

Timed Intercourse, IUI and IVF: An Introduction

Understanding the Fertility-Treatment Journey — Natural Conception, Ovulation Monitoring, Intrauterine Insemination, IVF, ICSI, Treatment Selection and the Supportive Role of Unani Medicine

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A Message From Dr. Nizamuddin Qasmi

One of the most common fears I see in couples attending an infertility consultation is:

“Doctor, will we have to undergo IVF?”

Some couples become frightened as soon as they hear the word:

infertility.

They assume that the treatment pathway is:

consultation → IVF.

That is not how evidence-based fertility care should work.

For many couples, the correct treatment may initially be:

better timing of intercourse,

treatment of an ovulation problem,

treatment of erectile or ejaculatory dysfunction,

correction of a hormonal disorder,

selected management of male-factor infertility,

intrauterine insemination—commonly called IUI.



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For other couples, however, spending months or years repeatedly trying simpler treatments may waste valuable reproductive time.

A woman with:

bilateral tubal blockage,

severe hydrosalpinx,

significantly advanced reproductive age,

or a couple with:

severe male-factor infertility

may need IVF or IVF with ICSI much earlier.

The central question is therefore not:

“Which treatment is cheapest or most advanced?”

The correct question is:

“Which treatment gives this particular couple a reasonable chance of pregnancy without unnecessary delay, risk or intervention?”

In November 2025, the World Health Organization published its first global guideline for the prevention, diagnosis and treatment of infertility. WHO emphasizes evidence-based, people-centred fertility care and recognizes that infertility treatment may range from simpler interventions to medically assisted reproduction such as IVF according to the cause and circumstances.

That is also the principle I follow at Saira Health Care:

Use the simplest treatment that is medically appropriate—but do not allow “simple treatment” to become prolonged ineffective treatment when a more effective option is clearly indicated.

What Is Infertility?

WHO defines infertility as a disease of the male or female reproductive system characterized by failure to achieve pregnancy after:

12 months or more of regular unprotected sexual intercourse.

WHO estimates that approximately:

one in six people of reproductive age

experience infertility during their lifetime.



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Infertility may result from:

Female factors

ovulatory disorders,
tubal disease,
endometriosis,
uterine abnormalities,
reproductive ageing.

Male factors

low sperm production,
poor motility,
abnormal sperm function,
reproductive-tract obstruction,
hormonal disorders,
sexual/ejaculatory dysfunction.

Combined factors

Both partners may contribute.

Unexplained infertility

Basic fertility testing may appear reasonably normal, yet pregnancy does not occur.

Therefore:

fertility treatment cannot responsibly be chosen until the couple has been evaluated.

Fertility Treatment Is a Ladder, but Not Everyone Starts on the Same Step

I often explain fertility treatment to patients as a ladder.

The possible steps may include:

Timed intercourse

then:

IUI



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then:

IVF

and, where required:

IVF with ICSI.

But this is only a simplified educational model.

Not every couple should climb every step.

Some couples may conceive with properly timed intercourse.

Some benefit from IUI.

Some should proceed directly to IVF.

For example:

a woman with both fallopian tubes completely blocked does not gain much from repeated timed-intercourse cycles or ordinary IUI.

Why?

Because both still require:

sperm and egg to meet naturally inside a fallopian tube.

IVF is different because:

fertilization takes place outside the body.

Understanding this one principle helps patients understand why treatment choice depends on anatomy and diagnosis.

Three Basic Fertility Approaches

Timed Intercourse

Sperm and egg meet:

naturally inside the woman's reproductive tract.

The doctor helps identify or induce ovulation and advises intercourse at the most fertile time.

IUI — Intrauterine Insemination

Fertilization still takes place:

naturally inside the fallopian tube.



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But specially prepared sperm are placed directly into the uterus near ovulation.

IVF — In Vitro Fertilization

Eggs are removed from the ovaries and fertilized:

outside the body in a laboratory.

One or more embryos are later transferred into the uterus according to the treatment plan.

This is the fundamental difference.

What Is Timed Intercourse?

Timed intercourse means:

planning sexual intercourse around ovulation to maximize the likelihood that sperm are present when an egg is released.

It may be used in a:

completely natural cycle,

or combined with:

ovulation-induction medication,

ultrasound monitoring,

urinary LH testing,

an ovulation trigger.

Timed intercourse is one of the least invasive fertility interventions.

Natural-Cycle Timed Intercourse

A woman who already ovulates normally may simply identify her fertile period using:

menstrual-cycle tracking,

cervical mucus,

urinary LH kits.

The couple then has regular intercourse around:

the fertile window.

This is not technically a complicated fertility procedure.



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But proper counselling can be extremely useful.

What Is the Fertile Window?

For practical fertility counselling, the fertile window includes approximately:

the five days before ovulation plus the day of ovulation.

Because sperm survive longer than the ovulated egg, intercourse before ovulation is particularly important.

For many couples, intercourse every:

one to two days

during this interval gives excellent exposure.

Timed intercourse should therefore not mean:

“You must have sex at exactly 10 PM on ovulation day.”

Human fertility does not work according to one exact minute.

Timed Intercourse With Ovulation Induction

Sometimes timed intercourse is combined with medicine that helps:

induce ovulation.

This is different from simply tracking natural ovulation.

For example, a woman with:

PCOS,

irregular or absent ovulation

may receive an appropriate ovulation-induction treatment.

The doctor may monitor:

follicle development,

endometrium,

ovulation timing.

Intercourse is then advised during the appropriate fertile period.



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Ovulation Induction and Ovarian Stimulation Are Not Exactly the Same

These terms are often confused.

Ovulation induction

is primarily intended to make a woman who is not ovulating:

produce and release an egg.

Ovarian stimulation

may be used in an already ovulating woman to encourage:

more than one mature follicle,

often as part of:

IUI,

IVF.

This distinction matters because treatment goals and risks are different.

Who May Benefit From Timed Intercourse?

Timed intercourse may be reasonable for selected couples where:

the woman is relatively young,

at least one fallopian tube is functional,

semen parameters are adequate for natural conception,

infertility duration is not excessive,

ovulation is occurring or can be induced,

there is no major structural fertility problem.

It may be particularly useful when:

intercourse was previously poorly timed.

Timed Intercourse Can Also Help Ovulatory Disorders

A woman with PCOS may rarely ovulate naturally.

Once effective treatment produces ovulation:

properly timed intercourse may be enough for conception.



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The patient does not automatically require:

IUI,

IVF.

This is one reason I emphasize:

treat the cause before assuming the couple needs advanced reproductive technology.

Sexual Function Must Be Normal Enough for Timed Intercourse to Work

Timed intercourse requires:

intercourse.

That sounds obvious, but it is frequently overlooked.

Pregnancy opportunity may be reduced when there is:

erectile dysfunction,

performance anxiety,

anejaculation,

severe delayed ejaculation,

vaginismus,

painful intercourse.

A couple may accurately identify ovulation every month but still have very little effective sperm deposition.

At Saira Health Care, this is particularly important because my practice combines:

Sexual Disorders & Infertility.

Performance Anxiety During Timed Intercourse

I frequently see a man who says:

“Doctor, normally I have no erection problem, but whenever my wife tells me the ovulation test is positive, I cannot perform.”

This is a genuine clinical problem.

Fertility treatment can accidentally turn sexual intercourse into:



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a performance examination.

The man begins thinking:

“Today I have to perform.”

That anxiety itself can produce:

loss of erection,

delayed ejaculation,

avoidance of intercourse.

In such cases:

sexual counselling and treatment of performance anxiety may increase natural conception opportunities.

When Timed Intercourse Is Unlikely to Help

Timed intercourse cannot correct every infertility problem.

It may be ineffective or inappropriate in:

bilateral tubal blockage,

severe hydrosalpinx,

azoospermia,

severe male-factor infertility,

certain severe reproductive abnormalities.

