Unani Medicine vs IUI vs IVF/ICSI: Choosing the Right Fertility Treatment

A Modern Evidence-Based and Unani Perspective on Infertility Treatment

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Introduction: "Doctor, Should We Try Unani Treatment, IUI or Go Directly for IVF?"

This is one of the most important questions couples ask me.

A husband and wife may come to my clinic with a thick file of reports and say:

"Doctor, one fertility centre has advised IVF, but we would first like to try natural or Unani treatment. Is that reasonable?"

Another couple asks:

"We have already tried medicines for several months. Should we now do IUI?"

Someone else says:

"Our tubes are blocked. Can we avoid IVF?"

And sometimes a couple has already undergone:

- two or three IUIs,
- one unsuccessful IVF cycle,
- many supplements,
- various traditional treatments,

yet they still do not understand why each treatment was prescribed.

My answer is always based on one fundamental principle:

The best fertility treatment is not the most natural treatment, the most expensive treatment or the most technologically advanced treatment. It is the treatment most appropriate for the actual cause of infertility, the age of the couple, their reproductive potential and the time available.

Infertility affects approximately:

1 in 6 people of reproductive age worldwide

at some point in life, according to the World Health Organization. WHO published its first global evidence-based infertility guideline on **28 November 2025**, emphasizing safer, more equitable and progressively appropriate fertility care.

The comparative research supplied for this article rightly argues that infertility treatment should move beyond a simplistic binary of:

“modern medicine versus traditional medicine.”

It describes IUI and IVF as modern reproductive technologies and Unani Tibb as a traditional constitutional system, while arguing for a more nuanced decision pathway.

I agree with that broader principle.

However, the systems do not have equal evidence for every fertility problem.

Modern reproductive medicine has a major advantage when we need to:

- induce ovulation reliably,
- bypass severely damaged fallopian tubes,
- retrieve eggs,
- fertilize eggs in a laboratory,
- perform ICSI for important male-factor infertility,
- freeze embryos,
- use donor eggs or sperm,
- test embryos for selected genetic disorders.

Unani medicine, on the other hand, may offer valuable individualized supportive care involving:

- diet,
- lifestyle,

- menstrual health,
- metabolic health,
- sexual health,
- traditional reproductive pharmacotherapy,
- general wellbeing.

The safest and most clinically intelligent model is therefore often:

integration without confusion.

That means:

use Unani medicine where it can reasonably support the patient,

but:

use modern fertility technology when an anatomical, biological or time-sensitive reproductive barrier requires it.

First, 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.

However, couples should not always wait a full year before evaluation.

In clinical practice, fertility evaluation is generally started:

- after 12 months when the woman is under 35,
- after approximately 6 months at age 35 or older,
- much sooner when the woman is around 40 or when a known fertility problem exists.

The male and female partner should generally be assessed:

at the same time.

ASRM specifically recommends obtaining reproductive history and at least one semen analysis early when a male partner contributes to pregnancy.

Why Fertility Treatment Must Begin With Diagnosis

I frequently tell patients:

“Do not choose IVF, IUI or Unani medicine before you know what you are treating.”

Consider four couples.

Couple A

Woman age 27:

- regular ovulation,
- open tubes,
- normal ovarian reserve.

Man:

- normal semen.

Infertility:

- 14 months.

This may be unexplained infertility.

Couple B

Woman age 30:

- PMOS/PCOS,
- irregular ovulation,
- both tubes open.

Man:

- normal semen.

The main problem may be:

anovulation.

Couple C

Woman age 32:

- both tubes severely damaged,
- hydrosalpinx.

No herbal uterine tonic can make sperm travel through a completely destroyed tube reliably.

Couple D

Woman age 39:

- low ovarian reserve,
- infertility for four years.

Even when nutritional and Unani support may be helpful for general wellbeing:

time becomes one of the main fertility treatments.

These couples should not receive the same plan.

The Essential Fertility Evaluation Before Choosing Treatment

A rational fertility assessment usually considers several areas.

Female Age

Age is one of the strongest determinants of reproductive potential.

It influences:

- egg quantity,
- egg chromosomal competence,
- miscarriage risk,
- IVF prognosis.

This is why an apparently gentle treatment that consumes six or twelve months may have very different consequences at:

- age 25,
- age 39.

Ovulation

The clinician should determine whether the woman:

- ovulates regularly,
- has PMOS-related anovulation,
- has hypothalamic amenorrhea,

- has another endocrine disorder.

Fallopian Tubes

Tubal patency may be assessed with:

- HSG,
- HyCoSy,

where clinically appropriate.

A woman with truly severe bilateral tubal obstruction has a fundamentally different treatment requirement from a woman with two patent tubes.

Uterus

Ultrasound and selected additional investigations can identify:

- fibroids,
- polyps,
- adenomyosis,
- congenital abnormalities,
- endometrial disease.

Ovarian Reserve

When appropriate, assessment may include:

- AMH,
- antral follicle count.

These tests mainly help estimate:

the remaining recruitable follicle pool and expected ovarian response.

They do not directly measure egg quality.

Male Semen Analysis

This is essential.

Important parameters include:

- concentration,
- total sperm number,
- motility,
- morphology.

A couple may think infertility belongs to the woman when the major problem is actually:

male-factor infertility.

Sexual Function

A couple may have medically normal fertility parameters yet face:

- vaginismus,
- painful intercourse,
- erectile dysfunction,
- ejaculatory problems,
- extremely infrequent intercourse.

A fertility clinic that ignores sexual health may miss the true reason conception is not occurring.

This is one reason my focused practice in:

Sexual Disorders & Infertility

allows fertility to be viewed more broadly.

The Three Main Treatment Paths Discussed in This Article

1. Unani Medicine

Traditional individualized fertility support.

2. IUI

Intrauterine insemination.

3. IVF

In vitro fertilization.

ICSI is a specialized fertilization method often used within IVF when appropriate.

These treatments should not be regarded as:

three levels of the same medicine.

They work in completely different ways.

Understanding the Unani System of Medicine

Unani Tibb is a traditional Greco-Arabic medical system influenced historically by physicians including:

- Hippocrates,
- Galen,
- Ibn Sina.

It views health through traditional concepts such as:

Mizaj – temperament

and:

Akhlat – humors.

The four traditional Akhlat are:

- Dam – blood,
- Balgham – phlegm,
- Safra – yellow bile,
- Sauda – black bile.

The supplied comparative research describes infertility, or **'Uqr**, through this constitutional framework rather than only as an isolated reproductive-organ disorder.

Modern Biology and Unani Physiology Are Not the Same

This distinction is essential for a textbook-quality article.

