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

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Introduction: "Doctor, Why Am I Not Getting Pregnant?"

When a woman or couple comes to me after months or years of trying for pregnancy, one of the most common questions I hear is:

"Doctor, all I want to know is why I am not conceiving."

Another patient may say:

"My periods are regular, so how can I have infertility?"

A woman with PCOS may ask:

"If I make my periods regular, will I definitely become pregnant?"

Another patient may arrive holding an AMH report and say:

"Doctor, my AMH is low. Does this mean pregnancy is impossible?"

And many couples reach us after years of treatment in which only the woman was investigated while the male partner never had even a basic semen analysis.

The first thing I explain is:

Female infertility is not one disease.

Pregnancy requires many biological steps to occur correctly:

- a healthy egg must develop,

- ovulation must occur,
- sperm must be available,
- at least one fallopian tube generally needs to allow sperm and egg to meet,
- fertilization must occur,
- the embryo must travel to the uterus,
- the uterine cavity and endometrium must be suitable for implantation.

A problem at any of these stages can reduce the chance of pregnancy.

The World Health Organization 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 **1 in 6 people worldwide** experience infertility during their lifetime.

This means infertility should not automatically be considered:

“the woman's problem.”

Male factors, female factors, combined factors and unexplained infertility all occur.

At **Saira Health Care**, I therefore prefer:

couple-based fertility evaluation

rather than treating one partner in isolation.

Female Infertility Is Different From Recurrent Miscarriage

This distinction is important.

Infertility

Means difficulty:

achieving pregnancy.

Recurrent Pregnancy Loss

Means pregnancy occurs but is repeatedly lost.

These are related reproductive problems, but:

they are not the same diagnosis.

A woman who conceives repeatedly but miscarries needs a different investigation pathway from a woman who has never become pregnant.

Primary and Secondary Female Infertility

Female infertility can be:

Primary Infertility

A pregnancy has never previously been achieved.

Secondary Infertility

Difficulty achieving another pregnancy after a previous conception.

WHO recognizes both primary and secondary infertility.

Secondary infertility is often underestimated because patients think:

"I already have one child, so fertility cannot be the problem."

But fertility can change because of:

- age,
- ovulation changes,
- tubal infection,
- pelvic surgery,
- endometriosis,
- diminished ovarian reserve,
- changes in the male partner's fertility.

When Should a Woman Seek Infertility Evaluation?

For women without an obvious fertility problem, ASRM recommends beginning infertility evaluation:

Under 35 years

after:

12 months

of regular unprotected intercourse without pregnancy.

Age 35 years or above

after:

6 months.

Over 40 years

a more immediate fertility evaluation may be appropriate.

Evaluation should begin sooner—without waiting 6 or 12 months—when there is already a known risk factor such as:

- very irregular periods,
- absent menstruation,
- suspected tubal disease,
- known endometriosis,
- previous pelvic infection,
- previous chemotherapy or radiation,
- diminished ovarian reserve risk,
- known male-factor infertility,
- significant sexual dysfunction.

How Does Normal Conception Occur?

To understand infertility, I like patients to understand the normal sequence first.

Step 1: Follicle Development

Inside the ovary, several follicles begin developing during the menstrual cycle.

Usually one becomes the:

dominant follicle

containing the egg most likely to ovulate.

Step 2: Ovulation

The mature egg is released from the ovary.

This is:

ovulation.

Without ovulation, natural fertilization cannot occur.

Step 3: Tubal Pickup

The end of the fallopian tube attempts to collect the released egg.

The egg then moves into the tube.

Step 4: Sperm Transport

After intercourse, sperm travel through:

- vagina,
- cervix,
- uterus,
- fallopian tube.

Step 5: Fertilization

Sperm and egg normally meet in the fallopian tube.

One sperm fertilizes the egg.

Step 6: Embryo Development

The fertilized egg divides repeatedly while moving toward the uterus.

Step 7: Implantation

The embryo reaches the uterine cavity and implants in the:

endometrium.

A problem at any point may reduce pregnancy chances.

Main Causes of Female Infertility

The major causes can broadly be divided into:

1. Ovulation disorders

2. Age-related decline
3. Diminished ovarian reserve
4. Polycystic ovary syndrome
5. Primary ovarian insufficiency
6. Tubal disease
7. Endometriosis
8. Uterine abnormalities
9. Cervical factors
10. Endocrine disease
11. Lifestyle/metabolic factors
12. Sexual factors
13. Treatment-related infertility
14. Unexplained infertility

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1. Ovulation Disorders

Ovulatory dysfunction is one of the most important female infertility causes.

ASRM notes that ovulatory dysfunction is identified in roughly:

15% of infertile couples

and may account for up to approximately:

40% of female infertility.

Possible causes include:

- PCOS,
- obesity,
- significant weight loss,
- excessive exercise,
- hypothalamic dysfunction,
- thyroid disease,
- hyperprolactinemia,

- ovarian aging,
- primary ovarian insufficiency.

Symptoms Suggesting Ovulatory Dysfunction

Possible clues include:

- very irregular periods,
- infrequent menstruation,
- missed periods,
- cycle lengths repeatedly outside the normal range,
- excessive facial/body hair in PCOS,
- acne,
- major weight change,
- milk discharge from breasts when not breastfeeding.

However:

a woman can sometimes have a reproductive problem despite apparently regular periods.

Do Regular Periods Mean Ovulation Is Always Normal?

In most women with regular predictable cycles of approximately:

21–35 days

ovulation is very likely, and ASRM states that additional routine testing to confirm ovulation is usually unnecessary unless other findings—such as hirsutism—raise concern.

This can prevent unnecessary hormone testing.

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2. PCOS and Female Infertility

Polycystic ovary syndrome—PCOS—is one of the most common causes of:

anovulatory infertility.

Women may experience:

- irregular periods,

- infrequent ovulation,
- excess androgen symptoms,
- acne,
- unwanted hair growth,
- metabolic problems,
- insulin resistance.

But an important point is:

PCOS does not mean permanent infertility.

Many women with PCOS can achieve pregnancy naturally or with appropriate treatment.

Modern First-Line Treatment of PCOS-Related Anovulatory Infertility

The **2023 International Evidence-Based PCOS Guideline** recommends:

letrozole as first-line pharmacological ovulation induction

for infertile women with PCOS and anovulation when no other infertility factor is present.