It can also be an inefficient use of time in:

older women with a time-sensitive fertility situation,

couples with very long-standing infertility.

What Is IUI?

IUI stands for:

Intrauterine Insemination.

During IUI:

semen is collected,



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sperm are processed or “washed,”

a concentrated preparation of motile sperm is produced,

the sperm are placed through the cervix directly into the uterus using a thin catheter.

Fertilization does **not** occur in the laboratory.

The sperm must still:

move toward the fallopian tube,

meet the egg,

fertilize it naturally.

Mayo Clinic describes IUI as placing specially prepared sperm directly into the uterus around the time one or more eggs are released.

Why Is Sperm “Washed” for IUI?

The laboratory separates sperm from much of the:

seminal fluid,

debris,

non-motile cells.

The aim is to produce a smaller volume containing a higher concentration of:

useful motile sperm.

This preparation is then inserted directly into the uterus.

Why Does IUI Help?

During ordinary intercourse, sperm must travel:

vagina → cervix → uterus → fallopian tube.

Only a fraction successfully pass through the cervix.

IUI bypasses:

the vaginal and cervical portion of that journey.

ASRM patient guidance explains that placing prepared sperm past the cervix shortens the sperm's journey toward the fallopian tubes.

However:



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IUI does not bypass the fallopian tubes.

This is crucial.

At Least One Functional Fallopian Tube Is Generally Needed for IUI

After IUI, fertilization still usually occurs:

inside a fallopian tube.

Therefore, if both tubes are completely blocked:

IUI cannot solve the problem.

This is one of the clearest differences between:

IUI,

IVF.

Who May Benefit From IUI?

IUI may be considered in selected patients with:

unexplained infertility,

mild male-factor infertility,

cervical-factor infertility,

difficulty depositing sperm through intercourse,

erectile or ejaculatory dysfunction,

use of appropriately screened donor sperm,

selected ovulatory problems.

Mayo Clinic specifically lists unexplained infertility, mild male-factor infertility, cervical problems and ovulatory infertility among circumstances where IUI may be used.

IUI for Erectile or Ejaculatory Dysfunction

IUI can sometimes be very useful when sperm production is adequate but:

intercourse cannot occur,

ejaculation cannot reliably occur intravaginally.



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Cleveland Clinic notes that IUI can be used in circumstances involving erection or ejaculation dysfunction.

But I also ask:

Is the sexual disorder treatable?

If erectile dysfunction can be successfully treated, the couple may regain the possibility of:

natural conception.

IUI is therefore an option, not always a replacement for sexual-medicine treatment.

IUI for Mild Male-Factor Infertility

The concept is logical:

collect semen,

concentrate the better motile sperm,

bypass the cervix,

place them closer to the fallopian tubes.

But:

IUI has limits.

If the number of usable motile sperm is extremely low:

washing does not manufacture additional sperm.

The probability of IUI success falls as male-factor severity increases.

Therefore, severe male infertility may be better treated with:

IVF with ICSI.

There is no universally applicable single sperm-count threshold that decides this for every laboratory and couple.

Female age and the post-wash motile sperm count also matter.

IUI for Unexplained Infertility

Unexplained infertility is diagnosed when basic investigation does not reveal a clear cause.



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This generally means that the couple has evidence of:

ovulation,

at least one patent fallopian tube,

sufficiently adequate semen for the chosen treatment.

ESHRE emphasizes that unexplained infertility is:

a diagnosis of exclusion

rather than a single known disease.

For many couples with unexplained infertility:

ovarian stimulation combined with IUI

is commonly used before IVF.

What Does ASRM Recommend for Unexplained Infertility?

ASRM's evidence-based guideline concludes that for many couples with unexplained infertility, a reasonable initial strategy is:

approximately 3–4 cycles of ovarian stimulation with oral medication plus IUI,

followed by:

IVF

if pregnancy has not occurred.

Importantly, ASRM recommends moving to IVF rather than routinely adding:

gonadotropin-stimulated IUI

after oral-agent IUI failure because injectable stimulation can substantially increase:

multiple pregnancy,

ovarian hyperstimulation risk.

This recommendation applies particularly to:

unexplained infertility

and should not be treated as a universal protocol for every diagnosis.

Natural-Cycle IUI Versus Stimulated IUI



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In unexplained infertility, simply performing IUI in a completely natural cycle has not consistently provided the same benefit as:

ovarian stimulation + IUI.

ASRM states that natural-cycle IUI is generally not recommended as a treatment for unexplained infertility because it appears less effective than stimulated IUI and may provide little advantage over expectant management.

This distinction is important.

Not every procedure called:

“IUI”

has the same evidence or outcome.

What Happens During an IUI Cycle?

A typical cycle may include:

Step 1 — Baseline assessment

The doctor reviews:

ultrasound,

cycle history,

semen findings.

Step 2 — Natural cycle or ovarian stimulation

The woman may either:

ovulate naturally,

or receive:

fertility medication.

Step 3 — Ovulation monitoring

Monitoring may involve:

urinary LH,

ultrasound,

selected hormonal testing.

Step 4 — Ovulation trigger where indicated



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Some treatment cycles use:

hCG

to help time ovulation.

Step 5 — Semen collection and preparation

The sample is processed in the laboratory.

Step 6 — Insemination

A thin catheter is passed through the cervix.

The prepared sperm are placed:

inside the uterus.

The actual insemination usually takes only:

a few minutes.

Does IUI Hurt?

Most patients experience:

little discomfort,

mild cramping,

brief catheter-related discomfort.

A small amount of spotting can occasionally occur.

Serious complications from the insemination procedure itself are uncommon.

Mayo Clinic describes IUI as generally simple and safe, with infection and minor spotting among possible risks.

The Major Risk in Stimulated IUI Is Often Not the Catheter

The more important concern can be:

ovarian stimulation.

If several follicles mature:

more than one egg can be fertilized.

This increases the chance of:



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twins,

triplets,

higher-order multiple pregnancy.

Multiple pregnancy increases risks such as:

premature birth,

low birth weight,

pregnancy complications.

Cleveland Clinic also identifies multiple pregnancy and ovarian hyperstimulation as risks when fertility medication is combined with IUI.

Why Follicle Monitoring Matters in Stimulated IUI

If too many follicles develop:

pregnancy probability may increase,

but so does:

multiple-pregnancy risk.

Therefore, fertility treatment should not aim simply to:

“produce as many eggs as possible.”

The objective is:

safe pregnancy.

A responsible clinic may sometimes recommend:

cancelling an IUI cycle,

avoiding unprotected intercourse

if ovarian response creates unacceptable risk.

Is IUI Better Than IVF?

This is the wrong way to frame the question.

IUI is:

simpler,



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less invasive,

generally less expensive.

IVF is:

more complex,

more invasive,

generally more expensive,

often more effective per treatment cycle.

But:

a more powerful treatment is not automatically the correct first treatment.

Likewise:

a simpler treatment is not automatically better if it has little realistic chance of success.

When Is IUI Unlikely to Work Well?

IUI becomes less suitable in situations such as:

bilateral tubal blockage,

severe hydrosalpinx,

severe male-factor infertility,

confirmed azoospermia without usable ejaculated sperm,

certain advanced reproductive-age situations,

repeated appropriately performed IUI failure.

The exact decision depends on:

age,

ovarian reserve,

sperm after preparation,

duration of infertility,

diagnosis.



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How Many IUI Cycles Should Be Tried?

There is no single rule for every couple.

For unexplained infertility, ASRM commonly recommends:

approximately 3–4 cycles

of oral ovarian stimulation plus IUI before moving to IVF.

Cleveland Clinic similarly notes that many pregnancies from IUI occur during the first several cycles, while older age or very low sperm counts may justify moving to IVF sooner.

But a woman of:

40

should not automatically follow the same timeline as a woman of:

27.