For example, it would not be correct to claim:

Balgham = insulin resistance

or:

Safra = estrogen

or:

cold uterus = low progesterone.

These are:

different conceptual frameworks.

Modern medicine describes reproduction through:

- hormones,
- gametes,
- anatomy,
- genetics,
- cellular biology.

Unani medicine describes health through traditional:

- Mizaj,
- Akhlat,
- faculties,
- diet,
- lifestyle,
- constitutional balance.

One system should not be artificially translated into the other.

What Can Unani Medicine Contribute to Fertility Care?

Its most rational strengths include:

- individualized dietotherapy,
- lifestyle modification,
- attention to sleep and daily habits,
- reproductive-health support,
- menstrual-health support,
- sexual-health management,
- selected traditional pharmacotherapy,

- whole-person counselling.

These areas can be particularly useful in patients with:

- unhealthy lifestyle,
- metabolic problems,
- menstrual irregularity,
- mild reproductive dysfunction,
- sexual-health concerns,
- psychological strain associated with infertility.

Major Unani Treatment Modalities

Ilaj-bil-Ghiza

Dietotherapy.

Ilaj-bit-Tadbir

Regimenal therapy.

Ilaj-bid-Dawa

Pharmacotherapy.

Ilaj-bil-Yad

Surgical/manual treatment within the traditional framework.

For fertility, I commonly consider the first three as supportive strategies.

Ilaj-bil-Ghiza: Dietotherapy

Food and metabolic health influence reproduction.

Depending on the patient, a modern-compatible Unani fertility diet may emphasize:

- adequate protein,
- vegetables,
- fruit,
- pulses,
- nuts,

- seeds,
- healthy fats,
- appropriate whole grains,
- hydration.

It may limit:

- excessive sugar,
- highly processed food,
- repeated deep frying,
- tobacco,
- excessive alcohol.

Diet is especially important when infertility coexists with:

- obesity,
- PMOS,
- insulin resistance,
- undernutrition.

But:

food cannot mechanically reopen a severely blocked fallopian tube.

Ilaj-bit-Tadbir

This includes traditional regimenal care.

Lifestyle elements such as:

- regular physical activity,
- good sleep,
- healthy body weight,
- stress management

can form useful supportive fertility care.

What About Hijama?

Hijama is a recognized traditional regimenal procedure.

The supplied research describes proposed fertility roles for Hijama involving circulation, inflammation and PMOS.

However:

these proposed mechanisms should not be presented as established clinical facts.

There is currently insufficient high-quality evidence to claim that Hijama reliably:

- restores ovulation,
- reverses insulin resistance,
- increases implantation,
- improves IVF live-birth rates,
- cures endometriosis,
- treats tubal obstruction.

It may be considered as supervised complementary regimenal care for appropriate patients, but not a replacement for:

- ovulation induction,
- surgery,
- IUI,
- IVF.

Dalk and Traditional Massage

Massage may help:

- relaxation,
- wellbeing,
- muscular discomfort.

But abdominal massage should not be claimed to:

- reposition all displaced uteri,
- reopen tubes,
- increase ovarian reserve.

Physical comfort and fertility treatment are different outcomes.

Abzan and Local Therapies

Traditional sitz baths or local regimens may be used in some Unani settings.

However, active:

- cervicitis,
- sexually transmitted infection,
- PID

requires appropriate modern diagnosis and antimicrobial treatment when infection is present.

Local herbal procedures should never introduce:

- irritation,
- contamination,
- ascending infection

into the reproductive tract.

Unani Pharmacotherapy

Classical fertility formulations are traditionally selected according to patient presentation.

Descriptions may include actions such as:

- Muqawwi-e-Rahim – uterine tonic,
- Muwallid-e-Mani – reproductive/gamete-supporting,
- Muqawwi-e-Bah – sexual/reproductive tonic.

These are:

traditional pharmacological classifications.

They should not automatically be translated into claims such as:

“proven to increase IVF live birth.”

What Does the Clinical Evidence for Unani Infertility Treatment Show?

This is where careful wording is necessary.

There are:

- case reports,
- small clinical studies,
- traditional pharmacological research.

There is not yet a large body of high-quality multicentre trials comparable with:

- IVF registries,
- modern reproductive guidelines.

Unani and Anovulatory Infertility

The uploaded research cites a small comparative study involving a formulation containing:

- Withania somnifera,
- Anogeissus latifolia,
- Nymphaea alba,
- Barleria prionitis,

compared with clomiphene.

Reported ovulation rates varied across three cycles, and conception occurred in some women.

This is an interesting clinical signal.

However, the study is:

- small,
- old,
- not sufficient to establish equivalence with modern ovulation-induction therapy.

Therefore it should not be translated into:

“Unani treatment is scientifically equal to clomiphene.”

Larger randomized trials measuring:

- live birth,
- adverse events,
- reproducibility

are needed.

Unani and Unexplained Infertility

A 2024 NIUM-associated case report described a couple with unexplained primary infertility for three years who conceived after three months of supervised Unani formulations.

Another published case described conception and subsequent live birth after treatment of idiopathic primary infertility; the authors themselves stated that randomized trials are needed before efficacy can be established.

These are:

encouraging individual outcomes.

They are not a valid basis for stating:

“Unani success rate is 15–20%.”

Unani and Tubal Disease

A published 2011 case report from NIUM described a woman with:

unilateral tubal blockage

who conceived within two months while receiving Unani formulations.

However:

- her obstruction was unilateral,
- conception can occur through the opposite healthy tube,
- the study did not demonstrate repeat tubal patency as the primary outcome.

Therefore it cannot prove that:

the blocked tube was reopened by medicine.

This is an excellent example of why successful conception and anatomical cure are not always the same claim.

Can We Compare a “Unani Success Rate” Directly With IUI or IVF?

At present:

No—not scientifically.

The uploaded analysis provides a simple table suggesting:

- Unani ~10–18%,
- IUI ~10–15%,
- IVF ~30–50%.

That table is convenient but too simplistic for a professional disease article.

Why?

Because IUI and IVF outcomes are measured through:

- large cohorts,
- defined cycles,
- registries,
- age-specific outcomes.

Unani studies are generally:

- small,
- heterogeneous,
- uncontrolled,
- case based,
- not consistently reporting live birth per cycle.

It would therefore be scientifically misleading to say:

“Unani is as successful as IUI.”

There is not enough comparable evidence to make that conclusion.

What Is IUI?

IUI means:

Intrauterine Insemination.

It is a relatively simple medically assisted reproduction procedure.

The male partner provides a semen sample.