The **WHO 2025 infertility guideline** similarly suggests:

letrozole over clomiphene citrate or metformin

for infertility due to PCOS-related ovulatory dysfunction.

Where letrozole cannot be used, other options may include:

- clomiphene citrate,
- metformin in selected situations,
- combined approaches.

What If Oral PCOS Treatment Fails?

WHO 2025 suggests:

gonadotropins

over laparoscopic ovarian drilling after unsuccessful oral pharmacological therapy such as:

- letrozole,
- or clomiphene plus metformin.

If appropriate pharmacological treatment remains unsuccessful, WHO suggests:

IVF

rather than simply continuing expectant management indefinitely.

This is particularly important when reproductive time matters.

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3. Female Age

Female age is one of the strongest predictors of natural fertility.

ASRM describes female age as:

the single most important predictor of fecundity.

As age increases:

- egg number declines,
- egg chromosomal abnormalities become more common,
- miscarriage risk rises,
- natural conception probability falls.

This decline becomes especially important after the mid-30s and accelerates later.

Can Medicine Reverse Egg Aging?

No current medicine can reliably:

- make a 40-year-old egg biologically 25 years old,
- restore the original ovarian egg pool.

Lifestyle and supportive care remain useful for health, but:

age-related egg quality decline cannot presently be reversed by herbal, Unani, hormonal or supplement therapy.

This is why unnecessary delay should be avoided.

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4. Diminished Ovarian Reserve

Ovarian reserve refers mainly to:

the remaining quantity of oocytes.

Tests commonly used include:

- AMH,
- antral follicle count,
- early-cycle FSH and estradiol.

But this subject is frequently misunderstood.

Low AMH Does Not Mean "No Pregnancy"

AMH is useful mainly for estimating:

- ovarian reserve,
- expected response to ovarian stimulation,
- probable egg yield during IVF.

ASRM emphasizes that ovarian reserve tests are good predictors of:

oocyte quantity and treatment response

but poor independent predictors of:

natural reproductive potential.

Therefore:

low AMH does not automatically mean natural pregnancy is impossible.

Likewise:

high AMH does not guarantee pregnancy.

Age remains more important for predicting reproductive success.

Can AMH Tell Egg Quality?

Not directly.

AMH mainly reflects:

egg quantity

rather than egg genetic quality.

A younger woman with low AMH may still have relatively good-quality remaining oocytes.

An older woman may have higher AMH but greater age-related chromosomal risk.

Can Treatment Permanently Increase the Egg Reserve?

There is currently no established treatment proven to:

create a new normal ovarian egg reserve

in routine clinical practice.

Claims such as:

"This medicine permanently increases egg number"

should therefore be treated cautiously.

Treatment should focus on:

- making appropriate use of the remaining ovarian reserve,
- correcting associated reproductive problems,
- not wasting reproductive time.

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5. Primary Ovarian Insufficiency

Primary ovarian insufficiency means reduced or intermittent ovarian function at a younger-than-expected age.

It may involve:

- irregular or absent menstruation,
- raised gonadotropins,
- low estrogen,
- reduced fertility.

Causes can include:

- genetic conditions,
- autoimmune disease,
- chemotherapy,
- radiation,
- surgery,
- unexplained causes.

This is not the same as ordinary PCOS.

Treatment and reproductive counselling are completely different.

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6. Fallopian-Tube Disease

Healthy fallopian tubes play an essential role in natural conception.

Tubal infertility may result from:

- blockage,
- scarring,
- adhesions,
- hydrosalpinx,
- damage to fimbriae.

WHO lists tubal disorders among the important causes of female infertility and notes associations with:

- untreated sexually transmitted infections,
- postpartum infection,
- pelvic infection,
- abdominal/pelvic surgery.

Genital Tuberculosis

In regions where tuberculosis is prevalent, genital TB can be an important cause of:

- tubal damage,
- endometrial damage,
- infertility.

It should be considered particularly when clinical history or imaging raises suspicion.

Unnecessary empirical TB treatment, however, should be avoided without appropriate evaluation.

Hydrosalpinx

A hydrosalpinx is a fallopian tube that has become:

- blocked,
- dilated,
- filled with fluid.

Hydrosalpinx can adversely affect:

- natural conception,
- IVF implantation.

WHO 2025 suggests:

salpingectomy or tubal occlusion before IVF

rather than relying on aspiration alone for women with hydrosalpinx.

Can Blocked Tubes Be Reopened With Medicine?

This question is extremely important.

A completely scarred or anatomically damaged fallopian tube should not be assumed to reopen simply with:

- herbal medicine,
- oral medication,
- supplements.

The treatment depends on:

- site of blockage,
- degree of damage,
- age,
- other fertility factors.

WHO 2025 suggests:

Women under 35 with mild-to-moderate tubal disease

selected surgery may be considered before IVF.

Women under 35 with severe tubal disease

IVF is generally favored.

Women 35 or older with tubal disease

WHO generally suggests IVF rather than tubal surgery.

This is a very important age-dependent treatment distinction.

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7. Endometriosis

Endometriosis occurs when tissue similar to endometrium grows outside the uterus.

Possible symptoms include:

- painful periods,
- chronic pelvic pain,
- painful intercourse,
- infertility,
- ovarian endometrioma.

Endometriosis can affect fertility through:

- pelvic adhesions,
- distorted anatomy,
- ovarian involvement,
- inflammatory mechanisms.

Does Hormonal Suppression Cure Endometriosis-Related Infertility?

Hormonal medicines can be effective for:

endometriosis pain.

But treatment that suppresses ovulation does not generally improve fertility while a woman is actively trying to conceive.

ESHRE and ASRM guidance therefore do not support hormonal suppression simply to improve spontaneous pregnancy rates in infertile women with endometriosis.

Does Every Endometrioma Need Surgery Before IVF?

No.

ESHRE specifically recommends against routinely operating on an ovarian endometrioma before ART simply to improve live birth because:

- clear benefit has not been demonstrated,
- surgery may reduce ovarian reserve.

Surgery may still be considered for:

- significant pain,
- suspicious findings,
- difficulty accessing follicles,
- other individualized reasons.

