Integrated Fertility Care: A Modern and Unani Roadmap to Achieving Pregnancy

A Comprehensive Guide to Female and Male Fertility Assessment, Unexplained Infertility, Hormonal and Structural Factors, Lifestyle Optimization, Unani Medicine, IUI, IVF and Responsible Integrative Treatment

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Introduction

When a couple comes to me after months or years of trying for pregnancy, I believe the most useful first question is not:

"Which fertility medicine should we start?"

The better question is:

"What is preventing pregnancy in this particular couple, and what is the safest, most realistic way to address it?"

Modern reproductive medicine has given us extraordinary diagnostic tools. We can evaluate ovulation, ovarian reserve, the uterus, fallopian tubes, sperm concentration and motility, endocrine disorders and many other factors. When necessary, modern fertility treatment can stimulate ovulation, treat selected structural disease, place sperm directly within the uterus through IUI, or allow fertilization outside the body through IVF.

Unani medicine approaches fertility from another perspective. Rather than looking only at one hormone, one ovary or one semen report, it traditionally considers **Mizaj, diet, digestion, physical activity, sleep, emotional state and the functional condition of the reproductive system as part of the health of the whole person**.

The detailed background prepared for this article describes precisely this idea: modern reproductive medicine provides powerful structural and hormonal assessment, whereas Unani medicine provides a broader constitutional framework, creating the possibility of an

integrated, individualized fertility pathway rather than forcing patients to choose one system exclusively.

I agree with the principle of integration, but I believe it must be **scientifically disciplined**.

Integration does not mean mixing every available medicine or therapy.

It means using each system where it is most useful, understanding its limitations and never delaying an effective treatment because an unproven therapy has promised a guaranteed natural pregnancy.

That approach has become even more relevant since the World Health Organization published its **first global guideline for the prevention, diagnosis and treatment of infertility in November 2025**. WHO now provides evidence-based pathways covering prevention, diagnosis, ovulatory disorders, tubal disease, uterine disorders, male infertility and unexplained infertility.

What Is Infertility?

WHO defines infertility as a disease of the male or female reproductive system characterized by failure to achieve pregnancy after **12 months or more of regular unprotected sexual intercourse**.

Approximately **one in six people of reproductive age experience infertility during their lifetime**. Infertility may result from male factors, female factors, a combination of both, or remain unexplained after standard evaluation.

This definition is important because infertility is not automatically a female disease.

A woman may be ovulating normally but have significant tubal disease. A man may have normal erections but severe sperm abnormalities. Both partners may have mild contributing problems, or both may appear normal on standard testing while pregnancy still does not occur.

For this reason, I prefer **couple-based fertility care**.

Why Diagnosis Should Come Before Treatment

The material supplied for this article correctly emphasizes the importance of establishing a biological baseline before beginning holistic treatment. It notes that structural barriers should first be identified because a blocked fallopian tube, significant uterine abnormality or another anatomical problem cannot responsibly be managed by guesswork.

This is one of the central principles of my approach.

If a woman has bilateral hydrosalpinx, prescribing six months of general fertility tonics without evaluating the tubes wastes reproductive time.

If a man has azoospermia, giving supplements without finding out whether the problem is obstruction or testicular sperm production may delay appropriate treatment.

If a woman's infertility is caused by failure to ovulate, identifying the cause of anovulation is more useful than repeatedly treating the uterus.

Modern investigation allows integrative treatment to become more accurate rather than less traditional.

The Modern Fertility Assessment: What Do We Need to Know?

A high-quality infertility evaluation should be systematic and should begin with the least invasive tests that are likely to answer clinically relevant questions.

ASRM recommends an efficient evaluation covering ovulatory function, the female reproductive tract and male semen assessment, with both partners evaluated in parallel when appropriate.

The practical questions I want answered are:

Essential question	What we are trying to understand
Is ovulation occurring?	Whether an egg is being released regularly
Is ovarian reserve relevant?	How the ovaries may respond to fertility treatment
Are the fallopian tubes sufficiently patent?	Whether sperm and egg have a pathway to meet
Is the uterine cavity appropriate?	Whether significant structural disease is present
Are sperm parameters adequate?	Male concentration, motility, morphology and other factors
Is there a sexual-function problem?	Whether effective intercourse and ejaculation are occurring
Is there an endocrine disorder?	Selected thyroid, prolactin or other hormonal abnormalities
Has age changed the treatment urgency?	Whether waiting could reduce future options

Essential question	What we are trying to understand
Are all basic findings normal?	Whether the couple meets criteria for unexplained infertility

The important point is not to perform every possible fertility test. It is to perform **the right investigation at the right time**.

Ovulation: Is an Egg Actually Being Released?

Irregular or absent ovulation is an important cause of female infertility.