Female Age Changes the IUI Versus IVF Decision

This is extremely important.

Every month has a different reproductive value according to age.

ASRM found evidence that in women with unexplained infertility aged approximately:

38–42,

immediate IVF may result in higher pregnancy rates and shorter time to pregnancy compared with spending additional cycles on stimulated IUI first.

Therefore:

age can change the treatment ladder.

This does not mean every woman over 38 automatically requires IVF.

But the value of avoiding delay becomes much more important.

What Is IVF?

IVF means:

In Vitro Fertilization.

“In vitro” means:



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outside the body.

In IVF:

eggs are obtained from the ovaries,

sperm are obtained,

fertilization occurs in a laboratory,

resulting embryos are cultured,

an embryo is later placed into the uterus.

Mayo Clinic describes IVF as a complex series of procedures and one of the most effective forms of assisted reproductive treatment involving eggs/embryos and sperm.

The Biggest Biological Difference Between IUI and IVF

With IUI:

fertilization still happens in the woman's body.

With IVF:

fertilization happens in the laboratory.

This means IVF can bypass some important barriers that IUI cannot.

IVF Bypasses the Fallopian Tubes

This is why IVF is so important in:

bilateral tubal infertility.

Eggs are removed directly from the ovaries.

They do not need to travel down the damaged tubes to encounter sperm.

An embryo is later placed directly into:

the uterus.

Therefore IVF can overcome many types of severe tubal-factor infertility.

Mayo Clinic lists damaged or blocked fallopian tubes among important indications for IVF.

What Happens During IVF?



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Although IVF protocols differ, a typical treatment cycle has several stages.

Stage 1 — Ovarian Stimulation

The ovaries are stimulated with medication to develop:

multiple follicles.

Why not simply retrieve one natural egg?

Because not every egg will:

be mature,

fertilize,

develop into a usable embryo.

Obtaining several eggs improves the opportunity to create embryos.

Stage 2 — Monitoring

The ovaries are monitored using:

transvaginal ultrasound,

sometimes hormonal blood tests.

The doctor evaluates:

follicle number,

follicle development,

ovarian response.

Stage 3 — Final Maturation Trigger

At the appropriate point, medication is administered to complete:

final oocyte maturation.

Egg retrieval is scheduled according to the protocol.

Stage 4 — Egg Retrieval

Eggs are collected using:

a transvaginal ultrasound-guided needle.



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Sedation or anaesthesia is generally used.

The eggs are passed to the embryology laboratory.

Stage 5 — Sperm Preparation

The male partner usually produces a semen sample.

If sperm cannot be obtained from the ejaculate, selected patients may require:

epididymal sperm retrieval,

testicular sperm retrieval.

The appropriate technique depends on:

the male diagnosis.

Stage 6 — Fertilization

There are two main laboratory approaches.

Conventional IVF

Eggs are placed with prepared sperm in the laboratory.

A sperm fertilizes the egg without direct injection.

ICSI

A single sperm is injected directly into an egg.

What Is ICSI?

ICSI stands for:

Intracytoplasmic Sperm Injection.

An embryologist selects one sperm and injects it directly into the cytoplasm of a mature egg.

ICSI is especially important in some forms of:

severe male-factor infertility.

It may be used when there is:

very low sperm number,



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severely impaired sperm movement,
surgically retrieved sperm,
previous significant fertilization difficulty,
selected other indications.

IVF and ICSI Are Not the Same Thing

Patients frequently say:

“We had ICSI.”

Technically:

ICSI is a fertilization technique performed within an IVF cycle.

The woman still undergoes:

ovarian stimulation,

egg retrieval,

embryo culture,

embryo transfer/frozen embryo planning.

The difference lies in:

how sperm and egg are combined.

Does Everyone Undergoing IVF Need ICSI?

No.

ASRM found no clear improvement in clinical pregnancy or live-birth rates from routinely adding ICSI to conventional IVF for couples with unexplained infertility and no male-factor indication, although ICSI can reduce the risk of complete fertilization failure in selected situations.

Therefore:

ICSI should have a clinical reason.

It should not automatically be presented as:

“More advanced, therefore always better.”



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What Happens After Fertilization?

A fertilized egg develops through early embryonic stages.

Embryologists monitor development.

Depending on the protocol:

embryo transfer may occur after several days,

suitable embryos may be frozen.

A commonly used stage is:

blastocyst.

A blastocyst generally develops approximately:

five to six days after fertilization,

although development varies.

Fresh Versus Frozen Embryo Transfer

A fresh embryo transfer occurs:

within the same ovarian-stimulation cycle.

A frozen embryo transfer—or FET—occurs:

in a later cycle

using a previously cryopreserved embryo.

The choice depends on:

ovarian response,

uterine/endometrial conditions,

risk of OHSS,

genetic testing,

clinic strategy.

Neither is universally superior for:

every patient.

Does More Embryos Mean Better IVF?



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Not necessarily.

Transferring multiple embryos can increase:

multiple pregnancy.

Multiple pregnancies carry substantially greater risks for:

mother,

babies.

Modern IVF increasingly aims for:

healthy singleton live birth,

not simply a positive pregnancy test.

This is why:

single-embryo transfer

is often an important safety strategy in appropriate patients.

ASRM also notes that IVF-related multiple-pregnancy risk can be reduced through elective single-embryo transfer.

Does IVF Guarantee Pregnancy?

No.

This is one of the most important messages I give couples.

IVF increases the probability of conception in many infertility conditions.

But it cannot guarantee:

fertilization,

embryo development,

implantation,

continuing pregnancy,

live birth.

Outcomes depend strongly on:

female age

as well as:



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ovarian reserve,
egg quality,
sperm factors,
embryo biology,
uterine factors,
diagnosis.

Mayo Clinic emphasizes that IVF success depends on factors including age and the underlying cause of infertility.

Why Age Matters So Much in IVF

IVF can help sperm and egg meet.

It can bypass tubes.

It can overcome certain severe sperm problems using ICSI.

But IVF cannot make:

an older egg biologically young.

Age-related changes in oocyte chromosome competence remain important.

Therefore:

IVF can overcome some infertility barriers—but not reproductive ageing itself.

Does Low AMH Mean IVF Is Impossible?

No.

AMH primarily reflects:

ovarian reserve and expected response to stimulation.

A low AMH may predict:

fewer eggs retrieved.

It does not automatically mean:

no eggs,

no embryos,



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no pregnancy.

The woman's:

age

remains critically important.

Two women with the same AMH at ages:

27,

41

do not have equivalent reproductive situations.

Does High AMH Guarantee IVF Success?

No.

High AMH often suggests:

more follicles,

stronger response.

But embryo competence and pregnancy still depend on:

age,

egg quality,

sperm,

embryo development,

uterus.

When May IVF Be Recommended Earlier?

IVF may be considered earlier in situations such as:

bilateral tubal blockage,

severe tubal damage,

selected hydrosalpinx situations,

severe male-factor infertility,

repeated failure of less invasive treatment,



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advanced reproductive age,
some endometriosis cases,
need for preimplantation genetic testing,
fertility preservation in selected patients.

Mayo Clinic lists blocked tubes, sperm problems, endometriosis, genetic disorders and fertility preservation among recognized reasons IVF may be used.

Hydrosalpinx and IVF

Hydrosalpinx means a fallopian tube has become:

blocked,
distended with fluid.

This condition can reduce IVF implantation and pregnancy outcomes.

Therefore, significant hydrosalpinx may need treatment:

before embryo transfer.

A patient should not assume:

“IVF bypasses the tube, so the hydrosalpinx no longer matters.”

The fluid itself may still adversely affect:

the uterine environment.

IVF for Severe Male-Factor Infertility

IVF combined with ICSI has transformed treatment for many severe male-factor conditions.

Even when very few sperm are available, an embryologist may need only:

one suitable sperm per mature egg

for ICSI.

