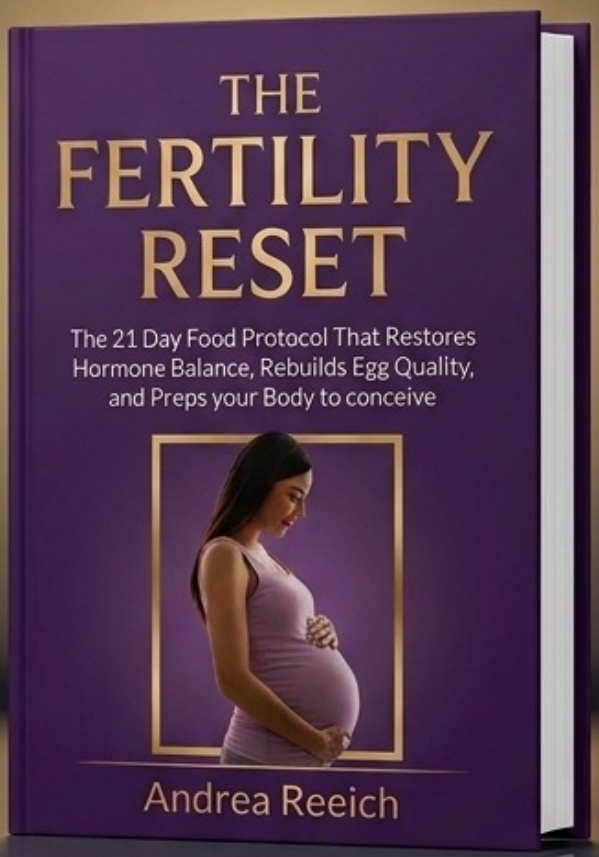

THE
FERTILITY
RESET
The 21 Day Food Protocol That Restores Hormone Balance, Rebuilds Egg Quality, and Preps your Body to conceive
Andrea Reeich

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A practical 21-day guide to nourishment, cycle awareness, partner participation, and medical readiness.

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Before You Begin

MEDICAL AND EDUCATIONAL DISCLAIMERThis guide is for educational purposes only. It is not medical advice, diagnosis, or treatment. Consult a qualified healthcare professional before making changes to your diet, medicines, supplements, exercise, or fertility care. Do not stop prescribed medicines without professional guidance. Seek urgent medical care for severe or one-sided pelvic pain, heavy bleeding, fainting, breathing difficulty, possible ectopic-pregnancy symptoms, a serious allergic reaction, or thoughts of self-harm.

Results and experiences vary. This guide does not guarantee pregnancy, hormone correction, improved egg quality, implantation, prevention of miscarriage, or a live birth. Food and lifestyle practices may support general and preconception health, but they cannot diagnose or treat every cause of infertility.

HOW TO INTERPRET

"RESET"In this guide, "reset" means replacing confusion with a structured, evidence-informed routine. It does not mean that every hormone can be restored, every egg can be rebuilt, or conception can be guaranteed in 21 days.

TERMINOLOGY

NOTEIn May 2026, polycystic ovary syndrome (PCOS) was renamed polyendocrine metabolic ovarian syndrome (PMOS) through a global consensus process. Both terms appear where needed so the guide remains clear to readers whose clinicians, records, or search results still use PCOS.

EVIDENCE

NOTEClinical recommendations are anchored to authoritative sources including the World Health Organization (WHO), the American Society for Reproductive Medicine (ASRM), the American College of Obstetricians and Gynecologists (ACOG), the Centers for Disease Control and Prevention (CDC), the U.S. Food and Drug Administration (FDA), the American Urological Association (AUA), the Endocrine Society, and the international evidence-based PMOS/PCOS guideline. Reference notes appear at the end of each chapter, with a selected master reference list at the end of the guide.

INTRODUCTION

Your Body Is Not a Failed Project

I know why you opened this guide.

You did not come here because you needed another colourful meal plan to save on your phone and forget about after three days. You came because trying to conceive has started taking up more space in your heart, your marriage, your prayer life, and your thoughts than you ever expected.

Every month begins with hope.

You calculate your dates. You watch your discharge. You check your cycle-tracking app. You may even plan intimacy so carefully that it starts feeling like an appointment instead of something you once enjoyed.

Then your period arrives.

Sometimes you cry openly. Other times, you clean yourself up, walk back into the sitting room, and behave as if nothing happened.

You congratulate another friend in the family WhatsApp group. You smile when a relative asks when you will "give them good news." You listen quietly while people recommend herbs, supplements, prayer houses, bitter mixtures, special sexual positions, okra water, expensive tests, and one more miracle product.

After a while, it becomes difficult to know what is true.

That confusion is exactly why this guide exists.

This Is Not Another Pregnancy Promise

Let us begin with the truth.

No meal, seed, fruit, soup, herbal drink, sexual position, or 21-day routine can guarantee that you will become pregnant. Food cannot reopen blocked fallopian tubes, correct every sperm problem, reverse every effect of age, treat endometriosis, or prevent every miscarriage.

Difficulty conceiving can be connected to ovulation, the ovaries, fallopian tubes, uterus, hormones, sperm health, sexual function, age, underlying medical conditions, or a combination of factors. Sometimes testing does not immediately reveal a clear cause. Fertility is not solely a woman's responsibility.

This guide will therefore not tell you that your body is refusing pregnancy because you have failed to eat the right food.

It will not tell you that a dark period means your eggs are weak.

It will not ask you to put your legs against a wall, insert mixtures into your vagina, stop your medication, or avoid a fertility clinic because natural food is supposedly more powerful than medical care.

What this guide will do is help you take control of the parts of preconception health that are genuinely within your reach.

Over the next 21 days, you will learn how to:

- Build balanced meals using familiar African foods
- Improve the consistency and variety of your diet
- Identify habits that may affect a future pregnancy
- Understand your menstrual cycle and likely fertile window
- Prepare useful questions for a healthcare professional
- Reduce some of the pressure surrounding intimacy
- Involve your partner in the preparation process
- Recognise when food and lifestyle changes are not enough
- Create habits you can continue beyond day 21

You are not being promised a positive pregnancy test at the end of this guide.

You are being given a clearer, safer, and more organised way to prepare for pregnancy.

What "Reset" Means in This Guide

The word "reset" does not mean that your hormones will be repaired in three weeks.

It does not mean your egg quality will suddenly return to what it was several years ago. It does not mean every irregular cycle will become exactly 28 days.

A reset means interrupting confusion.

It means moving away from random internet remedies and beginning a structured routine based on nourishment, cycle awareness, medical readiness, and sustainable habits.

Twenty-one days is enough time to:

- Organise your meals
- Increase the variety of foods you eat
- begin taking an appropriate folic acid supplement after checking what is suitable for you
- Review your medicines and supplements
- Reduce alcohol and smoking exposure
- Start tracking your cycle more accurately
- Improve communication with your partner
- Prepare for a medical consultation where necessary

These actions may not immediately change your fertility status, but they can improve your preconception preparation and reduce the feeling that you are simply guessing your way through the process.

Health authorities recommend preparing for pregnancy before conception because some health conditions, medicines, habits, and exposures can affect pregnancy from its earliest stages. (CDC, 2025; ACOG/ASRM, 2019)

Food Matters, but Food Is Not Everything

Food provides the protein, carbohydrates, fats, vitamins, minerals, and energy your body needs to function.

A balanced diet can support your general health, metabolic health, and nutritional readiness for pregnancy. It may also help you manage conditions such as PCOS when used as part of a complete care plan.

But there is no scientifically established list of five foods that can rebuild every woman's eggs.

There is also no single fertility diet that works for everyone.

A woman managing PCOS may have different nutritional needs from a woman with endometriosis, diabetes, anaemia, thyroid disease, or no diagnosed condition. A person who needs to gain weight safely should not follow the same plan as someone whose clinician has recommended gradual weight reduction.

This is why the meals in this guide are flexible.

You will work with food groups rather than miracle ingredients. You will learn how to combine vegetables, fruit, beans, eggs, fish, whole or minimally processed carbohydrates, nuts, seeds, and other familiar foods according to your needs and budget.

You do not need imported berries, expensive powders, or a supermarket full of foreign products.

Ugu, ewedu, beans, moi-moi, eggs, sardines, mackerel, millet, oats, yam, sweet potato, plantain, groundnuts, avocado, oranges, pawpaw, tomatoes, and other ordinary foods can all contribute to a varied diet.

They are not medicines.

They are nourishing foods that can become part of a healthier routine.

Preconception Health Begins Before the Positive Test

Many women begin thinking seriously about health only after seeing two lines on a pregnancy test.

However, some of the earliest stages of development happen before a person may know that pregnancy has occurred. That is one reason preparation should begin beforehand.

One important step is folic acid.

For most people at average risk who could become pregnant, established guidance recommends 400 micrograms (mcg) of folic acid every day, beginning at least one month before pregnancy. Some people need a different prescribed amount because of their medical history or medication, so a healthcare professional should advise them rather than allowing them to double or combine supplements independently. (CDC, 2025; ACOG/ASRM, 2019)

Preconception preparation may also include:

- Reviewing prescription and over-the-counter medicines
- Reviewing herbs, bitters, teas, and supplements
- Managing diabetes, high blood pressure, thyroid disease, or other conditions
- Updating relevant vaccinations
- Avoiding smoking and recreational drugs
- Avoiding alcohol when pregnancy is possible
- Discussing previous miscarriages or pregnancy complications
- Addressing persistent vaginal dryness or painful intercourse

- Assessing the male partner where conception is delayed

Do not stop a prescribed medicine because you are trying to conceive unless the prescribing clinician instructs you to do so.

Some medicines may need to be changed, but suddenly discontinuing treatment can also be harmful. The safe step is a medication review, not an independent decision.

You Do Not Have to Earn Motherhood

There is a particular kind of blame that women experience when pregnancy does not happen easily.

People may act as though you are not relaxed enough, not prayerful enough, not feminine enough, not sexually available enough, or not eating correctly enough.

That blame is unfair.

Infertility is a recognised reproductive-health condition. It can affect women and men, and its emotional effects can include distress, stigma, anxiety, grief, and financial pressure. (WHO, 2025)

You are not less of a woman because conception has taken longer than expected.

Your partner is not less of a man if a sperm-related factor is discovered.

Seeking medical help does not mean you have lost faith. Using evidence-based medication does not mean you have failed to be natural. Eating well does not mean you must reject clinical care.

These approaches can work together.

This guide is here to help you become a more informed participant in your care, not to place the entire responsibility for pregnancy on your plate.

How to Use the Next 21 Days

You do not need to execute every recommendation perfectly.

Perfection will only turn this guide into another source of pressure.

Instead, use the following rhythm:

Read

Complete one section at a time. Do not rush ahead and attempt to change everything in one day.

Act

Each chapter gives you a practical action, checklist, tracker, or conversation to complete.

Record

Write down what you eat, what you notice about your cycle, the questions that arise, and any symptoms that require attention.

Review

At the end of each week, identify what worked, what was difficult, and what needs to be adjusted.

Escalate

Where a symptom or fertility history requires medical attention, arrange the appointment. Do not wait for the 21 days to finish.

The goal is not to prove that you can follow a strict protocol.

The goal is to leave these 21 days better nourished, better organised, better informed, and clearer about your next step.

> **With the ground rules clear, the next chapter turns intention into action. You will begin with a 20-minute readiness reset that organises your history, identifies safety concerns, and gives you one practical next step today.**



CHAPTER 1

The 20-Minute Fertility Readiness Reset

> *Evidence base: See the chapter's Reference Notes; key clinical recommendations also carry parenthetical source anchors.*

Before we discuss meals, fertile windows, supplements, or intimacy, you need to know where you are starting from.

Not emotionally.

Practically.

Many women have tried so many different things that they no longer have one clear picture of their fertility journey. Test results are stored in different bags. Cycle dates are scattered across applications. Supplement bottles are sitting beside herbal mixtures. One doctor said one thing, while an auntie said the opposite.

This first exercise will help you gather the most important information in one place.

It will not change your hormones in 20 minutes.

The noticeable result is clarity.

By the end, you will have:

A completed fertility safety screen

A list of medicines and supplements to review

A balanced meal planned for tomorrow

- One clear action to take next

A page you can carry to a medical appointment

Set a timer for 20 minutes.

Take a pen, this guide, your phone calendar, and any medicine or supplement you currently use.

Let us begin.

Minutes 1-5: Complete Your Fertility Safety Screen

Read every statement below and tick the ones that apply to you.

