# Female Counselling for Achieving Pregnancy: A Complete Modern and Unani Approach to Preconception Health, Fertility and Emotional Well-Being

**A Comprehensive Guide to Preparing for Pregnancy, Understanding the Fertile Window, Identifying Fertility Problems and Using Unani Medicine Responsibly**

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## Introduction

When a woman comes to me and says, “Doctor, I want to become pregnant. What should I do?” I do not believe that the first response should always be a medicine, an injection or an expensive fertility test.

Very often, the first requirement is **proper counselling**.

Female counselling for achieving pregnancy means helping a woman understand her menstrual cycle, fertile period, age-related fertility, general health, nutrition, medicines, previous pregnancies, possible reproductive disorders, emotional well-being and the right time to seek medical investigation.

For some women, appropriate counselling and simple changes are enough to improve the way they are trying for pregnancy. For others, counselling helps us identify a condition such as ovulatory dysfunction, polycystic ovary syndrome, thyroid disease, tubal blockage, endometriosis, uterine abnormality or a male-factor fertility problem that requires medical treatment.

Counselling should therefore never be understood simply as “giving motivational advice.” In reproductive medicine, good counselling is a structured clinical process that helps a woman and her partner make informed decisions while avoiding unnecessary fear, investigations and treatment.

This has become even more important following the World Health Organization's **first global guideline for the prevention, diagnosis and treatment of infertility**, published in November 2025. WHO emphasizes prevention, fertility education, healthy lifestyle, diagnosis of male and female factors, progressive treatment according to clinical findings and **ongoing psychosocial support** for people affected by infertility.

At Saira Health Care, my approach is to combine these contemporary principles with the useful preventive and individualized concepts of the **Unani system of medicine**, while being clear about where modern diagnostic tests and fertility treatments are necessary.

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**What Does "Female Counselling for Achieving Pregnancy" Mean?**

Pregnancy counselling begins before conception.

It is often called **preconception counselling** or **prepregnancy counselling** when the woman has not yet become pregnant. When conception has been delayed, it may become part of formal fertility counselling.

The purpose is not to guarantee pregnancy. No ethical doctor can promise that counselling, medicine or any particular treatment will definitely result in conception.

Instead, the objectives are to understand the woman's reproductive situation, optimize conditions for a healthy pregnancy, identify factors that may interfere with conception and guide the couple toward appropriate investigation or treatment when necessary.

The American College of Obstetricians and Gynecologists describes prepregnancy counselling as an opportunity to optimize a woman's health, address modifiable risks and prepare for pregnancy. Important areas include medical conditions, medications and supplements, immunizations, nutrition, body weight, substance use and the need for STI screening.

The CDC's updated July 2026 pregnancy-planning guidance similarly recommends discussing existing medical conditions, medicines, vaccinations and lifestyle with a healthcare professional before conception.

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**Why Counselling Before Pregnancy Is So Important**

Many women believe pregnancy planning starts only after a positive pregnancy test.

In reality, some of the most important decisions should ideally be made **before conception**.

A woman's nutritional status, chronic illnesses, smoking or alcohol exposure, medications and certain infections can influence pregnancy from its earliest stages—sometimes before she realizes she is pregnant.

Preconception counselling gives us an opportunity to identify these issues early.

It can also prevent unnecessary anxiety. I frequently see women who become worried after trying for only one or two months because they believe pregnancy should happen immediately.

Human reproduction does not work that way.

Even in a healthy couple, conception is a probability in each menstrual cycle rather than a certainty. Understanding this prevents women from considering themselves “infertile” prematurely.

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**Understanding Normal Fertility**

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

That definition does not mean everyone should wait exactly 12 months before seeking medical advice.

Age and medical history matter.

The American Society for Reproductive Medicine recommends infertility evaluation after approximately **12 months for women younger than 35**, after approximately **6 months for women aged 35 years or older**, and potentially more immediately in women over 40 or when a known condition associated with infertility is already present.

If a woman has very irregular periods, previous pelvic inflammatory disease, known blocked tubes, severe endometriosis, previous ovarian surgery or another major fertility concern, there may be no reason to wait the full 12 months.

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**Female Age Is One of the Most Important Fertility Factors**

One of the most important—but sometimes difficult—parts of fertility counselling is discussing age realistically.

Women are born with a finite number of eggs. Both the number and reproductive competence of eggs decrease with time.

This decline becomes more clinically important in the mid-to-late thirties and continues thereafter.

ASRM describes female age as the **single most important predictor of fecundity**. It also cautions that ovarian-reserve tests should supplement rather than replace counselling based on age and diagnosis.

I explain this carefully because age counselling should not become fear counselling.

