Unexplained Infertility: Causes, Diagnosis, Modern Treatment and the Role of Unani Medicine

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Introduction: "Doctor, All Our Reports Are Normal—Then Why Are We Not Getting Pregnant?"

One of the most difficult fertility consultations is not always the one in which we find a severe problem.

Sometimes the most confusing situation is when:

- the woman's periods appear normal,
- she appears to be ovulating,
- the fallopian tubes are open,
- the uterus looks normal,
- the husband's semen analysis falls within accepted reference ranges,

yet pregnancy still does not occur.

Couples often come to me and say:

"Doctor, every report is normal. Then what exactly is wrong?"

Another patient asks:

"If everything is normal, why have we not conceived after two or three years?"

Some couples have already undergone:

- repeated ultrasound scans,
- hormone tests,
- semen analyses,
- HSG,
- supplements,
- fertility medicines,

without receiving a clear diagnosis.

This situation is called:

Unexplained Infertility

or:

Idiopathic Infertility.

The word **"unexplained" does not mean imaginary infertility**.

It simply means:

standard clinical investigations have not identified a definite cause.

The World Health Organization's first global infertility guideline, published on **28 November 2025**, now gives a clear minimum definition. WHO suggests diagnosing unexplained infertility when the couple has failed to achieve pregnancy after 12 months of regular unprotected intercourse, history and physical examination are normal in both partners, ovulation and tubal patency are presumptively confirmed in the woman, and semen parameters are within WHO reference ranges in the man.

The research supplied for this article similarly describes unexplained infertility as persistent failure to conceive despite normal standard evaluation and presents the traditional Unani interpretation through concepts such as *'Uqr, Mizaj* and *Akhlat*.

My first message to such couples is therefore:

"Normal basic reports do not mean that your fertility struggle is not real—and unexplained infertility does not mean there is no hope."

What Is Unexplained Infertility?

Unexplained infertility is:

a diagnosis of exclusion.

In other words, we first look for the common identifiable causes of infertility.

If these are not found, the couple may be categorized as having unexplained infertility.

According to current WHO criteria, the minimum assessment should show:

1. **Failure to achieve pregnancy after at least 12 months of regular unprotected intercourse**
2. **Normal relevant history and examination in both partners**
3. **Evidence that the woman is ovulating**
4. **At least one or both fallopian tubes considered patent as appropriate**
5. **Male semen parameters within accepted WHO reference ranges**

This does not mean every microscopic, molecular or genetic aspect of reproduction has been proven normal.

It means:

the standard clinical work-up has not found an explanation.

Is Unexplained Infertility Common?

Yes.

The percentage varies greatly depending on:

- how extensively couples are investigated,
- which diagnostic criteria are used,
- age,
- healthcare setting.

WHO cites a large multicountry study involving approximately 8,500 couples in which no cause was identified in about:

10.8% of infertility cases.

Other studies and clinical series have reported higher proportions, often in the range of roughly:

15–30%.

WHO specifically notes that reported prevalence varies because unexplained infertility depends on what conditions and tests have first been excluded.

ESHRE likewise treats unexplained infertility as an important diagnosis of exclusion and has issued a dedicated evidence-based guideline containing more than 50 recommendations.

"Unexplained" Does Not Mean "Nothing Is Wrong"

This distinction is critical.

Standard fertility testing is very useful, but human conception is extraordinarily complex.

For pregnancy to occur successfully:

1. a competent egg must develop;
2. ovulation must occur;
3. sperm must reach the fallopian tube;
4. sperm must interact normally with the egg;
5. fertilization must occur;
6. early embryo development must proceed normally;
7. the embryo must reach the uterus;
8. implantation must occur;
9. early pregnancy development must continue.

Basic clinical testing cannot directly observe every one of these processes during natural conception.

Therefore:

"No cause identified" is not the same as "every reproductive process has been proven perfect."

Infertility Versus Sterility

Couples are sometimes frightened by the word infertility.

Infertility usually means:

reduced probability of conception—not necessarily absolute inability to conceive.

A couple with unexplained infertility may still conceive:

- naturally,
- during expectant management,
- after IUI,
- through IVF.

WHO's 2025 treatment guideline specifically recognizes that spontaneous pregnancy remains possible in couples with unexplained infertility.

Primary and Secondary Unexplained Infertility

Primary Unexplained Infertility

The couple has never achieved a pregnancy and no cause is identified after appropriate evaluation.

Secondary Unexplained Infertility

Pregnancy occurred previously, but the couple is now unable to conceive again despite apparently normal standard evaluation.

Both require careful reassessment because:

- reproductive age changes,
- semen can change,
- tubal disease may develop,
- endometriosis may progress,
- lifestyle and medical conditions can change.

When Should a Couple Seek Fertility Evaluation?

Although WHO formally defines infertility after 12 months, clinical evaluation should often begin earlier according to female age.

ASRM recommends evaluation:

Woman younger than 35 years

after:

12 months

of regular unprotected intercourse.

Age 35 years or older

after:

6 months.

Age over 40 years

more immediate evaluation and treatment may be appropriate.

Evaluation should also begin earlier when there is an obvious risk factor such as:

- irregular or absent periods,
- known endometriosis,
- previous pelvic infection,
- suspected tubal disease,
- known male infertility,
- sexual dysfunction,
- chemotherapy/radiation history.

This is especially important in unexplained infertility because:

time itself affects fertility, particularly through female age.

Why Can Pregnancy Fail Even When Routine Tests Are Normal?

There are several possible explanations.

Some are scientifically plausible but difficult to diagnose routinely.

Others are areas of ongoing research.

Importantly:

possible hidden mechanisms should not be converted into unproven diagnoses.

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1. Female Age and Oocyte Quality

Female age is one of the most important fertility variables.

Even when:

- ovulation is normal,

- tubes are open,
- AMH is acceptable,

age influences:

- egg competence,
- chromosomal normality,
- embryo development,
- miscarriage risk.

WHO calls age the most important predictor of ovarian reserve, while ASRM describes female age as the strongest predictor of fecundity.

An egg's genetic competence cannot currently be determined simply through:

- AMH,
- ultrasound,
- a routine blood test.

Therefore some apparently unexplained infertility may reflect reproductive aging that standard testing cannot directly demonstrate.

