Fertility Diet and Lifestyle: Evidence-Based Nutrition, Exercise and Unani Guidance for Male and Female Fertility

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Introduction: "Doctor, What Should We Eat to Get Pregnant Faster?"

When couples come to me for infertility treatment, they frequently ask questions such as:

"Doctor, what should we eat to increase fertility?"

"Which foods improve egg quality?"

"What can my husband eat to improve sperm?"

"Should we stop sugar, milk, rice or gluten?"

"Is there a fertility diet that can help us conceive naturally?"

These are reasonable questions because reproductive health is connected with overall health.

The ovaries and testes are not isolated from the rest of the body. Reproduction is influenced by metabolism, nutrition, insulin sensitivity, body composition, sleep, tobacco exposure, alcohol, physical activity, chronic diseases and age.

The research supplied for this article correctly emphasizes the growing understanding that reproductive function interacts with metabolic health and that insulin regulation, oxidative stress and lipid metabolism are important biological pathways through which nutrition may influence reproductive physiology.

However, there is another equally important message:

There is no single scientifically proven "fertility diet" that guarantees conception.

The American Society for Reproductive Medicine states that evidence is insufficient to conclude that one specific dietary pattern or particular macronutrient reliably improves

natural fertility in otherwise ovulatory women, although a healthy diet remains appropriate for general and reproductive health.

WHO's first global infertility guideline, published on **28 November 2025**, recommends healthy diet, physical activity and tobacco cessation for people planning or attempting pregnancy, but these measures are part of fertility care rather than replacements for diagnosis and treatment.

This distinction matters.

A healthy lifestyle may help improve:

metabolic health, ovulation in some women, general sperm health, pregnancy preparation, cardiovascular health and treatment readiness.

But diet cannot reliably:

reopen severely blocked fallopian tubes, reverse advanced ovarian aging, correct major chromosomal abnormalities, restore a missing vas deferens, cure severe endometriosis, or replace IVF when IVF is medically required.

At Saira Health Care, my approach is therefore:

Use food and lifestyle as part of fertility treatment—not as a substitute for fertility diagnosis.

What Does "Fertility Diet" Actually Mean?

The term **fertility diet** does not refer to one official prescription.

It is better understood as:

a pattern of eating that supports metabolic, nutritional and reproductive health while avoiding dietary habits associated with poorer general health.

A fertility-supportive diet usually emphasizes minimally processed foods, adequate protein, vegetables, fruits, pulses, whole grains where appropriate, nuts, seeds, healthy fats and good micronutrient intake.

It also generally reduces:

excess added sugar, sugar-sweetened beverages, industrial trans fats, frequent ultra-processed foods and excessive alcohol.

This is very different from claims such as:

"Eat one date every morning and pregnancy will occur."

or:

“Drink one particular milk preparation and your AMH will rise.”

Those claims go far beyond current scientific evidence.

Infertility Is a Couple's Condition

The World Health Organization defines infertility as failure to achieve pregnancy after **12 months or more of regular unprotected sexual intercourse**.

Lifestyle advice should therefore involve:

both partners.

A woman may have excellent nutrition while the male partner:

smokes heavily, has obesity, uses anabolic steroids or has an untreated varicocele.

Likewise, a man may have excellent semen quality while the woman has:

bilateral tubal obstruction or severe anovulation.

For this reason, I prefer a:

couple-based fertility plan

rather than focusing on the woman alone.

How Nutrition Can Influence Reproductive Biology

There are several biologically plausible pathways linking nutrition with fertility.

The supplied source explains three particularly important areas: the insulin-androgen pathway, oxidative stress and lipid metabolism.

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1. Insulin, Androgens and Ovulation

Insulin is best known for regulating blood glucose, but it also interacts with ovarian hormone production.

When insulin resistance develops, the body may produce additional insulin to keep glucose controlled.

High insulin levels can contribute to increased androgen activity, particularly in women with PMOS/PCOS.

This may interfere with normal follicular development and ovulation.

This is why nutrition and physical activity are particularly important when infertility is associated with:

PMOS, obesity, metabolic syndrome or impaired glucose regulation.

However, not every woman with infertility is insulin resistant.

Therefore:

every infertile patient does not need an "insulin-resistance diet."

Diagnosis should come before treatment.

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2. Oxidative Stress and Reproductive Cells

Reactive oxygen species are naturally produced in the body.

In appropriate amounts, they participate in normal biological signaling.

The problem occurs when production exceeds the body's antioxidant defenses.

This is called:

oxidative stress.

Sperm are particularly vulnerable because their cell membranes contain high levels of polyunsaturated fatty acids and they have limited cytoplasmic antioxidant capacity.

Excessive oxidative stress may be associated with:

reduced sperm motility, membrane damage and sperm-DNA injury.

The uploaded research discusses this mechanism in detail for both oocytes and sperm.

But patients should be careful not to turn this concept into:

"Take as many antioxidants as possible."

Current AUA/ASRM male-infertility guidance states that the clinical benefits of antioxidant and vitamin supplements are of **questionable utility**, and evidence is insufficient to recommend one specific supplement regimen for infertile men.

Food-based nutrition and correcting genuine nutritional deficiencies are therefore different from taking large amounts of supplements without indication.

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3. Dietary Fats and Hormone Biology

Sex hormones are steroid hormones, and cholesterol plays an important role in steroid synthesis.

Cell membranes also contain fatty acids.

The quality of dietary fat therefore matters for:

cardiovascular health, metabolic health and potentially reproductive physiology.

The uploaded research correctly emphasizes the distinction between unsaturated fats and industrial trans fats.