A 35-year-old woman is not "too old" to conceive. Many women conceive naturally and have healthy pregnancies after 35. But time becomes increasingly valuable, so an appropriate investigation should not be unnecessarily postponed when conception is delayed.

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**The Menstrual Cycle and Ovulation**

One of the first questions I ask a woman trying to conceive is:

**"How regular are your periods?"**

A menstrual cycle gives us useful information about ovulation.

In many women with predictable cycles occurring approximately every 21–35 days, regular menstruation strongly suggests ovulatory cycles. ASRM notes that additional testing to confirm ovulation is not routinely required in women with consistently regular 21–35-day cycles unless other clinical findings indicate a problem.

Irregular or absent periods, however, may suggest a problem with ovulation.

Common causes can include polycystic ovary syndrome, major changes in body weight, thyroid disease, hyperprolactinaemia, perimenopause, excessive exercise or other endocrine conditions.

Correct counselling therefore begins by understanding the cycle rather than prescribing fertility medicines blindly.

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**What Is the Fertile Window?**

Many couples misunderstand the fertile period.

Some believe intercourse should occur only on the exact day of ovulation. Others abstain for many days because they believe "saving sperm" improves the chances of pregnancy.

Neither approach is usually necessary.

ASRM defines the **fertile window as the six-day interval ending on the day of ovulation**. The probability of conception is generally greatest during the days immediately preceding ovulation.

This happens because sperm can survive in the female reproductive tract for a period before ovulation, whereas the egg has a relatively short period during which fertilization can occur.

For a woman with a regular 28-day cycle, ovulation often occurs around the middle of the cycle, but it is a mistake to assume every woman ovulates on exactly “day 14.”

Cycle length and the timing of ovulation can vary.

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**How Often Should a Couple Have Intercourse When Trying to Conceive?**

This is one of the most frequent questions I receive.

For most couples, there is no need to turn sexual intercourse into a rigid medical timetable.

ASRM concludes that reproductive efficiency is highest when intercourse occurs approximately **every one to two days during the fertile window**. Having intercourse two or three times per week throughout the cycle can also provide almost comparable opportunities for many couples and may create less psychological pressure.

Frequent ejaculation does not normally “finish” or permanently weaken sperm.

Likewise, prolonged abstinence is not required to increase natural pregnancy chances.

Counselling should help a couple maintain regular intimacy without creating such a strict schedule that sex becomes stressful.

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**Ovulation Kits, Apps and Fertility Tracking**

Women often ask whether mobile applications can accurately identify ovulation.

They can be helpful, but they should not be treated as perfect.

Calendar applications predict fertility mainly from previous menstrual dates. Actual ovulation may vary between cycles.

Urinary **LH ovulation predictor kits** detect the hormonal surge that usually precedes ovulation by approximately one to two days and can therefore provide more direct information.

Cervical mucus changes can also help identify the fertile phase.

ASRM reports that fertility-awareness methods, including ovulation predictor kits and cervical mucus monitoring, may help couples appropriately time intercourse.

However, I discourage women from becoming obsessed with multiple daily measurements when tracking itself begins increasing anxiety.

A tool should support fertility counselling—not dominate the woman's life.

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**Does a Woman Need to Lie Down After Intercourse?**

This is another common fertility myth.

Some women lie flat for half an hour, raise their legs or place a pillow under the pelvis because they worry that semen leaking from the vagina means sperm has been "lost."

There is no good evidence that these practices improve natural conception.

ASRM notes that sperm can travel rapidly into the reproductive tract and that specific postcoital positions or routines have **no established benefit for fertility**.

Normal leakage after intercourse does not mean all sperm have come out.

This simple piece of counselling can remove considerable unnecessary worry.

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**Preconception Medical Review**

When I counsel a woman who plans pregnancy, I do not look only at the reproductive organs.

Pregnancy places demands on the entire body.

Conditions such as diabetes, hypertension, thyroid disease, epilepsy, psychiatric illness and certain autoimmune or cardiac disorders may influence fertility, pregnancy or the safety of medications.

ACOG recommends optimizing important chronic conditions before conception whenever possible.

The aim is not merely "to become pregnant." The aim is **to achieve pregnancy as safely as possible for the mother and future child**.

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**Review Every Medicine Before Pregnancy**

Women frequently remember to tell their doctor about prescription medicines but forget herbal products, supplements, powders or traditional formulations.

All can matter.

ACOG specifically recommends reviewing **prescription medicines, non-prescription medicines, nutritional supplements and herbal products** during preconception counselling because some can affect reproduction or pregnancy.

This point is especially important in integrative and Unani practice.

A woman should not stop an essential prescribed medication abruptly because she wants to conceive, but neither should she assume every herbal product is automatically safe during the preconception period or pregnancy.

Medication changes should be planned with the relevant clinician.