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2. Subtle Oocyte Problems

A woman can:

- ovulate regularly,
- have adequate ovarian reserve,

yet individual eggs may not always:

- mature correctly,
- fertilize successfully,
- support normal embryo development.

Natural-cycle testing cannot directly examine every oocyte.

This is one reason IVF sometimes provides additional diagnostic information because:

- eggs can be retrieved,
- fertilization can be observed,
- embryo development can be monitored.

3. Fertilization Failure

Standard semen analysis evaluates important parameters such as:

- sperm concentration,
- motility,
- morphology.

But fertilization also requires sperm to:

- undergo capacitation,
- interact with the zona pellucida,
- complete the acrosome reaction,
- fuse with the oocyte.

Routine semen analysis does not directly measure every one of these functions.

However:

this does not mean every couple with unexplained infertility should undergo advanced sperm testing.

Current ESHRE guidance specifically recommends **against routine sperm DNA fragmentation testing, antisperm-antibody testing, sperm chromatin tests, sperm aneuploidy screening and several other advanced male tests when standard semen analysis is normal.**

Tests should be ordered because they are clinically useful—not simply because pregnancy has not occurred.

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4. Tubal Function Beyond Simple Patency

An HSG primarily asks:

“Is contrast able to pass through the tube?”

But a healthy tube also needs:

- functioning fimbriae,
- healthy cilia,
- normal muscular movement,
- appropriate tubal environment.

A tube can therefore be technically:

open

yet not necessarily function perfectly.

Routine clinical medicine does not have an easy test for every aspect of tubal physiology.

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5. Mild or Undetected Endometriosis

Some women with endometriosis have:

- severe pain,
- ovarian endometriomas,
- visible disease.

Others have minimal symptoms.

Mild superficial endometriosis may not be obvious on routine ultrasound.

But this does **not** mean every woman with unexplained infertility should undergo surgery to search for hidden endometriosis.

ESHRE strongly recommends against routine diagnostic laparoscopy simply to diagnose unexplained infertility.

Surgery should be driven by:

- symptoms,
- examination,
- imaging,
- another clinical indication.

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6. Subtle Endometrial or Implantation Factors

Implantation requires communication between:

- embryo,
- endometrium,
- hormonal environment,
- immune and molecular signaling.

Modern research continues to investigate:

- implantation biology,
- endometrial receptivity,
- microbiome,
- inflammatory pathways.

But many commercial tests offered to infertile couples remain insufficiently validated.

If routine ultrasound assessment of the uterine cavity is normal, ESHRE states that no additional uterine investigation is routinely necessary in unexplained infertility.

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7. Embryo Chromosomal Abnormalities

Not every fertilized egg forms a genetically normal embryo.

Chromosomal errors may:

- prevent implantation,
- produce very early pregnancy loss,
- cause miscarriage.

These become more common as female age increases.

This is not necessarily identifiable during routine natural-conception evaluation.

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8. Timing and Frequency of Intercourse

Sometimes a couple believes intercourse is well timed but:

- intercourse is infrequent,
- ovulation timing is misunderstood,
- travel or work limits sexual contact,
- fertility anxiety reduces intercourse frequency.

The fertile window is approximately:

the six-day interval ending on the day of ovulation.

Appropriate sexual timing should always be reviewed before labelling infertility unexplained.

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9. Sexual Dysfunction

This is particularly relevant to my clinical work.

The couple may have:

- vaginismus,
- painful intercourse,
- erectile dysfunction,
- premature ejaculation with poor intravaginal deposition,
- ejaculatory dysfunction,
- reduced sexual frequency.

Such conditions may be missed if fertility assessment focuses only on:

- ultrasound,
- hormones,
- semen numbers.

ASRM specifically recognizes sexual dysfunction as a reason for earlier infertility assessment.

This is one reason Saira Health Care's combined focus on:

Sexual Disorders & Infertility

can be clinically useful.

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10. Male Fertility Can Be More Complex Than One Semen Analysis

A semen sample naturally varies.

A normal report is reassuring, but should still be interpreted with:

- history,
- physical findings,
- abstinence period,
- laboratory quality.

At the same time, I do not believe in frightening men with endless advanced tests when basic semen testing is normal.

ESHRE advises against routine:

- testicular imaging,
- antisperm antibodies,
- sperm DNA fragmentation,
- sperm chromatin condensation,
- sperm aneuploidy,
- reproductive hormone testing,
- semen microbiology

when semen analysis is normal and there is no other indication.

“Watery Semen” and Unexplained Infertility

Classical Unani literature discusses:

Riqqat-e-Mani

or thin/watery semen.

The supplied research gives considerable importance to this traditional concept and connects it with reproductive vitality and semen consistency.

This should be understood as:

a traditional Unani concept.

Modern fertility medicine does assess:

- coagulation,
- liquefaction,
- viscosity

when appropriate.

But semen that appears thin to the naked eye does not automatically mean:

- weak sperm,
- infertility.

Similarly:

semen leaking from the vagina after intercourse is normal and does not mean all sperm have been lost.

Sperm begin entering cervical mucus soon after ejaculation.

Chemical Pregnancy Is Not the Same as Unexplained Infertility

The supplied traditional discussion also relates weak uterine retention to very early pregnancy loss.

Modern medicine distinguishes:

Infertility

difficulty achieving pregnancy.

from:

Recurrent Pregnancy Loss

repeated loss after conception.

A biochemical pregnancy shows that:

conception occurred.

Couples with repeated biochemical or clinical pregnancy loss may therefore require an:

RPL-focused evaluation

rather than simply being labelled as having unexplained infertility.

How Is Unexplained Infertility Diagnosed?

A good diagnosis requires enough investigation to exclude important causes—but not every test available in medicine.

Step 1: Evaluate Both Partners Together

This is fundamental.

WHO emphasizes normal:

- history,
- examination

in both partners as part of the diagnosis.

I do not believe a woman should undergo months of tests while the male partner has never had a semen analysis.

Step 2: Detailed Female History

Important questions include:

- age,
- menstrual regularity,
- previous pregnancies,
- miscarriages,
- pelvic pain,
- painful intercourse,
- previous PID,
- tuberculosis risk,
- endometriosis,
- surgery,
- medications,
- weight change,
- chemotherapy/radiation.

Step 3: Confirm Ovulation

WHO's 2025 guideline suggests that where history and examination are normal—including regular cycles—presumptive ovulation may be confirmed using:

mid-luteal serum progesterone

rather than routine ultrasound follicle tracking purely for confirmation.