Women with predictable menstrual cycles approximately every 21–35 days are often ovulating, although exceptions occur. Women with very irregular periods deserve evaluation for causes such as PCOS, thyroid disease, hyperprolactinaemia, hypothalamic dysfunction and other endocrine conditions.

A common mistake is to perform large hormone panels repeatedly without first asking whether the woman actually has symptoms suggesting an endocrine disorder.

ASRM specifically lists several hormonal tests—including routine progesterone, FSH, LH, estradiol and prolactin—as tests that should **not automatically be ordered in every infertility evaluation unless clinically indicated**.

More testing does not automatically mean better fertility care.

PCOS and Fertility

Polycystic ovary syndrome, traditionally known as PCOS, is one of the most common endocrine disorders associated with irregular ovulation.

The contemporary international guideline diagnoses PCOS using a combination of **ovulatory dysfunction, clinical or biochemical hyperandrogenism, and polycystic ovarian morphology**, after excluding relevant alternative conditions. Two of these major features are generally required in adults.

This is an important correction to a common fertility myth:

An LH-to-FSH ratio above 2:1 is not a required diagnostic criterion for PCOS.

Likewise, seeing “polycystic ovaries” on ultrasound does not automatically establish the syndrome.

Modern fertility management therefore focuses on the woman's actual ovulation, metabolic condition and reproductive goals rather than treating an ultrasound picture alone.

PCOS in the Unani Framework

The supplied material associates PCOS-like patterns with a traditional **Balghami** or cold-and-moist constitutional state and describes *Su-e-Mizaj* as a possible traditional framework for understanding altered reproductive function.

These are valid concepts within Unani theory.

However, *Balgham* should not be described as scientifically identical to insulin resistance, LH abnormalities or ovarian follicles.

What I find especially useful about the Unani approach is its attention to **diet, body constitution, physical activity, metabolic health, sleep and individualized treatment**.

In women with PCOS, these areas can complement modern management particularly well, provided anovulation and metabolic risk are also treated according to current evidence.

Ovarian Reserve: Understanding AMH Correctly

Few fertility tests cause as much anxiety as AMH.

Anti-Müllerian hormone is useful because it reflects the pool of small ovarian follicles and can help predict response to ovarian stimulation.

But AMH primarily gives information about **egg quantity—not egg quality and not a yes-or-no answer about natural fertility**.

ASRM states that AMH and antral follicle count are useful ovarian-reserve markers and good predictors of ovarian response in IVF, but they are poor independent predictors of spontaneous reproductive potential. Extremely low AMH should not by itself be used to deny fertility treatment.

So if a woman tells me:

“My AMH is low. Does that mean I cannot become pregnant?”

my answer is:

No. It means we need to interpret ovarian reserve together with your age, cycle, diagnosis and overall fertility situation.

Female Age Still Matters More Than Any Supplement

One of the limitations of every fertility system—modern or traditional—is that we cannot completely reverse reproductive ageing.

Lifestyle can improve general health.

Metabolic treatment can improve ovulation.

Fertility medicine can stimulate remaining follicles.

IVF can make efficient use of available eggs.

But no diet, Unani formulation, antioxidant or “egg-rejuvenation” programme has been proven to convert an older egg population into that of a much younger woman.

ASRM emphasizes that ovarian-reserve markers are much weaker predictors of reproductive success than **female age itself**.

Therefore, integrative care should never cost a woman valuable reproductive time.

Fallopian Tubes: Can Sperm and Egg Meet?

Fallopian-tube disease is another major cause of infertility.

Untreated STIs, pelvic inflammatory disease, previous surgery, endometriosis and other pelvic conditions can produce tubal damage. WHO specifically recognizes blocked tubes among major female causes of infertility.

Hysterosalpingography, or HSG, is widely used for assessing tubal patency.

I prefer to describe HSG as an important **first-line test** rather than automatically calling it the perfect or absolute “gold standard,” because tubal spasm and technical factors can occasionally produce misleading findings.

The supplied material correctly emphasizes HSG's role in identifying obstruction and hydrosalpinx.

Can Unani Medicine Open Blocked Tubes?

This requires a very clear answer.

Unani medicine contains traditional concepts such as **Suddah**, obstruction, and medicines categorized as *Mufatteh-e-Sudad* or *Muhallil*.

These may be meaningful within traditional management of inflammation and functional disorders.

But a mature fibrotic scar within a fallopian tube is an anatomical problem.

There is currently insufficient high-quality clinical evidence to guarantee that oral Unani medicine, Hijama, massage, sitz baths or herbal irrigation can reopen severely scarred fallopian tubes.

If both tubes are severely damaged, IVF may be the treatment that provides the realistic route around the obstruction.

Recognizing that limit is not a rejection of Unani medicine. It is responsible reproductive medicine.

The Uterus and Endometrium

The uterus also requires appropriate evaluation.

Ultrasound can identify fibroids, adenomyosis, polyps, uterine abnormalities and other structural findings.