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8. Uterine Causes of Infertility

Potential uterine abnormalities include:

- endometrial polyps,
- submucosal fibroids,
- intrauterine adhesions,
- congenital abnormalities,
- adenomyosis,
- uterine cavity distortion.

Transvaginal ultrasound is usually the starting imaging test.

Depending on findings, further evaluation may include:

- saline infusion sonography,
- 3D ultrasound,
- hysteroscopy.

ASRM recommends ultrasound-based and cavity-directed investigation rather than performing invasive procedures indiscriminately.

WHO 2025 suggests saline infusion sonohysterography or appropriately available 3D ultrasound when a uterine cavity disorder is suspected.

Uterine Septum: Surgery Is Not Automatically Required

An interesting update from WHO 2025 is that for infertile women with:

- uterine septum,

- but no history of recurrent pregnancy loss,

WHO suggests that hysteroscopic septum resection:

should not routinely be performed solely for infertility.

This illustrates why:

not every anatomical abnormality automatically requires surgery.

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9. Intrauterine Adhesions

Adhesions—sometimes called:

Asherman syndrome

may develop after:

- uterine surgery,
- curettage,
- infection,
- pregnancy-related uterine procedures.

They may cause:

- light periods,
- absent periods,
- infertility,
- recurrent pregnancy problems.

Hysteroscopic treatment may be necessary when clinically significant.

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10. Fibroids

Fibroids are common and many women with fibroids conceive normally.

Their fertility significance depends on:

- size,
- location,
- whether they distort the uterine cavity.

Submucosal fibroids or other lesions that significantly alter the cavity may be more important than small outer-wall fibroids.

Therefore:

the presence of a fibroid does not automatically mean it caused infertility.

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11. Endocrine Disorders

Several hormonal conditions can affect ovulation.

Thyroid Disease

Both:

- hypothyroidism,
- hyperthyroidism

may affect menstrual and reproductive function.

ASRM includes TSH in the endocrine assessment when clinically appropriate.

Hyperprolactinemia

Elevated prolactin can suppress:

- GnRH,
- ovulation.

It may cause:

- irregular menstruation,
- absent periods,
- milk discharge.

WHO 2025 suggests:

cabergoline over bromocriptine

for infertility due to ovulatory dysfunction from hyperprolactinemia.

Treatment must first establish that prolactin is genuinely elevated and identify the cause.

Hypothalamic Amenorrhea

Ovulation may stop when the brain reduces reproductive hormone signaling because of:

- severe calorie restriction,
- very low body weight,
- excessive exercise,
- major stress,
- chronic illness.

Treatment focuses on correcting:

- energy deficiency,
- nutritional status,
- excessive exercise,

and fertility therapy when needed.

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12. Obesity and Metabolic Health

Obesity can affect:

- ovulation,
- PCOS,
- insulin resistance,
- pregnancy risks.

WHO 2025 and the international PCOS guideline recommend:

- healthy diet,
- physical activity,
- weight management where clinically appropriate.

This does not mean a woman should be blamed for infertility because of body weight.

Weight is simply one possible modifiable biological factor among many.

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13. Being Underweight

Very low body weight can also reduce fertility.

It may suppress:

- hypothalamic reproductive hormones,
- ovulation,
- estrogen.

Therefore the goal is:

healthy reproductive nutrition

rather than simply “lose weight.”

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14. Smoking

Smoking can negatively affect reproductive health and is one of the preventable fertility risk factors emphasized by WHO's 2025 infertility guideline.

Stopping tobacco is appropriate for:

- female fertility,
- male fertility,
- pregnancy health.

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15. Alcohol and Recreational Drugs

Heavy alcohol intake and recreational drug use can affect:

- general health,
- endocrine function,
- pregnancy safety.

A fertility plan should include honest discussion of these factors without judgment.

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16. Sexual Factors

Pregnancy may be reduced because of:

- infrequent intercourse,
- vaginismus,
- painful intercourse,

- erectile dysfunction in the partner,
- ejaculation problems,
- poorly timed intercourse.

Sexual-health problems therefore deserve assessment alongside reproductive testing.

This is particularly relevant at **Saira Health Care**, where our clinical focus includes both:

sexual disorders and infertility.

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17. Cancer Treatment and Fertility

Chemotherapy, radiation and ovarian surgery may reduce ovarian reserve or damage reproductive organs.

Where possible, women facing gonadotoxic treatment should receive fertility-preservation counselling before treatment.

Potential options may include:

- egg freezing,
- embryo freezing,
- other specialist fertility-preservation strategies.

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18. Unexplained Infertility

Sometimes:

- ovulation appears normal,
- tubes are open,
- uterine assessment is satisfactory,
- semen analysis is adequate,

yet pregnancy does not occur.

This is:

Unexplained Infertility

which is a diagnosis of exclusion.

It does not mean:

“nothing is wrong.”

It means standard testing has not identified a specific cause.

ESHRE's unexplained-infertility guideline emphasizes that evidence for many unnecessary add-on tests is weak or very low quality.

Modern Treatment of Unexplained Infertility

WHO 2025 recommends a stepwise approach.

After unsuccessful expectant management, stimulated IUI using:

- letrozole,
- or clomiphene citrate

may be considered rather than gonadotropin-stimulated IUI.

If stimulated IUI remains unsuccessful:

IVF may be appropriate.

An important WHO update is that in unexplained infertility with no male-factor indication:

routine ICSI should not automatically be added to IVF.

WHO recommends conventional IVF rather than IVF plus ICSI after failed stimulated IUI when there is no male-factor reason for ICSI.

Symptoms of Female Infertility

The main symptom is:

difficulty achieving pregnancy.

But underlying diseases may produce additional clues.

These can include:

- irregular menstruation,
- absent periods,
- very painful periods,
- heavy menstrual bleeding,
- abnormal hair growth,
- acne,
- pelvic pain,

- painful intercourse,
- abnormal vaginal discharge,
- milk discharge from breasts,
- symptoms of thyroid disease,
- hot flushes at a young age.

However:

many infertile women have no obvious symptoms at all.

How Female Infertility Is Diagnosed

A good infertility evaluation should be:

- systematic,
- efficient,
- as non-invasive as possible,
- individualized.

ASRM specifically recommends beginning with the least invasive methods that identify common causes.

Step 1: Evaluate the Couple Together

One of my strongest recommendations is:

do not investigate only the woman.