This can be important in:

severe oligozoospermia,
some forms of azoospermia with retrievable sperm.

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ICSI cannot create sperm where no usable sperm exist.

The male diagnosis must still be understood.

Azoospermia Does Not Automatically Mean Donor Sperm

A man with azoospermia requires evaluation to determine whether it is:

obstructive

or:

non-obstructive.

In selected men:

sperm may be surgically retrieved,

ICSI may then be performed.

In other men:

retrieval may be impossible.

Genetic diagnosis can also affect:

prognosis,

counselling.

Therefore, severe male infertility should be assessed properly before treatment decisions.

Does IUI Work in Azoospermia?

If there are no usable sperm in the ejaculate:

ordinary partner-sperm IUI cannot work.

IUI requires:

sperm to inseminate.

The couple may instead need:

sperm retrieval + IVF/ICSI,

or another family-building option according to the diagnosis and preferences.



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Timed Intercourse Versus IUI Versus IVF — Basic Comparison

Feature	Timed Intercourse	IUI	IVF
Where sperm are placed	Vagina through intercourse	Directly into uterus	Eggs and sperm meet in laboratory
Where fertilization occurs	Fallopian tube	Fallopian tube	Laboratory
Functional tube required	Yes	Yes	Not for fertilization
Egg retrieval required	No	No	Yes
Embryology laboratory required	No	Sperm preparation only	Yes
Usually invasiveness	Lowest	Low	Highest of the three
Relative cost	Lowest	Intermediate	Highest
Useful in severe tubal blockage	No	No	Often yes
Useful in severe male factor	Usually limited	Often limited	IVF/ICSI often considered
Multiple-pregnancy risk	Mainly if stimulated	Increased if multiple follicles develop	Controlled partly by embryo-transfer strategy

This table is only:

an introduction.

Individual treatment choice requires full clinical assessment.

Which Treatment Is Best?

There is no universally best treatment.

The best treatment is the one that gives:



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the appropriate balance of effectiveness, safety, invasiveness, cost and reproductive time

for that particular couple.

Factors That Decide Between Timed Intercourse, IUI and IVF

I usually consider:

Woman's age

This affects both natural fertility and ART outcome.

Ovarian reserve

Important particularly for treatment planning.

Ovulation

Is she ovulating naturally?

Fallopian tubes

Are they open and functional?

Semen quality

Is there enough usable motile sperm?

Duration of infertility

Two years of infertility is different from two months.

Previous treatment

Have appropriately performed IUI cycles already failed?

Endometriosis

Severity and age influence management.

Previous pregnancy

Primary and secondary infertility may have different histories.

Sexual function

Can effective intercourse occur?

Couple preference

Treatment burden and values matter.



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When Timed Intercourse May Be the Best First Step

Consider a woman aged:

27

with:

anovulatory PCOS,

normal tubes,

partner with good semen.

Once ovulation is successfully induced:

timed intercourse

may be a perfectly reasonable first treatment.

Going immediately to IVF may represent:

unnecessary intervention.

When IUI May Be the Better Step

Consider a couple with:

unexplained infertility,

patent tube or tubes,

adequate ovarian reserve,

sufficiently usable sperm,

younger female age.

A limited course of:

oral ovarian stimulation + IUI

may be reasonable before IVF.

For unexplained infertility, ASRM generally supports this sequence.

When IVF May Be More Rational

Consider a woman aged:

with prolonged infertility.

Even if IUI is technically possible, the couple may choose to avoid several low-yield months before IVF.

ASRM evidence indicates that immediate IVF can offer advantages in time to pregnancy for older women with unexplained infertility compared with additional IUI strategies.

Example — Bilateral Tubal Block

Woman:

30 years old,

regular ovulation,

semen normal,

both fallopian tubes truly blocked.

Timed intercourse cannot bypass:

the blocked tubes.

IUI also cannot bypass:

the blocked tubes.

IVF can.

This is a classic example where:

moving directly toward IVF may be medically logical.

Example — Mild Male-Factor Infertility

Suppose semen shows:

mildly reduced motility,

reasonable post-wash sperm count,

female partner is young,

tubes are open.

IUI may provide:

a reasonable intermediate treatment.



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Example — Severe Male-Factor Infertility

Suppose there is:

extremely low sperm concentration,

poor movement.

Repeated IUI may have very little value.

The couple may need:

IVF with ICSI.

This is why every low sperm count should not be treated identically.

Example — Erectile Dysfunction but Normal Fertility Tests

If:

ovulation is normal,

tubes are open,

semen production is good,

but intercourse repeatedly fails because of erectile dysfunction:

treat the erectile disorder.

If necessary, IUI may bypass the sperm-delivery problem.

But a couple should not automatically undergo IVF when the main barrier is:

treatable sexual dysfunction.

Example — Vaginismus

A woman may have:

normal ovulation,

open tubes,

healthy reproductive organs.

But vaginal penetration is impossible.

The first priority may be:



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treatment of vaginismus.

Selected couples may temporarily use assisted insemination.

Again:

sexual medicine is part of fertility medicine.

Example — PCOS and Anovulation

If the woman does not ovulate consistently:

correct or induce ovulation.

Timed intercourse may then be sufficient.

If pregnancy does not occur after appropriate treatment:

additional evaluation,

IUI

may become appropriate.

The key is not to jump directly from:

“irregular period”

to:

IVF.

Example — Repeated Failed IUI

A couple has undergone:

four properly monitored oral-stimulation IUI cycles

for unexplained infertility without pregnancy.

At this stage, ASRM recommends considering:

IVF

rather than repeatedly escalating to conventional gonadotropin-IUI cycles with higher multiple-pregnancy risk.

Is IUI Always Cheaper Than IVF?



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Per cycle:

usually yes.

But cost effectiveness depends on:

probability of success,

number of attempts,

woman's age,

diagnosis.

Six unsuccessful IUI cycles followed by IVF may ultimately cost more in:

money,

emotional energy,

reproductive time

than earlier IVF in a poorly selected IUI candidate.

Therefore:

cost per procedure is not the same as cost per live birth.

Is IVF Always Faster?

Not always.

For younger couples with a good prognosis for natural conception or simple treatment:

immediate IVF may represent unnecessary intervention.

For older or poorer-prognosis couples:

earlier IVF can sometimes shorten time to pregnancy.

Treatment should therefore be individualized.

Success Rates Should Always Be Interpreted Carefully

Patients frequently ask:

“What is the success rate of IUI?”

or:

“What is the IVF success rate?”



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There is no single meaningful number that applies to everyone.

Outcome depends on:

age,

diagnosis,

ovarian reserve,

sperm,

number of follicles,

embryo quality,

previous treatment.

Clinic advertisements sometimes quote:

pregnancy rates

rather than:

live-birth rates.

These are not the same outcome.

A positive hCG test is:

not yet a live birth.

Patients should ask specifically:

“What is the live-birth rate for patients like me?”

Age-Specific Outcomes Are More Useful Than One Overall Clinic Percentage

A clinic treating many women in their 20s may report a very different average from a clinic treating women in their 40s.

Therefore:

overall percentages can mislead.

Whenever fertility outcomes are discussed, ask whether the number is:

per started cycle,

per egg retrieval,

per embryo transfer,



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clinical pregnancy,

ongoing pregnancy,

live birth.

These denominators are different.

The Emotional Difference Between Timed Intercourse, IUI and IVF

Treatment burden generally increases as care becomes more intensive.

Timed intercourse

may create:

timing pressure,

sexual performance anxiety.

IUI

may involve:

medication,

scans,

semen collection,

clinic procedures.

IVF

may involve:

injections,

repeated monitoring,

egg retrieval,

embryology decisions,

embryo transfer,

frozen embryo decisions,

financial and emotional burden.

WHO recognizes the significant psychological and social burden associated with infertility.



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A responsible fertility plan therefore considers:

emotional burden as well as biological probability.