Do not panic if you tick a box. A tick is not a diagnosis. It simply tells you that a professional assessment may be more useful than continuing to experiment alone.

Trying-to-Conceive Timeline

- ☐ I am younger than 35 and have had regular unprotected intercourse for 12 months without becoming pregnant.
- ☐ I am 35 or older and have been trying for six months without becoming pregnant.
- ☐ I am older than 40 and would like to become pregnant.
- ☐ I am unsure how long we have been trying consistently.

Fertility evaluation is generally recommended after 12 months of regular unprotected intercourse for women younger than 35 and after six months for women aged 35 or older. For women older than 40, more immediate evaluation may be appropriate. Earlier assessment is recommended when symptoms, medical history, or a known condition may affect fertility. (ASRM, 2021)

Menstrual-Cycle History

- [ ] My periods are frequently absent.
- [ ] My cycles are consistently very irregular.
- [ ] I sometimes go several months without menstruating.
- [ ] My bleeding is unusually heavy or lasts much longer than expected.
- [ ] My period pain regularly prevents me from working, sleeping, or completing normal activities.
- [ ] I have severe pelvic pain outside my period.
- [ ] I have been told that I may not be ovulating.
- [ ] I have been diagnosed with PCOS, endometriosis, fibroids, adenomyosis, thyroid disease, or another condition that may affect reproduction.

A missing period, when it is not explained by pregnancy, breastfeeding, menopause, or another expected reason, can be a sign of a health problem. It should not automatically be treated with food, herbs, or supplements without investigating the cause.

Pregnancy History

- [ ] I have experienced two or more pregnancy losses.
- [ ] I have previously had an ectopic pregnancy.
- [ ] I have experienced a molar pregnancy.
- [ ] I have had surgery involving my uterus, ovaries, or fallopian tubes.
- [ ] I have previously had a serious pregnancy complication.

Two or more spontaneous pregnancy losses meet the current ASRM definition of recurrent pregnancy loss and can justify a clinical evaluation. The losses do not have to be consecutive; confirmed molar and ectopic pregnancies are excluded from this definition. (ASRM, 2026)

Sexual and Vaginal Health

- [ ] Sex is regularly painful.

- [ ] I experience persistent vaginal dryness.
- [ ] I bleed during or after sex.
- [ ] I have unusual discharge, itching, burning, or an unpleasant odour.
- [ ] I experience difficulty with penetration.
- [ ] My partner has difficulty with erection, ejaculation, or intercourse.

Persistent dryness, pain, unusual discharge, or bleeding after sex deserves proper assessment. These symptoms can have several causes and should not be assumed to result from poor diet or low fertility.

Partner Factors

- [ ] My partner has never had a semen analysis despite prolonged difficulty conceiving.
- [ ] My partner has a history of testicular injury, surgery, infection, or undescended testicles.
- [ ] My partner currently uses testosterone or anabolic steroids.
- [ ] My partner has difficulty with erection or ejaculation.
- [ ] My partner smokes heavily, uses recreational drugs, or drinks excessive alcohol.
- [ ] We have treated fertility as my responsibility alone.

Infertility may involve male factors, female factors, both partners, or factors that initially remain unexplained. A complete fertility assessment should not focus only on the woman.

Your Result

Count the boxes you ticked.

If you did not tick any box:

Continue with the programme while keeping track of your cycle, nutrition, and trying-to-conceive timeline.

If you ticked one or more boxes:

You may still use this guide for general nourishment and preparation, but write down the symptom or history and arrange an appropriate medical discussion.

If you ticked a timeline, pregnancy-loss, severe-pain, or absent-period box:

Do not postpone evaluation until you finish the 21 days.

The purpose of this screen is not to frighten you. It is to protect you from spending months treating a possible medical problem with meal plans alone.

Minutes 6-10: Audit Your Preconception Essentials

Now review the habits and products that may affect pregnancy preparation.

Folic Acid

- ☐ I currently take a supplement containing folic acid.
- ☐ I have checked the amount of folic acid on the label.
- ☐ I am not taking several supplements with overlapping ingredients.
- ☐ I have asked a clinician whether I need a different dose because of my medical history or medication.

For most average-risk people who could become pregnant, the standard recommendation is 400 micrograms (mcg) of folic acid daily, starting at least one month before conception. Some people require a higher prescribed amount, but more is not automatically better. (CDC, 2025; ACOG/ASRM, 2019)

Write the name and amount of your current supplement:

Supplement name: _____:

Folic acid per serving: _____:

Number of servings taken daily: _____:

Questions I need to ask: _____:

Medicines

List every prescription medicine, pain medicine, skin treatment, weight-loss product, fertility medicine, or over-the-counter drug you currently use.

For each one, tick the correct statement:

- ☐ A qualified clinician knows that I am trying to conceive.
- ☐ I need to arrange a medication review.
- ☐ I have been considering stopping this medicine without advice.

If you ticked the final box, do not stop the medicine today. Write down the name of the prescribing clinician or clinic and arrange a review.

Herbs, Bitters, Teas and Supplements

List every herbal mixture, powder, tea, fertility capsule, detox product, vaginal product, or traditional remedy you use.

Now ask:

- ☐ Do I know every ingredient?
- ☐ Is the quantity of each ingredient stated?
- ☐ Has a qualified clinician reviewed it?
- ☐ Am I combining it with prescription medication?
- ☐ Does the seller claim it can guarantee pregnancy, unblock tubes, rebuild eggs, clean the womb, or replace fertility treatment?

Do not assume that "natural" means harmless.

An unlabelled mixture can contain ingredients that interact with medication, affect the liver or kidneys, cause gastrointestinal problems, or be unsafe in early pregnancy. If the ingredients and quantities are unknown, pause its use and discuss it with an appropriate healthcare professional.

Do not insert herbs, soap, lime, alum, yoghurt, steaming mixtures, or other substances into the vagina to change its pH or improve conception.

Alcohol, Smoking and Other Exposures

Tick the statements that apply:

- ☐ I currently drink alcohol.
- ☐ I smoke cigarettes or use tobacco.
- ☐ I vape.
- ☐ I use recreational drugs.
- ☐ I am regularly exposed to another person's cigarette smoke.
- ☐ My partner smokes, drinks heavily, or uses recreational drugs.
- ☐ I need support to stop safely.

Guidance for people planning pregnancy recommends avoiding alcohol, smoking, and certain drugs. Anyone who finds it difficult to stop should seek support rather than hiding the problem or feeling ashamed. (CDC, 2025; ACOG/ASRM, 2019)

Write one action:

The exposure I will address first: _____:

The person or service I will contact: _____:

The date I will take action: _____:

Minutes 11-15: Build Tomorrow's Nourishment Plate

You do not need to change your entire kitchen today.

Your next task is to plan one balanced meal for tomorrow.

A simple plate can include:

A source of protein

A vegetable or fruit

A whole or minimally processed carbohydrate

A source of healthy fat

- Water

Choose one item from each group.

1. Choose Your Protein

- [ ] Beans
- [ ] Moi-moi
- [ ] Lentils
- [ ] Eggs
- [ ] Sardines
- [ ] Mackerel
- [ ] Tilapia or another fish

- [ ] Chicken
- [ ] Lean meat
- [ ] Unsweetened yoghurt, where suitable
- [ ] Another protein: _____

2. Choose at Least One Vegetable or Fruit

- [ ] Ugu
- [ ] Ewedu
- [ ] Okra
- [ ] Spinach
- [ ] Cabbage
- [ ] Carrots
- [ ] Tomatoes and peppers
- [ ] Garden eggs
- [ ] Orange
- [ ] Pawpaw
- [ ] Banana
- [ ] Watermelon
- [ ] Mango
- [ ] Another option: _____

3. Choose a Carbohydrate

- [ ] Yam
- [ ] Sweet potato
- [ ] Unripe plantain
- [ ] Rice
- [ ] Oats
- [ ] Millet
- [ ] Sorghum
- [ ] Whole-grain bread

- [ ] Garri or another cassava food in a suitable portion
- [ ] Another option: _____

4. Add a Healthy Fat Where Needed

- [ ] Groundnuts
- [ ] Sesame seeds
- [ ] Pumpkin seeds
- [ ] Cashews
- [ ] Walnuts
- [ ] Avocado
- [ ] A moderate amount of plant oil used in cooking
- [ ] Another option: _____

5. Choose Your Drink

- [ ] Water
- [ ] Unsweetened beverage
- [ ] Another option: _____

Write Out Tomorrow's Meal

Meal: _____:

Protein: _____:

Vegetable or fruit: _____:

Carbohydrate: _____:

Healthy fat: _____:

Drink: _____:

Preparation needed tonight: _____:

Sample Combinations

You may use one of these examples:

- Moi-moi with vegetables and an orange
- Beans, unripe plantain, and vegetable sauce
- Grilled fish, yam, and ugu
- Egg sauce, sweet potato, and fruit
- Oats with groundnuts, egg, and fruit
- Rice and beans with mixed vegetables
- Millet porridge with egg and pawpaw
- Sardines with whole-grain bread, tomatoes, and avocado

The purpose is not to create a magical fertility plate.

The purpose is to start building meals that are more balanced, varied, and repeatable.

Minutes 16-20: Choose Your Correct Next Step

You now need to decide which path matches your current situation.

PATH A: Begin the 21-Day Plan

Choose this path when:

You have not reached the recommended fertility-evaluation timeline

You have no major red-flag symptoms

You want to improve your preconception habits

You understand that the plan cannot guarantee pregnancy

- Write:

My Day 1 start date: _____:

My main nutrition goal: _____:

My main wellbeing goal: _____:

My cycle-awareness goal: _____:

PATH B: Begin the Plan and Arrange an Appointment

Choose this path when:

You have irregular periods

You have persistent vaginal dryness or painful sex

You have a known health condition

You need a medicine or supplement review

Your partner may need assessment

You have concerns that should not be managed through food alone

- Write:

The clinician or clinic I will contact: _____:

The concern I will mention: _____:

The date I will call or book: _____:

The records I will take: _____:

PATH C: Prioritise Clinical Evaluation

Choose this path when:

You are under 35 and have been trying for at least 12 months

You are 35 or older and have been trying for at least six months

You are over 40 and planning pregnancy

Your periods are absent or severely irregular

You experience severe pain

You have had two or more pregnancy losses

You have a history strongly associated with infertility

A partner factor may be involved

You may still follow the general nutrition guidance in this book, but the guide should support your care rather than delay it.

Write:

My reason for seeking evaluation: _____:

My appointment deadline: _____:

Who will attend with me: _____:

Your One-Page Fertility Readiness Summary

Complete this page and keep it somewhere accessible.

About Me

Name: _____:

Age: _____:

Date completed: _____:

How long we have been trying: _____:

Average cycle length, if known: _____:

Date my last period started: _____:

Diagnosed Conditions

- ☐ PCOS
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Adenomyosis
- ☐ Thyroid condition
- ☐ Diabetes or prediabetes
- ☐ High blood pressure
- ☐ Anaemia
- ☐ Previous pelvic infection
- ☐ Other: _____

Pregnancy History

Number of previous pregnancies: _____:

Number of births: _____:

Number of pregnancy losses: _____:

Previous ectopic or molar pregnancy: _____:

Current Products

Prescription medicines: _____:

Over-the-counter medicines: _____:

Supplements: _____:

Herbs or traditional mixtures: _____:

Symptoms or Concerns

- ☐ Irregular periods
- ☐ Missing periods

- [ ] Severe period pain
- [ ] Heavy bleeding
- [ ] Pelvic pain
- [ ] Painful sex
- [ ] Vaginal dryness
- [ ] Unusual discharge
- [ ] Bleeding after sex
- [ ] Acne or unusual hair growth
- [ ] Other: _____

Partner Information

Has my partner had a semen analysis? Yes / No

Relevant medical or sexual concerns: _____:

My Next Step

- [ ] Begin the 21-day preparation plan
- [ ] Begin the plan and arrange a medical review
- [ ] Prioritise a fertility evaluation

Action date: _____:

Before You Close This Chapter

Look at what you have completed.

In 20 minutes, you have moved from scattered thoughts to a written plan.

You know whether your fertility history requires medical attention. You have identified medicines or supplements that need review. You have planned tomorrow's meal. You have chosen a next step.

That is your first reset.

Not a sudden change in your ovaries.

Not a promise that your period will arrive differently.

Not a guarantee that you will conceive this month.

Your first reset is the moment you stop allowing panic, internet noise, and random recommendations to direct your decisions.