A sensible fertility-supportive pattern favors:

olive oil, nuts, seeds, fish and other sources of unsaturated fats

over frequent intake of:

industrially produced trans fats and heavily processed fried foods.

What Should Couples Reduce?

Rather than using the frightening term:

“fertility-destroying foods,”

I prefer to identify dietary patterns worth reducing.

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1. Industrial Trans Fats and Frequently Fried Ultra-Processed Food

Older cohort research found associations between greater trans-fat intake and ovulatory infertility.

The uploaded research highlights these findings.

Many countries have significantly reduced industrial trans fats in the food supply, but partially hydrogenated fats and poor-quality repeatedly heated frying oils may still occur in some food environments.

A reasonable approach is to minimize:

commercial pastries, repeated deep-fried fast foods, highly processed bakery products and foods containing partially hydrogenated oils where these remain available.

The objective is broader metabolic health—not fear of an occasional food.

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2. Sugar-Sweetened Drinks and Excess Added Sugar

Frequent intake of:

soft drinks, sweetened juices, energy drinks and highly sweetened beverages

can contribute to:

excess calorie intake, poorer glucose regulation and weight gain.

The supplied research discusses observational associations between sugar-sweetened beverages and lower fecundability.

It is reasonable to make:

water, unsweetened beverages and minimally sweetened drinks

the routine choice.

But one sugary drink does not cause infertility.

The concern is the:

long-term dietary pattern.

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3. Large Amounts of Refined, Low-Fiber Carbohydrates

Highly refined carbohydrates can produce rapid glucose rises.

Examples include frequent intake of:

sweets, highly refined bakery foods, sugary breakfast cereals and large portions of refined carbohydrates without adequate fiber or protein.

For women with insulin resistance or PMOS, improving carbohydrate quality can be especially useful.

A better pattern includes:

whole grains where suitable, beans, lentils, vegetables and higher-fiber carbohydrate sources.

Should Everyone With Infertility Stop Rice?

No.

This is a common question in India.

Rice is not an infertility toxin.

The relevant factors include:

portion size, total dietary pattern, fiber, metabolic health, accompanying vegetables/protein and individual glucose control.

A patient with diabetes or insulin resistance may need a different carbohydrate plan from a healthy person without metabolic disease.

Should Everyone Avoid Gluten?

No.

The uploaded paper correctly notes that there is no evidence that gluten itself reduces fertility in the general population.

A gluten-free diet is important when someone has:

celiac disease

or another medically established indication.

Removing gluten unnecessarily can make a diet:

more expensive, more restrictive and occasionally nutritionally poorer.

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4. Frequent Processed Meat

Processed meats such as:

sausages, salami, bacon and other highly processed meat products

are best limited as part of a generally healthy diet.

Observational studies have associated unhealthy Western dietary patterns with poorer semen or fertility-related outcomes, although causation is difficult to prove.

A fertility-supportive diet can obtain protein from a mixture of:

pulses, beans, eggs, fish, poultry, dairy or other suitable sources.

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5. Excess Alcohol

The relationship between small amounts of alcohol and fertility is not perfectly clear.

ASRM notes that heavy intake is best avoided and that chronic alcohol misuse in men is associated with poorer reproductive and sexual-health parameters.

Once pregnancy occurs:

alcohol should be avoided because no safe pregnancy level has been established.

For couples actively trying to conceive, minimizing or avoiding alcohol is a simple and reasonable approach.

What About Dairy? An Important Correction

The uploaded research gives considerable emphasis to an older Nurses' Health Study observation suggesting:

high-fat dairy may be associated with a lower risk of ovulatory infertility, while low-fat dairy may be associated with greater risk.

This is interesting epidemiological evidence.

But it should not be converted into:

“Women trying to conceive must avoid low-fat dairy.”

ASRM notes that research on particular foods—including full-fat dairy—remains observational and inconsistent, and randomized trials are needed.

Therefore I do not recommend that every woman:

replace all low-fat dairy with cream, butter or ice cream

in the name of fertility.

Dairy choice should consider:

overall calorie needs, cardiovascular health, diabetes risk, tolerance and personal preference.

Foods to Prioritize

There is no magic food, but certain broad dietary groups are appropriate for general reproductive health.

Vegetables and Fruits

A variety of vegetables and fruits provides:

folate, vitamin C, carotenoids, polyphenols, potassium, fiber and other micronutrients.

Rather than searching for one:

“fertility fruit,”

I encourage variety.

Different colors generally indicate different plant compounds.

Pulses, Beans and Plant Proteins

The source paper discusses observational data linking greater plant-protein intake with a lower risk of ovulatory infertility.

Useful options include:

lentils, chickpeas, beans, peas, soy foods and nuts.

This does not mean animal protein must be eliminated.

A balanced fertility diet can include both plant and animal proteins according to:

nutrition, culture and medical needs.

Whole Grains and High-Fiber Foods

Fiber-containing foods can improve:

satiety, bowel health and glucose control.

Examples include:

oats, whole grains, pulses, beans, vegetables and seeds.

These may be particularly useful for women with:

PMOS or insulin resistance.

Nuts, Seeds and Unsaturated Fats

Examples include:

walnuts, almonds, seeds, olive oil and other unsaturated-fat sources.

These can replace some heavily processed fats.

A Mediterranean-style eating pattern is often used as a practical model because it emphasizes:

vegetables, legumes, whole grains, olive oil, nuts and fish.

However, even here we need scientific humility.

A systematic review of Mediterranean dietary patterns found that the evidence for pregnancy/live-birth improvement remains inconsistent.

A newer 2025 meta-analysis in men found associations between Mediterranean-style eating and some semen measures, but evidence for medically assisted reproductive outcomes remains an evolving area.