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**Folic Acid Before Pregnancy**

One of the simplest evidence-based interventions before pregnancy is **folic acid**.

The CDC recommends **400 micrograms of folic acid daily**, starting at least one month before pregnancy and continuing during early pregnancy, because adequate folate reduces the risk of serious neural-tube defects affecting the baby's brain and spinal cord.

Some women require a different dose because of specific risk factors or medical circumstances. This should be decided individually by the treating clinician.

Folic acid is therefore not a fertility drug—it does not guarantee conception—but it is an important part of preparing safely for pregnancy.

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**Nutrition and Fertility**

Patients often ask me for one “fertility food.”

Unfortunately, there is no single food that guarantees pregnancy.

ASRM states that evidence is insufficient to show that one particular diet or specific macronutrient pattern reliably improves natural fertility in otherwise healthy women. A healthy overall diet is nevertheless encouraged for general and reproductive health.

From a practical counselling perspective, I encourage a balanced diet containing appropriate protein, vegetables, fruits, whole grains, healthy fats and micronutrients rather than relying on so-called fertility superfoods.

Extreme diets, prolonged fasting and severe calorie restriction may interfere with reproductive health in susceptible women.

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**Healthy Body Weight**

Both significant underweight and obesity can be associated with reproductive problems.

Obesity may contribute to ovulatory dysfunction, including in women with polycystic ovary syndrome, while very low body weight or extreme exercise can suppress normal hypothalamic signals required for ovulation.

ACOG recommends working toward an appropriate preconception weight because high and low BMI can be associated with infertility and pregnancy complications.

This should be approached sensitively.

The purpose is not to criticize a woman's appearance. The purpose is to improve metabolic and reproductive health where weight is clinically relevant.

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**Smoking and Fertility: Important New 2026 Evidence**

Tobacco is particularly important in fertility counselling.

On **8 September 2026**, WHO released an updated evidence summary on tobacco and infertility.

WHO reported that women who currently smoke had approximately a **40% higher risk of infertility** than women who do not smoke in the reviewed evidence. It also found reproductive harms in men, including associations with abnormal semen parameters and sexual dysfunction, and noted that second-hand smoke may also negatively affect fertility.

This is one of the clearest modifiable issues I discuss with couples.

Smoking cessation is valuable not only after a woman becomes pregnant but **while she and her partner are planning conception**.

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**Alcohol and Other Substances**

Women attempting pregnancy should also consider alcohol and recreational drug use carefully.

CDC advises people preparing for pregnancy to stop alcohol, smoking and certain drug use because of risks during pregnancy.

ACOG states that there is no established safe amount of alcohol during pregnancy and recommends identifying substance use during prepregnancy counselling.

Because pregnancy may occur before a missed period alerts a woman, preconception habits matter.

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**Vaccination Before Pregnancy**

Vaccination status is another important and often overlooked part of counselling.

Some infections during pregnancy can seriously affect the mother or developing baby.

ACOG recommends reviewing immunization status before conception, including vaccines relevant to rubella, varicella, hepatitis B and other conditions according to clinical circumstances. Some live vaccines require an interval before conception and are not administered during pregnancy.

This is why vaccination planning should occur before pregnancy rather than waiting until a woman has already conceived.

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**Screening for Sexually Transmitted Infections**

A previous untreated reproductive infection may affect future fertility.

Chlamydia and gonorrhoea can cause pelvic inflammatory disease and subsequent tubal damage in some women.

WHO specifically identifies untreated STIs among preventable contributors to infertility and emphasizes prevention as part of modern fertility care.

STI testing is not required in exactly the same way for every woman, but risk assessment should be incorporated into preconception counselling.

Past pelvic inflammatory disease, recurrent genital infection or previous ectopic pregnancy may also influence whether tubal evaluation is required later.

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**PCOS and Counselling for Pregnancy**

Polycystic ovary syndrome is one of the common causes of ovulatory difficulty.

Women may have irregular cycles, increased facial or body hair, acne, metabolic abnormalities or ultrasound features consistent with PCOS.

Counselling is particularly valuable because the woman needs to understand that PCOS does **not** mean pregnancy is impossible.

Management depends on whether ovulation is occurring, weight and metabolic health, age, duration of infertility and other male and female factors.

The mistake is to treat an ultrasound appearance alone without evaluating the woman as a whole.

Modern fertility assessment identifies ovulatory dysfunction in a significant proportion of infertile couples, and PCOS is among the common underlying causes.

**Thyroid and Hormonal Problems**

Thyroid disorders can interfere with menstrual regularity, ovulation and pregnancy.

Prolactin abnormalities may also contribute to absent or irregular menstruation in selected women.

However, fertility counselling should avoid ordering every hormone test for everyone.