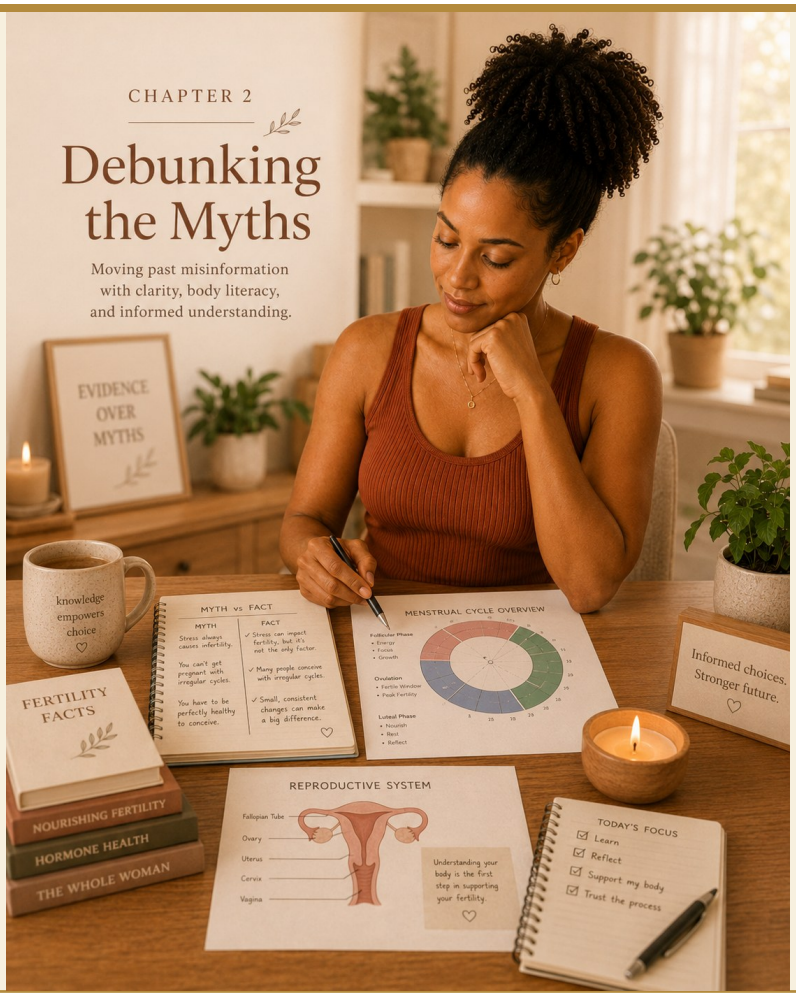
For the next 21 days, you will build from this foundation.

Keep your completed readiness summary. You will return to it at the end of the programme to review what you changed, what you learned, and which steps still need professional support.

> **In the next chapter, you will learn what ovulation, fertilisation, implantation, ovarian reserve, egg quality, and sperm health actually mean, without the myths that have made fertility feel more confusing than it needs to be.**

Reference Notes for the Introduction and Chapter 1

- World Health Organization. Infertility Fact Sheet. Updated November 28, 2025.
- American Society for Reproductive Medicine. Fertility Evaluation of Infertile Women: A Committee Opinion.
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- American College of Obstetricians and Gynecologists. Prepregnancy Counseling.
- Office on Women's Health. Preconception Health.
- American Society for Reproductive Medicine. Recurrent Pregnancy Loss: A Committee Opinion. 2026.
- National Institute of Child Health and Human Development. Amenorrhea.
- National Health Service. Vaginal Dryness and Vaginal Bleeding Between Periods or After Sex.



CHAPTER 2

Fertility Without the Myths

> *Evidence base: See the chapter's Reference Notes; key clinical recommendations also carry parenthetical source anchors.*

When you have been trying to conceive for some time, almost every normal body change can begin to feel like a message.

A longer cycle may feel like evidence that something is wrong. A painful period may make you wonder whether your womb is rejecting pregnancy. Clear discharge can produce excitement, while darker menstrual blood can create fear.

Then somebody tells you that your eggs are weak.

Another person says your womb is too cold. Someone else says sperm is leaking out after sex, so you should raise your legs against the wall. Before long, you are monitoring every sensation but still do not understand what is actually happening inside your body.

This chapter will help you replace those frightening explanations with a clear picture of fertility.

You do not need to become a doctor.

You simply need to understand enough to ask better questions, recognise misinformation, and know which part of the fertility process may require attention.

The Fertility Journey in Plain Language

For pregnancy to occur naturally, several events must happen in the correct sequence.

The ovary must develop and release an egg. Sperm must be present and able to travel through the female reproductive tract. At least one fallopian tube must allow the egg and sperm to meet. Fertilisation must occur, and the resulting embryo must continue developing before attaching to the lining of the uterus.

A difficulty at any stage can reduce the chance of pregnancy.

This is why fertility cannot be explained by food alone.

It is also why a regular period, a positive ovulation test, or a normal-looking discharge does not prove that every part of the process is working perfectly.

Let us break the process down.

Step One: An Egg Develops Inside the Ovary

A woman is born with a supply of immature eggs stored inside tiny structures called follicles.

During each menstrual cycle, a group of follicles begins responding to hormonal signals. Usually, one becomes dominant and continues developing until it releases an egg during ovulation.

The egg released this month did not begin developing when your last period started. Human follicle development is a long biological process that begins months before the final stage leading to ovulation. The exact duration varies depending on which developmental stages are counted, but it is far longer than 21 days.

This matters because it corrects a popular promise.

No food can take an egg from "poor quality" to "perfect quality" in three weeks.

A nourishing routine may support your general health and help correct nutritional deficiencies where they exist, but that is different from claiming that a short food programme can rebuild an egg.

Step Two: Ovulation Occurs

Ovulation is the release of an egg from the ovary.

It happens after a sequence of hormonal signals involving the brain, pituitary gland, and ovaries. The egg then enters the fallopian tube, where it may meet sperm.

Many women have been taught that ovulation always happens on day 14, but professional guidance treats this as a rough textbook estimate rather than a universal rule. (ASRM, 2022)

That is not correct.

Day 14 is only an estimate commonly associated with a 28-day cycle. Even among women whose periods appear regular, the exact day of ovulation can change from one cycle to another. For counselling purposes, the fertile window is generally defined as the six-day interval ending on the day of ovulation. (ASRM, 2022)

A cycle that is not exactly 28 days is not automatically abnormal.

Some women naturally have shorter or longer cycles. What matters is the overall pattern, how much the cycle varies, whether ovulation appears to occur, and whether there are symptoms that suggest a medical condition.

Having a Period Does Not Always Prove Ovulation

Menstrual bleeding and ovulation are connected, but they are not the same thing.

A woman can sometimes experience bleeding without having released an egg normally. This is called an anovulatory cycle.

It is also possible for a person to ovulate irregularly. This may occur with PCOS, thyroid conditions, elevated prolactin, significant weight change, low energy intake, excessive exercise, perimenopause, and other medical or physiological circumstances.

This does not mean you should diagnose yourself based on one unusual month.

Cycles can occasionally vary because of illness, travel, sleep disruption, stress, or other temporary changes. The concern becomes more important when periods are repeatedly absent, highly unpredictable, unusually painful, or associated with other symptoms.

A medical evaluation may use menstrual history, ovulation-predictor information, blood testing, ultrasound, or other methods depending on the person's situation. No single home sign gives a complete diagnosis.

Step Three: Sperm Travels Toward the Egg

After ejaculation, sperm enters the vagina and begins moving through the cervix toward the uterus and fallopian tubes.

A single sperm may eventually fertilise the egg. Fertilisation usually occurs in a fallopian tube, not in the uterus.

Millions of sperm may be released, but the number alone is not the only factor that matters.

A semen analysis may assess features such as:

- Semen volume
- Sperm concentration
- Total sperm count
- Movement, known as motility
- Shape, known as morphology
- Other features depending on the laboratory and clinical situation

One unusual result does not always provide a final answer. Semen findings can vary, and abnormal results may need to be repeated or reviewed by an appropriate specialist.

Male fertility evaluation is not an optional extra after every possible test has been performed on the woman. Professional guidance recommends evaluating both partners when infertility is being investigated.

This is especially important in cultures where the woman is blamed first.

A wife may be drinking bitter mixtures, tracking every meal, and attending prayer programmes while her husband has never completed a semen analysis.

That is not a complete fertility plan.

Step Four: Fertilisation Occurs

Fertilisation happens when a sperm enters an egg and their genetic material combines.

The fertilised egg is called a zygote. It begins dividing into more cells as it travels toward the uterus.

Fertilisation does not guarantee that a pregnancy will continue.

The developing embryo must divide appropriately, travel through the fallopian tube, reach the uterus, and begin the implantation process.

Some fertilised eggs do not continue developing. Others may not implant successfully. These early events can happen before a missed period, so the person may never know that fertilisation occurred.

This is one reason pregnancy cannot be reduced to whether you ate the correct food or remained in the correct position after sex.

Step Five: Implantation Begins

Implantation is the process through which the developing embryo attaches to and begins entering the uterine lining.

It begins several days after fertilisation, commonly around five to seven days afterward, although biological timing varies.

A healthy uterine lining is important, but the phrase "prepare the womb" is often used too loosely in fertility marketing.

Food cannot simply wash, warm, open, or clean the womb.

The uterus may be affected by conditions such as fibroids, polyps, adenomyosis, scar tissue, congenital differences, or inflammation. The fallopian tubes may also be blocked or damaged.

A meal plan cannot diagnose these conditions.

Where a person's history suggests a uterine or tubal problem, clinical evaluation may involve ultrasound, an X-ray procedure used to assess the tubes, saline ultrasound, hysteroscopy, or other investigations chosen by the clinician.

Egg Quality and Ovarian Reserve Are Not the Same Thing

These two terms are often mixed together.

Ovarian reserve

Ovarian reserve refers broadly to the remaining quantity of eggs or follicles in the ovaries.

Tests such as anti-Müllerian hormone, commonly called AMH, antral follicle count, and sometimes follicle-stimulating hormone may be used as part of an ovarian-reserve assessment.

These tests can be useful in specific clinical situations, particularly when estimating how the ovaries may respond to fertility medication.

However, an ovarian-reserve result does not directly tell you whether you can or cannot become pregnant naturally. ASRM notes that ovarian-reserve tests are useful mainly for anticipating response to ovarian stimulation and are poor independent predictors of unassisted pregnancy; they should be interpreted alongside age, medical history, diagnosis, and the full clinical picture. (ASRM, 2020; ASRM, 2021)

A low AMH result does not automatically mean that pregnancy is impossible.

A high AMH result does not guarantee pregnancy either.

Egg quality

"Egg quality" is an informal way of describing whether an egg has the biological ability to be fertilised, develop into a viable embryo, and potentially result in a healthy birth.

There is no simple blood test that directly examines the quality of every egg remaining inside the ovaries.

Age is one of the strongest indicators used when discussing egg-related reproductive potential because the likelihood of chromosomal abnormalities in eggs rises as women get older. Fertility generally decreases with age, with a more noticeable decline from the mid-thirties onward.

That information should be used for planning, not for shaming.

Women do not cause reproductive ageing by failing to eat enough avocado, drinking cold water, working too hard, or delaying one particular supplement.

Can Egg Quality Be Rebuilt?

This is where we must be especially honest.

No food protocol has been proven to reverse reproductive ageing or rebuild egg quality. Nutrition can support general and preconception health, but this is not the same as reversing age-related changes in eggs. (ASRM, 2020; ASRM, 2022)

Researchers continue to study nutrition, antioxidants, supplements, mitochondrial function, environmental exposures, and other factors. Some interventions may eventually prove useful for selected groups, particularly in fertility-treatment settings.

That is not the same as having evidence that a certain soup, seed, tea, or supplement will repair eggs naturally.

Be cautious when a seller says:

- "This food makes old eggs young again."
- "Your eggs will be rebuilt in 21 days."
- "You do not need fertility treatment."
- "Low AMH can be completely reversed."
- "This supplement guarantees healthy embryos."
- "Every miscarriage is caused by weak eggs."
- "Pregnancy will happen once your body feels safe."

These statements may sound comforting, but they turn complicated biology into a sales promise.

A responsible approach is different.

You can support your overall health by eating adequately, addressing medical conditions, avoiding smoking and recreational drugs, reducing harmful exposures, and following professional preconception guidance.