Hysteroscopy may be valuable when direct visualization of the uterine cavity is required.

However, not every infertility case should be attributed to a vague “weak uterus.”

The source supplied for this article discusses **Zof-e-Raham**, or uterine weakness, as a classical Unani concept associated with impaired reproductive function.

This can be used as a traditional descriptive framework.

It should not automatically be equated with implantation failure, weak cervical tissue, inadequate progesterone or a specific modern disease unless objective evidence supports that diagnosis.

Progesterone and the Controversy Around “Luteal Phase Deficiency”

Progesterone is essential for normal implantation and early pregnancy.

But diagnosing infertility simply because a single progesterone result appears “low” can be misleading.

ASRM's updated guidance explains that progesterone fluctuates substantially during the day and that a single value can demonstrate that ovulation occurred but cannot reliably define the quality of the luteal phase. Importantly, isolated **luteal phase deficiency has not been proven to be an independent cause of infertility**, and no treatment has been shown to improve pregnancy rates in natural, unstimulated cycles on that basis alone.

Therefore, the supplied source's suggestion that a mid-luteal progesterone measurement can straightforwardly diagnose a treatable luteal defect should be interpreted more cautiously.

Progesterone certainly has important roles in particular fertility-treatment protocols—but that is different from giving it routinely to every naturally cycling woman.

Thyroid Function and Fertility: An Important Modern Correction

The supplied material suggests that a TSH of 4.0 mIU/L may be “normal” generally but that fertility requires TSH below 2.5 mIU/L.

Current evidence is more nuanced.

ASRM's 2024 guideline found that TSH levels between **2.5 and 4.0 mIU/L were not associated with increased miscarriage risk** and advises against routine levothyroxine treatment solely to improve pregnancy or live-birth outcomes in women labelled with subclinical hypothyroidism. It also recommends targeted rather than indiscriminate thyroid testing in infertility.

Women with known overt hypothyroidism or established thyroid disease still require appropriate management, and pregnancy-specific targets may apply to women already taking thyroid replacement.

The lesson is simple:

Do not treat one universal TSH number as a fertility guarantee.

Male Fertility Must Be Investigated at the Same Time

A woman should not undergo months of repeated treatment before her male partner has even had a semen analysis.

WHO identifies low sperm levels, absent sperm, abnormal motility, abnormal morphology and ejaculatory problems among major causes of male infertility.

Semen analysis is therefore an essential component of a couple's infertility evaluation.

If sperm are severely abnormal, the male partner may require additional hormonal, urological or genetic assessment depending on the findings.

At Saira Health Care, this is particularly important because our work includes both **male sexual disorders and infertility**.

Sexual Disorders Can Also Prevent Conception

Not every fertility problem comes from eggs, tubes or sperm.

A couple may have normal reproductive investigations but difficulty with vaginal intercourse because of erectile dysfunction, severe premature ejaculation before penetration, vaginismus, painful intercourse, delayed ejaculation or reduced sexual desire.

If sperm cannot be deposited effectively within the vagina during the fertile period, conception may be difficult even when semen quality is reasonable.

This is one of the areas where a physician with a focused practice in both **sexual medicine and infertility** can provide particularly useful couple-based assessment.

What Is Unexplained Infertility?

Unexplained infertility is diagnosed when standard fertility evaluation does not identify a clear cause despite continued inability to conceive.

The supplied article views this category as a limitation of purely structural medicine and proposes that subtler functional or Unani constitutional disturbances may still be present.

I believe this idea can be useful as a motivation to care for the whole patient, but it must be expressed carefully.

Modern reproductive medicine does **not** assume that “unexplained” means nothing is happening.

It means the currently recommended clinical evaluation has not found an identifiable explanation.

ESHRE's evidence-based guideline specifically describes unexplained infertility as a **diagnosis of exclusion** and notes that evidence for many additional tests and alternative treatments remains limited or very low quality.

We therefore should not replace one unknown with another unproven diagnosis.

How Modern Medicine Treats Unexplained Infertility

Management depends on factors such as age, duration of infertility and previous treatment.

ASRM's evidence-based guideline recommends, for many couples with unexplained infertility, a limited course—often three or four cycles—of **ovarian stimulation with oral medicines plus IUI**, followed by IVF when appropriate if this is unsuccessful. Women of more advanced reproductive age may warrant faster progression to IVF.

This is a particularly important area for integrative medicine.

Diet, sleep, exercise and emotional support can continue alongside evidence-based fertility treatment, but complementary treatment should not indefinitely postpone progression when time matters.

The Unani View of Fertility: Mizaj and Akhlat

At the heart of Unani medicine is the concept of **Mizaj**, or temperament.

The supplied source describes Mizaj through the qualities of heat, coldness, moisture and dryness and relates reproductive function to appropriate constitutional balance.

Unani medicine also describes four *Akhlat*:

Dam, or blood; **Balgham**, or phlegm; **Safra**, or yellow bile; and **Sauda**, or black bile.