When a male partner is contributing sperm, semen analysis should usually be performed as part of the initial evaluation.

Step 2: Detailed History

I ask about:

- age,
- duration of infertility,
- previous pregnancies,
- menstrual cycle,

- previous miscarriages,
- pelvic pain,
- sexual function,
- previous infections,
- pelvic operations,
- contraception history,
- tuberculosis risk,
- medications,
- chemotherapy/radiation,
- family history,
- lifestyle.

Step 3: Menstrual and Ovulation Assessment

A regular 21–35-day cycle often indicates ovulation.

If cycles are irregular, evaluation may include:

- pregnancy testing,
- thyroid testing,
- prolactin where appropriate,
- PCOS evaluation,
- other endocrine testing.

Step 4: Ultrasound

Transvaginal ultrasound can assess:

- ovaries,
- follicles,
- endometrium,
- fibroids,
- ovarian cysts,

- endometriomas,
- uterine structure.

It may also provide:

antral follicle count.

Step 5: Ovarian Reserve

Tests may include:

- AMH,
- antral follicle count,
- FSH with estradiol.

But I again emphasize:

ovarian reserve testing guides treatment; it does not give a simple yes/no answer about whether a woman can conceive.

Step 6: Tubal Patency

The tubes may be assessed with:

- hysterosalpingography – HSG,
- hysterosalpingo-contrast sonography,
- related contrast imaging.

ASRM considers HSG or sonographic methods appropriate initial tests for tubal patency.

Step 7: Uterine Cavity Evaluation

Depending on clinical findings:

- transvaginal ultrasound,
- saline sonography,
- 3D ultrasound,
- hysteroscopy

may be considered.

Step 8: Laparoscopy Is Not Routine for Every Infertile Woman

Older infertility practice sometimes involved diagnostic laparoscopy very early.

Modern guidance is more selective.

ASRM states that laparoscopy should not be routinely performed in every infertile woman without:

- suspected pelvic pathology,
- significant pain,
- another surgical indication.

Step 9: Male Partner Semen Analysis

The male partner's semen should be assessed for:

- concentration,
- motility,
- morphology,
- volume,
- other clinically relevant findings.

Female infertility treatment cannot be planned rationally without considering male fertility.

Tests That Should Not Be Ordered Automatically

More testing does not always equal better fertility care.

ASRM does not recommend routine use of tests such as:

- postcoital testing,
- immunological testing,
- thrombophilia panels,
- endometrial biopsy,
- diagnostic laparoscopy,

without a specific indication.

This prevents unnecessary costs and confusion.

Modern Treatment of Female Infertility

There is no universal female-infertility medicine.

Treatment depends on:

the cause.

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1. Lifestyle and Preconception Care

Useful general measures include:

- no smoking,
- balanced diet,
- physical activity,
- appropriate weight management,
- adequate sleep,
- control of diabetes,
- treatment of thyroid disease,
- reducing harmful substance use.

WHO 2025 emphasizes lifestyle and prevention as important components of fertility care.

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2. Ovulation Induction

Women who do not ovulate regularly may receive:

- letrozole,
- clomiphene citrate,
- gonadotropins,
- other cause-specific therapy

depending on the diagnosis.

In PCOS:

letrozole is now preferred first line when no other infertility factor is present.

3. Treat Endocrine Causes

This may include:

- thyroid treatment,
- hyperprolactinemia treatment,
- correction of severe energy deficiency,
- targeted endocrine therapy.

The objective is not simply to induce one period.

It is to restore:

reproductive endocrine function.

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4. Tubal Surgery

Selected younger women with limited tubal disease may benefit from:

- reconstructive surgery.

But extensive tubal damage or increasing age often makes:

IVF

more appropriate.

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5. Hysteroscopic Treatment

Selected uterine problems may be treated hysteroscopically, such as:

- significant polyps,
- intrauterine adhesions,
- cavity-distorting lesions.

But surgery should be performed because the abnormality is clinically relevant—not simply because something was visible on imaging.

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6. Endometriosis Treatment

Treatment depends on:

- age,
- pain,
- severity,
- ovarian reserve,
- tubal condition,
- duration of infertility.

Possible options include:

- selected surgery,
- IUI,
- IVF.

Hormonal suppression is generally used for pain management rather than to improve fertility while actively attempting pregnancy.

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7. IUI – Intrauterine Insemination

During IUI:

- sperm are processed,
- concentrated motile sperm are placed in the uterus around ovulation.

It may be used for:

- unexplained infertility,
- selected mild male-factor infertility,
- certain ovulatory situations,
- donor sperm treatment.

IUI requires consideration of:

- tubal patency,
- sperm quality,
- female age.

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8. IVF – In Vitro Fertilization

During IVF:

1. ovaries are stimulated,
2. eggs are retrieved,
3. eggs and sperm are brought together in the laboratory,
4. embryos develop,
5. an embryo is transferred to the uterus.

IVF may be particularly useful in:

- severe tubal disease,
- unsuccessful ovulation induction,
- advanced reproductive age,
- severe endometriosis,
- prolonged unexplained infertility,
- combined male/female factors.

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9. ICSI

During ICSI:

one sperm is injected directly into an egg.

ICSI is particularly useful for:

- significant male-factor infertility,
- surgically retrieved sperm,
- selected fertilization problems.

It is not automatically necessary for every case of female infertility.

WHO 2025 specifically recommends against routine ICSI addition in unexplained infertility when no male-factor indication exists.

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10. Donor Eggs

In selected situations involving:

- severe ovarian insufficiency,

- age-related ovarian failure,
- repeated inability to obtain usable eggs,

donor-oocyte IVF may be discussed.

This is a deeply personal reproductive choice requiring:

- careful counselling,
- informed consent.

The Unani Concept of Female Infertility

Classical Unani literature generally describes infertility using terms such as:

'Uqr

or infertility/barren state.

Traditional descriptions consider:

- reproductive-organ function,
- Mizaj,
- general health,
- nutrition,
- menstrual health,
- uterine health,
- constitutional factors.

Modern Unani literature continues to use **'Uqr** for infertility. Published Unani case reports and reviews use this terminology for female infertility.

However, I believe traditional terminology should be used carefully.