Therefore:

Mediterranean-style eating is a healthy option—not a guaranteed fertility treatment.

Fish and Omega-3 Sources

Fish can provide:

protein, iodine, selenium and omega-3 fatty acids.

Women planning pregnancy should choose varieties lower in:

mercury

and follow local pregnancy/preconception seafood guidance.

Fish should not be eliminated automatically because of mercury concerns; the goal is:

appropriate fish selection.

Folate-Rich Foods and Folic Acid

Folate is important in DNA synthesis and cell division.

Food sources include:

leafy vegetables, beans, pulses and citrus fruits.

But women capable of becoming pregnant should not rely only on food folate.

CDC currently recommends:

400 micrograms of folic acid every day

for people capable of becoming pregnant to help prevent neural-tube defects.

MTHFR: A Very Important 2026 Correction

Many fertility patients are told:

“You have an MTHFR gene variant, so you cannot process folic acid.”

Current CDC guidance explicitly says this is:

not correct.

People with common MTHFR variants can process folic acid, and **400 mcg daily remains recommended**.

CDC states that folic-acid intake matters more for blood folate levels than common MTHFR variants.

Therefore common MTHFR variants are not, by themselves, a reason to:

avoid folic acid

or insist that every woman requires methylfolate.

Does Folate Increase Fertility?

Folic acid is clearly recommended because it reduces the risk of:

neural-tube defects.

Its role should not be exaggerated into:

"folic acid guarantees conception."

It does not.

It is essential:

preconception care

rather than a cure for infertility.

Does Vitamin D Improve Fertility?

Vitamin D deficiency is common in many populations.

Some studies have associated low vitamin D status with fertility outcomes, and a meta-analysis found possible improvement in clinical pregnancy rates with supplementation in certain infertile populations, while other reproductive outcomes were less consistent.

My approach is therefore:

correct vitamin D deficiency when present rather than prescribe megadoses to every infertility patient.

Vitamin D should not be presented as an IVF or pregnancy guarantee.

Should Couples Take Antioxidant Supplements?

This is especially common among men.

Products may contain:

CoQ10, carnitine, vitamin C, vitamin E, zinc, selenium and many other substances.

Some studies report semen improvements.

But AUA/ASRM guidance states that evidence remains inadequate to recommend one specific antioxidant or vitamin regimen for male infertility.

Therefore:

supplements should not replace evaluation of the cause of abnormal semen.

A man with severe varicocele, hormonal disease, obstruction or genetic infertility should not spend years taking antioxidant capsules without proper diagnosis.

Healthy Weight and Fertility

Body weight is relevant to reproductive health.

Both:

very low energy availability

and:

significant obesity/metabolic disease

can affect reproduction.

But fertility care should avoid:

weight stigma.

Not every person with obesity is infertile, and not every person with a normal BMI is fertile.

ASRM specifically notes that most women and men with obesity are fertile even though obesity is associated with increased reproductive and pregnancy risks.

Obesity and Female Fertility

Obesity can be associated with:

ovulatory dysfunction, reduced response to ovulation treatment, metabolic abnormalities and pregnancy complications.

It is especially relevant in:

PMOS/PCOS.

For anovulatory women with obesity, weight reduction may improve:

spontaneous ovulation and chances of unassisted conception.

But this requires nuance.

Does Weight Loss Before IVF Increase Live Birth?

Not consistently.

ASRM's review of randomized trials found that preconception weight-loss programmes have **not consistently improved live-birth rates** in infertile women undergoing fertility treatment, particularly those who are already ovulating or undergoing IVF.

Weight management may still improve:

general health, metabolic health and some pregnancy risks.

But fertility treatment should not automatically be delayed for many months simply to reach an arbitrary BMI, especially when:

female age is increasing or ovarian reserve is reduced.

Do You Need a BMI of 20–24.9 to Become Pregnant?

No.

The supplied material proposes a narrow “ideal” BMI target.

That is too rigid for individual fertility care.

BMI is:

a screening tool—not a fertility pass/fail number.

Treatment decisions should consider:

metabolic health, blood pressure, diabetes, physical fitness, anesthesia safety, age and reproductive urgency.

ASRM specifically states that obesity alone should not serve as a universal basis for denying fertility treatment.

Being Underweight and Fertility

Very low body weight or insufficient energy intake can suppress the reproductive axis.

This may lead to:

hypothalamic amenorrhea, low estrogen and absent ovulation.

This is particularly relevant in:

athletes, restrictive dieting, eating disorders and relative energy deficiency.

For these women, aggressively exercising more or eating less is not:

fertility optimization.

Restoring adequate:

energy intake, nutrition and body function

may be essential.

Exercise and Fertility

Regular physical activity benefits:

cardiovascular health, glucose regulation, insulin sensitivity, mental health and body composition.

WHO's current infertility guideline includes physical activity among recommended lifestyle measures for people planning or attempting pregnancy.

The goal should usually be:

regular sustainable activity.

Walking, cycling, resistance training, yoga, swimming and other suitable activities can all be useful.

Can Too Much Exercise Reduce Female Fertility?

Yes, particularly when intense exercise creates:

energy deficiency.

The problem is not exercise itself.

It is the combination of:

very high training load, inadequate nutrition, low body fat in some patients and hypothalamic suppression.

This can result in:

irregular periods or amenorrhea.

Therefore I do not tell every healthy woman:

“Never do HIIT.”

Instead, I ask:

Are periods regular? Is nutrition adequate? Is exercise excessive? Is recovery sufficient?

Exercise in Men

Regular physical activity is generally beneficial for men's:

metabolic, cardiovascular and sexual health.