You can also ask for timely assessment rather than spending valuable months testing one unverified method after another.

What Your Period Can Tell You

Your period can provide useful information.

You should record:

The date bleeding begins

The number of bleeding days

- How often your cycle occurs
- Whether the cycle is reasonably consistent
- Whether the bleeding is very heavy
- Whether pain disrupts normal activities
- Whether spotting occurs between periods
- Whether there is bleeding after sex

This record can help a clinician understand your cycle pattern.

However, your period cannot directly tell you:

The number of eggs remaining

- Whether your fallopian tubes are open
- Whether your partner's sperm is healthy
- Whether fertilisation occurred
- Whether every hormone is balanced
- Whether a future embryo will be chromosomally normal
- Whether pregnancy will occur during the next cycle
- Menstrual Blood Does Not Need to Look "Perfect"

Menstrual blood may appear bright red, dark red, brown, or almost black at different points during a period.

Blood that leaves the uterus more slowly may darken as it is exposed to oxygen. Small clots can sometimes occur, particularly during heavier flow.

Colour alone does not diagnose infertility or egg quality.

This does not mean every menstrual symptom should be ignored.

Seek medical advice when bleeding is extremely heavy, lasts unusually long, occurs between periods, repeatedly contains large clots, is accompanied by severe pain, or creates symptoms such as weakness, dizziness, or shortness of breath.

The useful question is not, "Is my blood clean?"

The useful questions are:

Is my bleeding pattern changing?

Is it interfering with my life?

Could I be losing enough blood to become anaemic?

Do my pain and bleeding suggest a condition requiring assessment?

Ovulation Pain and Discharge Are Clues, Not Proof

Some women notice clear, slippery cervical mucus around the fertile window. Others do not notice an obvious change.

Some experience mild one-sided discomfort near ovulation. Others feel nothing.

The presence or absence of these symptoms does not prove that an egg is good or bad.

Cervical mucus can help with fertile-window awareness, but it can also be affected by infection, medication, breastfeeding, hormonal changes, and individual differences.

Severe or persistent pelvic pain should never be celebrated as a sign that ovulation is becoming stronger. It deserves attention, particularly when it is accompanied by painful sex, heavy bleeding, fever, faintness, or increasing discomfort.

Fertility Is More Than an Ovary

One of the most harmful fertility myths is that the woman only needs to "fix her eggs."

Natural conception depends on several areas working together:

- Ovulation and cycle function
- Egg and ovarian factors
- Fallopian-tube function

The uterus and uterine lining

- Sperm production and function
- Sexual function and timing
- General and hormonal health
- Age and reproductive history

Infertility may result from male factors, female factors, a combination of both, or causes that remain unexplained after initial evaluation.

You cannot identify every factor through symptoms.

That is why clinical assessment exists.

Your Fertility Factors Map

This exercise will help you organise what you know, what you do not know, and what requires action.

It is not a diagnostic test.

Use the following symbols:

- ✓ Known or already assessed
- ? Unknown
- ! Concern or symptom present
- N/A Not applicable

SECTION A: Ovulation and Cycle

Mark each line.

___ My periods usually come within a reasonably predictable range.

___ I record the first day of each period.

___ I know approximately how long my cycles are.

___ I sometimes notice fertile cervical mucus.

___ I use ovulation-predictor tests correctly, where appropriate.

___ I have not gone three months or longer without a period unless pregnant, breastfeeding, or medically expected.

___ My periods are not so painful that they repeatedly stop normal activity.

___ My bleeding is not unusually heavy or prolonged.

___ I have discussed persistent cycle irregularity with a clinician.

My notes

My next action

- ☐ Continue tracking for three cycles.
- ☐ Discuss irregular or absent periods with a clinician.
- ☐ Ask whether I am likely to be ovulating.
- ☐ Take my cycle records to an appointment.

SECTION B: Uterus and Fallopian Tubes

Mark each line.

___ I have no known history of ectopic pregnancy.

___ I have no known history of pelvic inflammatory disease.

___ I have no known history of untreated sexually transmitted infection.

___ I have no previous pelvic or abdominal surgery that may be relevant.

___ I have no known fibroids, polyps, adenomyosis, or uterine abnormality.

___ I do not experience severe pelvic pain.

___ I do not experience persistent pain during sex.

___ A clinician has assessed my uterus where appropriate.

___ My fallopian tubes have been assessed where clinically appropriate.

My notes

My next action

- ☐ No immediate action identified.
- ☐ Ask whether uterine imaging is appropriate.
- ☐ Ask whether tubal assessment is appropriate.
- ☐ Discuss previous surgery, infection, or ectopic pregnancy.

SECTION C: General and Hormonal Health

Mark each line.

___ I have reviewed my thyroid health where indicated.

___ I have no unexplained milky breast discharge when not breastfeeding.

___ I have discussed symptoms of PCOS where relevant.

___ Diabetes or blood-sugar problems are being managed.

___ My blood pressure is being managed.

___ I am not experiencing major unexplained weight change.

___ I eat enough food to support my daily energy needs.

___ I am not exercising at a level that has stopped my periods.

___ My medicines and supplements have been reviewed for pregnancy.

___ I take an appropriate folic acid supplement.

My notes

My next action

- ☐ Arrange a general preconception review.
- ☐ Request a medication review.
- ☐ Discuss possible PCOS or thyroid symptoms.
- ☐ Discuss absent periods or major weight changes.

SECTION D: Partner and Sperm Health

Mark each line.

___ My partner understands that fertility is shared.

___ My partner has discussed relevant medical history.

___ My partner does not use testosterone or anabolic steroids.

___ My partner has no untreated sexual or ejaculation difficulty.

___ My partner has disclosed previous testicular injury, surgery, or infection.

___ My partner has completed a semen analysis where indicated.

___ Abnormal semen results have been professionally reviewed.

___ My partner is willing to attend appointments where necessary.

My notes

My next action

- ☐ Discuss a semen analysis.
- ☐ Arrange a male fertility or urology consultation.
- ☐ Review testosterone, steroids, medicines, smoking, or drug use.
- ☐ Attend the next appointment together.

SECTION E: Timing and Duration

Mark each line.

___ We have intercourse regularly.

___ We are not depending on one exact day each month.

___ We understand that the fertile window includes several days.

___ We have been trying for fewer than 12 months and I am under 35.

___ We have been trying for fewer than six months and I am 35 or older.

___ We have reached the point where fertility evaluation is recommended.

___ Intimacy has not become so stressful that we avoid sex.

___ We know when and where to seek help.

My notes

My next action

- ☐ Continue trying with better fertile-window awareness.
- ☐ Reduce pressure around one "perfect" day.
- ☐ Arrange a fertility evaluation.
- ☐ Discuss sexual pain, erection, or ejaculation concerns.

Review Your Map

Now look at every section.

Circle all the question marks.

These are not failures. They are simply areas where you do not yet have enough information.

Underline every exclamation mark.

These are symptoms, risks, or concerns that may require professional attention.

Place a star beside the three actions that matter most now.

My Three Priority Actions

The First Action I Will Complete

Action: _____:

Date: _____:

Person involved: _____:

What I need to prepare: _____:

Fertility Myth Check

Read each statement and mark it true or false before checking the answer.

1. Every woman ovulates on day 14.

Answer: False.

Ovulation timing varies. Day 14 is an estimate based on a 28-day cycle, not a universal rule.

2. A regular period proves that both fallopian tubes are open.

Answer: False.

Period regularity cannot confirm tubal function.

3. Dark menstrual blood means the eggs are weak.

Answer: False.

Menstrual colour does not measure egg quality.

4. Low AMH automatically means natural pregnancy is impossible.

Answer: False.

Ovarian-reserve tests do not reliably predict an individual's chance of unassisted pregnancy.

5. A high AMH level guarantees good fertility.

Answer: False.

AMH is only one part of ovarian-reserve assessment and does not guarantee pregnancy.

6. The woman should complete every fertility test before the man is assessed.

Answer: False.

Both partners should be evaluated when infertility is being investigated.

7. A healthy diet can support preconception health.

Answer: True.

A balanced diet contributes to general health and nutritional preparation, but it cannot guarantee pregnancy or correct every cause of infertility.

8. Food can reopen blocked tubes.

Answer: False.

Tubal blockage requires proper diagnosis and medical management.

9. Severe period pain should be ignored because pain means the womb is working.

Answer: False.

Severe or disabling pain may require assessment.

10. A 21-day programme cannot guarantee rebuilt egg quality.

Answer: True.

Egg and follicle development extends over months, and no short food programme has been shown to reverse every factor affecting egg quality.

Before You Close This Chapter

Your fertility is not one organ, one hormone, or one meal.

It is a sequence.

An egg must develop and be released. Sperm must be healthy enough to reach it. The reproductive tract must allow them to meet. Fertilisation and embryo development must occur. The embryo must reach the uterus and implant.

Understanding this sequence protects you from anyone who claims that one ingredient controls the entire process.

It also removes some unnecessary blame.

You may have areas of your health that can be supported through nourishment and lifestyle. You may also have areas that need testing, treatment, or specialist care.

Both can be true.

Your action from this chapter is simple:

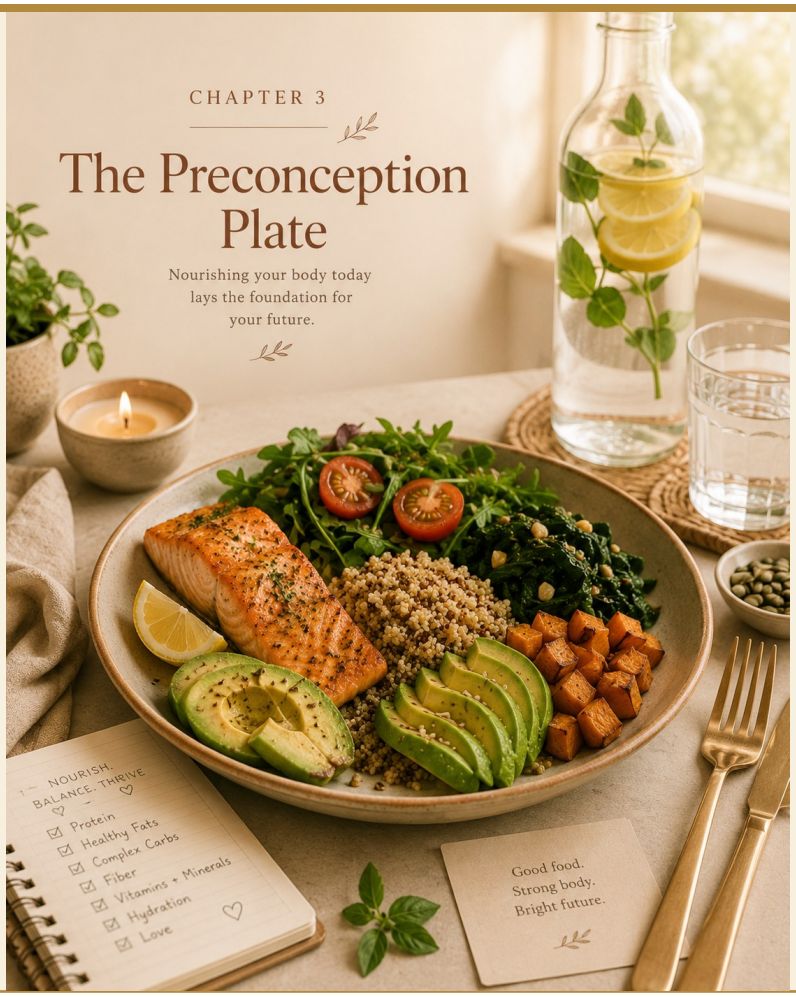
Complete the Fertility Factors Map. Identify your three most important unknowns or concerns. Then take one real step to address the first one.

> **In the next chapter, we will move into food.**

You will learn how to build an evidence-based preconception plate from ordinary foods available in Nigerian and other African markets, without expensive powders, frightening restrictions, or miracle-food promises.

Reference Notes for Chapter 2

- American Society for Reproductive Medicine. Optimizing Natural Fertility: A Committee Opinion.
- American Society for Reproductive Medicine. Fertility Evaluation of Infertile Women: A Committee Opinion.
- American Society for Reproductive Medicine. Testing and Interpreting Measures of Ovarian Reserve: A Committee Opinion.
- World Health Organization. Infertility Fact Sheet. Updated November 2025.
- American Urological Association and American Society for Reproductive Medicine. Diagnosis and Treatment of Infertility in Men.
- National Library of Medicine. Fetal Development.
- National Center for Biotechnology Information. Morphology and Physiology of the Ovary.
- American Society for Reproductive Medicine. Recurrent Implantation Failure: A Committee Opinion. 2026.