Modern diagnoses such as:

- bilateral hydrosalpinx,
- low AMH,
- anovulatory PCOS,
- endometriosis,
- uterine adhesions

should not be replaced by vague traditional labels once modern investigations are available.

Rahim – Uterine Health in Unani Medicine

The:

Rahim

or uterus occupies an important place in traditional Unani gynecology.

Classical treatment often considers:

- uterine strength,
- menstrual health,
- constitutional state,
- reproductive readiness.

In a contemporary integrative approach, this traditional assessment may complement—not replace—modern evaluation of:

- uterine cavity,
- endometrium,
- fibroids,
- adhesions,
- tubal disease.

Mizaj and Female Fertility

In Unani medicine:

Mizaj

refers to constitutional temperament.

I may consider factors such as:

- body constitution,
- appetite,
- digestion,
- sleep,

- activity,
- menstrual pattern,
- general vitality,
- sexual health.

However:

Mizaj should not replace ovulation testing, ultrasound, HSG or ovarian-reserve assessment when these are medically indicated.

The two systems answer different questions.

Akhlat and Modern Hormones Are Different Concepts

The Unani system traditionally describes:

- Dam,
- Balgham,
- Safra,
- Sauda.

These are part of a historical humoral framework.

They should not be directly equated with:

- estrogen,
- progesterone,
- AMH,
- FSH,
- LH,
- prolactin,
- insulin.

This distinction is important for academically responsible integrative medicine.

The Four Major Unani Treatment Modalities

CCRUM identifies four broad treatment methods:

Ilaj-bil-Ghiza

Dietotherapy

Ilaj-bit-Tadbir

Regimenal therapy

Ilaj-bid-Dawa

Pharmacotherapy

Ilaj-bil-Yad

Surgery

This is important because authentic Unani medicine is broader than simply:

“giving herbal medicine.”

Ilaj-bil-Ghiza in Female Infertility

Diet can be particularly relevant when fertility is affected by:

- PCOS,
- metabolic dysfunction,
- obesity,
- undernutrition,
- poor general health.

I may advise:

- vegetables,
- fruits,
- adequate protein,
- pulses,
- whole grains,
- nuts,
- seeds,
- healthy fats.

Diet should be individualized.

There is no one:

“fertility food”

that can:

- reopen both blocked tubes,
- reverse ovarian aging,
- cure severe endometriosis,
- guarantee pregnancy.

Ilaj-bit-Tadbir

Regimenal care may focus on:

- physical activity,
- adequate rest,
- sleep,
- stress management,
- healthy weight,
- general constitutional health.

This overlaps meaningfully with modern lifestyle recommendations for PCOS and fertility.

Ilaj-bid-Dawa

Unani pharmacotherapy may be selected according to:

- menstrual pattern,
- associated gynecological disease,
- general health,
- traditional diagnosis,
- modern fertility investigations.

Classical and contemporary Unani practice includes formulations traditionally described as:

- Mu‘in-i-Haml,
- Muqawwi-i-Rahim,

and related reproductive-support medicines.

However:

the evidence is not equally strong for every medicine or infertility diagnosis.

What Does Scientific Research on Unani Female Infertility Show?

There is some published clinical literature, but the evidence remains limited.

For example, a published case report from the **National Institute of Unani Medicine** described a woman with unexplained primary infertility who conceived after three months of Unani formulations.

The authors themselves stated that:

randomized clinical trials are still needed to establish efficacy.

Unani Treatment in Tubal Disease: Important Caution

An older NIUM case report described pregnancy in a woman with:

unilateral tubal blockage

after Unani therapy.

This is interesting, but it must be interpreted correctly.

A woman with one open tube can sometimes conceive naturally.

Therefore this single case report does **not** prove that Unani medicine physically reopened a blocked fallopian tube.

I would never use one case report to promise:

“blocked tubes will definitely open with medicine.”

Emerging Unani Research in PCOS

PCOS is an area where traditional treatment is particularly interesting because lifestyle, metabolism, menstrual irregularity and ovulatory dysfunction overlap with several classical Unani therapeutic principles.

A 2021 review involving a researcher from CCRUM discussed PCOS and infertility, and recent Unani literature continues to explore traditional approaches for reproductive and endocrine disorders.

A 2025 review from researchers associated with the National Institute of Unani Medicine also discusses the potential role of phytoestrogen-containing Unani herbs in gynecological disorders.

These publications support continued research.

But:

they do not replace the strong guideline evidence supporting letrozole as first-line ovulation induction for PCOS-related infertility.

Where Unani Medicine May Be Most Useful

In my clinical approach, Unani treatment may be especially valuable as part of individualized care when female infertility is associated with:

- irregular menstrual cycles,
- PCOS,
- poor diet,
- metabolic imbalance,
- obesity,
- undernutrition,
- general constitutional weakness,
- lifestyle problems,
- selected unexplained infertility.

The treatment plan may focus on:

- cycle health,
- reproductive nutrition,
- general health,
- weight/metabolic factors,
- sleep,
- activity,
- stress,
- individualized Unani pharmacotherapy.

Where Unani Medicine Should Not Delay Necessary Modern Treatment

This is equally important.

Unani treatment should not delay:

Severe bilateral tubal disease

where IVF may be the realistic fertility treatment.

Hydrosalpinx

where surgery/occlusion before IVF may be needed.

Advanced female reproductive age

where time is critical.

Severe diminished ovarian reserve

where prolonged empirical treatment may reduce future opportunities.

Significant uterine adhesions

where hysteroscopic treatment may be required.

Severe endometriosis

where surgery or ART may be more appropriate.

Primary ovarian insufficiency

which requires specialist reproductive and endocrine counselling.

Significant male-factor infertility

which may require ICSI.

A good integrative physician should know:

when traditional treatment is useful and when referral is more useful.

Dr. Nizamuddin Qasmi's Individualized Female-Infertility Approach

At Saira Health Care, I do not believe every infertile woman should receive one identical "pregnancy medicine."

My approach is structured.

Step 1: Establish the Couple's Fertility History

I ask:

- How long have you been trying?
- Have you conceived before?
- Were there previous miscarriages?
- Is intercourse regular?
- Is intercourse painful?
- Is there vaginismus or sexual difficulty?

Step 2: Consider Female Age Early

Age can alter the entire treatment strategy.