ASRM recommends a targeted approach: menstrual history often provides useful information about ovulation, while thyroid, prolactin and androgen testing are selected according to symptoms and clinical indications.

This prevents unnecessary cost and confusing results.

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**Understanding AMH and Ovarian Reserve**

Few tests create as much anxiety in fertility clinics as **AMH**, or anti-Müllerian hormone.

AMH can provide useful information about ovarian reserve and expected response to ovarian stimulation.

But it is important to understand what AMH does **not** tell us.

A low AMH value does not mean that natural pregnancy is impossible. Likewise, a high AMH value does not guarantee fertility.

ASRM specifically cautions that ovarian-reserve testing is a poor standalone predictor of natural fertility and should not be used as a general screening test in women who do not otherwise meet criteria for infertility.

I therefore never like to counsel a woman from an AMH number alone.

Age, ovulation, tubes, uterus, sperm and the complete clinical history matter.

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**Fallopian Tubes and the Uterus**

For pregnancy to occur naturally, ovulation alone is not enough.

At least one functional pathway generally needs to exist for sperm and egg to meet.

If a woman's history suggests tubal disease—or she is undergoing a formal infertility evaluation—tests such as **hysterosalpingography (HSG)** or hysterosalpingo-contrast sonography may be used to evaluate tubal patency.

ASRM recommends HSG or appropriate ultrasound-based studies for tubal evaluation and does not recommend routine diagnostic laparoscopy solely for tubal testing without another indication.

Ultrasound can also identify conditions such as fibroids, ovarian cysts and some uterine abnormalities.

Counselling helps explain why a test is being performed rather than simply giving the woman a long list of investigations.

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**Fertility Is Not Only a Female Issue**

Perhaps the most important misconception in infertility counselling is the idea that if pregnancy is not happening, something must be wrong with the woman.

That is incorrect.

Male factors contribute substantially to infertility.

Modern guidelines recommend that when a male partner is involved in conception, **his assessment should occur in parallel rather than only after months of testing the woman**. At least one semen analysis is generally part of the initial male evaluation when infertility is being investigated.

This is also a principle I strongly emphasize at Saira Health Care.

Female counselling should never become female blaming.

Pregnancy depends on the reproductive health of both partners.

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**Emotional Counselling Is Part of Fertility Treatment**

Infertility can be emotionally exhausting.

The woman may experience sadness every time menstruation starts. Family members may ask repeated questions. Social events may become uncomfortable. Some women begin comparing themselves with friends or relatives who conceived easily.

Treatment cycles can create hope followed by disappointment.

WHO's 2025 global infertility guideline specifically recognizes that infertility can contribute to **depression, anxiety, stigma, isolation and financial stress**, and recommends ongoing access to psychosocial support as part of fertility care.

This is an important development because emotional health should not be treated as something separate from fertility care.

**Stress and Fertility: Avoiding Oversimplification**

Patients frequently hear:

**“You are not pregnant because you are stressed.”**

I do not consider this a helpful statement.

Stress can affect quality of life, sexual relationships, sleep and treatment adherence. Severe physiological or psychological stress can also influence menstrual function in certain women.

But telling a woman that her infertility is simply due to stress can be unfair and medically misleading.

A blocked fallopian tube is not opened by relaxation. Severe sperm abnormalities are not corrected by telling a couple to stop worrying.

Psychological counselling should help patients cope with fertility treatment—not blame them for being anxious.

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**Relationship Counselling and Timed Intercourse**

When couples are trying to conceive, sexual intimacy can gradually become a medical duty.

The woman begins calculating dates. The man feels pressure to perform on command. Both partners may become anxious if intercourse does not occur on the “correct” night.

Good fertility counselling should prevent this.

Because intercourse every one to two days during the fertile period is generally sufficient, there is room for flexibility.

If strict ovulation tracking is damaging the relationship, simplifying the plan may actually improve the couple's overall experience without substantially compromising their opportunity for conception.

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**Counselling After Previous Miscarriage**

Women who previously experienced miscarriage commonly approach the next pregnancy with fear.

A single early miscarriage is unfortunately common and does not automatically mean that another miscarriage will occur.

However, repeated pregnancy loss deserves appropriate investigation according to the clinical circumstances.

Counselling should allow the woman to discuss grief, anxiety about recurrence and concerns about her ability to carry a pregnancy.

I believe these conversations are especially important because pregnancy should not become a nine-month period of constant fear.

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**Counselling After Previous Ectopic Pregnancy**

A previous ectopic pregnancy may indicate underlying tubal disease and can increase anxiety when a woman conceives again.

In such women, earlier assessment after a positive pregnancy test may be appropriate to confirm that the pregnancy is developing in the correct location.