CHAPTER 3

The Evidence-Based Preconception Plate

> *Evidence base: See the chapter's Reference Notes; key clinical recommendations also carry parenthetical source anchors.*

Food is often presented as either completely unimportant or almost magical.

One person tells you that what you eat has nothing to do with fertility. Another tells you that one bowl of soup, seed mixture, fruit combination, or herbal drink will rebuild your eggs and make you pregnant.

The truth sits between these two extremes.

Food matters because your body needs enough energy, protein, healthy fats, vitamins, minerals, and fibre to function well. A balanced eating pattern can support your general health, blood-sugar regulation, nutritional status, and preparation for pregnancy.

But food is not a fertility treatment for every condition.

No plate can open blocked fallopian tubes. No fruit can correct a serious sperm problem. No soup can remove fibroids, reverse reproductive ageing, or guarantee implantation.

The aim of this chapter is therefore simple:

To help you build balanced meals from familiar foods without fear, expensive ingredients, extreme restrictions, or false promises.

Stop Looking for the Perfect Fertility Food

When women are trying to conceive, they are often given long lists of foods to avoid.

No cold water.

No rice.

No yam.

No fruit after a particular time.

No tomatoes.

No chicken.

No carbohydrates.

No food cooked yesterday.

After removing everything people have labelled "bad," the woman is left hungry, frightened, and unsure of what to eat.

You do not need a perfect fertility food.

You need an eating pattern that is varied, adequate, affordable, and sustainable.

The American Society for Reproductive Medicine states that there is insufficient evidence to conclude that a particular diet or specific balance of carbohydrates, proteins, and fats improves natural fertility for everyone. Some healthy dietary patterns have shown promising associations, but they should not be marketed as guaranteed conception programmes. (ASRM, 2022)

A healthy diet still matters.

The World Health Organization recommends an eating pattern built around adequacy, balance, moderation, and diversity, including vegetables, fruits, legumes, nuts, and whole grains while limiting excessive free sugars, salt, and unhealthy fats. These principles support overall health and nutritional readiness for pregnancy. (WHO, 2026)

The difference is in the promise.

A balanced meal can nourish you.

It cannot promise you a baby.

The Preconception Plate Formula

You do not need to count every calorie or weigh every grain of rice.

Use this simple plate structure as a starting point:

- Approximately half the plate from vegetables, with fruit included across the day
- Approximately one quarter from a protein-rich food
- Approximately one quarter from a whole or minimally processed carbohydrate

A moderate source of healthy fat

- Water as your regular drink

This is not a rigid medical prescription.

Your exact needs depend on your body size, activity level, medical conditions, appetite, cultural habits, pregnancy status, and the guidance of your clinician or dietitian.

The plate is simply a visual tool that helps you notice what may be missing.

For example, a large plate of white rice with two small pieces of meat may provide carbohydrate and some protein, but very little vegetable variety or fibre.

You do not need to throw the rice away.

You can reduce the amount slightly, add beans or fish, and fill more of the plate with vegetables.

That is what practical nourishment looks like.

Part One: Vegetables and Fruit

Vegetables and fruit provide fibre and a range of vitamins, minerals, and plant compounds.

Different colours often represent different nutrient profiles, so variety matters more than choosing one so-called fertility vegetable.

Useful African options include:

- Ugu
- Ewedu
- Okra
- Waterleaf
- Spinach
- Bitter leaf
- Cabbage
- Carrots
- Tomatoes
- Bell peppers
- Garden eggs
- Green beans
- Cucumber
- Pawpaw
- Oranges
- Mango
- Watermelon
- Banana
- Pineapple
- Guava
- Avocado

You do not need every item on this list.

Choose what is available, affordable, and suitable for you.

Frozen vegetables can also be useful when fresh options are expensive or unavailable. Canned vegetables can be used where necessary, although products with very high added salt should be limited.

Fruit juice is not identical to whole fruit.

Whole fruit generally contains more fibre and is easier to portion than sweetened juices. Water should remain your regular drink rather than replacing every fruit serving with juice.

Practical vegetable target

At lunch or dinner, ask:

- Can I identify at least one meaningful portion of vegetables on this plate?

If the vegetables are only the small amount of tomato and pepper used to colour the stew, add more.

That may mean:

- Adding steamed vegetables beside the meal
- Increasing the ugu or other greens in a soup
- Adding cabbage and carrots to rice
- Serving cucumber, tomato, and garden-egg salad
- Adding okra or mixed vegetables to a sauce
- Eating a piece of fruit after the meal

Do not turn this into punishment.

The goal is greater variety, not forcing yourself to eat a mountain of raw vegetables when your stomach does not tolerate them.

Part Two: Protein

Protein supports the maintenance and repair of body tissues and contributes to many biological processes.

Useful protein foods include:

- Beans
- Lentils

- Peas
- Moi-moi
- Akara prepared with moderate oil
- Eggs
- Sardines
- Mackerel
- Tilapia
- Salmon where affordable
- Chicken
- Turkey
- Lean meat
- Unsweetened yoghurt or milk where tolerated
- Tofu or soy foods
- Groundnuts and seeds, although these also contain significant fat

You do not need to eat meat at every meal.

Beans, lentils, peas, and soy foods can contribute useful plant protein. Combining them with other foods across the day can help create a varied eating pattern.

Fish can be a valuable source of protein and healthy fats, but seafood choices matter during pregnancy planning because some fish contain more mercury than others. Where you are uncertain about a particular fish, ask a qualified clinician or dietitian for guidance based on the fish commonly sold in your region.

How much protein belongs on the plate?

As a simple starting guide, use a portion roughly similar to the size and thickness of your palm.

This may look like:

- Two eggs
- One moderate piece of fish
- One moderate piece of chicken

A generous serving of beans

- One or two wraps of moi-moi, depending on size and the rest of the meal

Your actual requirement may be higher or lower.

The purpose of the hand guide is convenience, not medical precision.

Do not fear eggs

Eggs are often removed from fertility meal plans because of myths about hormones or cholesterol.

For most people, eggs can be included as part of a balanced diet unless there is a specific allergy, intolerance, medical restriction, or personal choice.

The same principle applies to beans.

Beans do not need to be eaten every day to be beneficial, and they should not be avoided simply because they are considered "ordinary." They are affordable, filling, and easy to combine with vegetables and carbohydrates.

Part Three: Carbohydrates

Carbohydrates are often blamed for every reproductive problem.

Women are told to stop eating rice, yam, bread, garri, plantain, potatoes, oats, and fruit at the same time.

That approach is usually difficult to sustain and may leave some women under-eating.

Carbohydrates are a major source of energy. The more useful question is not whether a food contains carbohydrate, but:

How processed is it?

What portion am I eating?

What am I eating with it?

Does it provide fibre?

How does it affect my blood sugar and hunger?

Do I have a condition requiring individualised guidance?

Useful options include:

- Oats
- Millet
- Sorghum
- Brown or parboiled rice
- Beans and rice
- Yam
- Sweet potato
- Unripe or ripe plantain
- Whole-grain bread
- Corn
- Ofada rice
- Whole-grain swallow options where available
- Garri or other cassava products in an appropriate portion

You do not need to pretend that only imported quinoa is healthy.

The amount and combination often matter more than choosing the most fashionable ingredient.

For example:

Less balanced: A very large mound of rice with a small amount of stew and no vegetables.

More balanced: A moderate rice portion with beans, grilled fish, and mixed vegetables.

Less balanced: Several slices of white bread with a sugary drink.

More balanced: Bread with egg, tomato, avocado, and water.

Less balanced: A very large portion of swallow with little soup and minimal protein.

More balanced: A moderate swallow portion with a vegetable-rich soup and fish, meat, or another protein.

Do not label the first meals as poisonous.

Think of the second meals as better structured.

Part Four: Healthy Fats

Fat is necessary for health.

The goal is not to remove all oil from your food. It is to use fats thoughtfully and avoid turning every meal into a pool of oil.

Sources of mostly unsaturated fats include:

- Avocado
- Groundnuts
- Cashews
- Walnuts
- Sesame seeds
- Pumpkin seeds
- Olive oil where available
- Other suitable plant oils used moderately
- Fatty fish such as sardines and mackerel

Nuts and seeds are nutritious, but portions still matter because they are energy-dense.

A small closed handful may be a practical snack portion for many adults. Eating an entire large bottle of groundnuts while watching television is not the same as adding a moderate serving to a meal.

Palm oil is part of many West African meals.

You do not need to treat it as forbidden, but the amount used matters. Vegetable soup does not become more nourishing simply because oil is floating above it.

Measure oil rather than pouring directly from the bottle without checking.

Part Five: Water

Water should be your regular drink.

You do not need alkaline water, fertility water, womb-cleansing water, or water infused with a secret ingredient.

Plain clean water is enough.

Sugary drinks, sweetened juices, energy drinks, and heavily sweetened teas can add substantial sugar without providing the same fullness as solid food.

You do not need to eliminate every enjoyable drink forever.

Begin by reducing frequency and portion.

A practical first step may be:

- Replacing one daily soft drink with water
- Diluting an overly sweet homemade drink
- Reducing the number of spoons of sugar in tea
- Keeping a refillable water bottle nearby
- Drinking water with meals instead of sweetened beverages
- Folic Acid: The One Preconception Essential Food Alone May Not Cover

Folate is a B vitamin found naturally in foods such as leafy vegetables, beans, citrus fruits, and fortified products.

Folic acid is the form used in many supplements and fortified foods.

For people at average risk who may become pregnant, established guidance recommends taking 400 micrograms (mcg) of folic acid daily, beginning at least one month before conception. This helps reduce the risk of neural tube defects affecting the developing baby's brain and spine. (CDC, 2025; ACOG/ASRM, 2019)

Food remains important, but it may not reliably provide the recommended amount of folic acid on its own.

Check your supplement label.

Do not assume every product marketed as a women's multivitamin or fertility supplement contains the correct amount.

Supplement label check

Write down:

Product name: _____:

Serving size: _____:

Folic acid per serving: _____:

How many servings I take daily: _____:

Other products containing folic acid: _____:

Date I will confirm suitability: _____:

Some people need a higher prescribed dose because of their health history, previous pregnancy history, or medication. Do not increase the dose independently. Ask a qualified clinician.

What About PCOS?

If you have PCOS, you may have been told that one exact diet is compulsory.

Some people recommend very low-carbohydrate eating. Others promote fasting, dairy elimination, gluten elimination, vegan eating, detox programmes, or expensive supplement combinations.

The 2023 international evidence-based guideline for the condition now called PMOS recommends healthy lifestyle behaviours, including nutritious eating and physical activity, for general health and symptom management. It also states that evidence does not support one specific diet composition as superior for every person with the condition. (International PCOS Guideline, 2023; terminology updated in 2026)

Your approach should therefore be individualised.

Some women may benefit from adjusting carbohydrate portions and improving carbohydrate quality, particularly where blood-sugar regulation is a concern. Others may need support with adequate eating, digestive symptoms, food access, body image, or disordered eating.

Do not punish yourself with a diet you cannot maintain.

Do not stop medication because your meals have improved.

Nutrition, physical activity, medication, fertility treatment, and psychological support may all have a role depending on your symptoms and goals.

What If I Am Overweight?

Weight can affect reproductive and pregnancy health in some people, but fertility should not be reduced to a number on the scale.

Women in larger bodies are often told to "just lose weight" without a proper investigation of ovulation, fallopian tubes, uterine health, sperm, thyroid function, PCOS, medication, or other relevant factors.

That is incomplete care.

Where weight change is recommended, it should be approached safely and without crash dieting.

Rapid restriction can produce nutrient deficiencies, increase food obsession, and become impossible to maintain.

Begin with behaviours:

- Build more balanced plates
- Increase vegetable and fruit variety
- Reduce frequent sugary drinks
- Eat adequate protein

- Choose less-refined carbohydrates more often
- Cook with measured amounts of oil
- Move regularly in a way your body tolerates
- Improve sleep
- Seek individualised support where possible

ASRM recognises that obesity may affect fertility and pregnancy outcomes in some women and men, but decisions about fertility care should still consider age, medical history, and the complete clinical picture.

What If I Am Underweight or Frequently Skip Meals?

Not every woman trying to conceive needs to eat less.

