacological ovulation induction when appropriate and permitted.

Unani supportive management should not prevent her from receiving effective ovulation treatment when it is needed.

Why "Natural Pregnancy at Any Cost" Can Be Harmful

Many couples come to fertility clinics specifically because they want a natural pregnancy.

I respect this preference.

But sometimes patients spend years using different medicines because they have been told that IVF, IUI or surgery must always be avoided.

That can be harmful.

If both fallopian tubes are severely damaged, lifestyle modification alone cannot create a physical passage.

If sperm production is extremely limited, waiting several years may not improve reproductive potential.

If a woman is approaching 40 with diminished ovarian reserve, reproductive time becomes critically important.

Natural conception is desirable when realistic, but the goal should be **a safe and informed pathway to pregnancy rather than attachment to one method at all costs**.

When Lifestyle Optimization Is Not Enough

A couple should seek proper fertility assessment rather than relying solely on lifestyle measures when there is prolonged infertility, severe menstrual irregularity, absent ovulation, known tubal disease, repeated ectopic pregnancy, severe endometriosis, previous major pelvic infection, azoospermia, markedly abnormal semen parameters or another significant reproductive condition.

Modern fertility evaluation exists precisely to determine **why pregnancy is not happening**.

WHO's 2025 guideline recommends progressing from fertility education and simpler interventions toward treatments such as intrauterine insemination or IVF when the diagnosis and circumstances justify them.

My Approach as Dr. Nizamuddin Qasmi

When a couple consults me at **Saira Health Care**, I do not begin by assuming that every infertility problem comes from "toxins," stress, poor diet or hormonal weakness.

I begin with the question:

What is actually preventing pregnancy?

I consider the duration of infertility, ages of both partners, menstrual history, evidence of ovulation, previous pregnancy, miscarriage or ectopic pregnancy, history of pelvic infection, PCOS, thyroid or metabolic problems, sexual function and previous fertility treatment.

The male partner's reproductive health is assessed rather than placing the entire responsibility on the woman.

Where clinically appropriate, I review semen analysis, hormonal reports, ultrasound, tubal investigations and other available records.

Once important structural and endocrine causes have been considered, lifestyle becomes part of a targeted plan rather than a generic prescription.

The Special Integrative Role of Unani Medicine in My Practice

My training in Unani medicine encourages me to consider **Mizaj, diet, digestive health, activity, rest, sleep, emotional state and overall constitution**.

I regard these as particularly useful in preconception health.

For selected patients, individualized Unani pharmacotherapy may also have a role.

However, I do not believe in confusing traditional theory with modern laboratory biology.

For example, *Tanqiya* is a classical Unani concept. It should not automatically be described as the removal of free radicals from the ovaries.

Mushil treatment is a traditional purgative intervention. It should not be promised as a cure for blocked fallopian tubes.

Mizaj is useful within Unani diagnosis. It does not replace thyroid testing when hypothyroidism is suspected.

This distinction allows traditional medicine to be used responsibly.

Contribution of Saira Health Care in Sexual Disorders and Infertility

At **Saira Health Care**, our work in infertility is closely linked with sexual and reproductive health.

Some couples struggle to conceive because of ovulation or tubal disease. Others have male-factor infertility. Some have sexual problems that make regular intercourse difficult, such as erectile dysfunction, premature ejaculation, vaginismus or painful intercourse.

Others have both medical and psychological concerns.

Our contribution is therefore broader than simply providing a fertility medicine.

We aim to help patients understand fertility scientifically, review existing investigations, identify when further testing may be needed, address sexual-health barriers, improve modifiable lifestyle factors and provide individualized Unani supportive care where appropriate.

When modern fertility treatment, hormonal therapy, surgery, IUI or IVF is indicated, patients should receive an honest explanation rather than indefinite treatment without measurable progress.

The Importance of Emotional Support at Saira Health Care

Infertility can create an enormous emotional burden.

A couple may become anxious every month, avoid family gatherings, feel blamed by relatives or gradually lose sexual intimacy because intercourse becomes a scheduled fertility task.