The laboratory:

- separates motile sperm,
- removes much of the seminal fluid,
- concentrates an appropriate sperm fraction.

A thin catheter is then used to place prepared sperm directly into the:

uterine cavity

around ovulation.

The sperm still needs to:

- enter a fallopian tube,
- reach the egg,
- fertilize it naturally.

Therefore:

IUI does not bypass the fallopian tubes.

What Does IUI Actually Change?

Natural intercourse deposits semen in the vagina.

In IUI:

selected motile sperm are placed much closer to the fallopian tubes.

This can help increase the probability that enough sperm reach the site of fertilization.

When Is IUI Useful?

Depending on the couple, IUI may be considered for:

- unexplained infertility,
- selected mild male-factor infertility,
- donor-sperm treatment,
- some ejaculatory/sexual problems,
- selected cervical-factor situations.

When Is IUI Usually Not Appropriate?

IUI is generally unsuitable when there is:

- true severe bilateral tubal obstruction,
- some severe male-factor conditions,
- situations where IVF is otherwise clearly indicated.

Because sperm still need to reach the egg through a tube:

IUI cannot bypass both severely blocked fallopian tubes.

Natural-Cycle IUI Is Not Always Helpful

An important correction to the simplistic view of IUI is that:

IUI without ovarian stimulation is not automatically useful in unexplained infertility.

ASRM found strong evidence that natural-cycle IUI is:

- less effective than ovarian-stimulation IUI,
- probably no more effective than expectant management

for unexplained infertility.

WHO 2025: The New Unexplained-Infertility Pathway

WHO now suggests the following sequence.

First Line

Expectant management

for appropriate couples rather than unstimulated IUI.

Expectant management includes:

- fertile-window advice,
- healthy lifestyle,
- defined follow-up.

Studies informing this recommendation commonly used approximately:

3–6 months.

Second Line

If expectant management fails:

stimulated IUI

with:

- clomiphene,
- or letrozole.

WHO conditionally suggests these oral agents.

Why Not Start Every Couple With Unani for 6 Months?

Because WHO's recommendation depends on:

- prognosis,
- age,
- diagnosis.

A woman age 27 with short-duration unexplained infertility may have time for:

- supportive Unani treatment,
- healthy lifestyle,
- expectant management

within a defined period.

But a woman:

age 39

with long-standing infertility should not lose six months simply because:

“natural treatment should always come first.”

This is one of the most important corrections to the supplied decision framework.

How Successful Is IUI?

There is no single accurate:

“IUI success rate.”

Success varies with:

- female age,
- diagnosis,
- ovarian stimulation,
- sperm parameters,
- duration of infertility.

For example, an ASRM-reviewed randomized trial involving unexplained infertility found a cumulative live-birth rate of about:

31% across three clomiphene-IUI cycles

versus approximately 9% with expectant management in that particular study.

That does not mean:

31% per cycle.

Per-cycle outcomes are substantially lower.

Therefore internet statements such as:

“IUI has exactly 15% success”

are not good individualized counselling.

Risks of IUI

IUI itself is relatively low-risk.

Possible complications include:

- temporary cramping,
- spotting,
- rare infection.

The more important risk often comes from:

ovarian stimulation.

If too many follicles develop, the risk of:

- twins,
- higher-order multiple pregnancy

increases.

This is why monitoring matters.

What Is IVF?

IVF means:

In Vitro Fertilization.

“In vitro” means:

outside the body in a laboratory environment.

Unlike IUI, IVF bypasses the fallopian tubes.

Basic IVF Process

Step 1: Ovarian Stimulation

Fertility medicines stimulate multiple follicles.

Step 2: Monitoring

Ultrasound and sometimes hormone measurements assess:

- follicular development,
- treatment response.

Step 3: Final Maturation Trigger

An appropriate medication is used to prepare eggs for retrieval.

Step 4: Egg Retrieval

Under ultrasound guidance, eggs are aspirated from follicles through a transvaginal procedure.

Step 5: Fertilization

Eggs are exposed to sperm using:

- conventional IVF,

- or ICSI when appropriate.

Step 6: Embryo Culture

Embryos are observed during early development.

Step 7: Embryo Transfer or Freezing

An embryo may be transferred into the uterus.

Suitable additional embryos may be:

cryopreserved

for future use.

What Is ICSI?

ICSI means:

Intracytoplasmic Sperm Injection.

A laboratory embryologist injects one sperm directly into an egg.

ICSI is especially useful in selected situations involving:

- severe male-factor infertility,
- surgically retrieved sperm,
- some previous fertilization failures.

Does Every IVF Patient Need ICSI?

No.

This is a very important 2026 update.

ASRM's current committee opinion states:

routine ICSI for non-male-factor infertility does not improve live-birth rates.

ASRM specifically does not recommend routine ICSI solely for:

- unexplained infertility,
- diminished ovarian reserve,

- advanced maternal age,
- low oocyte yield,
- PGT-A

when there is no male-factor indication or prior fertilization failure.

WHO also strongly recommends conventional IVF rather than automatically adding ICSI after failed stimulated IUI in unexplained infertility without a male-factor indication.

When Is IVF Especially Important?

IVF can be particularly valuable in:

- severe bilateral tubal disease,
- selected severe male-factor infertility,
- unsuccessful lower-intensity treatment,
- some advanced-age situations,
- situations requiring donor oocytes,
- selected genetic indications,
- other individual reproductive conditions.

IVF and Bilateral Tubal Disease

IVF bypasses the tubes.

This makes it one of the most important treatments for:

severe bilateral tubal infertility.

WHO 2025 specifically suggests IVF rather than reconstructive surgery for:

- women under 35 with severe tubal disease,
- women age 35 or above with tubal disease.

Therefore:

a blanket recommendation to try months of traditional medicine first in severe tubal infertility can be harmful.

Mild Tubal Disease Is Different

Interestingly, WHO does not recommend IVF for every tubal problem.

For women:

- under 35,
- with mild-to-moderate tubal disease,

WHO conditionally suggests:

tubal surgery rather than immediate IVF.

This demonstrates why fertility decisions cannot be reduced to:

“IVF is always best.”

Hydrosalpinx

A hydrosalpinx is:

a damaged, distally blocked, fluid-filled fallopian tube.

This is particularly important before IVF.

WHO suggests:

- salpingectomy,
- or tubal occlusion

before IVF in women with hydrosalpinx.

Unani treatment should not be used to delay this evidence-based intervention when hydrosalpinx is significantly affecting IVF prognosis.

IVF Success Rates: Why Age Matters So Much

It is misleading to say:

“IVF success is 30–50%.”