Extreme:

anabolic-steroid use, overtraining or heat exposure

can be harmful to reproductive health.

A particularly important warning is:

testosterone injections and anabolic steroids can suppress sperm production.

Men actively trying for pregnancy should never start testosterone therapy without discussing fertility plans with a qualified clinician.

Sleep and Fertility

Sleep regulates:

metabolic, hormonal and neurological systems.

The attached source discusses circadian biology and melatonin as possible reproductive modulators.

There are plausible reasons why chronic:

sleep deprivation, shift-work disruption and circadian disturbance

could affect reproductive health.

But:

sleep improvement should be regarded as health optimization rather than a proven infertility cure.

A practical goal for most adults is approximately:

7–9 hours of regular sleep

where possible.

Should Women Take Melatonin for Egg Quality?

Melatonin has antioxidant effects and has been studied as an adjunct during assisted reproduction.

A 2024 systematic review suggested an improvement in fertilization rate, but evidence regarding the most important outcomes—particularly live birth—is not sufficiently strong to recommend routine melatonin for every infertility patient.

Therefore:

do not self-prescribe high-dose melatonin as an "egg-quality medicine."

Sleep hygiene is different from pharmaceutical supplementation.

Stress and Fertility

Infertility can itself produce enormous stress.

Couples may experience:

anxiety, depression, family pressure, sexual-performance anxiety and relationship strain.

The uploaded source describes biological pathways through which the stress system and reproductive system interact.

These interactions are scientifically plausible.

But I never tell a patient:

"You are not becoming pregnant because you are thinking too much."

That statement:

blames the patient and oversimplifies infertility.

Stress management may improve:

quality of life, sleep and sexual wellbeing.

It should not replace evaluation of:

tubes, ovulation, sperm or other causes.

What About Yoga and Mindfulness?

Yoga, mindfulness and relaxation techniques can be useful for:

stress, anxiety and general wellbeing.

They may be incorporated into fertility care when patients enjoy them.

Their strongest role is:

psychological and general-health support.

They should not be advertised as treatments that:

open tubes or regenerate eggs.

Acupuncture and Fertility

The uploaded research presents acupuncture quite positively.

Recent meta-analyses have reported possible improvements in clinical pregnancy or live birth around IVF, but the certainty of evidence is generally low and methodologies differ substantially between trials. One large review specifically characterized the evidence as low or extremely low for many outcomes.

A more recent analysis also found possible reproductive benefits but reported increased early miscarriage in pooled data, illustrating why the evidence remains difficult to interpret.

Therefore:

acupuncture may be used as an optional complementary therapy, but it is not an established substitute for fertility treatment.

Tobacco: One of the Clearest Modifiable Risks

Among lifestyle factors, smoking is one of the strongest concerns.

ASRM reports substantial adverse associations between cigarette smoking and female fertility, including increased infertility and miscarriage risk.

WHO's 2025 infertility guideline specifically recommends:

tobacco cessation

for people planning or attempting pregnancy.

This applies to:

cigarettes, tobacco products and nicotine exposure.

Couples should also minimize:

secondhand smoke.

What About Vaping?

Vaping should not be treated as a harmless fertility alternative.

Electronic cigarettes may expose users to:

nicotine, solvents, metals and other aerosol chemicals.

Although long-term fertility data remain less complete than for cigarettes:

nicotine dependence should be addressed rather than replacing one exposure with another.

Cannabis and Recreational Drugs

ASRM discourages recreational drug use in people attempting conception.

Cannabis has been associated in some studies with altered sperm parameters, although fertility data remain inconsistent.

For couples trying to conceive:

avoiding recreational drugs is the safest approach.

Caffeine: Do You Need to Stop Coffee?

Usually:

No.

ASRM states that moderate caffeine consumption—approximately one to two cups of coffee per day or equivalent—has no apparent adverse effect on fertility.

Very high intake, around:

500 mg/day or more

has been associated with lower fertility in some studies.

For women who may become pregnant, a conservative practical approach is to keep caffeine around:

200 mg/day or less.

Male Fertility Diet: What Matters?

Men often ask:

“What food increases sperm fastest?”

Sperm production is not transformed by one meal.

Spermatogenesis takes:

several weeks to months.

A sensible male fertility plan focuses on:

balanced nutrition, tobacco cessation, avoiding anabolic steroids, appropriate physical activity, healthy metabolic status and evaluation of abnormal semen when present.

A 2025 systematic review found associations between Mediterranean-style dietary adherence and some semen-quality outcomes.

But a healthy diet does not replace medical investigation of:

azoospermia, severe oligospermia, varicocele, endocrine disease or genetic infertility.

Heat and Male Fertility

The testes function best at a temperature slightly lower than core body temperature.

Repeated substantial heat exposure may affect sperm production in susceptible men.

Practical precautions may include avoiding excessive prolonged:

hot tubs, sauna exposure or direct scrotal heating

when semen is already abnormal.

There is no need for an otherwise healthy man to become obsessed with every brief heat exposure.

Timing Intercourse Correctly

One of the simplest evidence-based fertility interventions is often overlooked.

The fertile window is approximately:

the six days ending on the day of ovulation.

ASRM states that pregnancy probability is maximized when intercourse occurs:

every one to two days during the fertile window.

Intercourse two to three times per week generally produces nearly similar results and may be easier for many couples.

Fertility care should not make intercourse:

mechanical, stressful or compulsory.

Does Daily Ejaculation Reduce Sperm?

Not in a man with normal semen.

ASRM notes that frequent ejaculation does not generally reduce fertility and that men should not be instructed to “save sperm” for long periods.