Psychological support is therefore not an optional luxury.

ESHRE's psychosocial-care guidance emphasizes recognizing patients' emotional needs throughout infertility treatment, while WHO's latest guideline recommends ongoing psychosocial support.

At Saira Health Care, I believe counselling should help the patient understand what is happening rather than simply adding another medicine to the prescription.

A Practical Preconception Fertility Plan

For many couples, a sensible plan includes healthy, sustainable meals; regular moderate physical activity; tobacco cessation for both partners; avoidance of recreational drugs; appropriate alcohol counselling; folic acid for the woman; adequate sleep; control of diabetes, thyroid disease and other chronic conditions; review of medicines and supplements; appropriate timing of intercourse; and fertility evaluation at the correct time.

WHO's current guidance supports many of these lifestyle and preventive principles while emphasizing that treatment should progress according to the identified infertility factor.

No detoxification protocol should substitute for this basic foundation.

How Long Should Lifestyle Changes Be Tried Before Seeking Treatment?

There is no single answer.

A young couple who has only recently started trying and has no known fertility concern can reasonably focus on healthy lifestyle and appropriate timing.

A couple who has already tried unsuccessfully for 18 months should not be told to complete another six-month detox programme before investigation.

A woman aged 38 or 40 deserves more time-sensitive counselling than a woman aged 23.

A man with azoospermia requires medical investigation rather than simply three months of walnuts and antioxidants.

The correct timing depends on the **clinical context, not a fixed wellness programme**.

Common Myths About Fertility Optimization

“If I remove all toxins from my body, pregnancy will happen.”

There is no scientifically defined general “toxin load” responsible for most infertility, and commercial detoxification has not been proven to treat infertility.

“Stress is the reason I am not pregnant.”

Stress can affect wellbeing and may affect reproductive function in some severe physiological situations, but infertility should never automatically be blamed on emotional stress.

“Sleeping nine hours will improve egg quality.”

Adequate sleep is important for general health, and sleep disturbance is associated with poorer reproductive outcomes in some studies, but no specific sleep duration guarantees improved egg quality.

“A fertility diet can replace treatment.”

No. Diet supports health but cannot correct every anatomical or endocrine cause of infertility.

“More supplements mean better egg quality.”

No. Supplements can have side effects, interactions and uncertain benefits. They should be selected individually.

“Herbal medicine is always safe.”

No. Herbal medicines are biologically active and need appropriate prescribing and quality control.

“Unani purification can unblock any fallopian tube.”

There is no high-quality evidence that classical purgation or cleansing reliably reverses severe fibrotic tubal obstruction.

Frequently Asked Questions

What is the best diet for fertility?

There is no single scientifically proven fertility diet. A balanced pattern emphasizing minimally processed foods, vegetables, fruits, pulses, whole grains, adequate protein and healthy fats is reasonable. ASRM states that evidence is insufficient to recommend one particular dietary pattern specifically to increase natural fertility.

Can reducing sugar improve fertility?

It may be especially helpful for metabolic health in women with insulin resistance, PCOS, prediabetes or diabetes. It does not guarantee pregnancy.

Is folic acid useful before pregnancy?

Yes. WHO recommends 400 micrograms daily from when a woman begins trying to conceive until 12 weeks of pregnancy for most women.

Does smoking affect fertility?

Yes. WHO's September 2026 evidence summary found that current female smokers had approximately a 40% higher infertility risk, and smoking is also associated with male reproductive and sexual dysfunction.

Can stress cause infertility?

Severe physiological stress can interfere with reproductive hormonal signalling in some circumstances, but ordinary stress should not be assumed to be the sole cause of infertility.

Does mindfulness improve fertility?

Mindfulness has reasonably good evidence for reducing anxiety and depression and improving quality of life in women with infertility. Evidence that it directly increases live-birth rates is less certain.

Is sleep important for fertility?

Sleep is important for overall health, and studies show associations between sleep disturbance and female infertility or ART outcomes. Causality and the ideal sleep intervention for fertility are still being studied.

Is seven to nine hours of sleep compulsory for conception?