Success depends strongly on:

- age,
- diagnosis,

- egg source,
- treatment history,
- embryo factors,
- clinic,
- outcome definition.

Final 2023 SART national data from U.S. member clinics provide an instructive example.

Using a woman's own eggs, live birth per intended egg retrieval including all embryo transfers linked to the retrieval was approximately:

Female age	Live birth
Under 35	**53.2%**
35–37	**39.9%**
38–40	**26.2%**
41–42	**13.2%**
Over 42	**4.1%**

These are:

U.S. national registry averages—not promises for an individual patient and not India-specific success rates.

The table demonstrates an extremely important principle:

time matters.

Why IVF Statistics Can Be Confusing

A fertility centre may report:

- pregnancy per embryo transfer,
- live birth per transfer,
- live birth per egg retrieval,
- cumulative live birth,
- biochemical pregnancy.

These are not the same.

The most meaningful outcome for patients is usually:

live birth.

When clinics advertise only their highest pregnancy percentage, patients should ask:

“What is the live-birth rate for women of my age using their own eggs?”

IVF Risks

IVF is a well-established medical treatment, but it is not risk-free.

Possible risks include:

- medication effects,
- egg retrieval complications,
- bleeding,
- infection,
- ovarian hyperstimulation syndrome,
- multiple pregnancy if excessive embryos are transferred,
- emotional stress,
- financial burden.

Ovarian Hyperstimulation Syndrome – OHSS

OHSS is a complication of ovarian stimulation.

Women at increased risk include those with:

- high AMH,
- PMOS/PCOS,
- expected high oocyte yield.

Modern protocols substantially reduce risk through:

- individualized stimulation,
- GnRH antagonist protocols,
- appropriate trigger strategies,

- embryo cryopreservation when indicated.

ASRM's current guideline specifically recommends identifying high-risk women and using prevention strategies.

IVF Does Not Have to Mean Twins

Modern fertility practice increasingly aims for:

one healthy baby at a time.

ASRM recommends single embryo transfer for many favorable-prognosis patients, particularly younger women and when a euploid embryo is available.

Final 2023 SART data show that embryo transfer practices are now predominantly oriented toward:

- singleton births,
- fewer multiple pregnancies.

Comparing Unani, IUI and IVF Correctly

Feature	**Unani Medicine**	**IUI**	**IVF/ICSI**
Main concept	Individualized traditional whole-person support	Places prepared sperm inside uterus	Retrieves eggs and creates embryos outside body
Fertilization location	Inside body	Inside fallopian tube	Laboratory
Requires functional tube?	Natural conception generally does	**Yes**	**No**
Helps severe bilateral tubal blockage directly?	Not reliably	No	**Yes, by bypassing tubes**
Role in unexplained infertility	Supportive/integrative; evidence limited	Evidence-based after appropriate expectant management	Used if lower-intensity treatment fails or

			prognosis indicates
Mild male factor	May support general male health	Sometimes useful	IVF/ICSI depending severity
Severe male factor	Should not delay specialist treatment	Often inadequate	IVF/ICSI may be important
PMOS/anovulation	Lifestyle/Unani support may complement care	May be used in selected fertility pathways	Usually later unless additional indication
Evidence base	Mostly traditional literature, case reports, small trials	Multiple controlled studies/guidelines	Large trials, registries and international guidelines
Invasiveness	Usually low for oral/diet/lifestyle care	Low-to-moderate	Higher
Cost	Usually lower	Intermediate	Higher
Can guarantee pregnancy?	No	No	No

A Better Way to Compare Cost

The supplied analysis provides fixed Indian price ranges for Unani treatment, IUI and IVF.

Those figures can quickly become outdated because cost varies with:

- city,
- hospital,
- medication dose,
- laboratory,
- ICSI,
- embryo freezing,
- genetic testing,

- donor treatment.

A professional website should therefore avoid promising one national fixed cost unless:

the actual clinic providing treatment publishes the current complete price.

WHO emphasizes that fertility care can create severe financial burden, particularly when patients must pay out of pocket. In some settings, even one IVF cycle can cost an amount comparable with or greater than annual household resources.

The Hidden Cost of Waiting

This is one of the most important concepts in fertility medicine.

A less expensive treatment is not always:

the more economical fertility strategy.

Consider a woman age 40.

She might spend six months on:

- supplements,
- herbs,
- repeated unmonitored treatment.

The monetary cost may be lower than IVF.

But her:

reproductive time has also been spent.

For older women or women with very low ovarian reserve:

time can be more valuable than medicine.

The Hidden Cost of Over-Treatment

The opposite is also true.

A young couple with:

- good prognosis,
- unexplained infertility of short duration

may not necessarily need immediate IVF.

WHO now suggests expectant management first in appropriately diagnosed unexplained infertility.

Starting IVF too early can expose patients to:

- cost,
- procedures,
- emotional burden

without always being necessary.

Unani Versus IUI Versus IVF: Which One Should Come First?

There is no universal answer.

Here is the evidence-based approach I prefer.

Scenario 1: Young Couple With Short-Duration Unexplained Infertility

Example:

- female age 27,
- regular ovulation,
- open tubes,
- normal semen,
- infertility 12–18 months.

A reasonable approach may include:

- fertile-window counselling,
- healthy diet/lifestyle,
- correction of identified health issues,
- individualized Unani supportive management if desired,
- defined expectant management.

WHO states that expectant management was generally provided for approximately:

3–6 months

in the studies informing its guideline.

However:

this is not proof that every couple should undergo three to six months of Unani medicines.

The period is:

- expectant management,
- not mandatory traditional pharmacotherapy.

Scenario 2: Unexplained Infertility After Expectant Management

Current WHO guidance suggests:

stimulated IUI with clomiphene or letrozole.

Unani diet and lifestyle support may continue if:

- safe,
- disclosed to the fertility specialist,
- not interfering with treatment.

Scenario 3: Failed Stimulated IUI

After unsuccessful appropriate IUI:

IVF becomes the logical next step for many couples.

ASRM similarly recommends a limited course of oral-agent ovarian stimulation plus IUI followed by IVF rather than repeatedly escalating gonadotrophin-IUI cycles.

Scenario 4: PMOS/PCOS With Anovulation

If the main fertility issue is:

failure to ovulate

then lifestyle and metabolic treatment can be very important.

Individualized Unani:

- dietotherapy,
- lifestyle care

may complement management.

But modern ovulation-induction treatment should not be withheld when appropriate.

The correct treatment is not simply:

“Hijama first, medicine later.”

It should be selected from the actual reproductive diagnosis.