I do not want a woman of:

39 or 40 years

to spend several years trying treatment after treatment without understanding the importance of reproductive time.

Step 3: Understand the Menstrual Cycle

I ask:

- Are periods regular?
- How many days apart?
- Are they very painful?
- Have periods stopped?
- Is there excessive bleeding?

This helps direct the investigation.

Step 4: Assess Ovulation and PCOS

If ovulation is abnormal, I determine:

- PCOS?

- thyroid?
- prolactin?
- weight-related?
- hypothalamic?
- ovarian insufficiency?

Treatment then follows the cause.

Step 5: Evaluate Ovarian Reserve Appropriately

Where useful, I review:

- AMH,
- AFC,
- FSH/estradiol.

But I explain:

AMH is not a pregnancy score.

Step 6: Evaluate Tubal Patency

Where appropriate:

- HSG,
- contrast sonography

may be used.

This is essential before repeatedly giving ovulation medicine to a woman whose tubes may be severely damaged.

Step 7: Evaluate the Uterus

I assess for:

- fibroids,
- polyps,
- adhesions,

- congenital abnormalities,
- adenomyosis.

Step 8: Consider Endometriosis

Especially when there is:

- severe period pain,
- painful intercourse,
- chronic pelvic pain,
- endometrioma.

Step 9: Evaluate the Male Partner at the Same Time

This saves:

- time,
- money,
- emotional distress.

It is not rational to stimulate a woman's ovaries repeatedly without knowing whether the male partner has:

- azoospermia,
- severe oligozoospermia,
- poor motility.

Step 10: Correct Lifestyle and Metabolic Factors

This may include:

- smoking cessation,
- nutrition,
- physical activity,
- diabetes management,
- weight optimization,

- sleep.

Step 11: Add Individualized Unani Treatment

Where appropriate, I may integrate:

- Mizaj assessment,
- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- supervised Unani pharmacotherapy.

The aim is to:

support reproductive health and correct modifiable factors

rather than promising to reverse every structural infertility cause.

Step 12: Monitor Objective Outcomes

Treatment should be assessed through:

- cycle regularity,
- evidence of ovulation,
- ultrasound when needed,
- hormone results,
- pregnancy outcome.

A patient saying:

“I feel healthier”

is valuable—but it does not prove:

- blocked tubes opened,
- AMH increased meaningfully,
- ovulation normalized.

Step 13: Use Guideline-Supported Ovulation Treatment When Needed

For PCOS-related anovulation:

letrozole is currently preferred first line when appropriate.

Unani supportive care can still be used alongside appropriately supervised fertility treatment.

Step 14: Consider IUI at the Appropriate Time

Particularly in:

- unexplained infertility,
- selected mild reproductive problems.

Step 15: Do Not Delay IVF When Clearly Indicated

This is especially important in:

- severe tubal disease,
- hydrosalpinx after appropriate treatment,
- failed ovulation therapy,
- increasing age,
- prolonged infertility,
- combined male/female factors.

Saira Health Care's Contribution to Female Infertility

Saira Health Care's current public profile identifies the clinic's areas of work as including:

- male infertility,
- female infertility,
- PCOD/PCOS,
- irregular menstrual cycles,
- reduced AMH,
- sexual disorders.

The clinic describes its model as:

- patient-centered,

- individualized,
- based on traditional Unani assessment,
- combined with modern diagnostic understanding and lifestyle guidance.

Why Our Sexual-Health and Infertility Focus Matters

Female infertility may overlap with:

- painful intercourse,
- vaginismus,
- low libido,
- relationship anxiety,
- male sexual dysfunction.

For example, a woman may undergo years of:

- hormone tests,
- ultrasound,
- medicines

when the real barrier to conception is:

inability to complete intercourse because of vaginismus.

A clinic familiar with both sexual health and fertility can identify this difference.

About Dr. Nizamuddin Qasmi

I am **Dr. Nizamuddin Qasmi**, Founder and Chief Physician of **Saira Health Care**, with a 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 public physician profile lists:

- BUMS,
- MD,
- CGO,
- Certificate in Infertility,
- Certificate in Urology – London, UK,

and describes my focused work involving male and female sexual disorders and infertility.

Saira Health Care's current published professional material additionally lists:

- **Masters in Male Infertility – MasterHealthPro (HealthPro)**
- **Integrated Sexual and Reproductive Health – ISRH, UNFPA**.

Success Rates in Female Infertility

Patients often ask:

“Doctor, what is your success rate?”

This cannot be answered responsibly with one percentage.

Compare:

Patient A

Age 24, PCOS-related anovulation, open tubes, normal semen.

Patient B

Age 39, very low ovarian reserve, severe bilateral tubal damage.

Patient C

Age 30, normal evaluation, unexplained infertility.

Patient D

Age 32, severe male-factor infertility requiring ICSI.

All are “infertility patients.”

But their prognosis is completely different.

Therefore:

there is no scientifically meaningful universal cure rate for female infertility.

Success depends on:

- age,
- cause,
- ovarian reserve,
- sperm quality,
- duration of infertility,
- treatment used.

How Success Stories Should Be Presented

A responsible fertility success story should ideally include:

1. age,
2. duration of infertility,
3. primary or secondary infertility,
4. menstrual/ovulation diagnosis,
5. ovarian reserve where relevant,
6. tubal status,
7. male partner semen status,
8. treatment given,
9. duration,
10. whether conception was natural, IUI or IVF,
11. pregnancy/live birth outcome,
12. patient consent.

This gives patients:

realistic hope rather than advertising claims.

Psychological Impact of Female Infertility

Infertility can cause:

- sadness,
- guilt,
- anxiety,
- depression,
- relationship strain,
- family pressure,
- social stigma.

WHO's 2025 infertility guideline highlights the major:

- emotional,
- psychological,
- financial

burden infertility can create.

I often remind patients:

Infertility is a medical condition—not a measure of a woman's value.

A woman should not be blamed because pregnancy has not occurred.

Common Myths About Female Infertility

Myth 1: Infertility is mainly a female problem.

Fact: Male, female, combined and unexplained causes all occur.

Myth 2: Regular periods guarantee fertility.

Fact: Regular cycles suggest ovulation, but tubal, uterine, endometriosis or male factors may still prevent pregnancy.

Myth 3: Irregular periods mean pregnancy is impossible.