Some women are skipping breakfast, working all day without lunch, exercising intensely, and eating one small meal at night.

Others have removed so many foods that they are no longer meeting their energy needs.

Significant under-eating and low energy availability can disturb menstrual function in some women. A missing period should not be celebrated as evidence that the diet is "detoxifying" the body.

Your plate may need to include:

- Larger portions
- More frequent meals
- Planned snacks
- Extra healthy fats
- Adequate carbohydrates
- Regular protein
- Support for nausea, poor appetite, or digestive symptoms
- Assessment for an eating disorder or medical condition where relevant

If your periods have stopped after major weight loss, restrictive eating, or intense exercise, arrange a clinical review.

Build Your Plate Template

Use this tool for lunch and dinner during the next seven days.

Step 1: Choose a protein

- ☐ Beans or lentils
- ☐ Moi-moi
- ☐ Eggs
- ☐ Fish
- ☐ Chicken or turkey
- ☐ Lean meat
- ☐ Tofu or soy food
- ☐ Unsweetened dairy product
- ☐ Other: _____

Step 2: Choose a carbohydrate

- ☐ Rice
- ☐ Yam
- ☐ Sweet potato
- ☐ Plantain
- ☐ Oats
- ☐ Millet
- ☐ Sorghum
- ☐ Corn
- ☐ Whole-grain bread
- ☐ Swallow
- ☐ Other: _____

Step 3: Add vegetables

- [ ] Leafy vegetable
- [ ] Okra
- [ ] Cabbage
- [ ] Carrot
- [ ] Tomato
- [ ] Pepper
- [ ] Cucumber
- [ ] Garden egg
- [ ] Mixed vegetables
- [ ] Other: _____

Step 4: Add fruit across the day

- [ ] Orange
- [ ] Pawpaw
- [ ] Banana
- [ ] Mango
- [ ] Watermelon
- [ ] Pineapple
- [ ] Guava
- [ ] Other: _____

Step 5: Add healthy fat where needed

- [ ] Avocado
- [ ] Groundnuts
- [ ] Nuts
- [ ] Seeds
- [ ] Fish

- [ ] Measured plant oil
- [ ] Other: _____

Step 6: Choose your drink

- [ ] Water
- [ ] Unsweetened drink
- [ ] Lightly sweetened drink
- [ ] Other: _____

The Hand Portion Guide

Use your hand when you do not have measuring cups.

This is a general guide, not a prescription.

Protein

Start with approximately one palm-sized portion.

Carbohydrate

Start with approximately one cupped-hand portion.

Vegetables

Aim for one or two fists, depending on the meal and your tolerance.

Fat

Start with approximately one thumb-sized portion of oil, nut butter, or similar concentrated fat.

Fruit

One moderate whole fruit or an amount that fits roughly into your fist may serve as a practical starting portion.

Adjust according to your hunger, body size, activity level, health needs, and professional advice.

Seven Balanced African Meal Combinations

Meal 1: Beans and plantain plate

Beans

Boiled or roasted plantain

Ugu, cabbage, or another vegetable

Water

Meal 2: Fish and yam plate

Grilled or stewed fish

Boiled yam

Vegetable sauce

Orange or pawpaw later in the day

Meal 3: Rice and beans plate

Moderate rice portion

Beans

Chicken or fish if desired

Mixed vegetables

Water

Meal 4: Egg and sweet-potato plate

Boiled or scrambled eggs

Sweet potato

Tomato, pepper, and spinach sauce

Fruit

Meal 5: Moi-moi plate

Moi-moi

Vegetable salad or cooked greens

Pap with minimal added sugar, oats, or another suitable carbohydrate

Water

Meal 6: Soup and swallow plate

Moderate swallow portion

Vegetable-rich soup

Fish, chicken, lean meat, or another protein

Water

Meal 7: Quick workday plate

Whole-grain bread

Egg, sardine, or bean filling

Tomato and cucumber

Avocado where available

Water

Your One-Day Starter Plan

Complete this tonight and use it tomorrow.

Breakfast

Protein: _____:

Carbohydrate: _____:

Fruit or vegetable: _____:

Drink: _____:

Lunch

Protein: _____:

Carbohydrate: _____:

Vegetables: _____:

Drink: _____:

Dinner

Protein: _____:

Carbohydrate: _____:

Vegetables: _____:

Drink: _____:

Optional snack

- ☐ Fruit
- ☐ Unsweetened yoghurt
- ☐ Nuts or groundnuts
- ☐ Boiled egg
- ☐ Roasted corn
- ☐ Another option: _____

Preparation checklist

- ☐ I have checked what is already in the kitchen.
- ☐ I know what needs to be purchased.
- ☐ I have washed or cut vegetables.
- ☐ I have prepared a protein source.
- ☐ I have filled my water bottle.
- ☐ I have decided what I will eat before becoming very hungry.

The Three Questions to Ask at Every Meal

Before eating, ask:

- 1. Where is my protein?

If you cannot identify it, add beans, eggs, fish, chicken, yoghurt, tofu, or another suitable option.

2. Where is my colour?

If the meal is mainly beige, white, or brown, add a vegetable or fruit.

3. Will this meal keep me satisfied?

A meal made only from refined carbohydrate may leave you hungry again quickly. Add protein, fibre, vegetables, and a moderate source of fat.

These three questions are easier to remember than a long list of fertility rules.

Before You Close This Chapter

Your preconception plate does not need to be exotic.

It does not need to be photographed beautifully.

It does not need to contain five miracle ingredients.

It needs to be realistic enough that you can repeat it.

Your action for the next seven days is to use the Build Your Plate Template for at least one main meal every day.

Do not try to become perfect.

Notice your patterns.

Perhaps you rarely eat vegetables unless they are hidden in stew. Perhaps breakfast is always bread and a sweet drink. Perhaps you eat protein only at dinner. Perhaps you buy supplements but regularly skip meals.

That information is useful.

> **In the next chapter, we will look more closely at five food groups that can strengthen the quality and variety of your eating pattern.**

They will not be presented as egg-rebuilding superfoods.

They will be presented as what they truly are: accessible sources of nourishment that can help you build a more consistent preconception routine.

Reference Notes for Chapter 3

- American Society for Reproductive Medicine. Optimizing Natural Fertility: A Committee Opinion.
- American College of Obstetricians and Gynecologists. Prepregnancy Counseling.
- American College of Obstetricians and Gynecologists. Good Health Before Pregnancy: Prepregnancy Care.
- World Health Organization. Healthy Diet. Updated January 26, 2026.
- International Evidence-Based Guideline for the Assessment and Management of Polycystic Ovary Syndrome. 2023.
- American Society for Reproductive Medicine. Obesity and Reproduction: A Committee Opinion.



CHAPTER 4

Five Food Groups, Not Five Fertility Superfoods

> *Evidence base: See the chapter's Reference Notes; key clinical recommendations also carry parenthetical source anchors.*

There is something very attractive about being told that five special foods can solve a fertility problem.

It feels simple.

Buy these ingredients. Eat them at these exact times. Avoid everything else. Wait for your hormones to balance and your eggs to become stronger.

But your reproductive health is not controlled by five miracle foods.

Your body needs a range of nutrients, and no single ingredient provides everything. Even a highly nutritious food cannot correct blocked fallopian tubes, severe endometriosis, a significant sperm problem, thyroid disease, or every cause of irregular ovulation.

This chapter will still give you five categories to focus on.

The difference is that we will use five nourishing food groups, not five foods presented as medicine.

These groups can help you improve the variety and nutritional quality of your meals using ingredients you can find in Nigerian, Ghanaian, East African, or other African markets.

You do not need to buy everything.

Your task is to select affordable foods from each group and create a routine you can actually maintain.

Food Group One: Leafy Vegetables and Colourful Produce

Vegetables and fruits provide fibre, vitamins, minerals, and plant compounds that support general health.

No vegetable can directly rebuild an egg.

However, eating a wider variety of produce can help improve the overall quality of your diet and reduce the likelihood that your meals depend mainly on refined carbohydrates and heavily processed foods.

Useful leafy vegetables

Depending on where you live, your options may include:

- Ugu
- Ewedu
- Waterleaf
- Spinach
- Bitter leaf
- Scent leaf
- Afang or okazi
- Kale

- Sukuma wiki
- Amaranth leaves
- Cabbage
- Cassava leaves, when properly prepared
- Cowpea leaves

Choose vegetables that are familiar and available.

You do not need to abandon local greens because someone online said only kale and broccoli support fertility.

Ugu is not inferior because it is common.

Ewedu is not less useful because it is inexpensive.

The healthiest food plan is often the one you can continue without struggling to find the ingredients every week.

Useful colourful vegetables

Add variety with:

- Tomatoes
- Red, green, or yellow peppers
- Carrots
- Pumpkin
- Garden eggs
- Okra
- Green beans
- Cucumber
- Beetroot
- Aubergine
- Onions

The small quantity of tomato and pepper used in stew may not provide a full vegetable portion.

Where possible, add a vegetable side, increase the amount of vegetables in the sauce, or prepare a soup where vegetables form a meaningful part of the meal.

Useful fruits

Choose from:

- Orange
- Pawpaw
- Mango
- Banana
- Guava
- Pineapple
- Watermelon
- Apple
- Pear
- Tangerine
- African star apple
- Avocado
- Berries where available and affordable

You do not need an imported fruit bowl containing strawberries, blueberries, and kiwi before your diet becomes healthy.

Local fruit still counts.

How to use this group

Aim to include vegetables in at least one or two main meals and eat fruit across the day according to your needs.

Examples include:

- Adding ugu to egg sauce
- Adding cabbage and carrots to rice
- Serving cucumber and tomato with bread and eggs
- Increasing vegetables in okra soup
- Eating pawpaw after breakfast
- Carrying an orange to work

- Adding garden eggs to a snack plate
- Using vegetables to increase the volume of stew or sauce
- Budget strategy

Buy produce that is in season.

Seasonal fruit and vegetables are often less expensive and easier to find. You can also reduce waste by buying smaller amounts more frequently or washing, cutting, and freezing suitable vegetables before they spoil.

Important correction

Do not judge your fertility by how many green foods you eat.

A woman can eat vegetables every day and still have a fertility condition requiring medical care. Another woman may have an imperfect diet and still conceive.

Nutrition supports health. It does not determine who deserves or receives pregnancy.

Food Group Two: Beans, Lentils, and Peas

Beans and related foods are among the most useful ingredients in an affordable African meal plan.

They provide plant protein, fibre, carbohydrates, and several vitamins and minerals. They can also make meals more satisfying and reduce the need to depend on meat at every meal.

Options include:

- Black-eyed beans
- Brown beans
- Honey beans
- Lentils
- Chickpeas
- Pigeon peas
- Green peas
- Bambara nuts
- Cowpeas

- Split peas
- Soybeans
- Bean flour used for moi-moi or akara
- Practical ways to eat them

You can prepare:

- Beans with plantain
- Rice and beans
- Moi-moi with vegetables
- Bean porridge with fish
- Lentil stew
- Chickpea salad
- Beans with sweet potato
- Bean and vegetable soup
- Akara with pap, oats, or vegetables
- Bean filling for bread or wraps

Akara can still fit into a balanced eating pattern, but preparation matters.

When it absorbs a large amount of oil, it becomes more energy-dense. You do not need to ban it completely. Use a moderate portion and combine it with fruit, vegetables, or another less oily food.

Reducing digestive discomfort

Some people avoid beans because of gas and bloating.

Try the following:

- Start with smaller portions
- Increase the amount gradually
- Soak dried beans before cooking
- Discard the soaking water
- Cook until properly soft
- Chew slowly

- Avoid eating an unusually large quantity at once
- Notice whether one type of bean is easier to tolerate than another

Persistent severe bloating, abdominal pain, diarrhoea, constipation, or other digestive symptoms should be discussed with a healthcare professional.

Budget strategy

Cook a larger batch and divide it into smaller portions.

Use some for bean porridge, some for rice and beans, and some for a quick workday meal. Freezing cooked beans can reduce preparation time and help prevent the habit of buying fast food because cooking feels too stressful.

Important correction

Beans do not increase fertility simply because they contain plant protein.

They are useful because they can improve the nutritional balance of a meal. They should not be sold as a replacement for ovulation medication or medical assessment.

Food Group Three: Eggs, Fish, and Other Quality Proteins

Protein-rich foods provide building materials used throughout the body.

They also help meals feel more satisfying.