Long abstinence can sometimes worsen:

motility and semen quality.

Is There a Best Sexual Position for Pregnancy?

No.

There is no good evidence that:

missionary position, keeping legs elevated or lying still after intercourse

improves fertility.

ASRM states that specific sexual positions and post-coital routines do not improve pregnancy probability.

Lubricants and Fertility

Some lubricants impair sperm movement in laboratory testing.

But actual pregnancy studies are more reassuring.

Couples who require lubrication may choose:

fertility-compatible products

and should not be advised to tolerate painful intercourse.

Preconception Health Matters for Both Partners

A fertility lifestyle plan should also consider:

diabetes, thyroid disease, hypertension, medications, occupational exposures, sleep apnea and sexual dysfunction.

This is one reason fertility care should be:

medical care—not simply nutrition coaching.

The Unani Perspective on Fertility, Diet and Lifestyle

One of the strongest areas of overlap between modern preventive medicine and Unani medicine is the emphasis on:

daily living.

Unani medicine has long regarded health as being influenced by:

food, physical activity, rest, sleep, psychological state and environment.

Official CCRUM guidance identifies four major modes of Unani treatment:

Ilaj-bil-Tadbir – regimenal therapy; Ilaj-bil-Ghiza – dietotherapy; Ilaj-bid-Dawa – pharmacotherapy; Ilaj-bil-Yad – surgery.

CCRUM also describes the traditional **Asbab-e-Sitta Zarooriyah**, or essential lifestyle determinants, as central to preservation of health.

This makes diet and lifestyle a natural part of responsible Unani fertility care.

Ilaj-bil-Ghiza – Dietotherapy

In Unani medicine:

Ilaj-bil-Ghiza

means treatment or health support through diet.

For fertility patients, I may use this concept to individualize nutrition according to:

general health, body composition, menstrual pattern, metabolic status, digestion and reproductive goals.

This traditional approach can work well alongside modern nutrition because both recognize that:

dietary advice should be individualized.

Mizaj – Individualized Constitutional Assessment

Mizaj is the Unani concept of temperament.

Traditionally, an individual's state is considered according to qualities such as:

heat, coldness, moisture and dryness.

Modern medicine does not measure:

Mizaj

through a hormone test.

Likewise, traditional classifications should not be directly equated with:

insulin resistance, thyroid disease, AMH or testosterone.

The value of Mizaj in integrative practice is primarily:

individualization.

Two fertility patients may need completely different advice.

Akhlat and Fertility

Classical Unani physiology describes four humors:

Dam, Balgham, Safra and Sauda.

These are historical Unani physiological concepts.

They should not be falsely equated with:

blood glucose, insulin, estrogen, testosterone or inflammatory cytokines.

Responsible integrative care respects:

both traditions and scientific boundaries.

Traditional "Hot" and "Cold" Foods

Unani dietetics classifies foods according to their traditional Mizaj.

I may consider such concepts when providing individualized traditional advice.

But I do not recommend extreme dietary restriction simply because a nutritious food is traditionally categorized as:

hot or cold.

For example, removing:

fruit, yogurt, vegetables or pulses

without a specific nutritional reason can reduce diet quality.

The modern principles of:

balanced nutrition and adequate micronutrient intake

must be preserved.

Ilaj-bit-Tadbir – Regimenal Therapy

Unani regimenal care recognizes:

physical activity, sleep, daily routine and other lifestyle measures.

These are particularly useful in fertility patients with:

PMOS, obesity, metabolic disease, poor sleep, high stress or sedentary lifestyle.

The objective is not:

“detoxifying the reproductive organs.”

The objective is:

improving overall health in ways that may support reproductive function.

Does the Body Need a Fertility “Detox”?

The word detox is widely marketed.

The liver and kidneys already perform major detoxification functions.

There is no evidence that a juice cleanse, purge or fasting programme:

removes infertility toxins and makes pregnancy occur.

Extreme detox diets may actually cause:

protein deficiency, micronutrient deficiency and energy deficit.

Traditional Unani purgative or cleansing regimens, when used, should be:

clinically indicated and professionally supervised

rather than sold as universal infertility treatments.

Ilaj-bid-Dawa – Unani Pharmacotherapy

Unani herbs and formulations may be used for selected reproductive conditions according to:

the diagnosis and individual patient.

But:

herbal medicine is not automatically safer simply because it is natural.

Some traditional formulations can interact with:

fertility medicines, diabetes drugs, anticoagulants and other treatments.

Pregnancy safety also matters.

All medicines and supplements should be disclosed to the fertility specialist.

Can Unani Medicine Improve Fertility Through Lifestyle?

This is one of the areas where I consider Unani medicine particularly useful.

A supervised Unani fertility programme may help a patient work systematically on:

diet, sleep, activity, metabolic health, digestion, smoking cessation, weight where appropriate and sexual wellbeing.

These factors matter medically regardless of treatment system.

The traditional framework can therefore encourage:

whole-person adherence to healthy reproductive habits.

But Unani diet and lifestyle should not be presented as a replacement for:

HSG when tubes need testing, semen analysis when sperm need evaluation, letrozole when PMOS-related ovulation induction is required, varicocele treatment when indicated, or IVF when severe reproductive disease requires ART.

Dr. Nizamuddin Qasmi's Fertility Diet and Lifestyle Approach

When a couple asks me:

“Doctor, what should we change at home?”

I first determine:

whether lifestyle is the main problem or only one small part of a larger fertility diagnosis.

I review the woman's:

age, menstrual cycle, ovulation, ovarian reserve where indicated, tubal status and gynecological conditions.