These traditional concepts were developed centuries before modern endocrinology.

They should therefore be respected as a historical physiological model rather than presented as scientifically identical to insulin, progesterone, thyroid hormones, inflammation or fibrotic tissue.

This distinction is important for textbook-quality integrative medicine.

Why Mizaj Can Still Be Clinically Useful

Although Mizaj is not a laboratory test, the traditional emphasis on individual constitutional differences has practical value.

Two women with the same diagnosis may have very different clinical needs.

One patient with PCOS may have obesity and insulin resistance.

Another may have normal body weight.

One infertile woman may sleep poorly and smoke.

Another may have excellent lifestyle habits but severe tubal disease.

One male partner may have good semen parameters but erectile dysfunction.

Another may have no sexual problem but severe oligozoospermia.

The Unani principle of **individualization** therefore fits naturally with modern personalized medicine—as long as objective pathology is not overlooked.

Asbab-e-Sitta Zarooriya: A Strong Bridge Between Unani and Modern Preventive Care

One of the most useful contributions of Unani medicine to fertility care is the concept of the **Six Essential Factors**, or *Asbab-e-Sitta Zarooriya*.

These address food and drink, bodily movement and rest, psychological activity and repose, sleep and wakefulness, environment and air, and physiological retention and elimination.

These principles provide an excellent framework for preconception counselling because modern reproductive health also recognizes the importance of nutrition, exercise, tobacco avoidance, metabolic health and psychological wellbeing.

This is where I believe Unani medicine can contribute particularly strongly—**not by competing with diagnostic science, but by helping create a healthier biological environment in which treatment and conception occur.**

Ilaj-bil-Ghiza: Dietotherapy in Fertility Care

CCRUM formally recognizes **Ilaj-bil-Ghiza**, or dietotherapy, among the principal modes of Unani treatment.

For fertility patients, I use dietary counselling according to the woman's or man's health condition.

A patient with insulin resistance requires different nutritional advice from someone who is underweight.

A woman preparing for pregnancy requires adequate folate and other nutrients.

A man with metabolic disease may benefit from weight management and improved dietary quality.

However, there is no scientifically proven single “fertility diet.”

ASRM concludes that although healthy nutrition should be encouraged for general health, evidence remains insufficient that one particular dietary pattern, vitamin-enriched diet, antioxidant regimen or herbal programme reliably improves natural fertility in otherwise ovulatory women.

Folic Acid: Essential Preconception Care, Not a Fertility Drug

Women trying for pregnancy should generally take **400 micrograms of folic acid daily** before conception and during early pregnancy to reduce the risk of neural-tube defects.

Folic acid is not an ovulation medicine and does not guarantee conception.

Its role is preparation for a safer pregnancy.

The source material suggests using methylated folate especially for common MTHFR variants.

An important 2026 CDC clarification is that common MTHFR variants **do not require avoidance of folic acid**. People with these variants can process folic acid, and 400 micrograms daily remains effective. CDC states that folic acid—not an alternative folate form—is the folate with established evidence for neural-tube-defect prevention.

CoQ10, DHEA and Other Fertility Supplements

Fertility patients are often advised to take several supplements intended to improve “egg quality” or sperm function.

Some compounds have biologically plausible mechanisms and encouraging preliminary research.

But supplements should not become a substitute for diagnosis.

AMH cannot be restored to a young-age level by taking antioxidants.

A blocked tube does not reopen because mitochondrial supplements are being used.

DHEA is a hormone precursor and should not be regarded as an ordinary vitamin.

An integrative physician should use supplements selectively and explain the level of evidence honestly.

Ilaj-bil-Dawa: Where Unani Pharmacotherapy Fits

Ilaj-bil-Dawa, or pharmacotherapy, is another recognized mode of Unani treatment.

Traditional Unani materia medica includes medicines used historically for menstrual disorders, sexual weakness, semen abnormalities and reproductive support.

In my approach, Unani pharmacotherapy is most rational when we first understand **what condition is being treated**.

A patient with anovulation may require different treatment from someone who ovulates normally.

A male patient with sexual weakness requires a different plan from someone with azoospermia.

A woman with PCOS should not receive the same treatment as a woman with bilateral hydrosalpinx.

That is what individualized Unani practice should mean.

What About Asgandh and Satawar?

The supplied roadmap discusses herbs such as **Withania somnifera** and **Asparagus racemosus** as fertility-supportive agents.

These plants have traditional reproductive uses and biologically active compounds worthy of study.

However, they should not be described as proven methods for improving egg quality, regulating the entire HPO axis or guaranteeing endometrial receptivity.

Herbal treatment also requires particular caution once pregnancy may have occurred.

A medicine appropriate during preconception is not automatically appropriate during implantation, pregnancy or an IVF cycle.