What About Multiple Pregnancy?

A successful fertility treatment should not simply aim to produce:

as many fetuses as possible.

Twins and higher-order pregnancies have increased risk of:

preterm birth,

neonatal complications,

maternal complications.

With stimulated IUI, multiple ovulation can create multiple pregnancy.

With IVF, transferring multiple embryos can create the same problem.

Modern fertility treatment increasingly considers:

singleton live birth

the safest goal.

Ovarian Hyperstimulation Syndrome — OHSS

OHSS is a complication of ovarian stimulation.

The ovaries can become:

enlarged,

painful.

More severe disease can involve:

fluid shifts,

abdominal swelling,

breathing symptoms,

thrombosis risk.

Modern protocols have reduced severe OHSS substantially, but it remains an important treatment consideration.



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Stimulated IUI and IVF should therefore be:

medically monitored.

Fertility Treatment Does Not Replace Preconception Care

Before timed fertility treatment, IUI or IVF, couples should also consider:

folic acid,

chronic-disease control,

smoking cessation,

STI assessment where indicated,

medication review,

vaccination and pregnancy health.

The goal is not only:

conception.

The goal is:

a healthy pregnancy and live birth.

Male Evaluation Should Occur Before Repeated IUI

If semen quality is abnormal:

understand why.

Do not simply wash the sperm and repeat IUI indefinitely.

Male evaluation may identify:

clinical varicocele,

hormonal disease,

obstruction,

anabolic steroid use,

genetic infertility.

Treating the underlying cause may sometimes:

improve natural conception opportunities,



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change ART planning.

Female Evaluation Should Occur Before Choosing IUI

At least one functional tube generally needs to be present.

Therefore:

tubal status matters.

Ovarian reserve, uterine factors and age may also influence whether IUI is a reasonable use of time.

Does IVF Mean the Couple Has Failed?

Absolutely not.

Some patients emotionally interpret IVF as:

“Our bodies failed.”

That is not a medically useful way to see it.

IVF is simply:

a reproductive technology that bypasses particular biological barriers.

For a woman with bilateral tubal blockage, IVF is not a failure.

It is:

a logical solution to the anatomical problem.

For severe sperm impairment, ICSI is not evidence of reduced masculinity.

It is:

a laboratory method for assisting fertilization.

Does Choosing Timed Intercourse Mean the Doctor Is “Doing Nothing”?

No.

When chosen correctly, expectant management or timed intercourse can be:

an evidence-based decision.

A young couple with:



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short-duration unexplained infertility,

good prognosis

may have a meaningful chance of spontaneous conception.

The art of fertility medicine involves knowing:

when to intervene

and:

when not to over-treat.

Fertility Treatment and Unexplained Infertility

Unexplained infertility is one of the most important areas where treatment escalation must be balanced carefully.

ESHRE notes that unexplained infertility is a diagnosis reached after appropriate basic evaluation has failed to identify a specific cause and that much of the evidence for additional diagnostic and treatment interventions remains limited.

For many younger couples:

a period of expectant management,

followed by stimulated IUI

may be reasonable.

For older women:

earlier IVF may be preferable.

This illustrates why treatment cannot be reduced to one universal protocol.

What Does the Latest WHO Guidance Change?

WHO's 2025 global infertility guideline is important because it establishes a global evidence-based framework across:

prevention,

diagnosis,

male infertility,

ovulatory disorders,



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tubal disease,
uterine disorders,
unexplained infertility,
medically assisted reproduction.

The broader direction is:

diagnose accurately, offer evidence-based treatment and avoid unnecessary intervention or delay.

This is particularly important in regions where patients may either:

receive almost no fertility care,

or:

be pushed toward expensive ART very rapidly.

The Unani Perspective on Fertility Treatment

As a physician trained in the **Unani System of Medicine**, I believe fertility treatment should not focus only on:

ovaries,

sperm,

embryos.

Classical Unani medicine emphasizes the health of the whole person, including:

Mizaj,

nutrition,

digestion,

sleep,

physical wellbeing,

reproductive function,

sexual wellbeing.

WHO has published international standards and benchmarks for Unani medicine, recognizing the need for standardized terminology, practitioner competency and safe clinical practice.



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These principles can contribute meaningfully to:

supportive fertility care.

Where Unani Medicine May Be Particularly Useful

Individualized Unani treatment may have supportive value in selected patients with:

nutritional weakness,

metabolic imbalance,

digestive disturbances,

sleep disturbance,

sexual dysfunction,

mild idiopathic semen abnormalities,

selected menstrual problems,

general reproductive-health concerns.

It may be integrated alongside:

fertile-window counselling,

treatment of sexual dysfunction,

medically appropriate infertility management.

Unani Medicine and Male Fertility

Unani clinical literature contains small studies evaluating traditional formulations in:

oligospermia,

male reproductive disorders.

Some reported changes in:

sperm count,

motility,

semen parameters.

However, available studies are generally much smaller and methodologically weaker than the evidence base used for established fertility procedures.



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Therefore:

improvement in a semen parameter should not automatically be interpreted as proven improvement in live-birth rate.

This distinction is scientifically important.

Unani Medicine and Female Fertility

Traditional Unani management may provide supportive benefit in selected areas involving:

menstrual wellbeing,

nutrition,

body weight,

metabolic health,

sexual wellbeing.

But female infertility can arise from:

complete tubal blockage,

severe intrauterine adhesions,

diminished ovarian reserve,

advanced reproductive age,

congenital abnormalities.

These conditions cannot responsibly be treated as though they all represent:

one functional “uterine weakness.”

Can Unani Medicine Replace Timed Intercourse?

If the main problem is simply:

poor timing,

education may be enough.

No medicine is required to substitute for:

intercourse during the fertile period.



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Can Unani Medicine Replace IUI?

Sometimes IUI may be avoidable if an underlying treatable problem can be corrected.

For example:

sexual dysfunction,

ovulatory disorder

may respond to appropriate treatment.

But if IUI is indicated because of:

sperm-delivery problems,

unexplained infertility

and the couple chooses it after proper counselling, Unani medicine should not be represented as a scientifically proven replacement.

Can Unani Medicine Replace IVF?

This requires a very clear answer.

Not when IVF is medically required to bypass a major structural or severe reproductive problem.

Examples include:

bilateral severe tubal disease,

selected severe male-factor infertility,

situations requiring ICSI,

selected genetic treatment pathways.

Unani medicine cannot:

make sperm and egg meet naturally through completely nonfunctional tubes.

It cannot:

replace laboratory fertilization when fertilization requires ICSI.

Unani Medicine Cannot Reverse Reproductive Age

No traditional or modern medicine has been proven to:

restore a 42-year-old ovary to the biological state of a 25-year-old ovary.



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General health can be improved.

Metabolic health can be improved.

But reproductive ageing should not be denied.

Therefore, traditional treatment should never be used to:

postpone time-sensitive fertility care for years.

Integrative Care Before IVF

Unani medicine may still have a useful role before or alongside IVF through:

nutritional optimization,

digestive health,

sleep,

healthy lifestyle,

stress support,

sexual wellbeing.

But supportive therapy should be:

safe around ovarian stimulation and pregnancy.

Every:

Unani formulation,

herb,

supplement

should be disclosed to the IVF team because interaction and pregnancy-safety data may be limited.

“Natural” Does Not Automatically Mean Safe During IVF

This is important.

Some herbal preparations may have:

hormonal actions,

effects on liver enzymes,



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drug interactions,

uncertain pregnancy safety.

Therefore:

do not begin multiple herbal fertility products during IVF without discussing them with the treating team.

Responsible integrative medicine requires:

communication between systems of care.

Special Treatment Planning by Dr. Nizamuddin Qasmi

When a couple consults me, I do not start by asking:

“Do you want IUI or IVF?”

I first ask:

Why has pregnancy not occurred?