I also review the man's:

sexual function, semen analysis, testicular history, varicocele, medications and lifestyle.

Then I look at:

nutrition, physical activity, sleep, tobacco, alcohol, recreational drugs, weight, diabetes/metabolic health and intercourse timing.

Only after this assessment do I build:

an individualized fertility-support plan.

Step 1: Correct the Diagnosis Before Correcting the Diet

A woman with:

PMOS-related anovulation

may benefit greatly from metabolic lifestyle improvement.

A woman with:

bilateral severe hydrosalpinx

will not solve her infertility by eating more walnuts.

A man with:

azoospermia

needs diagnostic evaluation rather than a juice programme.

This is the foundation of my approach.

Step 2: Make the Diet Sustainable

I prefer a diet that a couple can follow for:

months and years

rather than a seven-day fertility challenge.

Healthy fertility eating is usually:

simple, diverse and culturally practical.

Step 3: Correct Deficiencies

When clinically indicated, I investigate or address:

iron, folate, vitamin B12, vitamin D or other nutritional issues.

But supplementation should be targeted rather than endless.

Step 4: Protect Reproductive Time

A 24-year-old woman and a 39-year-old woman should not be told:

“Try diet alone for one year.”

Female age strongly affects reproductive potential.

Healthy lifestyle can be started immediately while:

diagnosis and fertility treatment continue.

Step 5: Evaluate Both Partners

This prevents a common mistake:

months of diet and medicines for the woman while severe male infertility remains undiagnosed.

Step 6: Use Unani Principles Where They Add Value

I may integrate:

Ilaj-bil-Ghiza, Ilaj-bit-Tadbir and individualized traditional pharmacotherapy.

But I keep modern investigation and evidence-based treatment available when required.

Step 7: Measure Meaningful Outcomes

The goal is not simply:

weight loss, a “warmer” constitution or taking more supplements.

The meaningful outcomes depend on the patient and may include:

regular ovulation, healthier glucose control, improved semen findings, spontaneous conception, successful fertility treatment, healthy pregnancy and live birth.

Saira Health Care's Contribution to Fertility Lifestyle Education

Saira Health Care currently publishes patient education emphasizing that fertility is influenced by:

age, general health, hormones, medical conditions and lifestyle.

Its August 2026 fertility education specifically advises that couples should not depend on:

one food, exercise or home remedy

to guarantee pregnancy and encourages balanced diet, physical activity, healthy sleep and proper medical assessment.

This reflects the approach I prefer clinically:

education before exaggerated promises.

Saira Health Care describes its broader model as patient-centered and combines:

traditional knowledge, modern diagnostic understanding and lifestyle guidance.

About Dr. Nizamuddin Qasmi

I am:

Dr. Nizamuddin Qasmi

Founder & Chief Physician of **Saira Health Care**, with a focused clinical 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 professional material publicly lists this fertility and sexual-health focus and the additional training credentials used in my current physician byline.

This combined male and female reproductive perspective is useful because nutrition and lifestyle affect:

the couple—not only one partner.

Practical Fertility Nutrition Guide

Prioritize more often	Limit or reduce
Vegetables and seasonal fruits	Sugar-sweetened beverages
Pulses, lentils and beans	Frequent ultra-processed foods
Adequate high-quality protein	Industrial trans fats
Whole grains/high-fiber carbohydrates when suitable	Excess refined carbohydrates and added sugar
Nuts and seeds	Frequent processed meat
Olive oil and other unsaturated fats	Repeated deep-fried foods
Low-mercury fish where appropriate	Excess alcohol
Folate-rich foods	Recreational drugs
Suitable dairy according to nutritional needs	Extreme restrictive diets
Water and unsweetened beverages	“Detox” drinks marketed as fertility cures

The purpose of this table is not perfection.

A healthy diet is determined by:

what you eat most of the time.

Common Myths About Diet and Fertility

Myth: One superfood can make you pregnant.

Fact: No single food has been proven to guarantee conception.

Myth: Every infertile woman should avoid dairy.

Fact: Evidence regarding low-fat versus high-fat dairy is observational and insufficient to justify a universal restriction.

Myth: Everyone should stop gluten.

Fact: Gluten avoidance is appropriate for celiac disease or another valid medical indication, not all fertility patients.

Myth: Sugar alone causes PCOS.

Fact: PMOS/PCOS is multifactorial. Diet and insulin resistance can influence symptoms, but sugar is not its single cause.

Myth: Low AMH can be normalized by a fertility diet.

Fact: No diet is proven to regenerate a depleted ovarian follicle pool.

Myth: Full-fat dairy increases fertility.

Fact: Older observational studies suggest an association with ovulatory infertility risk, but this has not established full-fat dairy as a fertility treatment.

Myth: MTHFR means folic acid is dangerous.

Fact: CDC states that common MTHFR variants are not a reason to avoid folic acid.

Myth: More antioxidants are always better for sperm.

Fact: Current AUA/ASRM guidance says the benefits of fertility supplements are uncertain.

Myth: Obese women must lose weight before being allowed fertility treatment.

Fact: Obesity affects reproductive risk, but ASRM does not support a universal BMI threshold for denying treatment.

Myth: Losing weight always increases IVF live birth.

Fact: Trials have not consistently demonstrated improved live-birth outcomes from pre-IVF weight-loss programmes.

Myth: Vigorous exercise always harms fertility.

Fact: Exercise is beneficial. Problems mainly arise when excessive training causes energy deficiency or menstrual suppression.

Myth: Stress causes all unexplained infertility.

Fact: Stress affects wellbeing, but infertility should never be blamed on a patient's emotions.

Myth: Acupuncture is scientifically proven to make IVF work.