Ilaj-bil-Tadbeer: Regimenal Therapy

CCRUM also recognizes **Ilaj-bil-Tadbeer**, or regimenal therapy.

Traditional modalities may include measures such as massage, baths or Hijama according to the patient's traditional diagnosis.

These interventions may sometimes contribute to relaxation, wellbeing or treatment of appropriate non-fertility complaints.

However, current evidence does not establish Hijama, abdominal massage, Nutool or medicated sitz baths as treatments that reliably increase pregnancy or live-birth rates.

They cannot be promised to open fallopian tubes or improve ovarian reserve.

If they are used, I view them as **adjunctive—not replacements for fertility treatment**.

A Particular Warning About "Fertility Detox"

The supplied roadmap proposes several months of purification through *Munzij*, *Mushil* and Hijama before active conception attempts.

Munzij-Mushil is an authentic classical Unani concept.

But there is no modern evidence that every infertile couple requires a three-month purgative or detoxification programme before trying for pregnancy.

Strong purgation can cause dehydration or electrolyte abnormalities and may be inappropriate when conception could already have occurred.

Likewise, Hijama has not been shown to “remove reproductive toxins” or improve tubal patency.

I therefore do **not** consider prolonged detoxification a mandatory first stage for every fertility patient.

The first stage should be **diagnosis and safe preconception optimization**.

Stress and Infertility: Support the Patient, Do Not Blame Her

The supplied source describes psychological stress as a potent contraceptive mechanism and cites large reductions in conception probability.

This should be expressed more cautiously.

Severe physiological stress, major caloric restriction or intense exercise can disrupt hypothalamic reproductive signalling in some women.

But ordinary emotional stress does not explain every infertility case.

Infertility itself causes stress.

Telling a woman:

“You are not pregnant because you think too much”

can increase guilt and delay proper investigation.

Psychological counselling, mindfulness and stress-management strategies may improve anxiety, depression, relationship functioning and the experience of fertility treatment. They should be offered for these genuine benefits, not promoted as guaranteed methods of producing pregnancy.

WHO's new infertility guideline specifically emphasizes ongoing psychosocial support for people affected by infertility.

Sleep and Fertility

Good sleep supports physical and psychological health.

However, there is not a scientifically established fertility rule stating that exactly seven or eight hours of dark-room sleep produces better eggs or guarantees conception.

Sleep disruption may be associated with reproductive and metabolic disturbances, but association is not the same as proof that sleep optimization can treat infertility.

From a Unani perspective, **Naum-wa-Yaqzah**, sleep and wakefulness, remains an important health-preservation principle.

I therefore encourage adequate, regular sleep because it supports overall wellbeing—not because I want to make an exaggerated promise about egg quality.

Exercise and Fertility

Moderate physical activity is beneficial for cardiovascular and metabolic health and is particularly valuable in many patients with insulin resistance, obesity or PCOS.

At the same time, extreme exercise combined with inadequate energy intake can disturb menstruation and ovulation.

The Unani concept of **Riyazat-e-Motadil**, or moderate exercise, fits well with this practical modern principle.

The objective is neither inactivity nor exhaustion.

It is a sustainable level of physical activity appropriate to the patient.

Smoking: One of the Clearest Fertility Risks

Here the evidence is considerably stronger.

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

WHO reports that current female smokers had approximately a **40% higher risk of infertility** than nonsmokers in the systematic evidence reviewed. Tobacco is also associated with harmful effects on sperm and male sexual function, and second-hand exposure may affect reproductive health.

For couples trying to conceive, stopping tobacco deserves much greater priority than purchasing another fertility supplement.

This is an excellent example of **Hifz-e-Sehat—health preservation—working together with modern preventive evidence.**

Environmental Exposure: Avoid Fear-Based "Toxin" Marketing

Environmental pollutants and some occupational exposures may adversely affect reproductive health, and WHO acknowledges that certain toxins can affect eggs and sperm.

However, couples should not become frightened by claims that every plastic container, cosmetic product or environmental chemical has made them infertile.

Reasonable exposure reduction is sensible.

Expensive “detox” products intended to remove undefined toxins are not evidence-based fertility treatment.

The correct approach is **practical risk reduction rather than fear**.

Intercourse Timing and the Fertile Window

When no major infertility factor exists, understanding the fertile period can reduce time to conception.

ASRM defines the fertile window as approximately the **six days ending on the day of ovulation**. Reproductive efficiency is highest when intercourse occurs every one to two days during this period, although intercourse two or three times per week throughout the cycle provides nearly comparable opportunity for many couples.

The supplied roadmap appropriately proposes combining fertility-awareness signs with modern ovulation-prediction tools.

This is a useful example of responsible integration.

Should a Woman Raise Her Hips After Intercourse?

No evidence shows that raising the hips, lying in a particular position or remaining flat for prolonged periods increases natural fertility.

ASRM specifically states that **specific coital positions and post-coital routines have no demonstrated impact on fertility**.