I review:

Female factors

age,

ovulation,

ovarian reserve where indicated,

fallopian tubes,

uterine condition,

endometriosis.

Male factors

semen analysis,

previous fertility,

varicocele,

hormonal factors,

genetic risks,

sexual function.



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Couple factors

duration of infertility,

intercourse timing,

previous treatment,

reproductive goals.

Only then do we discuss:

timed intercourse, IUI or IVF.

My Approach to Timed Intercourse

I consider it when:

natural conception remains biologically realistic,

tubes are functional,

sperm are adequate,

age allows reasonable time,

ovulation can be identified or induced.

I also assess:

erectile function,

ejaculation,

painful intercourse.

This is particularly important in my practice.

My Approach to IUI

Before recommending IUI, I want to know:

Are the tubes suitable?

Is there enough usable sperm?

Is the woman's age compatible with spending time on IUI?

What is the diagnosis?

Has simpler treatment already failed?



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IUI should have:

a reason.

My Approach to IVF

IVF is considered when:

anatomy requires it,

severity of infertility requires it,

simpler treatment has appropriately failed,

reproductive age makes delay undesirable.

The objective is not to promote IVF unnecessarily.

Nor is it to avoid IVF when:

avoiding it may significantly reduce the couple's chance of pregnancy.

Saira Health Care's Contribution to Sexual Disorders & Infertility

At **Saira Health Care**, our particular focus is on the intersection between:

sexual medicine + male infertility + female infertility.

This matters because not every couple reaching an IVF clinic has an IVF-only problem.

For example:

Couple One

The main issue is:

erectile dysfunction.

Couple Two

The woman has:

irregular ovulation.

Couple Three

The man has:

mild sperm impairment.

Couple Four

The woman has:

bilateral tubal blockage.

These four couples should not receive:

the same treatment.

Our contribution is therefore to help identify:

the actual barrier to conception,

whether a less invasive treatment remains realistic,

when referral for ART is necessary,

how responsible Unani supportive treatment can be integrated without delaying essential fertility care.

Patient Example — Young Couple With Poorly Timed Intercourse

Woman:

age 26,

regular ovulation.

Man:

normal semen.

Tubes:

no known abnormality.

They have intercourse only once near the middle of each cycle.

My first intervention may simply be:

fertile-window education.

They do not automatically need:

IUI,

IVF.

Patient Example — Anovulatory PCOS

Woman:

29,

periods every 60–90 days.

Partner:

normal semen.

Tubes:

no major concern.

The primary treatment question is:

how can we restore or induce ovulation?

Properly induced ovulation plus timed intercourse may be enough.

IVF is not automatically the first answer.

Patient Example — Unexplained Infertility

Woman:

31,

ovulating normally,

tube or tubes patent.

Partner:

adequate motile sperm.

Infertility:

persistent.

A limited course of:

oral stimulation + IUI

can be an evidence-based next step.

ASRM generally recommends approximately 3–4 such cycles before IVF in appropriate unexplained-infertility patients.

Patient Example — Woman Age 40 With Long-Standing Infertility

This situation is different.



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I would not automatically advise:

six or eight IUI attempts.

Reproductive time is much more valuable.

Evidence supports consideration of earlier IVF in older women rather than prolonged lower-intensity treatment.

Patient Example — Both Tubes Blocked

Timed intercourse:

cannot bypass the problem.

IUI:

cannot bypass the problem.

IVF:

can bypass the tubes for fertilization.

This is why diagnosis comes before treatment choice.

Patient Example — Severe Male Factor

If very few usable sperm are present:

timed intercourse may have a low probability,

IUI may also offer very limited benefit.

IVF with:

ICSI

may be the more rational treatment.

Patient Example — Azoospermia

The first treatment is not:

automatically IVF.

The first step is:

determine the cause.



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If sperm production exists behind an obstruction:

sperm retrieval + ICSI may be possible.

If severe sperm-production failure exists:

prognosis depends on the underlying condition.

Again:

diagnosis first.

Patient Example — Erectile Dysfunction

A young couple has normal:

tubes,

ovulation,

sperm count.

But intercourse fails repeatedly.

A fertility clinic could technically perform:

IUI,

IVF.

But I would first ask:

Can the sexual disorder be treated?

If yes, natural conception may become possible.

This is one area where the combination of:

Sexual Disorders & Infertility

is particularly valuable.

Common Myths About Timed Intercourse

Myth: Timed intercourse means sex only once on ovulation day

Fact:

The fertile window covers several days.



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Myth: Ovulation medication always means IUI

Fact:

Ovulation induction can be combined with ordinary intercourse.

Myth: If timed intercourse fails once, IVF is required

Fact:

Natural conception is probabilistic.

One cycle proves very little.

Common Myths About IUI

Myth: IUI means the sperm fertilizes the egg in the laboratory

Fact:

No.

Fertilization still usually occurs:

inside the fallopian tube.

Myth: IUI works even when both tubes are blocked

Fact:

Generally no.

A functioning pathway through at least one tube is usually necessary.

Myth: IUI fixes every low sperm count

Fact:

No.

Severe male-factor infertility may require IVF/ICSI.

Myth: The more follicles produced for IUI, the better

Fact:

Too many follicles increase:
multiple-pregnancy risk.

Myth: IUI should be repeated indefinitely because it is cheaper

Fact:

Repeated low-yield treatment may waste:
money,
time,
reproductive potential.

Common Myths About IVF

Myth: IVF means the couple can never conceive naturally

Fact:

Not necessarily.
The reason IVF was recommended determines the natural-conception prognosis.

Myth: IVF guarantees a baby

Fact:

No fertility treatment guarantees live birth.

Myth: IVF always needs ICSI

Fact:

No.
ICSI should have an indication.

Myth: More embryos transferred means better treatment

Fact:

Multiple embryo transfer increases:



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multiple pregnancy.

Myth: IVF can make eggs younger

Fact:

No.

Myth: Low AMH means IVF cannot work

Fact:

Low AMH often predicts fewer eggs, not absolute impossibility of pregnancy.

Myth: IVF is always the best fertility treatment

Fact:

For some patients it is the best option.

For others it is:

unnecessary as a first treatment.

Frequently Asked Questions

What is timed intercourse?

Intercourse planned around the fertile window or medically predicted ovulation.

Does timed intercourse require fertility medicine?

Not necessarily.

It can be done during:

natural ovulation,

induced ovulation.

How often should intercourse occur?

For many couples:



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every 1–2 days during the fertile window

is reasonable.

Does timed intercourse work if both tubes are blocked?

No.

Can timed intercourse work with PCOS?

Yes, if ovulation occurs naturally or can be successfully induced.

Does timed intercourse help azoospermia?

No.

Azoospermia requires male evaluation.

What is IUI?

Prepared sperm are placed directly:

inside the uterus

near ovulation.

Does fertilization happen in the laboratory during IUI?

No.

It normally occurs:

inside the fallopian tube.

Does IUI require open tubes?

Generally at least one functional tube is required.

Is IUI painful?

Usually it causes little or mild short-lived discomfort.



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Does IUI require anaesthesia?

Usually:

no.

How long does the IUI procedure take?

The actual insemination generally takes only several minutes.

Can IUI be done without stimulation medicine?

Yes.

But for unexplained infertility, natural-cycle IUI is generally less effective than stimulated IUI and has limited advantage over expectant management according to ASRM.

How many IUI cycles should be tried?

For many appropriately selected couples with unexplained infertility:

approximately 3–4 oral-stimulation IUI cycles

are commonly recommended before moving to IVF.

Other diagnoses may require different plans.

Why not keep trying gonadotropin IUI?

Injectable gonadotropin stimulation can substantially increase:

multiple pregnancy,

OHSS

without providing the best overall treatment strategy after oral-agent IUI failure.

ASRM therefore recommends IVF rather than routine gonadotropin-IUI escalation for unexplained infertility after oral IUI failure.