If the first result suggests no ovulation, repeat testing can reduce misdiagnosis.

Clinical practice varies according to the individual patient.

Step 4: Assess the Uterus and Ovaries

Transvaginal ultrasound can identify:

- fibroids,
- polyps,

- adenomyosis,
- ovarian cysts,
- endometriomas,
- follicular abnormalities.

If ultrasound of the uterine cavity is normal and there are no other suspicious findings, ESHRE does not recommend routinely adding multiple invasive uterine procedures.

Step 5: Assess Tubal Patency

Common tests include:

- HSG,
- HyCoSy.

WHO recognizes these as important methods of establishing:

tubal patency.

If the tubes are genuinely blocked, the infertility is:

tubal-factor infertility

—not unexplained infertility.

Step 6: Semen Analysis

The male partner should undergo properly standardized semen testing.

The report should assess key parameters such as:

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

If clinically significant semen abnormality is found:

the diagnosis is no longer purely unexplained infertility.

Step 7: Ovarian Reserve When Appropriate

Testing may include:

- AMH,
- AFC,
- day 2/3 FSH

when clinically appropriate.

But WHO emphasizes that:

female age is the most important predictor of ovarian reserve.

AMH should not be treated as a simple:

“fertility score.”

Tests That Usually Do Not Need to Be Ordered Routinely

This is one of the most important modern changes in infertility care.

Couples with unexplained infertility are often offered an enormous list of expensive “hidden cause” investigations.

ESHRE's guideline advises against routine use of many of these when there is no specific clinical reason.

These include:

- diagnostic laparoscopy,
- post-coital testing,
- routine vaginal microbiome testing,
- routine antisperm-antibody testing,
- routine sperm DNA fragmentation,
- sperm chromatin testing,
- sperm aneuploidy screening,
- routine male hormone tests when semen is normal,
- semen HPV testing,
- semen microbiology,

- serum antisperm antibodies,
- broad autoimmune testing,
- many thrombophilia tests.

ASRM similarly discourages routine:

- laparoscopy,
- advanced sperm-function testing,
- postcoital testing,
- thrombophilia testing,
- immunological testing,
- endometrial biopsy

without another indication.

A professional fertility clinic should protect patients from:

both undertesting and overtreatment.

Modern Treatment of Unexplained Infertility

Treatment is necessarily somewhat empirical because:

there is no identified single defect to repair.

However, we now have much clearer evidence about the best sequence of treatment.

WHO 2025: First-Line Treatment

The newest global guidance is especially important.

For couples with unexplained infertility, WHO suggests:

expectant management first

rather than:

- unstimulated IUI,
- ovarian stimulation plus timed intercourse.

In the studies informing this recommendation, expectant management was generally used for approximately:

3–6 months.

What Is Expectant Management?

It does not mean:

“Do nothing and forget about the couple.”

It means structured counselling involving:

- fertile-window education,
- healthy lifestyle,
- appropriate intercourse timing,
- monitoring whether pregnancy occurs,
- clear agreement about when treatment will escalate.

WHO notes that spontaneous conception remains possible and that expectant management may prevent unnecessary intervention in couples with a reasonable prognosis.

Is Expectant Management Appropriate for Everyone?

No.

Treatment should be individualized according to:

- female age,
- duration of infertility,
- ovarian reserve,
- previous pregnancies,
- couple preference.

For example:

Couple A

Woman age 27, infertility 13 months, normal evaluation.

A short period of expectant management may be reasonable.

Couple B

Woman age 39, infertility for three years.

Waiting another six months simply because the infertility is “unexplained” may not be the best strategy.

ASRM notes that immediate IVF can offer a shorter time to pregnancy in older women, particularly around age 38 and above, compared with delaying through multiple lower-intensity treatments.

WHO 2025: Second-Line Treatment

If expectant management does not result in pregnancy, WHO suggests:

stimulated IUI – S-IUI

using either:

- clomiphene citrate,
- letrozole.

Why Stimulated IUI?

The idea is to:

1. develop a small controlled number of mature follicles;
2. process the semen;
3. place concentrated motile sperm directly into the uterus near ovulation.

This may increase:

- the number of available eggs,
- the number of motile sperm reaching the upper reproductive tract.

Clomiphene or Letrozole?

WHO currently suggests either for stimulated IUI in unexplained infertility.

The choice depends on:

- patient characteristics,

- local regulation,
- physician experience,
- ovarian response.

Why Not Gonadotropin IUI Routinely?

Injectable gonadotropins can produce:

- more follicles,
- higher cost,
- greater monitoring needs,
- multiple pregnancy,
- ovarian hyperstimulation risks.

WHO suggests oral stimulation with:

- clomiphene,
- or letrozole

rather than gonadotrophins for S-IUI in unexplained infertility.

ASRM similarly discourages gonadotropin-IUI as a routine step after oral-agent IUI because it adds:

- cost,
- complexity,
- multiple-gestation risk

without sufficient benefit compared with proceeding to IVF.

How Many IUI Cycles?

There is no single universally proven ideal number.

WHO notes that studies used:

- one to six cycles,

with more recent studies commonly using approximately:

three to six stimulated IUI cycles.

ASRM commonly recommends approximately:

3–4 cycles

of oral-agent ovarian stimulation plus IUI before moving to IVF.

The correct number should consider:

- female age,
- treatment response,
- infertility duration,
- emotional burden,
- cost.

WHO 2025: Third-Line Treatment

When stimulated IUI fails, WHO suggests:

IVF

rather than continuing expectant management indefinitely.

IVF can:

- retrieve eggs,
- expose eggs to sperm in the laboratory,
- observe fertilization,
- monitor embryo development,
- transfer embryos into the uterus.

It can therefore bypass or overcome several steps that remain invisible during natural conception.

Does Every Unexplained Infertility Couple Need ICSI?

No.

This is a particularly important 2025 update.

WHO makes a:

strong recommendation

that when IVF is performed for unexplained infertility after failed stimulated IUI and there is no male-factor indication:

conventional IVF should be used rather than automatically adding ICSI.

IVF and ICSI show similar overall pregnancy/live-birth outcomes in this setting, while ICSI adds:

- cost,
- resources,
- laboratory complexity.