Your options may include:

- Eggs
- Sardines
- Mackerel
- Tilapia
- Croaker
- Catfish
- Salmon where available
- Chicken
- Turkey
- Lean beef

- Goat meat
- Unsweetened yoghurt
- Milk where tolerated
- Tofu
- Soy foods
- Beans and lentils
- Eggs

Eggs are convenient, affordable, and easy to combine with other foods.

You can eat them:

- Boiled
- Scrambled with vegetables
- In tomato and pepper sauce
- With oats
- With sweet potato
- With bread and avocado
- As part of fried rice or vegetable rice

Eggs should not be eaten raw.

Cook them thoroughly, especially when pregnancy is possible, unless local food-safety guidance specifically confirms that a pasteurised product is safe for another preparation.

Fish

Fish can provide protein and, depending on the type, healthy fats.

Examples include sardines and mackerel, which are often more affordable than imported fish.

Because some fish contain more mercury than others, variety and local guidance matter. Avoid assuming that every large fish is suitable for frequent consumption simply because it is expensive.

When pregnancy is possible:

- Buy fish from a reliable source
- Cook it thoroughly

- Avoid raw or poorly stored seafood
- Check local guidance on fish with high mercury levels
- Vary the species you eat
- Meat and poultry

Chicken, turkey, beef, and goat meat can be included according to personal preference, health needs, and budget.

Choose portions that allow space for vegetables and carbohydrates instead of making meat the only meaningful part of the meal.

Trim excessive visible fat where appropriate and avoid repeatedly burning or charring meat.

Processed meats

Sausages, hot dogs, bacon, and similar processed meats can be convenient, but they are often high in salt and may contain less desirable fats.

They should not become the main protein source at every breakfast.

Use eggs, beans, fish, chicken, yoghurt, or other less-processed foods more often.

Food safety

Preconception preparation should include safe food handling because pregnancy may occur before you realise it.

Remember to:

- Wash your hands before cooking
- Keep raw meat separate from ready-to-eat foods
- Cook meat, poultry, fish, and eggs properly
- Refrigerate leftovers promptly
- Reheat stored foods thoroughly
- Avoid food with an unusual smell, texture, or damaged packaging
- Wash fruits and vegetables properly
- Use clean water
- Important correction

Eating eggs or fish cannot guarantee stronger eggs in the ovaries.

The similarity in the word "egg" causes unnecessary confusion. A chicken egg is a nutritious food. It does not directly become or rebuild a human egg.

Food Group Four: Whole or Minimally Processed Carbohydrates

Carbohydrates provide energy.

Your brain, muscles, and other tissues rely on glucose and other energy sources to function. Removing carbohydrates completely is neither necessary nor suitable for everyone.

The goal is to choose less-refined options more often and combine them with protein, vegetables, and healthy fats.

Useful options include:

- Oats
- Millet
- Sorghum
- Corn
- Brown rice
- Ofada rice
- Parboiled rice
- Whole-grain bread
- Yam
- Cocoyam
- Sweet potato
- Irish potato
- Unripe plantain
- Ripe plantain
- Cassava products
- Whole-grain swallow options
- Beans, which contain both carbohydrate and protein
- White rice is not poison

Many Nigerian meals include white rice.

You do not need to remove it completely unless a healthcare professional has given you a specific reason.

Improve the meal by changing the structure:

- Instead of:

A very large plate of rice

A small spoon of stew

- One small piece of meat

A sweet drink

- Try:

A moderate portion of rice

- Beans or fish

A generous serving of vegetables

- Water

This approach is more realistic than telling a household never to cook rice again.

Yam and plantain

Yam and plantain can be included in balanced meals.

Preparation and portion matter.

Boiled, roasted, or air-fried options may use less oil than deep-frying. When you choose fried plantain or fried yam, keep the portion moderate and combine it with beans, eggs, fish, or vegetables.

Swallow

Swallow is not automatically unhealthy.

The problem is often the proportion.

A very large ball of swallow with a small amount of soup may leave little space for vegetables and protein.

Use a moderate portion and make the soup count.

A useful soup should contain more than flavoured oil and water. Add vegetables and a suitable protein source.

Important correction

A low-carbohydrate diet is not automatically a fertility diet.

Some people with PCOS, diabetes, insulin resistance, or other conditions may benefit from individualised carbohydrate changes. That decision should reflect medical needs, food preferences, and professional guidance rather than social-media rules.

Food Group Five: Unsaturated Fats, Nuts, and Seeds

Dietary fat is necessary for health.

Fats contribute to cell structure, help the body absorb certain vitamins, provide energy, and support many biological processes.

Useful sources include:

- Avocado
- Groundnuts
- Cashews
- Walnuts
- Almonds where available
- Sesame seeds
- Pumpkin seeds
- Sunflower seeds
- Sardines
- Mackerel
- Olive oil
- Other plant oils used moderately
- Natural nut or seed butter
- Portion awareness

Nuts and seeds are nutritious, but they are easy to eat in very large quantities.

A practical portion might be a small closed handful.

Do not eat directly from a large container if you regularly lose track of the amount. Pour a portion into a small bowl and put the container away.

Cooking oil

Oil does not need to be completely removed from African cooking.

Measure it.

When oil is poured directly from the bottle, the quantity can become much larger than expected.

Try using a spoon, measuring cup, or smaller pouring container. Increase flavour with onions, peppers, tomatoes, garlic, ginger, herbs, spices, and proper cooking technique rather than relying only on oil.

Palm oil

Palm oil is culturally important in many dishes.

It does not have to be treated as forbidden. Use a sensible amount and avoid allowing oil to dominate the meal.

Seeds and fertility claims

Seeds are frequently marketed according to menstrual-cycle phases.

You may hear that one seed raises estrogen while another raises progesterone.

Current evidence does not support presenting seed cycling as a reliable treatment for hormone disorders or infertility.

You may still eat seeds because they provide nutrients.

Eat them as food, not as a guaranteed hormone prescription.

Your African Ingredient Substitution Chart

Use this chart when an ingredient is unavailable, too expensive, or unfamiliar.

Leafy vegetables

Original option: Ugu

Possible swaps: Spinach, amaranth leaves, sukuma wiki, ewedu, waterleaf, cabbage

Original option: Kale

Possible swaps: Ugu, spinach, sukuma wiki, amaranth leaves

Original option: Broccoli

Possible swaps: Cabbage, green beans, mixed leafy vegetables, cauliflower where available

Colourful vegetables

Original option: Bell peppers

Possible swaps: Local sweet peppers, tomatoes, carrots, pumpkin, garden eggs

Original option: Courgette

Possible swaps: Okra, cucumber, aubergine, pumpkin

Fruit

Original option: Berries

Possible swaps: Guava, orange, pawpaw, mango, watermelon, African star apple

Original option: Kiwi

Possible swaps: Orange, guava, pawpaw, pineapple

Original option: Imported apple

Possible swaps: Any affordable whole fruit in season

Plant proteins

Original option: Lentils

Possible swaps: Brown beans, black-eyed beans, pigeon peas, Bambara nuts, chickpeas

Original option: Chickpeas

Possible swaps: Beans, lentils, cowpeas, soybeans

Original option: Tofu

Possible swaps: Beans, moi-moi, lentils, eggs where suitable

Animal proteins

Original option: Salmon

Possible swaps: Sardines, mackerel, tilapia, croaker, other suitable local fish

Original option: Turkey breast

Possible swaps: Chicken, fish, eggs, beans

Original option: Greek yoghurt

Possible swaps: Unsweetened local yoghurt or milk where tolerated

Carbohydrates

Original option: Quinoa

Possible swaps: Millet, sorghum, oats, brown rice, beans and rice

Original option: Sweet potato

Possible swaps: Yam, cocoyam, plantain, Irish potato

Original option: Whole-grain pasta

Possible swaps: Brown rice, Ofada rice, millet, yam, plantain

Healthy fats

Original option: Almonds

Possible swaps: Groundnuts, cashews, sesame seeds, pumpkin seeds

Original option: Olive oil

Possible swaps: A suitable local plant oil used moderately

Original option: Chia seeds

Possible swaps: Sesame seeds, pumpkin seeds, groundnuts, other available seeds

The substitution does not need to match the original food perfectly.

Its purpose is to keep your meals balanced without making you believe health is only available through imported ingredients.

Build Your Personal Ten-Food List

Choose two foods from each group.

These will become the foundation of your next shopping list.

Group One: Vegetables and Fruit

Group Two: Beans, Lentils, and Peas

Group Three: Eggs, Fish, and Other Proteins

Group Four: Carbohydrates

Group Five: Healthy Fats, Nuts, and Seeds

Now check your list.

- ☐ I can find these foods locally.
- ☐ They fit my budget.
- ☐ I know how to prepare them.
- ☐ I enjoy most of them.
- ☐ At least some can be stored for several days.
- ☐ I have chosen foods, not expensive fertility products.

Your Seven-Day Food-Group Rotation

Use this plan to increase variety without preparing a completely different meal every day.

Day 1

Leafy vegetable: _____:

Protein: _____:

Carbohydrate: _____:

Fruit: _____:

Healthy fat: _____:

Day 2

Colourful vegetable: _____:

Protein: _____:

Carbohydrate: _____:

Fruit: _____:

Healthy fat: _____:

Day 3

Beans or lentils: _____:

Additional protein if needed: _____:

Carbohydrate: _____:

Vegetables: _____:

Fruit: _____:

Day 4

Fish or eggs: _____:

Carbohydrate: _____:

Vegetables: _____:

Fruit: _____:

Healthy fat: _____:

Day 5

Leafy vegetable: _____:

Protein: _____:

Carbohydrate: _____:

Fruit: _____:

Healthy fat: _____:

Day 6

Beans, lentils, or peas: _____:

Carbohydrate: _____:

Vegetables: _____:

Fruit: _____:

Healthy fat: _____:

Day 7

Use leftovers or repeat your easiest balanced meal.

Meal: _____:

Vegetable or fruit added: _____:

Protein added: _____:

Water prepared: Yes / No

The Market Basket Checklist

Before your next market visit, complete this list.

Vegetables

- [ ] One leafy vegetable
- [ ] One colourful vegetable
- [ ] Tomato, pepper, and onion where needed

Fruit

- [ ] Two affordable fruits in season

Plant protein

- [ ] Beans, lentils, peas, or moi-moi ingredients

Animal or alternative protein

- [ ] Eggs, fish, chicken, yoghurt, tofu, or another option

Carbohydrates

- [ ] Two staple options

Healthy fats

- [ ] Nuts, seeds, avocado, fish, or cooking oil

Preparation essentials

- [ ] Clean water
- [ ] Storage containers
- [ ] Seasonings and spices
- [ ] Freezer bags where required

Before You Close This Chapter

Your kitchen does not need to look like an imported wellness shop.

You need vegetables and fruit you can afford.

You need protein sources you will actually eat.

You need carbohydrates that provide energy without taking over the whole plate.

You need sensible amounts of healthy fats.

Most importantly, you need enough variety and consistency to continue beyond one enthusiastic week.

The five groups in this chapter do not rebuild eggs in 21 days.

They do something more honest.

They help you build a more nourishing eating pattern from foods already available around you.

Your action is to complete the Personal Ten-Food List and use it to prepare your next market basket.

> **In the next chapter, we will audit your kitchen properly.**

You will learn what genuinely deserves attention, including alcohol, smoking, excessive caffeine, unregulated herbs, unsafe vaginal products, food safety, and highly processed eating habits.

We will also remove the fear surrounding ordinary foods that have been falsely labelled as hormone destroyers.

Reference Notes for Chapter 4

- World Health Organization. Healthy Diet.
- American Society for Reproductive Medicine. Optimizing Natural Fertility: A Committee Opinion.
- American College of Obstetricians and Gynecologists. Prepregnancy Counseling.
- International Evidence-Based Guideline for the Assessment and Management of Polycystic Ovary Syndrome. 2023.
- United States Food and Drug Administration. Advice About Eating Fish for Those Who Might Become or Are Pregnant.
- Centers for Disease Control and Prevention. Food Safety for Pregnant People.



CHAPTER 5

The Kitchen Audit: What Actually Matters

> *Evidence base: See the chapter's Reference Notes; key clinical recommendations also carry parenthetical source anchors.*

When you are trying to conceive, your kitchen can quickly become a place of fear.

You begin wondering whether the seasoning cube is destroying your hormones. Someone tells you tomatoes increase estrogen. Another person says chicken causes fibroids, cold water weakens the womb, and rice stops ovulation.

Before long, you are afraid of ordinary food.

Let us remove that fear.