Fact: Some meta-analyses show possible benefits, but evidence quality is variable and often low.

Myth: Melatonin is a proven egg-quality medicine.

Fact: It is being studied, but current evidence does not establish routine use for improving live birth.

Myth: Unani medicine means taking only herbs.

Fact: Authentic Unani treatment also includes dietotherapy and regimenal therapy.

Myth: Natural treatment can replace IVF in every couple.

Fact: Structural, genetic or severe reproductive problems may require modern fertility treatment.

Frequently Asked Questions

What is the best fertility diet?

There is no universally proven best diet.

A balanced, minimally processed, Mediterranean-style pattern is a sensible option for general metabolic and reproductive health, but it cannot guarantee conception.

Which food increases egg quality?

No individual food has been proven to reliably increase human egg genetic quality.

Age remains one of the most important determinants of reproductive potential.

Which food increases sperm count?

No single food reliably treats low sperm count.

A healthy dietary pattern may support semen health, but abnormal sperm count requires medical evaluation.

Should we eat walnuts every day?

Walnuts are nutritious and provide healthy fats.

They can be part of a fertility-supportive diet, but they are not a treatment for every sperm disorder.

Should women consume full-fat milk?

Full-fat dairy does not need to be prescribed as a fertility medicine.

Choose dairy based on:

nutrition, calories, metabolic health and tolerance.

Is soy harmful to male fertility?

Current human evidence does not support the common claim that normal soy-food consumption “feminizes” men.

Soy foods can be part of a balanced diet.

Should we avoid sugar completely?

No.

The aim is to reduce:

excess added sugar and sugary drinks,

not create fear of every carbohydrate.

Is fruit sugar harmful?

Whole fruit contains:

fiber, water and micronutrients

and should not generally be equated with sugar-sweetened drinks.

Does coffee reduce fertility?

Moderate intake—roughly one to two cups daily—is generally not associated with clear fertility harm.

Very high caffeine intake should be avoided.

Should we stop alcohol?

Heavy drinking should be avoided.

Once pregnancy occurs, alcohol should be stopped.

Couples trying to conceive may reasonably minimize or avoid it.

Does smoking affect fertility?

Yes.

Smoking is one of the clearest modifiable fertility risks, especially for women, and WHO recommends tobacco cessation when planning pregnancy.

Should a woman take folic acid before pregnancy?

Yes.

CDC recommends:

400 mcg of folic acid daily

for people capable of becoming pregnant.

What if I have MTHFR?

Common MTHFR variants do not prevent the body from using folic acid.

CDC continues to recommend 400 mcg daily.

Should men take fertility antioxidants?

Not automatically.

AUA/ASRM states that benefits remain uncertain and evidence is insufficient to recommend one particular supplement combination.

How much exercise is good?

Regular moderate activity is appropriate for most people.

Women should avoid creating severe energy deficiency through excessive exercise plus inadequate food.

Can weight loss improve PCOS fertility?

In women with obesity and anovulation, weight reduction may improve:

ovulation and chances of unassisted conception.

But it does not guarantee pregnancy or live birth.

Should IVF be delayed until weight loss occurs?

Not automatically.

Female age, ovarian reserve and treatment urgency must be considered.

How much sleep is recommended?

A practical target for most adults is approximately:

7–9 hours

with a regular sleep schedule.

Can acupuncture improve fertility?

Some trials suggest possible benefits, especially around IVF, but evidence quality remains variable.

It should be considered complementary rather than a substitute for fertility care.

Can Unani medicine support fertility through diet?

Yes.

Ilaj-bil-Ghiza and Ilaj-bit-Tadbir provide traditional frameworks for individualized diet and lifestyle support.

But Unani treatment should be integrated with proper reproductive diagnosis.

Can Unani diet increase AMH?

There is insufficient high-quality evidence to claim that any diet or Unani regimen regenerates depleted ovarian reserve.

Can Unani medicine improve sperm health?

Traditional Unani treatment may support male reproductive health through individualized diet, lifestyle and medicines.

But severe sperm abnormalities require proper medical evaluation.

Latest Scientific Perspective: 2025–2026

Several developments are especially important.

WHO's First Global Infertility Guideline

On **28 November 2025**, WHO published its first global evidence-based infertility guideline.

One important message is that fertility care should include:

healthy diet, physical activity and tobacco cessation.

But WHO also emphasizes progressive diagnosis and treatment.

Lifestyle advice is therefore:

part of medical fertility care—not an alternative to it.

The Fertility-Diet Evidence Is Being Interpreted More Cautiously

Early observational research—particularly the Nurses' Health Study—generated enthusiasm about:

trans fats, vegetable protein, glycemic load, dairy and other specific dietary factors.

The uploaded source reviews these associations in detail.

These studies are valuable for generating hypotheses.

But ASRM's overall conclusion remains that:

robust evidence that one specific dietary pattern improves natural fertility is lacking.

This is why current fertility nutrition should emphasize:

healthy patterns rather than rigid fertility-food rules.

Mediterranean Diet Research Continues

A 2025 systematic review and meta-analysis reported associations between Mediterranean-diet adherence and certain semen-quality measures in men.

But earlier meta-analysis found fertility and pregnancy results too inconsistent to justify strong clinical claims.

The interpretation is:

promising association—not proven infertility treatment.

MTHFR Guidance Has Become Much Clearer

In **July 2026**, CDC specifically reaffirmed that people with common MTHFR gene variants can process:

folic acid

and should still receive the recommended daily amount.

This is an important correction to a large amount of fertility misinformation online.

Weight-Loss Advice Is Becoming More Individualized

Modern reproductive medicine is moving away from:

“Lose weight first, then we will treat you.”