Scenario 5: Mild Male-Factor Infertility

Management depends on:

- sperm concentration,
- total motile count,
- female age,
- infertility duration.

Lifestyle improvement and supervised Unani care may support:

- smoking cessation,
- metabolic health,
- sexual health.

Selected couples may benefit from:

IUI.

Scenario 6: Severe Male-Factor Infertility

When semen abnormalities are severe, the man needs:

proper male-infertility evaluation.

Possible causes include:

- varicocele,
- hormonal abnormalities,
- genetic disorders,
- obstruction,
- testicular failure,

- medications,
- anabolic steroids.

IVF with ICSI may be important depending on the diagnosis.

Traditional treatment should not become an excuse to delay:

genetic or urological evaluation.

Scenario 7: Azoospermia

Azoospermia means:

no sperm identified in the ejaculate after appropriate evaluation.

This is not one disease.

It can be:

- obstructive,
- non-obstructive,
- hormonal.

Treatment may involve:

- hormonal treatment in specific endocrine disease,
- reconstructive surgery,
- surgical sperm retrieval,
- micro-TESE,
- ICSI,

depending on the cause.

Azoospermia should not automatically be managed by:

"taking spermatogenic medicine for six months."

Scenario 8: Bilateral Severe Tubal Blockage

If both tubes are truly and severely damaged:

IUI cannot solve the problem.

Oral herbs cannot be promised to reopen the tubes reliably.

IVF directly bypasses the tubes.

WHO recommends IVF in women:

- under 35 with severe tubal disease,
- age 35 or older with tubal infertility.

Scenario 9: Hydrosalpinx

Hydrosalpinx requires particular attention.

Treatment may include:

- salpingectomy,
- tubal occlusion

before IVF.

No patient should be told:

“Take herbal treatment until the hydrosalpinx dries up”

if this delays fertility care.

Scenario 10: Advanced Maternal Age

Age is not merely one factor among many.

It directly influences:

- oocyte competence,
- embryo aneuploidy,
- miscarriage,
- IVF success.

Final SART data illustrate how rapidly autologous IVF success declines after the late 30s.

For a woman around:

38–40 years or older

the threshold for moving to ART may therefore be much lower.

Scenario 11: Very Low AMH

Low AMH mainly predicts:

- reduced ovarian response,
- fewer eggs during stimulation.

It does not automatically mean:

- no natural conception,
- no IVF chance.

But very low reserve plus increasing age is a reason to protect reproductive time.

Unani support should never be used to promise:

new egg creation.

Scenario 12: Sexual Dysfunction Preventing Intercourse

This is one situation where Saira Health Care's focus can be particularly useful.

If the real barrier is:

- vaginismus,
- erectile dysfunction,
- painful intercourse,
- ejaculation outside the vagina,

then the first treatment may need to address:

sexual function

rather than immediately moving to IVF.

Is IVF "Too Artificial"?

Some couples have moral or emotional discomfort with IVF.

It is important to respect that.

But IVF should not be portrayed as:

unnatural damage to the body

or a failure of traditional medicine.

It is a reproductive medical technology that helps bypass specific biological barriers.

Similarly:

choosing Unani medicine does not mean rejecting science.

A patient can receive:

- traditional supportive care,
- modern diagnostics,
- IVF when necessary.

Does IVF Cure the Underlying Disease?

Not always.

This is one legitimate distinction.

For example:

- IVF bypasses blocked tubes,
- it does not reconstruct them.

It may achieve pregnancy despite:

- severe male infertility,
- tubal disease.

Therefore IVF is often:

a fertility solution rather than a cure of the anatomical disease itself.

But when the primary objective is:

having a healthy child,

bypassing a disease can be entirely appropriate medicine.

Does Unani Medicine "Cure the Root Cause"?

Sometimes this phrase is used too loosely.

Correcting:

- poor lifestyle,
- nutritional imbalance,

- sexual dysfunction,
- metabolic problems

may indeed address important contributors.

But saying:

“Unani always treats the root cause while IVF only hides the disease”

would be inaccurate.

Sometimes the true root cause is:

- absent fallopian tubes,
- Y-chromosome deletion,
- severe tubal fibrosis,
- age-related oocyte depletion.

No lifestyle balancing can remove those biological facts.

Is Unani Medicine Non-Invasive and Risk-Free?

Usually oral diet/lifestyle-based Unani care is less invasive than IVF.

But:

natural does not mean automatically safe.

Traditional products may contain:

- pharmacologically active herbs,
- sedating substances,
- mineral preparations,
- metals.

Kushta and Heavy-Metal Safety

The supplied research correctly raises concern about:

Kushta formulations.

Herbomineral preparations require particularly careful:

- sourcing,
- manufacturing quality,
- dose control,
- regulatory compliance.

Contamination or improper preparation may expose patients to:

- lead,
- mercury,
- arsenic,
- other toxic substances.

Such exposures can harm:

- kidneys,
- nervous system,
- reproductive health.

Therefore:

I strongly discourage unsupervised Kushta use in infertility treatment.

Herb–Drug Interaction During IVF

A patient undergoing:

- gonadotrophin stimulation,
- ovulation induction,
- anticoagulation,
- embryo transfer

should tell her fertility team about every:

- Unani medicine,
- Ayurvedic formulation,
- supplement,
- herbal product.

“Herbal” should not be hidden from the IVF physician.

Traditional Medicines and Early Pregnancy

Many traditional reproductive formulations were historically used to:

- stimulate menstruation,
- alter uterine activity,
- influence reproductive function.

Once pregnancy is:

- possible,
- suspected,
- confirmed,

all medicines should be reviewed.

A fertility medicine appropriate before ovulation may not automatically be appropriate:

after conception.

Psychological Differences Between Treatment Approaches

Infertility is not merely a laboratory problem.

WHO recognizes the:

- psychological,
- social,
- financial

burden of infertility.

Emotional Burden of IVF

IVF may involve:

- injections,
- repeated monitoring,
- egg retrieval,
- waiting for fertilization results,

- embryo-development uncertainty,
- pregnancy-test anxiety.

A failed cycle can be emotionally difficult.

Emotional Advantages of Whole-Person Care

Traditional care often allows:

- longer consultation,
- diet discussion,
- sleep discussion,
- sexual-health discussion,
- constitutional assessment.

Patients may feel:

heard as people rather than viewed only as ovaries or sperm reports.

This is a genuine value.

But compassionate communication is not unique to Unani medicine.

Modern fertility care should also be:

patient-centered and compassionate.