No. It is a reasonable general adult-health target for many people but not a guaranteed fertility formula.

Can Unani medicine help improve fertility?

Unani medicine can provide useful **individualized supportive care**, particularly through diet, lifestyle, sleep, psychological wellbeing, constitution and selected pharmacotherapy. Its role should be matched to the actual diagnosis.

What is Tanqiya in Unani medicine?

Tanqiya is a classical Unani principle involving evacuation of morbid humoral material according to traditional theory. CCRUM formally recognizes it among Unani treatment principles.

Does Tanqiya remove modern "toxins" or oxidative stress?

Traditional Tanqiya should not automatically be equated with biomedical detoxification or elimination of reactive oxygen species. Those equivalences have not been scientifically established.

Is Munzij-Mushil therapy safe for everyone?

No. Purgative treatment can cause adverse effects and should only be considered by a qualified practitioner for an appropriate traditional indication. It should not be self-administered for infertility.

Can Hijama increase pregnancy rates?

Current evidence is insufficient to state that Hijama reliably increases natural-pregnancy or live-birth rates.

Can Unani medicine replace IVF?

No. If IVF is indicated because of severe tubal disease or another major fertility factor, Unani supportive treatment should not be used to indefinitely delay appropriate reproductive treatment.

Do both husband and wife need lifestyle changes?

Usually yes. Tobacco, metabolic health, diet, chronic disease, sleep and other health factors can be relevant to both male and female reproduction.

My Final Message to Couples Planning Pregnancy

When I counsel couples about fertility, I want them to understand that **good reproductive medicine begins long before a fertility procedure—but it also requires knowing when lifestyle measures have reached their limits**.

Your daily habits matter.

Food matters.

Smoking matters.

Sleep matters.

Physical activity matters.

Mental health matters.

The health of both partners matters.

The Unani system recognized centuries ago that food, activity, rest, psychological wellbeing, sleep and other essential aspects of daily life influence health. CCRUM continues to recognize these principles formally within **Asbab Sitta Daruriyya** and the wider Unani therapeutic framework.

This preventive philosophy can be highly useful in fertility care.

But it should be used with medical accuracy.

I do not want a woman with blocked tubes to spend years cleansing her body instead of having her tubes investigated. I do not want a man with severe azoospermia to believe that a particular food alone will restore sperm. And I do not want a couple to believe that their inability to conceive is simply because they are not relaxed enough.

At **Saira Health Care**, my approach is to bring the strengths of both perspectives together.

Use modern reproductive investigation to identify the cause.
Improve diet, tobacco exposure, exercise, sleep and metabolic health.
Support emotional wellbeing.
Use individualized Unani principles and medicines where appropriate.
And move to evidence-based fertility treatment when the diagnosis requires it.

The purpose of integrative fertility medicine should never be to create more treatments.

It should be to create a **clearer, safer and more individualized path toward pregnancy**.

About Dr. Nizamuddin Qasmi

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

BUMS – Hamdard University, Delhi
MD

CGO
Certificate in Infertility – MGBIMS, Delhi
Certificate in Urology – London, UK
Masters in Male Infertility – MasterHealthPro (HealthPro)
Integrated Sexual and Reproductive Health – ISRH, UNFPA

Dr. Nizamuddin Qasmi's work at **Saira Health Care** focuses on sexual disorders and infertility, including reproductive-health counselling, interpretation of fertility investigations and individualized integrative management.

Website: www.sairahealthcare.com

Medical Disclaimer

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

Diet, sleep, stress-management practices and Unani supportive care may contribute to overall reproductive health but should not delay appropriate investigation or evidence-based treatment for infertility.

Strong purgatives, venesection, cupping, herbal medicines, hormonal supplements and other traditional or complementary treatments should not be self-administered for fertility. Women who may already be pregnant require particular caution because treatments appropriate before conception may not be safe during pregnancy.

Couples experiencing prolonged infertility, severe menstrual irregularity, known tubal disease, azoospermia, recurrent pregnancy loss or other significant reproductive problems should seek individualized professional evaluation.