ICSI remains extremely useful when there is:

- significant male-factor infertility,
- surgically retrieved sperm,
- another specific indication.

Unexplained Infertility in the Unani System of Medicine

The Unani system has described infertility for centuries under the broad concept:

'Uqr

Traditional Unani medicine evaluates fertility through:

- Mizaj,
- Akhlat,
- reproductive faculties,
- diet,
- general health,
- sexual health,
- reproductive-organ function.

The supplied research emphasizes that Unani physicians may interpret apparently normal anatomy alongside qualitative traditional concepts such as *Sue Mizaj Barid* and *Sue Mizaj Ratab*.

This creates an interesting traditional perspective on unexplained infertility.

However, scientific clarity is essential:

these concepts should not be described as modern proven molecular causes of unexplained infertility.

Mizaj – Temperament

Unani physiology considers:

- Hararat – heat,
- Burudat – cold,
- Rutubat – moisture,
- Yubusat – dryness

as traditional qualities involved in constitutional health.

The individual pattern is described as:

Mizaj.

For fertility practice, one useful principle from this concept is:

individualization.

Two couples with identical “normal reports” may differ greatly in:

- age,
- body composition,
- nutrition,
- sleep,
- sexual function,
- metabolic health,
- fertility duration.

Therefore one identical prescription for every unexplained infertility couple is unlikely to be rational.

The Four Akhlat

Traditional Unani medicine describes four humors:

Dam

Blood

Balgham

Phlegm

Safra

Yellow bile

Sauda

Black bile

These are:

classical Unani physiological concepts.

They should not be equated directly with:

- estrogen,
- progesterone,
- insulin,
- inflammatory cytokines,
- semen parameters.

Sue Mizaj Barid – "Cold" Temperament

Some classical Unani explanations of infertility refer to:

Sue Mizaj Barid

or a traditionally "cold" reproductive temperament.

Historically, this has been associated with:

- reduced reproductive vigor,
- menstrual changes,
- weakness.

Modern medicine does not diagnose:

“cold uterus”

through a validated laboratory test.

Therefore, I use this terminology only when discussing:

the traditional Unani framework

—not as a substitute for:

- ovulation testing,
- HSG,
- semen analysis,
- ultrasound.

Quwwat-e-Tanasuliya – Reproductive Faculty

Unani physiology describes:

Quwwat-e-Tanasuliya

as reproductive power or reproductive faculty.

It reflects the broader traditional concept that successful conception depends not only on an anatomical organ existing, but on:

- the organ functioning appropriately,
- nutrition,
- overall constitutional health.

The concept can be useful philosophically when discussing whole-person fertility care.

But it is not a laboratory measurement.

Quwwat-e-Masika – Retentive Faculty

The supplied source gives particular attention to:

Quwwat-e-Masika

or traditional “retentive power.”

This concept historically refers to the body's capacity to retain reproductive material or pregnancy.

Modern implantation biology is much more complex and involves:

- embryo competence,
- endometrial signaling,
- hormonal communication,
- immune and cellular mechanisms.

Therefore:

Quwwat-e-Masika should not be claimed as a scientifically measured implantation mechanism.

It remains a traditional interpretive concept.

The Four Main Unani Therapeutic Approaches

A comprehensive Unani treatment plan is broader than simply prescribing herbs.

It may involve:

Ilaj-bil-Ghiza

Dietotherapy

Ilaj-bit-Tadbir

Regimenal therapy

Ilaj-bid-Dawa

Pharmacotherapy

Ilaj-bil-Yad

Surgical/manual intervention where relevant.

For unexplained infertility, the first three are most relevant as supportive approaches.

Ilaj-bil-Ghiza – Dietotherapy

I believe reproductive nutrition is valuable for both partners.

A practical fertility-supportive diet can include:

- vegetables,
- seasonal fruits,

- adequate protein,
- pulses,
- whole grains where suitable,
- nuts,
- seeds,
- appropriate healthy fats,
- adequate hydration.

The aim is to improve:

- nutritional status,
- metabolic health,
- healthy body composition,
- general reproductive wellbeing.

No Food Can Guarantee Pregnancy

Patients often search for:

- fertility seeds,
- fertility milk,
- fertility dates,
- fertility powders.

No single food has been proven to:

- guarantee ovulation,
- make every embryo implant,
- cure unexplained infertility.

Healthy nutrition is:

supportive care—not a fertility guarantee.

Traditional "Hot" and "Cold" Foods

Unani dietotherapy may classify foods according to:

- traditional temperament.

This can be used within an individualized traditional plan.

However, I would not advise a woman to unnecessarily eliminate nutritious foods such as:

- fruit,
- yogurt,
- vegetables

simply because they are broadly labelled “cold.”

Modern nutritional adequacy must remain a priority.

Ilaj-bit-Tadbir – Regimenal Therapy

This may focus on:

- regular physical activity,
- healthy sleep,
- stress management,
- healthy daily routine,
- weight management where appropriate.

These areas overlap meaningfully with evidence-based preconception care.

Stress and Unexplained Infertility

Infertility itself can cause:

- anxiety,
- sadness,
- relationship stress,
- sexual pressure.

Stress reduction can improve:

- quality of life,
- sleep,
- sexual wellbeing.

But I do not tell couples:

"You are infertile because you think too much."

That is unfair and medically oversimplified.

Psychological support should be:

part of compassionate care, not a way of blaming the patient.

Ilaj-bid-Dawa – Unani Pharmacotherapy

Traditional formulations may be chosen according to:

- individual presentation,
- reproductive history,
- male and female findings,
- Mizaj,
- accompanying symptoms.

For unexplained infertility, treatment should never be based merely on:

"All reports normal—therefore take this one medicine."

The couple still needs a complete assessment.

Scientific Evidence for Unani Medicine in Unexplained Infertility

There is a growing but still limited body of published Unani literature.

Most evidence currently consists of:

case reports and small clinical observations rather than large randomized trials.

2024 NIUM Unexplained Infertility Case Report

A 2024 case report from authors associated with the:

National Institute of Unani Medicine – NIUM

described a couple with unexplained primary infertility for three years.

After three months of supervised Unani formulations, the woman conceived.

Importantly, the authors themselves concluded that larger:

randomized clinical trials

are needed to establish efficacy.

This is the correct way to interpret the evidence.