Fact: Many ovulatory disorders—particularly PCOS—are treatable.

Myth 4: PCOS means permanent infertility.

Fact: Many women with PCOS conceive naturally or after ovulation treatment.

Myth 5: Metformin is the best first-line fertility medicine for every PCOS woman.

Fact: Current WHO and international guidelines prefer **letrozole** as first-line pharmacological ovulation induction when PCOS-related anovulation is the only infertility factor.

Myth 6: Low AMH means pregnancy is impossible.

Fact: AMH mainly predicts ovarian response and egg quantity; it does not independently determine the possibility of natural pregnancy.

Myth 7: AMH tells egg quality.

Fact: Age is more important for egg-quality-related prognosis.

Myth 8: High AMH guarantees fertility.

Fact: High AMH may occur in PCOS and does not guarantee ovulation or pregnancy.

Myth 9: Every blocked tube can be opened by medicine.

Fact: Significant structural tubal damage may require surgery or IVF.

Myth 10: Every fibroid causes infertility.

Fact: Fertility impact depends primarily on size and location.

Myth 11: Every endometrioma must be removed before IVF.

Fact: ESHRE advises against routine surgery solely to improve ART live-birth outcomes because surgery may reduce ovarian reserve.

Myth 12: Endometriosis hormones improve fertility while trying to conceive.

Fact: Hormonal suppression is useful for symptoms but generally does not improve fertility while ovulation is suppressed.

Myth 13: Every infertile woman needs laparoscopy.

Fact: ASRM does not recommend routine diagnostic laparoscopy without a clinical indication.

Myth 14: IVF always needs ICSI.

Fact: ICSI is mainly for specific indications such as male-factor infertility; WHO does not recommend routine ICSI for unexplained infertility without a male-factor reason.

Myth 15: Unani medicine has no role in female infertility.

Fact: Unani medicine can contribute through individualized diet, lifestyle, menstrual and general reproductive-health support. Small case-based Unani publications also exist, but stronger controlled studies are needed.

Myth 16: Unani medicine can cure every female infertility cause.

Fact: No medical system can honestly claim that.

Severe tubal damage, advanced ovarian aging and major anatomical disease may require surgery or assisted reproduction.

Frequently Asked Questions

What is female infertility?

It is infertility in which one or more female reproductive factors contribute to failure to achieve pregnancy.

How long should we try before seeking help?

Usually:

- under 35: 12 months,
- 35 or older: 6 months,

- over 40: earlier evaluation may be appropriate.

Should I wait if my periods are very irregular?

No.

Known ovulatory dysfunction is a reason for earlier evaluation.

What are the most common causes?

Important causes include:

- ovulatory dysfunction,
- PCOS,
- age,
- tubal disease,
- endometriosis,
- uterine factors,
- ovarian reserve problems.

Can PCOS infertility be treated?

Yes.

Lifestyle management and ovulation induction are highly important.

Current guidelines recommend letrozole first line in appropriate anovulatory PCOS infertility.

Can low AMH improve?

AMH can fluctuate and may change somewhat between tests, but there is no established therapy that reliably restores a depleted ovarian egg pool.

The clinically important goal is usually:

appropriate fertility planning.

Does low AMH mean no natural pregnancy?

No.

AMH alone is a poor predictor of unassisted conception.

Can one open tube result in pregnancy?

Yes.

Natural pregnancy can occur when one functional tube is open, assuming:

- ovulation,
- sperm,
- other factors

are favorable.

Can bilateral blocked tubes cause infertility?

Yes.

When both tubes are truly blocked or severely damaged, natural sperm-egg meeting becomes difficult or impossible.

IVF may bypass the fallopian tubes.

Can hydrosalpinx affect IVF?

Yes.

WHO recommends treating hydrosalpinx with salpingectomy or tubal occlusion before IVF when appropriate.

Can endometriosis cause infertility?

Yes.

It can affect pelvic anatomy, ovaries, tubes and the reproductive environment.

Can fibroids cause infertility?

Some can—especially those distorting the uterine cavity.

Many women with fibroids conceive without difficulty.

Can thyroid problems cause infertility?

They can contribute to ovulatory and menstrual problems.

Can high prolactin cause infertility?

Yes.

It can suppress ovulation.

Do both partners need evaluation?

Yes.

When a male partner is contributing to pregnancy, semen analysis should normally be considered early.

Is IUI the same as IVF?

No.

IUI

Places prepared sperm inside the uterus.

IVF

Retrieves eggs and fertilizes them in a laboratory.

When is IVF useful?

Examples include:

- severe tubal disease,
- failed simpler therapy,
- age-related urgency,
- severe endometriosis,
- combined fertility factors.

Can Unani medicine help female infertility?

It may offer meaningful supportive treatment through:

- diet,
- lifestyle,
- menstrual-health support,
- PCOS/metabolic management,
- individualized traditional pharmacotherapy.

Its role depends entirely on the cause of infertility.

Can Unani medicine open every blocked fallopian tube?

There is no high-quality evidence supporting that claim.

Structural tubal disease must be assessed through appropriate imaging and fertility planning.

Can Unani medicine increase AMH permanently?

There is currently insufficient high-quality evidence to claim that Unani therapy can recreate depleted ovarian reserve or guarantee a sustained rise in functional egg number.

Can Unani medicine help PCOS?

Unani lifestyle and individualized care may be useful supportive components for:

- menstrual health,
- diet,
- metabolic health.

But current guideline-supported ovulation induction should not be delayed when pregnancy is the immediate goal.

Is female infertility curable?

Many causes are:

- treatable,

- manageable,
- or can be bypassed with assisted reproductive technology.

But the word:

“cure”

depends on the underlying disease.

Latest Scientific Perspective: 2025–2026

Female infertility care has received one of its biggest recent updates through:

WHO's first global infertility guideline

published on **28 November 2025**.

The guideline contains recommendations addressing:

- diagnosis,
- ovulatory infertility,
- tubal disease,
- uterine disorders,
- male infertility,
- unexplained infertility,
- IUI,
- IVF.

PCOS: Letrozole Is Now Firmly Established as First Line

The WHO 2025 guideline and the 2023 international PCOS guideline both support:

letrozole

as preferred first-line pharmacological ovulation induction for appropriate women with PCOS-related anovulatory infertility.