Saira Health Care's Integrative Philosophy

Saira Health Care publicly describes its model as:

- patient-centered,
- individualized,
- combining traditional knowledge,
- lifestyle guidance,
- contemporary diagnostic understanding.

I consider this especially important in fertility treatment.

The aim is not:

Unani versus IVF.

The aim is:

the correct care at the correct time.

Dr. Nizamuddin Qasmi's Special Fertility Approach

When couples consult me at Saira Health Care, I prefer a structured approach.

Step 1: Evaluate Both Partners

I begin with:

- male history,
- female history,
- infertility duration,
- previous conception,
- sexual history.

Step 2: Review Existing Reports

I review actual:

- semen analysis,
- ultrasound,
- AMH,
- hormones,
- HSG/HyCoSy,
- previous IUI/IVF reports.

I do not rely only on:

“The doctor said everything is normal.”

Step 3: Identify the Real Fertility Barrier

Is it:

- ovulation,
- tubal disease,
- sperm,
- sexual dysfunction,
- endometriosis,
- age,
- ovarian reserve,
- unexplained infertility?

Step 4: Determine Reproductive Urgency

The question is:

How much time can safely be spent on conservative treatment?

Age is central.

Step 5: Correct Lifestyle and Reversible Factors

Where appropriate:

- tobacco cessation,
- healthy diet,
- activity,
- sleep,
- metabolic control,
- sexual-health treatment.

Step 6: Add Unani Assessment

I may assess:

- Mizaj,
- traditional reproductive features,
- constitutional health.

This is used as a:

traditional complementary framework

rather than replacing modern diagnosis.

Step 7: Ilaj-bil-Ghiza

Individualize diet.

Step 8: Ilaj-bit-Tadbir

Individualize:

- activity,
- sleep,
- stress management,
- appropriate traditional regimenal care.

Step 9: Ilaj-bid-Dawa

Selected Unani medicines may be considered based on the patient's:

- actual condition,
- fertility goal,
- safety.

Step 10: Set a Defined Review Date

I do not advise:

“Take medicine until pregnancy happens.”

There should be objective reassessment.

Step 11: Do Not Delay IUI When It Becomes Appropriate

For suitable unexplained infertility after appropriate expectant management:

stimulated IUI is evidence based.

Step 12: Do Not Delay IVF When It Becomes Appropriate

Especially in:

- severe tubal disease,
- older reproductive age,
- selected severe male factor,
- failed appropriate IUI,
- other significant indications.

Step 13: Use ICSI Only When There Is a Reason

Routine ICSI is not necessary for every IVF patient.

Step 14: Continue Safe Supportive Care During ART

Healthy:

- nutrition,
- sleep,
- emotional support,
- metabolic care

can continue alongside IVF.

There is no need to stop being a whole patient simply because laboratory fertilization is used.

When I Would Not Recommend Delaying ART for Unani Treatment

I would be particularly cautious about delay in:

- women around 38 or older,
- significant decline in ovarian reserve combined with increasing age,
- severe bilateral tubal disease,
- significant hydrosalpinx,

- severe male-factor infertility requiring ART,
- previous multiple unsuccessful conservative treatments,
- situations where genetic treatment planning requires IVF.

When a Short Integrative Approach May Be Reasonable

Depending on prognosis:

- younger age,
- short infertility duration,
- open tubes,
- ovulation present,
- reasonable semen parameters,
- no urgent reproductive factor,

may allow time for:

- lifestyle optimization,
- supervised Unani support,
- expectant management.

But the plan should remain:

time-limited and measurable.

Important Correction: There Is No Universal "Unani First" Rule

The uploaded report proposes:

"Unani First"

for an unexplained-infertility couple under 35.

I would modify that recommendation.

The evidence-based version is:

good-prognosis young couples may initially undergo a defined period of expectant management, during which safe lifestyle and individualized Unani supportive care may be used if desired.

That is not the same as saying:

Unani medicine must be tried before IUI.

WHO's actual evidence-based pathway is:

expectant management → stimulated IUI → IVF, individualized to prognosis.

Important Correction: "IVF Immediately for Every Bilateral Block" Is Also Too Simple

The uploaded analysis recommends IVF immediately for bilateral tubal blockage.

Current WHO guidance is more nuanced.

It considers:

- age,
- severity of tubal disease.

Women under 35 with:

- mild-to-moderate tubal disease

may sometimes benefit from surgery.

Severe disease or older age favors IVF.

Important Correction: Azoospermia Does Not Automatically Mean IVF/ICSI Immediately

Azoospermia must first be classified.

For example:

Hypogonadotropic hypogonadism

may respond to hormonal treatment.

Obstructive azoospermia

may sometimes be treated by reconstruction or sperm retrieval.

Non-obstructive azoospermia

requires different evaluation.

Therefore:

diagnosis precedes ART.

Common Myths About Unani, IUI and IVF

Myth 1: Unani medicine and IVF are opposites.

Fact: They can be used in an integrative fertility strategy when appropriate.

Myth 2: Natural treatment should always be tried first.

Fact: In severe tubal disease or time-sensitive infertility, delay may reduce reproductive opportunity.

Myth 3: IVF should always be the first treatment because it has the highest success.

Fact: Many young good-prognosis couples do not need immediate IVF.

Myth 4: IUI bypasses blocked tubes.

Fact: No. Fertilization after IUI still occurs in the fallopian tube.

Myth 5: IVF repairs blocked tubes.

Fact: IVF bypasses them.

Myth 6: Unani medicines can always open fallopian tubes.

Fact: High-quality evidence does not demonstrate reliable reversal of dense fibrosis or hydrosalpinx.

Myth 7: IVF is guaranteed to work under age 35.

Fact: Even in the best age group, no ART treatment guarantees live birth.

Myth 8: IVF has one universal success rate.

Fact: Outcomes are highly age- and diagnosis-dependent.

Myth 9: IUI success is always 15%.

Fact: Outcome varies with age, diagnosis and treatment protocol.

Myth 10: Unani success is equal to IUI.

Fact: Current evidence does not permit a scientifically valid direct success-rate comparison.

Myth 11: Every IVF needs ICSI.

Fact: Routine ICSI for non-male-factor infertility does not improve live-birth rates.

Myth 12: More embryos transferred means better IVF.

Fact: Multiple embryo transfer increases multiple-pregnancy risks. Single embryo transfer is preferred in many favorable-prognosis cases.

Myth 13: IVF always causes dangerous OHSS.

Fact: OHSS remains an important risk, but modern prevention strategies have substantially improved safety.

Myth 14: Herbal medicines have no side effects.

Fact: Natural medicines can interact with drugs and some herbomineral products can present toxicity risks.