Another 2024 Case With Live-Birth Outcome

A separate 2024 case report described a 25-year-old woman with three years of idiopathic primary infertility who conceived after two cycles of Unani treatment and subsequently delivered a healthy baby.

Again, the authors concluded that further randomized research is needed.

These cases are:

encouraging

but they do not establish:

- a universal pregnancy rate,
- superiority to expectant management,
- superiority to IUI,
- superiority to IVF.

Why Case Reports Are Not Enough to Calculate a Cure Rate

Unexplained infertility has a spontaneous pregnancy rate above zero.

Therefore, if one woman becomes pregnant after treatment, we cannot automatically know whether pregnancy occurred:

- because of the treatment,
- naturally during the treatment period,
- through better intercourse timing,
- because of multiple combined changes.

To prove treatment efficacy, studies should ideally compare:

- treated couples,
- similar untreated/control couples,

and measure:

- clinical pregnancy,
- live birth,
- adverse events.

Saira Health Care's Herbal Pregnancy Kit for Unexplained Infertility

The supplied research gives particular emphasis to:

Saira Health Care's Herbal Pregnancy Kit

as a couple-centered traditional fertility programme.

The supplied document describes a multi-component regimen involving:

- Spermogenic Powder,
- Prohamal,
- Habbe Hamal,
- Majun Moin Hamal

for the couple.

Saira Health Care Pharmacy's current 2026 product page also states that the Herbal Pregnancy Kit is designed to assist couples dealing with:

unknown or unexplained infertility.

The current package description lists:

- **1 box of Spermogenic Powder**
- **6 boxes of Prohamal**
- **Habbe Hamal**
- **Majun Moin Hamal Ambari**

and describes **Naved Nav** as an optional female-support product that is not included in the base package.

Why a Couple-Based Kit Makes Conceptual Sense

One positive aspect of this approach is that it does not assume infertility belongs only to:

the woman.

The kit is structured for:

- male reproductive support,
- female reproductive support,
- couple-based management.

This fits an important modern principle:

infertility should be assessed as a couple's reproductive condition whenever applicable.

Spermogenic Powder

The current Saira kit lists:

Spermogenic Powder

for the male partner.

In an integrative fertility programme, its purpose may be described as:

- traditional male reproductive support,
- semen-health support.

However:

a man whose semen analysis is genuinely normal does not automatically need treatment to "improve" sperm numbers.

The purpose of supportive care should be individualized rather than converting a normal semen report into a hidden disease.

Prohamal

The current Saira product page describes:

Prohamal

as a product used for both partners within the Herbal Pregnancy Kit.

It is best represented professionally as:

traditional reproductive-health support within an individualized Unani programme.

I have not identified a large independent product-specific randomized trial proving that Prohamal:

- increases live birth,
- cures unexplained infertility,

- improves implantation

compared with standard fertility management.

Therefore it should not be described as a guaranteed fertility medicine.

Habbe Hamal

Habbe Hamal is a traditional Unani formulation used in female reproductive practice.

An important safety point must be made.

Saira Health Care Pharmacy's current listing identifies ingredients including:

- **Afyun – Papaver somniferum**
- **Bhang – Cannabis sativa**
- Jaiphal,
- Zafran,
- Chhalia,
- Laung,

among other ingredients, and the page itself cautions against self-medication.

Therefore:

Habbe Hamal should not be treated like an ordinary vitamin or harmless over-the-counter fertility supplement.

Safety of Habbe Hamal Is Particularly Important

Because formulations may contain pharmacologically active opium- and cannabis-derived ingredients:

- physician supervision is essential,
- medicine interactions must be considered,
- sedation and other adverse effects are possible,
- national/local controlled-substance rules are relevant,
- it should not be continued automatically once pregnancy is possible or confirmed without immediate professional review.

I would strongly discourage:

self-prescribing Habbe Hamal from an internet dosage schedule.

The objective of traditional medicine should never come at the cost of:

- medication safety,
- pregnancy safety.

Majun Moin Hamal Ambari

The current Saira kit includes:

Majun Moin Hamal Ambari

for the female partner during the fertility programme.

It may be positioned as:

traditional female reproductive support

within supervised Unani care.

As with the other kit components, claims should remain proportional to evidence.

No product should be described as:

- guaranteeing implantation,
- preventing every miscarriage,
- guaranteeing pregnancy.

Does the Herbal Pregnancy Kit Cure Unexplained Infertility?

The most scientifically responsible answer is:

It may be used as an individualized Unani supportive programme for selected couples, but a guaranteed cure has not been established.

Saira Health Care's current product page markets the kit specifically for unexplained infertility.

However, I have not identified a high-quality independent randomized clinical trial of the complete Saira Health Care Herbal Pregnancy Kit showing that it reliably improves:

- live-birth rates,
- pregnancy rates,

over:

- expectant management,
- stimulated IUI,
- IVF.

Therefore:

traditional clinical experience and product description should not be confused with randomized evidence.

How I Would Use Unani Medicine Responsibly in Unexplained Infertility

The best role is an:

integrative role.

For an appropriately evaluated couple, Unani treatment may focus on:

- reproductive nutrition,
- sleep,
- lifestyle,
- sexual health,
- metabolic health,
- traditional Mizaj-based assessment,
- supervised pharmacotherapy.

But the couple should still have access to:

- stimulated IUI,
- IVF

when reproductive timing makes those options appropriate.

Dr. Nizamuddin Qasmi's Special Approach to Unexplained Infertility at Saira Health Care

When a couple comes to me saying:

“Doctor, everything is normal,”

I approach the case systematically.

Step 1: Make Sure It Really Is Unexplained Infertility

Before using the label, I confirm that the basic investigation is complete.

I review:

- duration of infertility,
- female age,
- ovulation,
- tubal patency,
- uterine findings,
- semen analysis.

Step 2: Evaluate Both Partners Together

This is one of the most important contributions of an infertility-focused clinic.

The couple is evaluated as:

one reproductive unit

while respecting each partner's individual health.

Step 3: Review Sexual Function

I ask about:

- intercourse frequency,
- erectile function,
- ejaculation,
- painful intercourse,
- vaginismus,
- timing around ovulation.

A sexual problem should not be incorrectly labelled:

unexplained infertility.

Step 4: Review Female Age Early

A woman of:

- 26 years

and a woman of:

- 39 years

with the same normal tests do not have the same prognosis.