Therefore, the supplied recommendation to elevate the hips in order to retain semen should not be presented as medically necessary.

Some seminal fluid naturally leaks out after intercourse. This does not mean that all sperm have been lost.

The Role of Unani Medicine During IUI and IVF

This is a particularly sensitive area.

I am supportive of whole-person care during assisted reproduction—nutrition, sleep, emotional support, treatment of general health problems and appropriate counselling can continue.

However, herbal medicines should **not automatically be continued during ovarian stimulation, egg retrieval, embryo transfer or early pregnancy**.

Some herbs can affect hormones, uterine activity, liver metabolism or interactions with fertility medicines.

The supplied roadmap suggests continuing certain uterine tonics and Asgandh during IVF phases.

I would make this more conservative:

Every herbal medicine should be reviewed individually with the fertility and Unani physicians before an IVF cycle, and non-essential medicines should not automatically be continued around embryo transfer or pregnancy.

Safety comes before theoretical benefit.

A Safer Integrated Fertility Roadmap

Rather than using a fixed twelve-month protocol for every couple, I prefer a **four-stage individualized pathway**.

Stage 1: Diagnose the Fertility Situation

The first stage establishes whether the couple has infertility and whether there is a recognizable male, female, combined or unexplained factor.

This may involve menstrual and reproductive history, semen analysis, confirmation of ovulatory function when necessary, ultrasound, tubal evaluation when indicated and targeted endocrine testing.

Modern reproductive medicine is strongest here.

The goal is to identify structural or biological problems before valuable time is lost.

Stage 2: Optimize General and Reproductive Health

Once major barriers have been identified, we address modifiable issues.

This may include stopping tobacco, correcting nutritional deficiencies, optimizing diabetes or thyroid disease, improving metabolic health, managing PCOS, improving sleep, treating relevant infection, reviewing medicines and addressing sexual dysfunction.

This is also where **Unani Hifz-e-Sehat, Mizaj-based counselling, Ilaj-bil-Ghiza and selected supportive treatment** can contribute strongly.

This phase may last several weeks or months when appropriate—but it should not delay time-sensitive fertility treatment in an older woman or a couple with severe disease.

Stage 3: Active Conception Treatment

For couples in whom natural conception remains realistic, this may involve fertile-window education and appropriately timed intercourse.

If ovulation induction is necessary, evidence-based medicine should be used.

When unexplained infertility or mild factors persist, treatment may progress to IUI according to age and circumstances.

The Unani role remains supportive, individualized and safety-conscious.

Stage 4: Escalate When Necessary

If significant structural infertility is present or appropriate simpler treatment has failed, surgery, IVF or ICSI may become the more realistic choice.

Unani care can remain supportive for nutrition, lifestyle and wellbeing, but should not be used to postpone a procedure that addresses the actual reproductive barrier.

Time Is an Important Fertility Treatment

One of the strongest parts of the source material is its recognition that **integration must not delay necessary treatment**, especially as female reproductive age advances.

I strongly agree.

A 24-year-old woman with recently diagnosed PCOS has a different time horizon from a 39-year-old woman with diminished ovarian reserve.

A woman under 35 with no known fertility disorder is generally evaluated after 12 months of unsuccessful attempts.

Women 35 and older generally warrant evaluation after approximately six months, while women over 40 or those with known infertility factors may deserve earlier assessment.

There is no benefit in losing reproductive years to repeated unproven treatments.

Unani Medicine Is Most Valuable When Its Role Is Clearly Defined

I believe Unani medicine has several important strengths in fertility care.

It emphasizes individual constitution rather than one-size-fits-all treatment.

It takes nutrition and digestive health seriously.

It incorporates physical activity, sleep and emotional state.

It recognizes the relationship between sexual health and reproduction.

It gives considerable attention to prevention and health maintenance.

CCRUM formally recognizes **Ilaj-bil-Ghiza, Ilaj-bil-Dawa, Ilaj-bil-Tadbeer and Ilaj-bil-Yad** as major modes of Unani therapy.

The modern challenge is to apply these strengths without attaching unsupported fertility claims to every traditional therapy.

That, in my opinion, strengthens Unani medicine rather than weakening it.

What Unani Medicine Should Not Be Asked to Do

No medical system should be expected to accomplish things it cannot reliably accomplish.

Unani medicine should not be promised to reverse biological ageing.

It should not be guaranteed to open every severely scarred fallopian tube.

It should not replace effective treatment for an active reproductive infection.

It should not be used to promise sperm production in every case of severe non-obstructive azoospermia.

It should not be presented as a guaranteed method for preventing miscarriage.

And it should not indefinitely postpone IVF when IVF is the most appropriate treatment.

The purpose of integrative medicine is **better treatment—not ideological loyalty to one system.**

Dr. Nizamuddin Qasmi's Individualized Integrative Approach

When a couple consults me at **Saira Health Care**, I begin with their story.