Myth 15: Kushta is automatically safe if it is traditional.

Fact: Quality control and appropriate medical supervision are essential.

Myth 16: IVF means the couple failed to conceive "naturally."

Fact: IVF is medical treatment for reproductive disease, not a moral judgment.

Myth 17: A failed IVF means pregnancy is impossible.

Fact: Prognosis depends on age, embryo availability, diagnosis and future treatment options.

Myth 18: If IUI fails once, IVF is mandatory immediately.

Fact: Treatment sequencing depends on diagnosis and prognosis; several oral-agent IUI cycles may be reasonable in unexplained infertility.

Frequently Asked Questions

Which is better: Unani or IUI?

They are not directly comparable.

Unani is a medical system providing individualized traditional care.

IUI is a specific reproductive procedure.

The correct choice depends on the fertility diagnosis.

Which is better: Unani or IVF?

If the issue is:

- lifestyle,
- metabolic health,
- mild functional problems,

Unani care may provide meaningful support.

If the issue is:

- severe bilateral tubal disease,
- selected severe male-factor infertility,
- time-sensitive reproductive decline,

IVF may provide a far more effective route to pregnancy.

Can I take Unani medicine while undergoing IVF?

Potentially, but only after discussing every medicine with:

- the Unani physician,
- the IVF specialist.

Some herbs may interact with medicines or be unsuitable during treatment or pregnancy.

Can Unani medicine improve IVF success?

Optimizing:

- lifestyle,
- nutritional deficiencies,
- metabolic health,
- sexual/psychological wellbeing

may improve general health.

However, there is insufficient evidence to claim that a particular Unani medicine or Hijama protocol reliably increases IVF live-birth rates.

Should I do IUI before IVF?

Often in:

- unexplained infertility,
- selected mild male factor.

But not always.

Severe tubal disease, age and other factors may justify earlier IVF.

How many IUIs should we try?

ASRM commonly recommends approximately:

3–4 oral-agent ovarian-stimulation/IUI cycles

for many unexplained-infertility couples before IVF.

WHO notes that the optimal number is uncertain; more recent evidence commonly involves approximately:

3–6 cycles.

Treatment should be individualized.

Can IUI work with both tubes blocked?

No, not when both tubes are truly and severely occluded.

Can IVF work without tubes?

Yes.

IVF bypasses the fallopian tubes.

Does IVF work after age 40?

Pregnancy is possible, but success using a woman's own eggs declines markedly with age.

Final 2023 SART data reported live birth per intended retrieval of approximately:

- 13.2% at age 41–42,
- 4.1% above 42,

using own eggs and counting linked transfers.

These U.S. registry figures are illustrative, not individual predictions.

Is ICSI better than IVF?

Only in selected situations.

Routine ICSI without male-factor infertility does not improve live-birth rates.

Can IVF be used for low AMH?

Yes.

Low AMH may mean:

- fewer eggs retrieved,

but it does not mean IVF is impossible.

Can Unani medicine increase AMH?

There is insufficient high-quality evidence that Unani treatment reliably regenerates depleted ovarian reserve.

Can Unani medicine improve sperm?

Traditional male fertility treatment may support:

- general health,
- lifestyle,
- selected semen problems.

But abnormal semen requires proper diagnosis.

What if sperm count is zero?

Azoospermia requires:

- hormonal,
- genetic,
- anatomical evaluation

before treatment is selected.

Is Hijama necessary before IVF?

No.

It is not a requirement of evidence-based fertility treatment.

Should every PCOS patient have Hijama?

No.

PMOS/PCOS is treated according to:

- ovulation,
- metabolism,
- pregnancy goal.

Is Unani treatment cheaper than IVF?

It is usually less costly because it does not involve:

- egg retrieval,
- embryology,
- laboratory fertilization.

However, the actual financial value depends on whether the treatment is appropriate.

A cheap ineffective treatment that consumes valuable reproductive time can ultimately become:

very expensive.

How I Counsel a Couple at Saira Health Care

I tell couples that there are three questions more important than:

“Which treatment is natural?”

They are:

1. What is preventing pregnancy?

2. How much reproductive time do we have?

3. Which treatment gives the best balance of effectiveness, safety, cost and patient preference?

After that, treatment becomes much clearer.

Saira Health Care's Contribution to Sexual Disorders & Infertility

Saira Health Care publicly describes its approach as patient-centered and focused on:

sexual disorders and infertility.

The clinic states that it combines:

- traditional knowledge,
- individualized care,
- lifestyle guidance,
- modern diagnostic understanding.

This integrated perspective can be particularly useful because fertility often involves more than one problem.

A couple may simultaneously have:

- PMOS in the woman,
- poor sperm motility in the man,
- sexual-performance anxiety,

- obesity or diabetes.

Treating only one laboratory value may miss the larger reproductive picture.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility

My professional education and additional training include:

- **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**

Saira Health Care's current published professional material lists this physician byline and describes my focused clinical practice in sexual disorders and infertility.

This combination of:

- Unani medicine,
- infertility-focused practice,
- male infertility training,
- sexual-health care,
- additional urological education

is especially useful because fertility decisions must consider:

both partners and the entire reproductive pathway.

My Clinical Philosophy: Not "Unani Versus IVF"—But the Right Treatment at the Right Time

If a 26-year-old woman with:

- normal ovarian reserve,
- open tubes,
- normal male semen,
- short-duration unexplained infertility

wants to spend a short period improving:

- diet,
- sleep,
- lifestyle,
- traditional reproductive health

before escalating treatment, that may be reasonable.

If a 39-year-old woman has:

- declining ovarian reserve,
- several years of infertility,

I would not advise her to sacrifice months simply because:

“traditional treatment should always be tried first.”

If both tubes are severely damaged:

IUI is not the answer.

If the man has a treatable endocrine cause of azoospermia:

automatic ICSI may not be the first answer either.

If stimulated IUI has failed:

repeating ineffective treatment indefinitely is not compassionate medicine.

And if IVF is medically indicated:

using IVF does not mean abandoning Unani principles of whole-person care.

A woman can still receive:

- healthy nutrition,
- sleep support,
- metabolic management,
- emotional support,

- carefully supervised traditional care

while undergoing modern fertility treatment.

This is the model I consider most rational.

Latest Scientific Perspective: 2025–2026

WHO's First Global Infertility Guideline

WHO's November 2025 guideline is the most important recent international development in infertility care.

It promotes:

- progressive treatment,
- diagnosis-specific care,
- healthier lifestyle,
- affordability and equity.

Unexplained Infertility

WHO recommends:

First line

Expectant management

in suitable couples.