Women with a previous ectopic pregnancy or known tubal disease may also deserve earlier fertility evaluation if conception is delayed rather than automatically waiting for 12 months.

This is why fertility counselling is always individualized.

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**Modern Fertility Evaluation**

If counselling and regular attempts at conception do not result in pregnancy within an appropriate period, the next stage is investigation.

A proper fertility evaluation should be **systematic, efficient and based on the most likely causes** rather than ordering every available test.

ASRM recommends assessment of ovulatory status, the female reproductive tract—including tubal patency when indicated—and the male partner's semen.

Depending on findings, treatment may range from lifestyle and timed-intercourse advice to ovulation induction, surgery, intrauterine insemination or IVF.

WHO's latest infertility guideline similarly recommends a progressive approach, beginning with fertility education and appropriate simpler management before moving toward more complex interventions when diagnosis and patient circumstances justify them.

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**Unani Medicine and Female Fertility Counselling**

The **Unani system of medicine** has traditionally placed strong emphasis on health preservation before disease develops.

This is one of the areas where I believe Unani medicine can contribute meaningfully to preconception care.

In Unani medicine, health is traditionally understood in relation to a person's **Mizaj**, or temperament, and the balanced functioning of the body's physiological systems.

Particular attention is given to the **Asbab-e-Sitta Daruriyya**, or Six Essential Factors.

The Central Council for Research in Unani Medicine formally defines these six factors as **air; food and drink; bodily movement and rest; mental activity and peace; sleep and wakefulness; and retention and evacuation**.

These concepts were formulated in a traditional medical framework, but several of their practical elements—healthy diet, adequate sleep, physical activity and psychological wellbeing—fit naturally alongside contemporary preconception counselling.

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**Mizaj: Individualized Care in Unani Medicine**

One of the strengths of traditional Unani medicine is that it does not regard every patient as physiologically identical.

**Mizaj**, or temperament, is used within the Unani system to understand differences between individuals and tailor diet and regimens accordingly.

CCRUM describes the holistic Unani approach as considering biological, psychological, social, environmental and lifestyle influences together with the patient's temperament.

In female fertility counselling, this principle can encourage a more individualized discussion of diet, sleep, physical activity, digestive health, menstrual pattern and general wellbeing.

However, I make an important distinction for my patients:

**Mizaj assessment is a traditional clinical framework. It cannot replace modern tests needed to diagnose blocked fallopian tubes, severe diminished ovarian reserve, thyroid disease, PCOS or other established fertility disorders.**

Both forms of assessment must be used within their proper limits.

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**Asbab-e-Sitta Daruriyya and Preconception Care**

The Six Essential Factors provide a particularly useful way to organize Unani counselling.

**Hawa**, or environment and air, reminds us to consider environmental health and avoid unnecessary toxic exposures.

**Makool-o-Mashroob**, or food and drink, supports an individualized balanced diet and appropriate nutritional preparation for pregnancy.

**Harakat-o-Sukoon Badani**, or bodily movement and rest, emphasizes suitable physical activity without extremes.

**Harakat-o-Sukoon Nafsani**, or mental activity and peace, recognizes the effect of emotional wellbeing and psychological strain on health.

**Naum-o-Yaqza**, or sleep and wakefulness, emphasizes adequate restorative sleep.

**Istifragh-o-Ihtibas**, or elimination and retention, represents a traditional physiological concept concerning appropriate bodily functions.

CCRUM's modern educational material continues to identify these six factors as central to Unani health preservation.

The value here is principally **preventive and lifestyle-oriented**, rather than a claim that balancing these factors alone can cure every form of infertility.

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**Ilaj-bil-Ghiza: Dietotherapy in Female Fertility Care**

**Ilaj-bil-Ghiza**, or dietotherapy, is an established mode of treatment within the Unani system. CCRUM formally describes dietotherapy alongside regimenal therapy, pharmacotherapy and surgery as recognized therapeutic approaches within Unani medicine.

For a woman attempting pregnancy, I consider diet an important supportive tool.

However, I do not tell patients that almonds, dates, milk, saffron or any single traditional food will guarantee pregnancy.

Instead, diet should support healthy body weight, adequate protein and micronutrient intake, metabolic health and general wellbeing.

Where iron, vitamin B12, folate, vitamin D or other deficiencies are suspected, these should be evaluated and corrected appropriately rather than assuming a generic fertility tonic will solve the problem.

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**Ilaj-bil-Tadbir and Lifestyle Regulation**

Unani medicine also includes **Ilaj-bil-Tadbir**, or regimenal therapy.

In a modern fertility context, its safest and most useful contribution often lies in lifestyle regulation, suitable exercise, relaxation and individualized health-promoting regimens.

This can complement contemporary recommendations for healthy diet and physical activity.