This is one of the most important current treatment updates for female infertility.

Tubal Treatment Is Now More Age-Specific

WHO's 2025 recommendations explicitly distinguish:

- younger women with mild tubal disease,
- severe tubal disease,
- women 35 years or older.

This makes fertility treatment more individualized rather than assuming all blocked tubes should receive the same surgery.

Unnecessary Procedures Are Being Reduced

Modern fertility medicine increasingly discourages:

- routine laparoscopy,
- unnecessary immunological testing,
- indiscriminate endometrial biopsy,
- unnecessary ICSI,
- routine endometrioma surgery before IVF.

This improves:

- safety,
- cost effectiveness,
- evidence-based care.

Fertility Treatment Is Becoming More Couple-Centered

WHO and ASRM increasingly emphasize:

parallel evaluation of both partners.

This reduces one of the most common fertility-care mistakes:

months or years of treatment of the woman without properly evaluating the man.

My Final Message to Women Facing Infertility

If you are having difficulty conceiving, please do not immediately conclude:

“I will never become a mother.”

And do not accept:

“Your AMH is low, so there is no chance.”

Likewise, do not accept:

“Take this medicine and every blocked tube will open.”

Instead ask:

How old am I?

Am I ovulating?

Are my periods regular?

Do I have PCOS?

What does my AMH actually mean for my age?

What is my antral follicle count?

Are my fallopian tubes open?

Do I have hydrosalpinx?

Is my uterus normal?

Could I have endometriosis?

Is my thyroid normal?

Is prolactin relevant?

Has my husband had semen analysis?

Can lifestyle and individualized Unani treatment improve my reproductive health?

Should I use ovulation induction?

Should we try IUI?

Is IVF now more appropriate than waiting?

These questions lead to rational fertility care.

Conclusion

Female infertility is a complex reproductive condition in which one or more female factors contribute to failure to achieve pregnancy.

Major causes include:

- ovulatory dysfunction,
- PCOS,
- age-related reproductive decline,
- diminished ovarian reserve,
- ovarian insufficiency,
- fallopian-tube disease,
- hydrosalpinx,
- endometriosis,
- uterine abnormalities,
- endocrine disease,
- metabolic factors,
- unexplained infertility.

The standard evaluation should generally assess:

ovulation, reproductive anatomy/tubal patency, and the male partner's semen at the same time.

Age matters greatly.

Evaluation should usually begin after:

- **12 months if under 35**
- **6 months if 35 or older**

and earlier when known infertility risk factors exist.

AMH and AFC are useful ovarian-reserve tools, particularly for predicting ovarian response during treatment, but:

low AMH alone does not mean pregnancy is impossible.

For PCOS-related anovulatory infertility:

letrozole is currently preferred first-line pharmacological treatment in appropriate women.

For severe tubal disease—particularly with increasing maternal age:

IVF may offer a more realistic route than reconstructive surgery.

For hydrosalpinx:

salpingectomy or tubal occlusion before IVF may improve the treatment pathway.

For unexplained infertility:

- expectant management,
- stimulated IUI,
- then IVF

may be used in a stepwise manner, and ICSI should not automatically be added when no male-factor indication exists.

The **Unani system of medicine** can provide meaningful individualized supportive care through:

- Mizaj-based assessment,
- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- supervised Ilaj-bid-Dawa,
- menstrual-health support,
- nutrition,
- lifestyle,
- metabolic optimization,
- general reproductive-health care.

Classical and contemporary Unani literature describes female infertility as:

‘Uqr

and some published case reports describe conception following Unani treatment in selected women.

However:

case reports are not proof of a universal cure.

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

- reopen every blocked fallopian tube,
- reverse age-related egg decline,
- restore depleted ovarian reserve,
- cure severe endometriosis,
- or replace IVF when IVF is medically indicated.

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

Evaluate both partners.

Understand female age and reproductive time.

Confirm whether ovulation occurs.

Diagnose PCOS correctly.

Interpret AMH responsibly.

Check the fallopian tubes where indicated.

Assess the uterus and endometrium.

Consider endometriosis.

Treat endocrine disease.

Correct lifestyle and metabolic factors.

Use individualized Unani care where appropriate.

Use guideline-supported ovulation induction when needed.

Use IUI when suitable.

Proceed to IVF without unnecessary delay when the fertility situation requires it.

And never guarantee pregnancy from one medicine, one laboratory result or one treatment system.

For every woman who asks me:

“Doctor, can my infertility be treated?”

my answer is:

Many causes of female infertility are treatable, and many others can be successfully managed with modern fertility techniques. The most important step is to identify the true cause early, evaluate both partners, use Unani medicine responsibly where it can support reproductive health, and move to modern fertility treatment without unnecessary delay when that offers the better chance of pregnancy.

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About the Author

Dr. Nizamuddin Qasmi

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

Professional Education & 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**

Saira Health Care's published profile identifies Dr. Nizamuddin Qasmi's focused clinical work as involving **male and female sexual disorders and infertility**, including PCOS, irregular menses and reproductive-health problems.

Medical Disclaimer

This article is intended for:

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

It is not a substitute for:

- individual consultation,
- gynecological examination,
- pregnancy testing,
- ultrasound,
- ovarian-reserve evaluation,
- tubal testing,
- endocrine testing,
- semen analysis,
- reproductive endocrinology consultation,
- fertility surgery,
- IUI,
- IVF.

Do not independently start:

- letrozole,
- clomiphene,
- metformin,
- gonadotropins,
- progesterone,
- cabergoline,
- thyroid medicines,
- fertility hormones,
- Unani medicines,
- herbal medicines,
- supplements

without appropriate professional supervision.

Do not delay specialist fertility evaluation because of prolonged empirical or alternative treatment if:

- the woman is 35 years or older,
- AMH/ovarian reserve is significantly reduced,
- both tubes are severely damaged,
- hydrosalpinx is present,
- significant endometriosis is suspected,
- primary ovarian insufficiency is suspected,
- infertility has persisted despite treatment,
- severe male-factor infertility is present.

No modern, Unani, herbal, surgical or assisted-reproductive treatment can ethically guarantee:

- natural conception,
- IVF success,
- pregnancy,
- live birth.

Saira Health Care
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Medical literature reviewed and updated: September 2026