Can IUI help mild low sperm count?



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Sometimes.

The usefulness depends particularly on:
motile sperm available after preparation,
female age,
other fertility factors.

Can IUI work with very severe sperm problems?

Its effectiveness becomes limited as the number of usable motile sperm falls substantially.

IVF/ICSI may be more appropriate.

Can IUI treat erectile dysfunction?

It can bypass the need for semen deposition through intercourse in selected situations.
But the erectile disorder itself should also be evaluated.

Can IUI help retrograde ejaculation?

Potentially, depending upon whether usable sperm can be recovered and prepared.

What is IVF?

Eggs are removed from the ovaries and fertilized with sperm:
outside the body in a laboratory,
after which embryo transfer can be performed.

Does IVF require egg retrieval?

Yes, when using the woman's own eggs.

Does IVF require hormone injections?

Most conventional IVF cycles use ovarian-stimulation medicines.



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Does IVF need open fallopian tubes?

No.

The tubes are bypassed for fertilization.

Can IVF work after tubal blockage?

Yes.

Tubal blockage is one of the important indications for IVF.

What is ICSI?

A single sperm is injected directly into:

a mature egg.

Is ICSI a different treatment from IVF?

ICSI is a fertilization method:

used within IVF.

Does everyone need ICSI?

No.

Routine ICSI has not been shown to improve live birth in every non-male-factor or unexplained infertility case.

When might ICSI be useful?

Examples include:

severe male-factor infertility,

surgically retrieved sperm,

selected previous fertilization failure.



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Does IVF guarantee fertilization?

No.

Does fertilization guarantee an embryo?

No.

Does an embryo guarantee implantation?

No.

Does a positive IVF pregnancy test guarantee live birth?

No.

Each stage represents another biological step.

What is embryo transfer?

The procedure of placing an embryo into:

the uterine cavity.

Does embryo transfer require surgery?

Usually no.

A thin catheter is generally passed through the cervix.

What is frozen embryo transfer?

Transfer of an embryo that was:

cryopreserved,

subsequently thawed

in a later treatment cycle.

Is frozen embryo transfer always better?



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No.

It is useful in many circumstances but the best strategy depends on the patient.

Can embryos be genetically tested?

Selected embryos created through IVF can undergo:

preimplantation genetic testing.

This is particularly relevant to selected inherited disorders and specific indications.

It is not automatically needed by every IVF patient.

Can IVF prevent every genetic condition?

No.

PGT cannot screen for every possible disease or guarantee a completely healthy child.

What is OHSS?

Ovarian hyperstimulation syndrome is an excessive response to ovarian-stimulation medicine.

Modern protocols reduce the risk, but it remains important.

Does IUI also cause OHSS?

The IUI catheter itself does not.

But:

ovarian-stimulation medicines used with IUI

can rarely cause OHSS.

Which has a greater chance of twins—IUI or IVF?

Both can produce multiple pregnancy.

In stimulated IUI, multiple follicles increase the risk.

In IVF, embryo-transfer strategy has a major effect.



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Can IVF reduce twin risk?

Yes.

Appropriate:

single-embryo transfer

can markedly reduce multiple pregnancy risk.

Should everyone try IUI before IVF?

No.

Who may go directly to IVF?

Depending on circumstances:

bilateral tubal disease,

severe male-factor infertility,

advanced reproductive age,

selected other diagnoses.

I am 40. Should I try many IUI cycles first?

Not automatically.

Reproductive time is important, and earlier IVF may be more appropriate in some older patients.

I am 28. Should I go directly to IVF after six months of trying?

Usually not without a specific indication.

A full fertility history and diagnosis should come first.

Does unexplained infertility always need IVF?

No.



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For many younger couples, oral stimulation plus IUI is a common first-line treatment after appropriate evaluation.

Is IVF better than IUI?

It is generally more powerful per cycle but:

more invasive,

more costly.

The correct choice depends on diagnosis.

Does AMH determine whether I need IVF?

No.

AMH is one component of ovarian-reserve assessment.

It does not independently determine treatment.

Can a low-AMH woman try IUI?

Sometimes.

But age, reserve severity, duration of infertility and treatment efficiency must be considered.

Can a normal-AMH woman need IVF?

Yes.

Examples include:

bilateral blocked tubes,

severe male-factor infertility.

Can semen analysis determine IUI versus IVF?

It contributes substantially.

But treatment choice also depends on:

female age,



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tubes,
infertility duration,
ovarian reserve.

Can varicocele treatment avoid IVF?

In selected infertile men with:

palpable clinical varicocele,

abnormal semen,

treatment may improve semen parameters and sometimes alter fertility options.

But it does not guarantee avoidance of ART.

Can Unani medicine help before timed intercourse?

It may provide supportive care for:

nutrition,

metabolic wellbeing,

sexual function,

menstrual health

where appropriate.

Can Unani medicine help avoid IUI or IVF?

In some patients, successful treatment of a genuinely correctable problem may allow natural conception.

But no responsible physician should promise:

“Unani treatment will definitely prevent IVF.”

Can Unani medicine open both severely scarred fallopian tubes?

There is not sufficient evidence to make that claim.

Established severe tubal disease may require:

surgery,

IVF.

Can Unani medicine treat mild semen abnormalities?

Selected small Unani studies have reported improvement in semen parameters, but evidence remains limited.

Treatment should depend on:

the cause.

Can Unani medicine cure genetic male infertility?

No medicine can rewrite a missing genetic region or chromosome.

Can Unani medicine be used during IVF?

Potentially selected supportive approaches may be used, but every formulation should be disclosed to the IVF team.

Safety and interactions matter.

Should I stop IVF medicines and use herbal treatment instead?

No.

Do not interrupt prescribed fertility treatment without discussing it with the fertility specialist.

Is Unani medicine useful for sexual dysfunction during fertility treatment?

It may be incorporated in selected cases together with:

sexual counselling,

appropriate medical treatment,

lifestyle care.

This can be especially useful where performance anxiety or sexual wellbeing is affecting intercourse.



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A Message From Dr. Nizamuddin Qasmi to Couples Starting Fertility Treatment

Please do not think:

“IVF is the first step.”

But also do not think:

“IVF must be avoided at any cost.”

Both ideas can be harmful.

The correct fertility treatment is:

the treatment appropriate to the cause.

If properly timed intercourse gives you a reasonable chance:

use it.

If IUI is appropriate:

use IUI.

If IVF offers the best realistic chance because of:

blocked tubes,

severe sperm problems,

age,

previous treatment failure,

then delaying IVF indefinitely may not be in your interest.

A Message to Women

Please remember that infertility treatment should never become:

endless testing and medication only for the woman.

The male partner must be assessed appropriately.

Your:

age,

ovarian reserve,

ovulation,



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tubes,

uterus

matter.

But so do:

semen,

male sexual function,

ejaculation.

Fertility belongs to:

the couple.

A Message to Men

Please do not say:

“My wife is not getting pregnant, so she needs IUI or IVF.”

You are part of the fertility assessment.

Your:

sperm count,

motility,

testicular health,

sexual function,

testosterone/steroid use

can change the entire treatment plan.

A semen analysis may determine whether:

timed intercourse,

IUI,

IVF/ICSI

is the most rational option.

A Message About IVF



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IVF is neither:

a punishment

nor:

a guaranteed solution.

It is a powerful reproductive technology.

It should be used when:

its benefits justify its burden.

Good fertility medicine does not promote unnecessary IVF.

Good fertility medicine also does not delay necessary IVF simply to continue low-probability treatments for years.

A Message About Unani Medicine

As a physician trained in Unani medicine, I value:

individualized care,

Mizaj,

nutrition,

digestion,

sexual wellbeing,

general reproductive health.

These factors can matter deeply to couples experiencing infertility.

But responsible Unani practice must also recognize:

anatomy.