Second line

Stimulated IUI with clomiphene or letrozole.

After unsuccessful S-IUI

IVF.

Tubal Infertility

WHO's recommendations now explicitly incorporate:

- female age,

- tubal-disease severity.

Mild-to-moderate disease in selected younger women may be treated surgically.

Severe disease or older age often favors IVF.

Hydrosalpinx

WHO recommends treatment of hydrosalpinx before IVF using:

- salpingectomy,
- or tubal occlusion.

ICSI Is Being Used More Selectively

ASRM's 2026 opinion states that routine ICSI does not improve live-birth outcomes for:

- non-male-factor infertility.

This means modern fertility medicine is itself moving away from the idea:

“more technology is always better.”

Conclusion

The choice between:

Unani medicine, IUI and IVF/ICSI

should never be made by ideology alone.

These approaches serve different purposes.

Unani medicine

can provide valuable individualized support through:

- Mizaj-based traditional assessment,
- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- Ilaj-bid-Dawa,

- sexual-health care,
- metabolic and lifestyle management.

Published Unani literature includes encouraging:

- small studies,
- individual infertility success reports.

However:

the evidence is currently insufficient to assign Unani medicine a reliable success rate directly comparable with IUI or IVF.

Case reports of pregnancy should stimulate research—not become universal cure claims.

IUI

is a relatively simple reproductive procedure that places prepared sperm inside the uterus.

It may be useful for:

- unexplained infertility after appropriate initial management,
- selected mild male-factor infertility,
- donor sperm.

It still requires:

a route through at least one functional fallopian tube.

Current WHO guidance recommends stimulated IUI with:

- clomiphene,
- or letrozole

after unsuccessful expectant management in appropriate unexplained-infertility couples.

IVF

retrieves eggs and creates embryos outside the body.

It bypasses the tubes and is especially important when:

- severe tubal disease exists,
- appropriate lower-intensity treatment has failed,
- selected significant male factor exists,
- reproductive time is limited.

Final SART 2023 data demonstrate how strongly IVF outcomes with a woman's own eggs depend on age, declining from approximately:

- 53.2% live birth per intended retrieval under 35,
- to 13.2% at age 41–42,
- to 4.1% above age 42.

These statistics make one principle very clear:

fertility treatment must protect time.

ICSI should also be used selectively rather than automatically. Current ASRM and WHO guidance does not support routine ICSI in unexplained or other non-male-factor infertility when conventional IVF is appropriate.

At **Saira Health Care**, my approach as **Dr. Nizamuddin Qasmi** is therefore:

Evaluate both partners.

Identify the actual fertility diagnosis.

Treat sexual dysfunction when it is interfering with conception.

Correct reversible lifestyle and metabolic factors.

Use individualized Unani dietotherapy, regimenal therapy and pharmacotherapy where appropriate.

Do not equate traditional humoral concepts directly with modern hormones.

Do not advertise Hijama, massage or herbs as proven treatments for anatomical obstruction.

Do not assign unsupported success percentages to Unani treatment.

Use IUI when it has a reasonable biological chance of working.

Do not use IUI when the tubes cannot support fertilization.

Use IVF when it provides the better route to pregnancy.

Use ICSI only when there is an appropriate indication.

Consider female age and ovarian reserve before spending reproductive time on prolonged conservative treatment.

Do not allow expensive technology to replace proper diagnosis.

And do not allow a preference for natural treatment to delay medically necessary reproductive care.

When a couple asks me:

“Doctor, should we choose Unani medicine, IUI or IVF?”

my answer is:

Do not choose a treatment system first—choose the correct diagnosis first. In a young couple with good reproductive potential, supervised Unani care and lifestyle optimization may form a useful part of conservative fertility management. When IUI offers a reasonable biological advantage, it should be used appropriately. When severe tubal disease, significant male-factor infertility, advanced reproductive age or failed lower-level treatment makes IVF the better option, IVF should not be unnecessarily delayed. The best fertility medicine is not about choosing tradition against technology; it is about using each method responsibly, at the correct time, for the correct patient, with the ultimate goal of a healthy pregnancy and live birth.

Selected Medical References

1. **World Health Organization.** *Guideline for the Prevention, Diagnosis and Treatment of Infertility.* Geneva: WHO; 28 November 2025.
2. **World Health Organization.** Treatment of Couples With Unexplained Infertility. WHO infertility guideline, 2025.
3. **World Health Organization.** Treatment of Infertility Due to Tubal Disease. 2025.
4. **American Society for Reproductive Medicine.** *Evidence-Based Treatments for Couples With Unexplained Infertility.*
5. **American Society for Reproductive Medicine.** *Intracytoplasmic Sperm Injection for Nonmale Factor Indications: Committee Opinion.* 2026.
6. **Society for Assisted Reproductive Technology.** Final National Summary Report, 2023.
7. **American Society for Reproductive Medicine.** *Prevention of Moderate and Severe Ovarian Hyperstimulation Syndrome.*
8. **Sultana A, Rahman KU, Nagaraj RB.** Conception in unilateral right tubal blockage with herbomineral formulations: a case report. 2011.
9. **Naaz A, Begum W, Wani GN.** Effect of Unani Formulations in the Management of Unexplained Primary Infertility: A Case Report. 2024.

Medical Disclaimer

This article is intended for:

- patient education,
- fertility awareness,
- general medical information.

It does not replace individualized evaluation by:

- gynecologists,
- reproductive-medicine specialists,
- urologists/andrologists,
- qualified Unani physicians.

Do not decide between:

- natural conception,
- Unani treatment,
- IUI,
- IVF,
- ICSI

using website success percentages alone.

Treatment should consider:

- female age,
- ovarian reserve,
- ovulation,
- fallopian tubes,
- uterus,
- semen parameters,
- sexual function,
- duration of infertility,
- previous treatment.

Do not delay specialist reproductive care in:

- severe bilateral tubal disease,
- hydrosalpinx,
- advanced female reproductive age,
- markedly reduced ovarian reserve,
- azoospermia,
- severe male-factor infertility,
- recurrent failed fertility treatment.

Do not independently use:

- fertility hormones,
- clomiphene,
- letrozole,
- gonadotrophins,
- Unani medicines,
- Kushta,
- herbal reproductive formulations,
- Hijama

as substitutes for proper diagnosis.

No Unani formulation, IUI procedure, IVF cycle or ICSI treatment can ethically guarantee:

- fertilization,
- implantation,
- pregnancy,
- live birth.

Saira Health Care
www.sairahealthcare.com

Medical literature reviewed and updated: September 2026