This directly affects how long conservative treatment should be continued.

Step 5: Confirm Ovulation

Where necessary, I review:

- cycle pattern,
- progesterone,
- ultrasound information.

Step 6: Review Tubal Testing Carefully

I check whether:

- HSG,
- HyCoSy

really confirms appropriate tubal patency.

Step 7: Review the Male Semen Report Myself

I do not simply accept:

“Doctor said it is normal.”

I review:

- concentration,
- motility,
- morphology,
- sample quality

in the clinical context.

Step 8: Avoid Unnecessary "Hidden Infertility" Tests

I do not believe every patient needs:

- immune panels,
- thrombophilia screening,
- sperm DNA fragmentation,
- laparoscopy,
- microbiome panels,
- expensive implantation tests.

ESHRE specifically discourages many of these as routine unexplained-infertility investigations.

Step 9: Assess Lifestyle and General Health

This includes:

- smoking,
- tobacco,
- alcohol,
- nutrition,
- physical activity,
- weight,
- sleep,
- chronic disease.

Step 10: Assess Traditional Mizaj

When Unani treatment is being considered, I evaluate the patient in the traditional framework as well.

But I keep:

traditional diagnosis and modern diagnosis clearly separated.

Step 11: Add Individualized Ilaj-bil-Ghiza and Ilaj-bit-Tadbir

I may recommend:

- tailored diet,
- physical activity,
- sleep optimization,
- reproductive timing,
- stress support.

Step 12: Use the Herbal Pregnancy Kit Only When Clinically Appropriate

The kit should not be handed to every couple without evaluation.

The current kit includes products intended for:

- male,
- female,
- couple use.

Because one component, Habbe Hamal, includes potent pharmacologically active ingredients, it particularly requires:

professional supervision.

Step 13: Set a Time Limit

This is crucial.

I do not believe a couple should take empirical therapy:

indefinitely.

For a younger good-prognosis couple, a defined period of conservative management may be reasonable.

For an older woman or a couple with long-standing infertility, fertility treatment should escalate sooner.

Step 14: Consider Stimulated IUI

If expectant/integrative care does not result in pregnancy:

S-IUI with clomiphene or letrozole

is consistent with WHO's current treatment pathway.

Step 15: Move to IVF When Appropriate

After unsuccessful S-IUI—or earlier when age/prognosis justifies it:

IVF should be discussed rather than losing reproductive time.

Step 16: Do Not Add ICSI Automatically

If semen is genuinely normal and there is no male-factor indication:

routine ICSI is not automatically necessary.

WHO recommends conventional IVF rather than routine IVF-ICSI for unexplained infertility after failed S-IUI.

What Does Treatment Success Mean?

In infertility, the most meaningful outcome is not:

- a “better pulse,”
- normal semen appearance,
- a hormone changing slightly.

Treatment success ultimately means:

a healthy live birth.

Intermediate outcomes can still be useful:

- ovulation,
- improved semen parameter,
- successful fertilization,
- clinical pregnancy.

But the final objective should remain clear.

Success Stories at Saira Health Care

Saira Health Care's current website describes its clinical work as focused on:

sexual disorders and male/female infertility

under Dr. Nizamuddin Qasmi.

Individual couples treated through the practice may report successful conception.

However, a professional website should present fertility success stories responsibly.

A strong case report should ideally include:

1. age of both partners;
2. infertility duration;
3. primary or secondary infertility;
4. ovulation assessment;
5. tubal status;
6. semen analysis;
7. treatment;
8. duration;
9. natural/IUI/IVF conception;
10. pregnancy outcome;
11. live-birth outcome;
12. patient consent.

One Pregnancy Does Not Establish a Universal Success Rate

Unexplained infertility has a spontaneous conception rate above zero.

Therefore, even a genuine successful case should be described as:

an individual outcome

rather than proof that:

- the same treatment will work for everyone,
- unexplained infertility has been permanently cured.

Psychological Impact of Unexplained Infertility

This diagnosis can be emotionally difficult because there is no obvious problem to "fix."

Patients often describe:

- frustration,
- guilt,
- anxiety,
- family pressure,
- reduced sexual enjoyment,
- financial stress.

Sometimes patients feel that doctors do not believe them because their reports are normal.

My message is:

the infertility is real even when its cause remains unexplained.

Psychological support is part of good fertility care.

Common Myths About Unexplained Infertility

Myth 1: If all reports are normal, the couple is completely fertile.

Fact: Standard testing cannot measure every biological step involved in conception.

Myth 2: Unexplained infertility means doctors performed the wrong tests.

Fact: Sometimes no cause is found even after appropriate evidence-based evaluation.

Myth 3: Every hidden cause needs an advanced test.

Fact: ESHRE advises against many routine advanced tests because they do not reliably improve treatment decisions.

Myth 4: Every unexplained infertility patient needs laparoscopy.

Fact: Routine diagnostic laparoscopy is not recommended.

Myth 5: Every man needs sperm DNA fragmentation testing.

Fact: Not when conventional semen analysis is normal and there is no additional indication, according to ESHRE.

Myth 6: A normal AMH proves good fertility.

Fact: AMH mainly reflects ovarian reserve/response and does not prove egg quality or natural conception potential.

Myth 7: Low-normal AMH automatically explains unexplained infertility.

Fact: Female age and the complete clinical picture matter more than one AMH number.

Myth 8: Watery-looking semen means infertility.

Fact: Appearance alone cannot diagnose sperm quality.

Myth 9: Semen leaking after intercourse means sperm cannot reach the egg.

Fact: Postcoital semen leakage is common and does not mean successful sperm transport cannot occur.

Myth 10: Stress is the sole cause.

Fact: Stress affects wellbeing but should not be used to blame couples for infertility.

Myth 11: Natural-cycle IUI is much better than trying naturally.

Fact: WHO suggests expectant management rather than unstimulated IUI as first-line care because benefit is minimal.

Myth 12: Fertility tablets with timed intercourse are automatically better than waiting.

Fact: WHO currently suggests expectant management rather than ovarian stimulation with timed intercourse as first-line management.

Myth 13: Gonadotrophin IUI is always stronger and therefore better.

Fact: It increases cost and multiple-pregnancy risk; WHO prefers oral agents for stimulated IUI.

Myth 14: Every IVF cycle for unexplained infertility needs ICSI.