A completely blocked tube remains a mechanical barrier.

genetics.

A chromosomal abnormality cannot be corrected through a tonic.

reproductive age.

Time cannot be reversed.

severe male infertility.



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Sometimes laboratory fertilization is necessary.

Therefore, I prefer an integrative approach:

modern reproductive diagnosis + appropriate fertility technology + responsible Unani supportive care.

That combination respects:

tradition,

science,

patient safety,

reproductive time.

Current Medical Understanding — 2026 Update

Modern infertility treatment is increasingly based on:

diagnosis + prognosis + patient preference.

WHO's first global infertility guideline, published in November 2025, establishes a comprehensive global framework for prevention, diagnosis and treatment and confirms that infertility may result from:

male,

female,

unexplained factors.

For **unexplained infertility**, current ASRM guidance supports:

3–4 cycles of ovarian stimulation with oral medication plus IUI

for many appropriately selected couples before:

IVF.

If those cycles fail, ASRM recommends moving to:

IVF

rather than routinely adding conventional gonadotropin-IUI cycles, because gonadotropin stimulation substantially increases risks such as:

multiple pregnancy,

OHSS.



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For women approaching or beyond the later 30s, treatment may need to be accelerated.

ASRM evidence suggests that in women aged approximately 38–42 with unexplained infertility:

immediate IVF can provide better treatment efficiency than prolonged IUI-first strategies.

Current evidence also does **not** support automatically adding ICSI to every IVF cycle when there is no male-factor indication. In unexplained infertility, routine ICSI has not consistently improved:

clinical pregnancy,

live birth

over conventional fertilization, although it can reduce complete fertilization failure in selected cases.

This gives us a clear 2026 principle:

More intervention is not automatically better.

But:

continuing ineffective low-level treatment is not automatically safer or wiser either.

The goal is:

the right treatment for the right couple at the right time.

Conclusion

Timed intercourse, IUI and IVF are not competing treatments. They are different tools for different fertility situations.

Timed intercourse

allows:

natural fertilization inside the female reproductive tract.

It may be appropriate when:

ovulation occurs or can be induced,

fallopian tubes are functional,

semen quality is adequate,



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reproductive time allows it.

IUI

places prepared sperm directly:

inside the uterus.

It may be useful for selected:

unexplained infertility,

mild male-factor infertility,

cervical factors,

sperm-delivery problems,

donor-sperm treatment.

But fertilization still occurs:

in the fallopian tube.

Therefore IUI cannot overcome:

bilateral tubal blockage.

IVF

moves fertilization:

outside the body.

Eggs are retrieved and fertilized in a laboratory before embryo transfer.

IVF may be especially useful in:

bilateral tubal disease,

severe male-factor infertility,

selected endometriosis,

repeated failure of simpler treatment,

advanced reproductive age,

genetic-treatment pathways.

ICSI

is a laboratory fertilization method used within IVF in which:

one sperm is injected directly into an egg.



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It is particularly valuable for selected severe male-factor infertility, but should not automatically be added to every IVF cycle.

For unexplained infertility, current ASRM guidance generally recommends:

3–4 cycles of oral ovarian stimulation + IUI,

followed by:

IVF

when those cycles fail in appropriately selected patients.

But age can change that sequence.

In older women, prolonged repeated IUI may waste valuable reproductive time, and earlier IVF may be appropriate.

The most important principle is:

Do not choose treatment only by its name.

Choose according to:

diagnosis,

female age,

ovarian reserve,

tubal condition,

semen quality,

sexual function,

previous treatment,

infertility duration.

From the **Unani perspective**, individualized traditional care can make a useful supportive contribution through attention to:

nutrition,

digestion,

metabolic wellbeing,

menstrual health,

male reproductive wellbeing,

sexual health.



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WHO has established benchmarks for safe Unani practice and standardized terminology, supporting a structured approach to integrating the system responsibly.

But Unani medicine should not be presented as a proven replacement for:

IVF in bilateral severe tubal disease,

ICSI when severe male-factor infertility requires direct sperm injection,

genetic counselling,

time-sensitive fertility care.

At **Saira Health Care**, my approach is:

**understand the couple → identify the cause → correct sexual and medical problems
→ use natural conception when reasonable → use IUI when appropriate → refer for
IVF/ICSI when it offers a meaningful advantage → integrate responsible Unani
supportive care without wasting reproductive time.**

My most important message is:

Fertility treatment should not be “IVF for everyone.”

And equally:

it should not be “avoid IVF at any cost.”

The best fertility care lies between these extremes:

accurate diagnosis, rational escalation and individualized treatment.

About the Author

Dr. Nizamuddin Qasmi

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

Qualifications & Professional Training

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



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Dr. Nizamuddin Qasmi is a well-qualified physician with a **specialized clinical focus on Sexual Disorders & Infertility** at Saira Health Care.

His clinical work integrates assessment of:

male infertility,
female infertility,
abnormal semen analysis,
oligospermia,
azoospermia,
ovulation disorders,
tubal-factor infertility,
reproductive infections,
erectile dysfunction,
ejaculation disorders,
painful intercourse,
performance anxiety affecting conception.

His fertility-treatment philosophy is based on:

diagnosis before escalation.

Depending upon the couple, evaluation may include:

menstrual and ovulatory assessment,
ovarian reserve where appropriate,
pelvic ultrasound,
tubal evaluation,
semen analysis,
male reproductive examination,
hormonal investigation,
sexual-function assessment.

The couple can then be counselled about whether their most reasonable pathway is:

natural conception/timed intercourse,



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IUI,

or:

IVF/ICSI.

Where clinically appropriate, individualized Unani supportive treatment may also be integrated to support:

nutritional wellbeing,

digestive health,

metabolic health,

menstrual wellbeing,

male reproductive wellbeing,

sexual health.

At **Saira Health Care**, the objective is not to push the couple toward the most complex treatment.

Nor is it to keep the couple on low-intensity treatment indefinitely.

The objective is to determine:

What is preventing conception?

Can it be corrected?

Is natural conception still realistic?

Is IUI likely to add meaningful benefit?

Would IVF save important reproductive time?

Is ICSI actually indicated?

and:

How can evidence-based fertility medicine and responsible Unani supportive care be integrated for this particular couple?

Medical Disclaimer

This article is intended for professional education and general public awareness. It does not replace individualized assessment by an appropriately qualified gynecologist, reproductive-medicine specialist, male-reproductive specialist/urologist or ART centre.



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Timed intercourse, IUI, IVF and ICSI have different indications and should not be selected solely on the basis of cost, convenience or advertising.

Timed intercourse and IUI generally require functional tubal anatomy for sperm and egg to meet naturally.

Bilateral tubal obstruction usually requires another fertility strategy, commonly IVF when clinically appropriate.

IUI success depends on multiple factors including:

female age,

cause of infertility,

sperm quality after preparation,

ovarian response.

Repeated IUI should not be continued indefinitely when prognosis is poor.

IVF does not guarantee:

fertilization,

embryo formation,

implantation,

pregnancy,

live birth.

ICSI should be used when clinically indicated and should not automatically be assumed to be superior to conventional IVF fertilization in every couple.

Ovarian-stimulation medication can increase the risks of:

multiple pregnancy,

ovarian hyperstimulation syndrome.

Treatment should therefore be appropriately monitored.

Unani medicine may be incorporated as supportive integrative care in selected patients, but it should not replace or delay clinically indicated treatment for:

bilateral severe tubal disease,

hydrosalpinx requiring appropriate management,

severe male-factor infertility,



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genetic reproductive disorders,

advanced age-related fertility decline,

other conditions requiring ART.

All herbal, Unani and nutritional products should be disclosed to the fertility team during IUI or IVF because pregnancy-safety and drug-interaction data may vary.

No fertility treatment—including timed intercourse, Unani treatment, IUI, IVF or ICSI—can guarantee pregnancy or live birth.



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