How long have they been trying?

What are their ages?

Are the menstrual cycles regular?

Is intercourse occurring effectively?

Has either partner achieved a pregnancy before?

Has the woman experienced pelvic infection, miscarriage, ectopic pregnancy, surgery, endometriosis or PCOS?

Has the man undergone a semen analysis?

Does he have erectile or ejaculatory problems?

Is either partner taking medicines, hormones or herbal preparations?

What investigations have already been completed?

These questions allow me to determine what the couple actually needs.

I then use modern diagnostic information where necessary and apply my Unani training to evaluate the broader patient—the **Mizaj, diet, digestion, sleep, activity, emotional wellbeing and general reproductive health**.

My aim is not to create the longest possible prescription.

My aim is to create the **clearest possible pathway toward pregnancy**.

What "Special Treatment" Means at Saira Health Care

When I speak about specialized treatment at Saira Health Care, I mean **individualized treatment based on the cause of infertility**.

It is not a secret universal fertility formula.

A woman with anovulatory PCOS should not receive the same treatment as a woman with bilateral hydrosalpinx.

A patient with normal ovarian reserve but vaginismus requires a different pathway from a woman approaching 40 with diminished reserve.

A man with erectile dysfunction but normal semen needs different treatment from a man with azoospermia.

A couple with unexplained infertility needs different counselling from a couple with severe tubal or male-factor disease.

This cause-based approach is where my focused work in **sexual disorders and infertility** becomes particularly important.

Contribution of Saira Health Care in Sexual Disorders and Infertility

At **Saira Health Care**, one of our important goals is reducing confusion around reproductive medicine.

Infertility patients are frequently exposed to contradictory claims.

One clinic may recommend IVF immediately.

Another may promise that every condition can be cured naturally.

One patient is told low AMH means pregnancy is impossible.

Another is told an herbal medicine can make her ovaries “young again.”

A man with poor semen quality may receive supplements without being properly evaluated.

A woman may undergo years of treatment while her husband's fertility has never been checked.

Our contribution is to encourage a more organized process:

understand the problem, explain the reports, investigate both partners, identify modifiable factors, use Unani care responsibly, and move toward modern fertility treatment when necessary.

That approach is more respectful of the patient's health, finances and reproductive time.

Important Scientific Clarifications for an Integrative Fertility Programme

For a website article intended to be medically credible, several commonly repeated claims deserve correction.

TSH below 2.5 mIU/L is not a universal fertility requirement for every woman. Current ASRM evidence does not show increased miscarriage risk simply because TSH is between 2.5 and 4.0 mIU/L.

An LH/FSH ratio of 2:1 or 3:1 is not required to diagnose PCOS. Modern diagnosis uses ovulatory dysfunction, androgen excess and polycystic ovarian morphology or appropriately used AMH.

Low AMH does not mean natural pregnancy is impossible. AMH predicts ovarian-response quantity better than spontaneous fertility.

Isolated luteal phase deficiency remains controversial. There is no reliable single diagnostic test and no proven fertility benefit from treating presumed isolated LPD in natural cycles.

Common MTHFR variants do not require methylated folate instead of folic acid. CDC continues to recommend folic acid.

Stress should not be described as a contraceptive. Psychological care is valuable, but infertility should not be blamed on anxiety.

A specific sleep duration has not been established as a fertility treatment.

Hijama, massage, Nutool or sitz baths have not been proven to reopen fallopian tubes or increase live-birth rates.

Raising the hips after intercourse has not been shown to improve conception.

These corrections make integrative fertility care **more credible, safer and more suitable for textbook-quality publication**.

Frequently Asked Questions

Can modern medicine and Unani medicine be used together for infertility?

Yes, when integration is properly supervised. Modern medicine is especially valuable for objective diagnosis, hormonal treatment, reproductive surgery, IUI and IVF. Unani medicine can contribute individualized diet, lifestyle, constitution-focused care and selected supportive therapies. The two should complement rather than replace one another.

Should I try Unani medicine before getting fertility tests?

That depends on your age, duration of infertility and medical history. When infertility criteria have been met, or when there is an obvious fertility risk, investigation should not be delayed.

What is unexplained infertility?

It means standard fertility evaluation has not identified a definite cause. It does not mean that no biological problem exists, but neither does it prove a hidden humoral disorder. ESHRE emphasizes that many additional tests and treatments proposed for unexplained infertility still have limited evidence.

Can Unani medicine treat unexplained infertility?

Unani care may be useful for improving general health, nutrition, metabolic wellbeing, lifestyle and sexual health. However, it should not be presented as a guaranteed cure for unexplained infertility.

Is AMH the most important fertility test?

No. AMH mainly provides information about ovarian reserve and expected response to stimulation. Age, ovulation, tubes, uterus and male fertility are also important.

Is low AMH reversible?