WHO's 2025 infertility guideline specifically encourages lifestyle interventions such as healthy diet, physical activity and tobacco cessation for individuals and couples planning or attempting pregnancy.

This is a good example of traditional preventive principles and modern evidence-based counselling moving in a similar practical direction.

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**Unani Pharmacotherapy and Pregnancy Planning**

Unani medicine includes a large pharmacopoeia and has traditionally used different formulations for menstrual irregularity, reproductive weakness and other women's health concerns.

However, fertility counselling should never begin with the assumption that every woman needs herbal medicine.

If a woman is ovulating regularly, has patent fallopian tubes, has no identified reproductive disease and her partner has normal semen parameters, unnecessary medicines may add cost and complexity without proven benefit.

Similarly, herbal medicines used **before pregnancy may not automatically be appropriate after pregnancy occurs**.

For this reason, at Saira Health Care I believe Unani pharmacotherapy should be individualized and periodically reviewed, especially when a woman is actively attempting conception.

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**Can Unani Medicine Increase the Chance of Pregnancy?**

This question deserves a balanced answer.

The Unani system can be particularly useful for **supportive and preventive care**, including individualized diet, sleep, lifestyle, emotional wellbeing and management of selected health complaints under a qualified practitioner.

However, there is currently insufficient high-quality evidence to state that “balancing the humours” or taking a particular Unani medicine will reliably increase live-birth rates across all causes of infertility.

A woman with bilateral blocked fallopian tubes requires a different approach from a woman with PCOS. A woman with diminished ovarian reserve requires different counselling from someone who simply has not identified her fertile window. A couple with severe male-factor infertility needs assessment of the male partner rather than repeatedly treating only the woman.

This is why I consider **diagnosis-based integration** more useful than giving everyone the same fertility formulation.

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**Modern Medicine and Unani Medicine: Where They Can Work Together**

Modern reproductive medicine gives us powerful tools for identifying **what is preventing conception**.

We can evaluate ovulation, hormones, ovarian reserve, uterine anatomy, fallopian tubes and male semen parameters.

Unani medicine contributes a traditional framework for looking at **how the individual is functioning as a whole**, including diet, rest, physical activity, emotional state and constitutional factors.

These approaches do not need to compete.

In my practice, I prefer to use modern investigation to answer questions that require objective diagnosis and Unani principles where they can safely contribute to lifestyle, general wellbeing and individualized supportive care.

This is much more useful than claiming that one system can solve every reproductive problem.

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**What I Discuss During a Female Preconception Consultation**

During a proper consultation, I may review the woman's age and how long she has been trying; menstrual-cycle length and regularity; previous pregnancies, miscarriage or ectopic pregnancy; previous contraception; history of pelvic infection or surgery; symptoms of PCOS, endometriosis or thyroid disease; weight and metabolic health; current prescription medicines, supplements and herbal preparations; vaccination and infection history; diet, sleep, exercise, tobacco, alcohol and environmental exposures; the frequency and timing of intercourse; emotional stress and relationship concerns; and the male partner's reproductive history.

If investigation is required, I then select tests according to the clinical situation rather than ordering a fixed package for every woman.

This is the difference between **fertility counselling and simply selling fertility tests**.

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**A Practical Counselling Plan for a Woman Trying Naturally**

For a generally healthy woman attempting natural conception, the core advice can be summarized simply: understand the cycle and fertile period; have regular intercourse rather than waiting for one supposedly perfect day; take appropriate preconception folic acid; avoid tobacco and recreational drugs and avoid alcohol when pregnancy is possible; maintain a balanced diet, sensible physical activity and healthy sleep; review existing medicines and vaccinations with a healthcare professional; and seek evaluation at the appropriate time or earlier when important risk factors are present.

This is often more valuable than immediately starting several medicines.

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**Counselling Women Aged 35 and Above**

For women aged 35 and above, fertility counselling should acknowledge the importance of time without creating panic.

ASRM recommends considering specialist evaluation after approximately six months of unsuccessful attempts in women aged 35 or older, while women over 40 may warrant more immediate assessment.

I generally explain that age affects egg quantity and quality but does not allow us to predict exactly when an individual woman will or will not conceive.

An AMH result should therefore never be used to frighten a patient or guarantee an outcome.

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**Counselling a Woman With Irregular Periods**

If cycles are consistently irregular, waiting a full year while assuming ovulation is occurring normally may waste time.

Evaluation may be needed for PCOS, thyroid dysfunction, prolactin abnormalities, significant weight change and other causes of ovulatory dysfunction.

Treatment then focuses on the underlying problem rather than simply providing a general “pregnancy medicine.”

Unani diet, lifestyle and constitutional care may be used as supportive measures where suitable, while endocrine or fertility treatment is selected according to established findings.