Fact: WHO recommends conventional IVF rather than routine ICSI when no male-factor indication exists.

Myth 15: Unani medicine has no role because tests are normal.

Fact: Unani medicine can provide individualized lifestyle, nutritional, sexual-health and traditional reproductive support.

Myth 16: A traditional medicine has been scientifically proven to cure every unexplained infertility case.

Fact: Current Unani evidence is mainly case-based; larger randomized clinical trials remain necessary.

Myth 17: Herbal means completely risk-free.

Fact: Herbal and Unani medicines can contain powerful pharmacological substances and require appropriate supervision.

Myth 18: Habbe Hamal is simply a vitamin fertility tablet.

Fact: Current Saira Pharmacy listings include Afyun and Bhang among its ingredients; self-medication is specifically discouraged.

Frequently Asked Questions

What exactly is unexplained infertility?

It means pregnancy has not occurred despite appropriate investigation showing no obvious:

- ovulatory,
- tubal,

- uterine,
- male semen

cause.

How long must we try before it is called infertility?

WHO's formal definition uses:

12 months of regular unprotected intercourse.

Clinical evaluation is generally started after:

- 12 months if the woman is under 35,
- 6 months at age 35 or older,
- earlier around age 40 or when known risk factors exist.

Can unexplained infertility resolve naturally?

Yes.

Some couples conceive without medical intervention.

That is one reason WHO recommends expectant management initially for appropriately selected couples.

How long should we wait naturally?

WHO's supporting studies generally used:

3–6 months

of expectant management after diagnosis.

The appropriate duration depends on:

- female age,
- ovarian reserve,
- infertility duration,
- couple preference.

What treatment comes after waiting?

Current WHO guidance suggests:

stimulated IUI with clomiphene or letrozole.

When should IVF be considered?

When:

- stimulated IUI has failed,
- female age makes delay undesirable,
- prognosis favors more rapid treatment.

WHO suggests IVF after unsuccessful S-IUI.

Is ICSI better than IVF?

Not routinely in unexplained infertility with normal semen.

WHO recommends:

IVF rather than automatically adding ICSI.

Should sperm DNA fragmentation be tested?

Not routinely when WHO-standard semen analysis is normal.

ESHRE advises against routine SDF testing in this setting.

Should immune tests be done?

Broad immunological testing is not routinely recommended without another medical indication.

Do I need laparoscopy?

Not routinely.

Laparoscopy may be appropriate when there is:

- pain,
- suspected endometriosis,
- pelvic disease,
- another surgical indication.

Can the woman's age alone matter even if tests are normal?

Yes.

Age strongly affects:

- egg quality,
- embryo chromosomal normality,
- fertility probability.

Can Unani medicine help unexplained infertility?

It may provide useful supportive care through:

- individualized nutrition,
- lifestyle,
- traditional Mizaj assessment,
- sexual-health management,
- supervised pharmacotherapy.

Published Unani case reports describe pregnancies after treatment, but larger controlled trials are still required.

What is unexplained infertility called in Unani medicine?

The broader classical term:

'Uqr

is used for infertility.

Various traditional states of:

- Mizaj,

- Akhlat,
- reproductive faculties

may then be considered individually.

What is the Saira Health Care Herbal Pregnancy Kit?

Saira Health Care's current pharmacy describes it as a one-month package designed to assist couples with:

unknown or unexplained infertility.

Its listed components currently include:

- Spermogenic Powder,
- Prohamal,
- Habbe Hamal,
- Majun Moin Hamal Ambari,

with Naved Nav presented separately as optional support.

Is the Herbal Pregnancy Kit scientifically proven to guarantee pregnancy?

No.

There is currently insufficient product-specific randomized evidence to guarantee:

- pregnancy,
- live birth.

It should be described as:

an individualized Unani supportive fertility programme

rather than a guaranteed treatment.

Can I order the kit and use it without consultation?

I do not recommend this.

This is particularly important because Habbe Hamal contains potent ingredients and the current pharmacy listing itself advises against self-medication.

How long does Unani treatment take?

There is no scientifically valid universal timeline.

Some Unani case reports describe conception after:

- two to three treatment cycles,

but these are individual cases and cannot be converted into a promised treatment duration.

Latest Scientific Perspective: 2025–2026

The most important recent update is:

WHO's first global infertility guideline

published on:

28 November 2025.

It includes dedicated recommendations for:

- diagnosis,
- unexplained infertility,
- expectant management,
- IUI,
- IVF,
- ICSI.

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1. WHO Now Defines Minimum Diagnostic Criteria Clearly

Unexplained infertility requires:

- ≥12 months without pregnancy,
- normal history/examination in both partners,
- presumptive ovulation,
- patent tubes,
- semen parameters within WHO ranges.

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2. Expectant Management Is a Formal First-Line Option

WHO suggests:

expectant management

rather than:

- unstimulated IUI,
- stimulated timed intercourse

for initial management in appropriate couples.

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3. Stimulated IUI Is the Next Step

After unsuccessful expectant management:

clomiphene-IUI or letrozole-IUI

may be used.

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4. Oral Drugs Are Preferred to Gonadotrophin IUI

WHO favors:

- clomiphene,
- letrozole

over gonadotrophins for stimulated IUI because injectable treatment adds:

- complexity,
- cost,
- potential harm.

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5. IVF Follows Failed Stimulated IUI

When S-IUI is unsuccessful:

IVF is recommended over simply continuing to wait indefinitely.

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6. Routine ICSI Is Being Reduced

WHO now strongly recommends:

conventional IVF rather than routine ICSI

for unexplained infertility when there is no male-factor indication.

This helps reduce:

- unnecessary procedures,
- unnecessary costs.

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7. Unnecessary Diagnostic Add-Ons Are Also Being Reduced

ESHRE's current unexplained-infertility guideline strongly discourages routine use of many tests that have become commercially popular but have limited clinical utility.

Modern fertility medicine is moving toward:

better-targeted testing rather than simply more testing.

Saira Health Care's Contribution to Sexual Disorders & Infertility

Saira Health Care publicly describes its clinical work as focused on:

Sexual Disorders & Infertility

with an individualized, patient-centered approach combining:

- traditional Unani knowledge,
- modern diagnostic understanding,
- lifestyle guidance.