There is no established treatment that reliably restores the ovarian follicle pool to a younger biological state. Treatment aims to make appropriate use of the remaining reproductive potential.

Does a high LH/FSH ratio prove PCOS?

No. The contemporary international PCOS diagnostic criteria do not require an abnormal LH/FSH ratio.

Can blocked tubes be treated naturally?

Mild or uncertain abnormalities require appropriate evaluation, but severe fibrotic obstruction or hydrosalpinx should not be promised a cure through oral medicines or regimenal therapy alone.

Should every infertile woman have TSH below 2.5?

No. Current ASRM evidence does not support treating every woman simply to reach a TSH below 2.5 mIU/L. Known thyroid disease should be appropriately managed according to individual circumstances.

Do I need methylfolate if I have an MTHFR variant?

Common MTHFR variants do not prevent the body from using folic acid. CDC states that 400 micrograms of folic acid remains appropriate and effective for neural-tube-defect prevention.

Can stress cause infertility?

Severe physiological stress can affect reproductive hormones in some circumstances, but ordinary emotional stress should not be assumed to be the cause of infertility. Psychological support can improve wellbeing during fertility treatment.

Is Hijama useful for fertility?

Hijama has a place in traditional regimenal medicine, but current evidence does not establish it as a treatment that reliably increases natural pregnancy or live-birth rates or corrects structural infertility.

Can Unani medicine support IVF?

Yes, potentially through general health, nutrition, sleep and emotional-support measures. However, herbal medicines should be individually reviewed with the treating fertility clinician because not every herb is appropriate during ovarian stimulation, embryo transfer or pregnancy.

When should IVF be considered?

That depends on age, diagnosis, duration of infertility and previous treatment. Severe bilateral tubal disease, significant male-factor infertility and failure of appropriate simpler treatments are among situations in which IVF may become appropriate. WHO's current guideline recommends a progressive, diagnosis-based approach.

Does choosing IVF mean natural or Unani treatment has failed?

No. IVF is a reproductive technology designed to overcome specific barriers. Choosing it when appropriate is not a failure of the patient or of another medical system.

My Final Message to Couples Seeking Pregnancy

Whenever I counsel a couple about infertility, I tell them that their treatment should begin with **clarity—not fear and not promises**.

Modern reproductive medicine gives us valuable answers.

Is ovulation occurring?

How urgent is the age factor?

Are the fallopian tubes open?

Is the uterus structurally healthy?

What does the semen analysis show?

Is there a treatable sexual disorder?

Does the couple have an identifiable fertility problem or unexplained infertility?

Once we understand those questions, Unani medicine can contribute another important dimension.

We can consider **Mizaj, diet, physical activity, digestion, sleep, psychological wellbeing and general constitutional health**.

We can use *Ilaj-bil-Ghiza* intelligently.

We can select Unani pharmacotherapy where appropriate.

We can encourage the health-preserving principles of *Asbab-e-Sitta Zarooriya*.

But integration must remain honest.

A structural problem deserves structural treatment.

An endocrine disease deserves accurate diagnosis.

A severe male factor deserves male evaluation.

And reproductive ageing deserves urgency rather than endless experimentation.

The supplied roadmap makes one particularly important point: **fertility treatment should not allow complementary care to postpone necessary intervention when reproductive time is being lost.**

That principle is central to my own approach.

At **Saira Health Care**, I do not believe the patient should be forced to choose between science and tradition.

I believe the correct question is:

“Which part of each system can genuinely help this individual couple?”

Use modern medicine to diagnose accurately and overcome barriers that require medical technology.

Use Unani medicine where its individualized, preventive and whole-person approach can responsibly support reproductive health.

Address lifestyle without blaming the patient.

Support emotional wellbeing without telling couples that infertility is “all stress.”

Move toward IUI, IVF or surgery when necessary.

And never promise what medicine cannot guarantee.

Our objective is not simply a positive pregnancy test. It is a safe, realistic and medically responsible pathway toward a healthy pregnancy and, ultimately, a healthy family.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi
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Dr. Nizamuddin Qasmi's clinical work at **Saira Health Care** has a specialized focus on sexual disorders and infertility, including male and female fertility problems, sexual-function difficulties, fertility counselling, interpretation of reproductive investigations and individualized integration of Unani supportive care.

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Medical Disclaimer

This article is intended for **general education and public awareness**. It is not a substitute for individualized fertility assessment, diagnosis or prescription and does not guarantee pregnancy.

Infertility has many possible female, male, combined and unexplained causes. Unani medicines, herbal products, purgation, Hijama, massage, supplements and other complementary approaches should not be used to postpone medically indicated investigation, hormonal treatment, surgery, IUI, IVF or other fertility treatment.

Herbal and Unani medicines should be reviewed particularly carefully during ovulation induction, IVF, embryo transfer and pregnancy because products appropriate during preconception may not necessarily be appropriate after conception.