ASRM acknowledges that pre-treatment weight loss does not consistently improve live-birth rates and that delay itself may reduce reproductive opportunity in some women.

The correct approach is:

shared decision-making.

My Final Message to Couples Trying to Conceive

When patients ask me:

“Doctor, what should we eat to become pregnant?”

I tell them:

Eat for health first and fertility second.

Do not build your entire fertility journey around:

one seed, one herb, one dairy product, one vitamin or one internet diet.

Instead ask:

Are we eating a balanced diet?

Are we getting enough protein and vegetables?

Do we consume excessive sugar or ultra-processed food?

Does either partner smoke?

Is alcohol excessive?

Are we physically active?

Is exercise becoming excessive?

Are we sleeping properly?

Is one partner underweight or metabolically unhealthy?

Is the woman taking folic acid?

Are we using unnecessary supplements?

Are we timing intercourse appropriately?

Have both partners been evaluated?

Is there PCOS, low AMH, blocked tubes, endometriosis or a male sperm problem that requires treatment?

Can Unani dietotherapy and lifestyle care support us?

Are we wasting fertility time trying only home remedies when medical treatment is indicated?

These are much more useful questions than:

“Which one food guarantees pregnancy?”

Conclusion

Nutrition and lifestyle are important parts of male and female reproductive health.

Modern research supports meaningful links between:

metabolism, insulin sensitivity, body composition, oxidative stress, tobacco exposure and reproductive physiology.

The attached research appropriately highlights metabolic pathways such as the insulin-androgen axis, oxidative stress and lipid metabolism and emphasizes that reproduction should not be viewed in complete isolation from general health.

However:

there is no single scientifically proven fertility diet.

Current ASRM guidance states that evidence remains insufficient to claim that particular dietary patterns or macronutrients reliably improve natural fertility, although a healthy diet should still be encouraged.

WHO's 2025 global infertility guideline now formally recommends:

healthy diet, physical activity and tobacco cessation

for individuals and couples planning or attempting pregnancy.

For practical nutrition, couples can emphasize:

vegetables, fruits, pulses, whole grains where appropriate, adequate protein, nuts, seeds, unsaturated fats and appropriate fish

while limiting:

sugar-sweetened beverages, frequent ultra-processed foods, industrial trans fats, repeated deep-fried foods, excessive processed meats and excess alcohol.

Women capable of pregnancy should receive:

400 mcg folic acid daily.

Current CDC guidance confirms that common MTHFR variants are not a reason to avoid folic acid.

Weight management should be individualized.

In anovulatory women with obesity, weight-loss interventions may improve:

ovulation and unassisted conception.

But preconception weight loss has not consistently been shown to improve live-birth rates in women already undergoing infertility treatment, and reproductive care should not be delayed automatically based on BMI alone.

Male fertility also benefits from attention to:

tobacco, anabolic steroids, metabolic health, physical activity and diet.

However, current AUA/ASRM guidance emphasizes that fertility supplements and antioxidants have uncertain clinical value and should not replace proper diagnosis.

The **Unani system of medicine** contributes a valuable whole-person framework through:

Ilaj-bil-Ghiza, **Ilaj-bit-Tadbir**, **Ilaj-bid-Dawa**, individualized **Mizaj** assessment and attention to daily health habits. Official CCRUM guidance recognizes dietotherapy and regimenal therapy as major modes of Unani treatment.

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

Evaluate the couple before prescribing a diet.

Identify the actual fertility diagnosis.

Improve metabolic and nutritional health.

Correct genuine deficiencies.

Stop tobacco and avoid recreational drugs.

Use regular appropriate physical activity.

Protect sleep and psychological wellbeing.

Use folic acid appropriately before pregnancy.

Do not overuse fertility supplements.

Use individualized Unani dietotherapy and regimenal care when suitable.

Continue evidence-based medical fertility treatment when necessary.

And never allow diet or herbal treatment to waste valuable reproductive time.

For every couple who asks:

"Can food and lifestyle really improve fertility?"

my answer is:

They can meaningfully support reproductive and overall health, especially when metabolic problems, unhealthy habits or nutritional deficiencies are present. But food should be considered one part of a complete fertility strategy. The best results come from combining healthy daily habits with accurate diagnosis, appropriate modern treatment and individualized Unani care where it is suitable—not from depending on one miracle food or supplement.

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Saira Health Care's current professional material identifies Dr. Nizamuddin Qasmi's focused clinical work in sexual disorders and infertility and describes its approach as combining traditional knowledge, individualized care, contemporary diagnostic understanding and lifestyle guidance.

Medical Disclaimer

This article is intended for general fertility education and reproductive-health awareness.

Diet and lifestyle advice do not replace:

semen analysis, ovulation assessment, hormone testing, ovarian-reserve evaluation, HSG/HyCoSy, ultrasound, genetic testing where indicated, fertility surgery, IUI, IVF or ICSI.

Do not independently begin:

high-dose vitamins, antioxidants, hormonal supplements, fertility medicines, melatonin, Unani medicines or herbal formulations

without appropriate professional guidance.

Do not delay fertility evaluation because of diet or lifestyle treatment if the woman is 35 years or older, ovarian reserve is significantly reduced, menstrual cycles are markedly irregular, fallopian tubes are blocked, significant endometriosis is suspected, severe male infertility is present or pregnancy has not occurred after an appropriate period of regular unprotected intercourse.

No diet, food, supplement, exercise programme, Unani medicine, IUI or IVF treatment can ethically guarantee:

conception, pregnancy or live birth.

Saira Health Care

www.sairahealthcare.com