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**Counselling After Many Years of Infertility**

When a couple has been trying for several years, counselling must become more diagnostic and realistic.

I do not believe it is appropriate to reassure them repeatedly that pregnancy will definitely occur “next month.”

The duration of infertility, age, ovarian reserve, tube status, semen parameters and previous treatments all matter.

WHO's current guideline recommends progressively moving from simpler fertility management to treatments such as IUI or IVF when clinical findings and patient preferences justify escalation.

Continuing the same ineffective approach indefinitely can cost a couple valuable reproductive time.

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**IVF and Assisted Reproductive Technology Counselling**

When IVF is being considered, counselling is as important as the laboratory procedure itself.

The patient should understand why IVF is being advised, what problem it is intended to bypass, expected chances according to age and diagnosis, possible risks, cost, emotional burden and the possibility that more than one cycle may be required.

An ethical counsellor should neither present IVF as an automatic first step nor treat it as something frightening that must always be avoided.

For some patients, simpler treatment is appropriate. For others, delaying IVF may reduce their realistic chance of pregnancy.

The decision should be individualized.

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**Counselling Must Include the Male Partner**

At Saira Health Care, I consider this an essential principle.

When pregnancy does not occur, the woman's counselling should include a discussion about male fertility rather than subjecting her to months of treatment before evaluating her partner.

ASRM recommends simultaneous evaluation of the male partner when applicable because male factors are common contributors to infertility.

This also helps remove the harmful cultural assumption that infertility is automatically a woman's problem.

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**Female Counselling and Sexual Health**

Some women attempting pregnancy experience painful intercourse, reduced desire, vaginal dryness, fear of intercourse or relationship problems.

These concerns can directly affect how often intercourse occurs and therefore influence the practical opportunity for conception.

They deserve respectful assessment rather than being dismissed as “mental tension.”

Similarly, a partner with erectile dysfunction, premature ejaculation or another sexual disorder may make properly timed intercourse difficult.

Because my clinical practice focuses on **sexual disorders as well as infertility**, I believe this overlap must be considered during fertility counselling.

Sometimes improving the couple's ability to have comfortable, regular intercourse is an important part of fertility management.

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**The Role of Saira Health Care in Female Fertility Counselling**

At **Saira Health Care**, our objective is not simply to tell a woman to “keep trying.”

We aim to understand **why pregnancy has not occurred and what the most appropriate next step should be**.

Our approach to female fertility counselling includes reproductive education, menstrual-cycle assessment, fertile-window guidance, review of lifestyle and general health, assessment of previous reproductive problems, interpretation of fertility investigations and evaluation of whether male-factor testing is required.

Where Unani medicine can reasonably support the woman's general health, nutrition, constitution and lifestyle, it can be integrated into the plan.

Where a medical condition requires modern hormonal treatment, antibiotics, surgery, reproductive imaging or assisted reproductive technology, these options should be discussed openly.

A woman should never lose valuable reproductive time because a healthcare provider refuses to recognize the limits of a particular treatment.

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**Dr. Nizamuddin Qasmi's Individualized Approach**

As a physician with a focused practice in **sexual disorders and infertility**, I believe every woman's fertility journey deserves individualized attention.

I do not treat a 24-year-old woman with irregular ovulation in exactly the same way as a 39-year-old woman with reduced ovarian reserve. I do not treat a woman with healthy tubes

and unexplained infertility in the same way as a woman with bilateral hydrosalpinx. And I do not repeatedly treat a woman when the major fertility problem is actually present in her male partner.

My approach begins with counselling.

I explain the menstrual cycle and fertile period. I review age, reproductive history and general health. I assess whether ovulation is occurring. I determine whether further investigation of the uterus or tubes is necessary. I encourage evaluation of the male partner when appropriate.

I also consider the principles of Unani medicine—particularly **Mizaj, Ilaj-bil-Ghiza and Asbab-e-Sitta Daruriyya**—when they can contribute to an individualized lifestyle and supportive plan.

However, I believe Unani care becomes stronger when it is integrated with accurate modern diagnosis rather than used in place of necessary investigation.

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**Why Counselling Should Never Promise "100% Pregnancy"**

Pregnancy is influenced by multiple biological variables.

Even apparently healthy couples cannot be guaranteed conception in a particular cycle.

No responsible healthcare professional—whether practicing Unani medicine, modern reproductive medicine or an integrative approach—should promise a **100% pregnancy rate, guaranteed conception or permanent cure of every form of infertility**.

Counselling should instead give the patient realistic expectations, explain what can be improved and identify which factors cannot be overcome by lifestyle or medicine alone.

That honesty protects patients from unnecessary emotional and financial harm.