This is particularly relevant in unexplained infertility because successful management may require attention to:

- female fertility,
- male fertility,
- sexual function,
- lifestyle,
- psychological wellbeing

at the same time.

About Dr. Nizamuddin Qasmi

I am:

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 describes my focused clinical work in:

Sexual Disorders & Infertility

and lists these additional professional-training credentials in the physician byline.

My Final Message to Couples With Unexplained Infertility

If you have been told:

“Everything is normal.”

but pregnancy has still not occurred, please do not think:

“Nothing can be done.”

But also do not allow anyone to frighten you by saying:

“There must be a hidden immune disease.”

or:

“You definitely have poor sperm DNA.”

or:

“Your uterus is rejecting the baby.”

without appropriate evidence.

Ask instead:

Was ovulation properly assessed?

Are the fallopian tubes genuinely open?

Is the uterus normal?

Was the semen analysis performed in a reliable laboratory?

How old is the female partner?

How long have we been trying?

Is intercourse occurring regularly in the fertile window?

Is there vaginismus, erectile or ejaculatory difficulty?

Do we truly need additional tests?

Would a short period of expectant management be reasonable?

Can individualized Unani diet, lifestyle and reproductive-health support be added safely?

Would Dr. Qasmi's Herbal Pregnancy Kit be appropriate for our individual case?

When should we move to stimulated IUI?

When should we move to IVF?

Do we really need ICSI?

These are the questions that lead to responsible fertility care.

Conclusion

Unexplained infertility is one of the most challenging areas of reproductive medicine because:

the problem is real even when standard investigations do not identify its cause.

According to the current WHO definition, unexplained infertility should be considered when a couple has:

- failed to achieve pregnancy after at least 12 months,
- normal relevant history and examination,
- evidence of ovulation,
- patent fallopian tubes,
- male semen parameters within WHO reference ranges.

Potential biological explanations may involve processes that standard fertility tests cannot fully observe, including:

- oocyte competence,
- fertilization,
- embryo development,
- subtle tubal function,
- implantation biology.

However:

possible hidden mechanisms do not justify indiscriminate advanced testing.

ESHRE currently discourages routine:

- laparoscopy,
- sperm DNA fragmentation,
- antisperm-antibody tests,
- microbiome testing,
- broad immune testing,
- several other add-ons

in properly diagnosed unexplained infertility without another indication.

The newest WHO treatment pathway is:

First line

Expectant management, usually for a defined period such as 3–6 months in appropriate couples.

Second line

Stimulated IUI with clomiphene or letrozole.

Third line

IVF after unsuccessful S-IUI.

And where there is no male-factor reason:

routine ICSI should not automatically replace conventional IVF.

The **Unani system of medicine** offers a different whole-person perspective using traditional concepts such as:

- ‘Uqr,
- Mizaj,
- Akhlat,
- Quwwat-e-Tanasuliya,
- Quwwat-e-Masika,
- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- Ilaj-bid-Dawa.

These can support:

- individualized nutrition,
- lifestyle,
- sexual-health care,
- general reproductive wellbeing,
- supervised traditional treatment.

Recent Unani case reports from 2023–2024 describe successful conceptions after treatment of couples with unexplained infertility, including a case with subsequent live birth. However, the authors themselves acknowledge the need for:

larger randomized clinical trials.

Saira Health Care's current **Herbal Pregnancy Kit** is specifically designed and marketed for unknown/unexplained infertility and currently includes couple-based components such as:

- Spermogenic Powder,
- Prohamal,
- Habbe Hamal,
- Majun Moin Hamal Ambari.

In my practice, I would describe this kit as:

an individualized Unani fertility-support programme—not a guaranteed cure for unexplained infertility.

This distinction is particularly important because some traditional formulations, including Habbe Hamal currently listed by Saira Pharmacy, contain potent pharmacological ingredients

such as Afyun and Bhang and therefore require professional supervision rather than self-medication.

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

Evaluate the couple together.

Confirm that infertility is genuinely unexplained.

Do not overlook sexual dysfunction.

Consider female age and reproductive time early.

Confirm ovulation and tubal patency.

Review semen carefully.

Avoid unnecessary expensive tests.

Optimize diet, sleep, lifestyle and reproductive health.

Use individualized Unani treatment responsibly where appropriate.

Use the Herbal Pregnancy Kit only after appropriate patient assessment and supervision.

Set a defined treatment timeline rather than continuing empirical treatment indefinitely.

Use stimulated IUI when appropriate.

Proceed to IVF without unnecessary delay when prognosis requires it.

Avoid routine ICSI when there is no indication.

And never guarantee pregnancy from one tablet, herbal kit or treatment system.

For every couple who asks me:

“Doctor, if all our reports are normal, can we still become parents?”

my answer is:

Yes. Unexplained infertility does not mean pregnancy is impossible. Many couples conceive naturally, some respond to stimulated IUI, and others achieve pregnancy through IVF. Unani medicine can be integrated responsibly to support the couple's overall reproductive health, but the most important principle is to protect reproductive time and choose each step according to age, prognosis and evidence rather than endlessly searching for a hidden disease.

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Medical Disclaimer

This article is intended for:

- patient education,
- fertility awareness,
- general reproductive-health information.

It is not a substitute for:

- individual medical consultation,
- ovulation assessment,
- pelvic ultrasound,
- HSG/HyCoSy,
- semen analysis,
- ovarian-reserve evaluation,
- fertility-specialist consultation,
- IUI,

- IVF.

Do not independently start:

- clomiphene,
- letrozole,
- gonadotrophins,
- progesterone,
- fertility hormones,
- Unani formulations,
- herbal medicines,
- Habbe Hamal,
- supplements

simply because your infertility has been labelled:

“unexplained.”

In particular, traditional formulations containing potent ingredients such as:

- Afyun,
- Bhang

require qualified professional supervision and should not be self-medicated or automatically continued when pregnancy is possible or confirmed.

Do not delay specialist fertility treatment if:

- the female partner is 35 years or older,
- ovarian reserve is significantly reduced,
- infertility has persisted for several years,
- stimulated IUI has repeatedly failed,
- a new male or female factor is discovered.

No modern, Unani, herbal, IUI, IVF or ICSI treatment can ethically guarantee:

- conception,
- implantation,
- pregnancy,

- live birth.

Saira Health Care
www.sairahealthcare.com

Medical literature reviewed and updated: September 2026