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**Frequently Asked Questions**

**How many days after a period should we try for pregnancy?**

There is no single correct day for every woman. The fertile window is approximately the six days ending on ovulation, and its timing depends on cycle length and individual variation. Intercourse every one to two days during this period generally provides a good opportunity for conception.

**Is day 14 always the day of ovulation?**

No. Day 14 is only an approximate example for some women with a 28-day cycle. Ovulation can vary between women and between cycles.

**How frequently should we have intercourse?**

Every one to two days during the fertile period provides the highest reproductive efficiency according to ASRM, although intercourse two to three times per week can also provide good coverage for many couples.

**Should I lie down after intercourse?**

There is no good evidence that remaining in a particular position after intercourse improves natural fertility.

**Does semen coming out after intercourse mean pregnancy cannot happen?**

No. Some seminal fluid normally leaks from the vagina after intercourse. This does not mean all sperm have been lost.

**When should I consult an infertility specialist?**

Women younger than 35 generally warrant evaluation after about 12 months of regular unprotected intercourse without conception. Women aged 35 or older should generally consider evaluation after approximately six months. Women over 40 or those with known fertility problems may need earlier assessment.

**Does low AMH mean I cannot become pregnant?**

No. AMH is mainly an ovarian-reserve marker and is useful in fertility-treatment planning. It does not independently determine whether natural conception is possible.

**Can stress alone cause infertility?**

Stress can affect wellbeing, relationships and sometimes menstrual function, but infertility should not automatically be attributed to stress. Appropriate biological causes must be assessed.

**Is folic acid necessary before pregnancy?**

Yes. CDC recommends 400 micrograms daily for most people capable of becoming pregnant, beginning at least one month before conception, to reduce the risk of neural-tube defects. Some women require different doses based on their medical history.

**Does smoking reduce fertility?**

Yes. WHO's September 2026 evidence summary reports significant associations between tobacco smoking and infertility and recommends counselling and cessation support for people planning pregnancy.

**Can Unani medicine help a woman trying to conceive?**

Unani medicine can be useful as **individualized supportive care**, particularly through diet, lifestyle, sleep, emotional wellbeing and management of selected health conditions under a

qualified practitioner. It should not be claimed to guarantee conception or replace necessary diagnostic or reproductive treatment.

**Can balancing the humours cure blocked fallopian tubes?**

There is insufficient high-quality evidence to claim that humoral correction or herbal treatment can reliably reopen severely scarred fallopian tubes. Structural tubal disease requires appropriate reproductive evaluation.

**Should the husband also be tested?**

Yes, when infertility is being investigated, parallel male evaluation is important. A semen analysis is commonly part of the initial assessment.

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**My Message to Women Trying to Become Pregnant**

Whenever a woman sits in front of me worried because pregnancy has not happened, my first aim is to replace confusion with a clear plan.

You should know **when you are likely to ovulate, how often intercourse is useful, when medical testing is necessary, what lifestyle factors matter and when waiting longer is no longer the best strategy**.

At the same time, pregnancy should not become the only thing controlling your life.

Repeated testing, strict sexual schedules, internet comparisons and monthly disappointment can create enormous psychological pressure. Fertility counselling should give you knowledge and direction—not another source of anxiety.

My background in Unani medicine teaches me to consider the woman as a whole person. Her diet, sleep, physical activity, emotional state, digestion, general health and individual constitution all deserve attention. The Unani concept of the Six Essential Factors continues to provide a useful traditional framework for maintaining health.

Modern reproductive medicine gives us another set of essential tools: accurate evaluation of ovulation, ovarian reserve where indicated, uterus, fallopian tubes and the male partner.

I believe the best approach is to use both responsibly.

**Counselling first. Diagnosis when needed. Lifestyle optimization for both partners. Appropriate Unani supportive care where suitable. Evidence-based fertility treatment when there is an identifiable medical problem. And emotional support throughout the journey.**

At **Saira Health Care**, this is the approach I aim to provide to women and couples seeking pregnancy—professional, confidential, individualized and focused not merely on a

laboratory report, but on helping patients understand the safest and most realistic route toward parenthood.

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**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 clinical work at **Saira Health Care** focuses on sexual disorders and infertility, with emphasis on confidential counselling, fertility education, appropriate investigation and individualized integrative care.

For more information, visit Saira Health Care.

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**Medical Disclaimer**

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

Women attempting conception should seek individualized medical advice when they have irregular menstruation, significant pelvic pain, previous pelvic infection or surgery, recurrent pregnancy loss, suspected tubal disease, advanced reproductive age or prolonged difficulty conceiving.

Unani medicines, herbal products and supplements should be reviewed by an appropriately qualified clinician before and during pregnancy. Unani supportive care should not delay necessary investigation, hormonal treatment, surgery or assisted reproductive treatment when these are clinically indicated.