There is no clinically validated list of common kitchen ingredients that can diagnose "estrogen dominance," prove that progesterone is low, or explain every fertility problem. Evidence does suggest that smoking, recreational drugs, excessive alcohol, high caffeine intake, some environmental exposures, and poor overall lifestyle patterns may affect reproductive or general health, but this is very different from declaring every packaged or familiar food a hormone destroyer.

This chapter will help you identify what deserves attention and what does not.

You will audit:

- Alcohol, smoking, and recreational drugs
- Caffeine
- Medicines and supplements
- Herbal fertility mixtures
- Fish and mercury
- Food safety
- Sugary and heavily processed foods
- Vaginal washes, steaming, and douching

The general quality of your pantry

The goal is not to create a perfect kitchen.

It is to remove avoidable risks, reduce confusion, and make safer choices while pregnancy is possible.

Begin With the Biggest Risks

Many fertility plans focus on tiny details while ignoring the habits that matter more.

A woman may be frightened of eating one banana at night while continuing to smoke, drink heavily, take several unregulated supplements, and use a vaginal cleansing mixture.

That is not a useful risk strategy.

Start with the areas that have clearer health implications.

Alcohol: Do Not Wait for a Positive Test

Pregnancy can begin before you realise that your period is late.

For this reason, a person actively planning pregnancy should not depend on a positive pregnancy test before reviewing alcohol intake.

ACOG advises people planning pregnancy not to drink alcohol. No safe amount or type of alcohol has been established during pregnancy.

This includes:

- Beer
- Wine
- Spirits
- Cocktails
- Alcoholic bitters
- Alcohol added to herbal mixtures
- Drinks marketed as tonics when they contain alcohol

If you drank before realising you were pregnant, do not spend the next several weeks attacking yourself.

Stop drinking and speak honestly with your healthcare professional. Hiding the amount does not protect you. Accurate information helps the clinician guide you properly.

Your alcohol check

- ☐ I do not currently drink alcohol.
- ☐ I drink occasionally.
- ☐ I drink every week.
- ☐ I sometimes drink heavily in one sitting.
- ☐ I use a herbal product that may contain alcohol.
- ☐ My partner's drinking regularly affects our health or relationship.

My next action

- ☐ Remove alcohol from the house.
- ☐ Stop buying alcohol during the trying-to-conceive period.
- ☐ Check the labels of bitters and tonics.
- ☐ Ask for professional support because stopping is difficult.

☐ Discuss my intake honestly at my next appointment.

Action date: _____:

Smoking, Vaping, Marijuana, and Other Drugs

Smoking is not only a pregnancy issue.

It is a reproductive-health issue for women and men. ASRM advises against smoking and recreational drug use when attempting pregnancy, and its guidance reviews reproductive concerns associated with cigarettes, vaping products, and marijuana.

This section includes:

- Cigarettes
- Cigars
- Shisha or hookah
- Vaping and e-cigarettes
- Marijuana
- Recreational drugs
- Anabolic steroids
- Nonmedical use of prescription drugs
- Regular exposure to another person's smoke

Do not assume vaping is harmless because there is no ash.

Do not assume marijuana is automatically safe because it is a plant.

Do not assume the male partner's habits are irrelevant. Fertility preparation belongs to both partners.

Your smoke and drug check

☐ I smoke cigarettes or another tobacco product.

☐ I vape.

☐ I use marijuana.

☐ I use another recreational drug.

- [ ] My partner uses one or more of these products.
- [ ] I am exposed to smoke at home or work.
- [ ] My partner uses testosterone or anabolic steroids.
- [ ] I need professional support to stop.

My reduction and support plan

Product or exposure: _____:

How often it occurs: _____:

My intended change: _____:

Who can support me: _____:

Date I will begin: _____:

Do not hide substance use from a clinician because you fear judgement.

The purpose of disclosure is to make care safer.

Caffeine: Measure Before You Panic

You do not necessarily need to throw away every tea bag or coffee jar.

Caffeine can be found in:

- Coffee
- Black tea
- Green tea
- Cola drinks
- Energy drinks
- Chocolate
- Some pain relievers
- Some workout or weight-loss products

The amount varies by product, cup size, brewing method, and serving strength.

For pregnancy, ACOG describes less than 200 milligrams per day as moderate intake and states that this amount does not appear to be a major contributor to miscarriage or preterm birth.

Because you may become pregnant before knowing it, using 200 milligrams as a practical upper limit can simplify preparation. Your clinician may recommend less if caffeine worsens anxiety, heart palpitations, reflux, migraines, or sleep problems.

Do not count cups blindly

One small cup of weak tea is not equal to one large mug of strong coffee.

Check labels where possible.

Energy drinks deserve particular attention because one container may contain several servings, added stimulants, and a large amount of sugar.

Your caffeine calculator

List everything containing caffeine that you usually consume.

Product

Serving size

Servings daily

Caffeine per serving

_____

_____

_____

_____ mg

_____

_____

_____

_____ mg

_____

_____

_____

_____ mg

_____

_____

_____

_____ mg

Estimated daily total: _____ mg:

My adjustment

- ☐ No change appears necessary.
- ☐ I will use a smaller cup.
- ☐ I will reduce the number of servings.
- ☐ I will replace one serving with water or a caffeine-free drink.
- ☐ I will stop using energy drinks.
- ☐ I will check whether my medication contains caffeine.

Reduce gradually if you consume large amounts daily. A sudden stop may leave some people with headaches or irritability.

Medicines: Review Them, Do Not Stop Them Carelessly

Prescription medication should not be treated like a kitchen toxin.

Some medicines may need to be adjusted before pregnancy. Others are important for controlling conditions that could become more dangerous if treatment is suddenly stopped.

Prepregnancy care should include a review of prescription medicines, over-the-counter products, vitamins, and other substances.

This includes medication for:

- High blood pressure
- Diabetes
- Thyroid disease
- Epilepsy
- Depression or anxiety
- Pain
- Acne or skin conditions
- Weight loss
- Blood clotting
- Autoimmune conditions
- Fertility treatment
- Any long-term health condition

Do not stop Clomid, letrozole, metformin, thyroid medicine, blood-pressure medicine, antidepressants, epilepsy medicine, or another prescribed treatment because someone said natural food is safer.

The correct step is a medication review.

Complete medication review sheet

Medicine

Dose

Why I take it

Prescriber

Reviewed for pregnancy?

_____

_____

_____

_____

Yes / No

_____

_____

_____

_____

Yes / No

_____

_____

_____

_____

Yes / No

_____

_____

_____

_____

Yes / No

_____

_____

_____

_____

Yes / No

Questions for the prescriber

Is this medicine suitable while trying to conceive?

What should I do if I become pregnant?

Is a safer alternative needed?

Should the dose be changed?

Does it interact with my supplements or herbs?

Must it be stopped gradually?

What symptoms should I report?

Appointment or call date: _____:

Supplements and Herbal Fertility Mixtures

A product does not become safe simply because the label says:

- Natural
- Organic
- Ancient
- African
- Traditional
- Womb cleansing
- Hormone balancing
- Egg boosting
- Fertility support

Many supplements have not been adequately tested in pregnant women. Supplements may interact with medication, contain amounts that differ from the label, or include ingredients not clearly disclosed.

This does not mean every herb is poisonous.

It means every concentrated herbal or supplement product should not be treated as ordinary food.

A small amount of ginger used while cooking is different from a high-dose ginger capsule. Fenugreek used in normal food quantities is different from a concentrated fertility mixture. The dose, preparation, combination, and person's medical history matter.

Fertility-product warning signs

Be cautious when the seller claims the product can:

- Guarantee pregnancy
- Unblock fallopian tubes
- Reverse low AMH
- Rebuild eggs
- Clean the womb
- Cure PCOS permanently
- Prevent miscarriage
- Replace fertility medication
- Work for every woman
- Produce results within a fixed number of days
- Also pause when:

The full ingredient list is missing

- Quantities are not stated

The product has no batch information

The seller refuses to discuss interactions

The mixture is sold in an unlabelled bottle

The instructions change depending on who is selling it

You are asked to combine many products

The product causes vomiting, diarrhoea, heavy bleeding, faintness, or severe pain

- Supplement inventory
- Product

Full ingredients known?

Dose

Reason for use

Clinician reviewed?

_____

Yes / No

_____

_____

Yes / No

_____

Yes / No

_____

_____

Yes / No

_____

Yes / No

_____

_____

Yes / No

_____

Yes / No

_____

_____

Yes / No

Immediate action

- [ ] I will continue only the supplements that have been reviewed.
- [ ] I will pause an unlabelled fertility mixture until it is reviewed.
- [ ] I will check whether several products contain the same vitamins.
- [ ] I will take photographs of every label to my appointment.
- [ ] I will report any adverse effects.

Vaginal Washing, Douching, Steaming, and pH Products

The vagina does not need to be scrubbed internally to become fertile.

Do not insert:

- Soap

- Lime or lemon
- Alum
- Salt water
- Herbal mixtures
- Yoghurt
- Dettol or antiseptic
- Perfume
- Powder
- Steaming preparations
- Unprescribed creams
- Products claiming to make the vagina alkaline

Douching removes some of the normal bacteria that help protect the vagina. It can increase the risk of infection and does not prevent pregnancy or sexually transmitted infections. It may also contribute to bacteria moving upward into the reproductive tract.

Changing vaginal pH is not a reliable fertility technique.

A healthy vagina naturally maintains its own environment. Semen leakage after sex does not mean all sperm has been lost, and internal washing after intercourse does not improve sperm retention.

Safer intimate-care habits

Wash the external vulval area gently

Use clean water or a mild, unscented product if tolerated

Do not wash inside the vagina

Change out of damp clothing

Avoid perfumed internal products

Seek care for persistent odour, itching, pain, burning, or unusual discharge

Complete prescribed treatment for an infection

Encourage the partner to be assessed or treated where necessary

Fish: Choose Wisely, Do Not Remove It Completely

Fish can provide protein and important nutrients.

The concern is not that all fish is dangerous. The concern is that some species contain more mercury than others.

FDA guidance recommends variety and lower-mercury choices for people who are or may become pregnant. Its pregnancy guidance recommends two to three servings per week from lower-mercury options.

Lower-mercury examples on the FDA list include sardines, salmon, tilapia, shrimp, catfish, and some mackerel species.

High-mercury fish on its avoid list include:

- Shark
- Swordfish
- King mackerel
- Marlin
- Orange roughy
- Bigeye tuna
- Tilefish from the Gulf of Mexico

Fish names differ between countries and markets.

For example, "mackerel" may refer to different species. Do not assume king mackerel and ordinary Atlantic or chub mackerel have the same mercury level.

Fish-shopping checklist

- ☐ I buy fish from a reliable source.
- ☐ I vary the type of fish I eat.
- ☐ I avoid fish known to contain high mercury.
- ☐ I ask for the species name where possible.
- ☐ I store fish at a safe temperature.
- ☐ I cook fish thoroughly.
- ☐ I avoid raw or poorly preserved seafood when pregnancy is possible.

Processed Foods, Sugar, Salt, and Frying

A processed food is not automatically poisonous.

Beans that have been dried, milk that has been pasteurised, and vegetables that have been frozen have all undergone processing.

The more useful concern is whether your diet depends heavily on products high in free sugars, sodium, unhealthy fats, or refined starch while containing little fruit, vegetables, legumes, whole grains, or quality protein.

WHO identifies a variety of minimally processed and unprocessed foods that are low in unhealthy fats, free sugars, and sodium as the foundation of a healthy diet.

This is about long-term health.

It is not proof that eating one biscuit damaged your eggs.

Foods to use less frequently

Sugary soft drinks

Large quantities of sweetened juice

Energy drinks

Sweets and pastries

Heavily salted packaged snacks

Frequent processed meats

Meals that are repeatedly deep-fried

Instant meals with little protein or vegetables

Products containing industrial trans fats

Excessive amounts of seasoning and salt

Practical improvements

Instead of banning everything, begin with one change:

- Replace one soft drink with water
- Add vegetables to instant noodles
- Add an egg, fish, or beans to a carbohydrate-heavy meal
- Reduce the amount of oil used when frying

- Keep fruit available for snacks
- Prepare beans or soup in advance
- Compare labels for sugar and sodium
- Use processed meat less often
- Eat takeaway meals less frequently

Food Safety Starts Before Pregnancy Is Confirmed

A person may be pregnant for several weeks before knowing it.

Developing safer food habits during preconception preparation can therefore be useful.

Pregnant people are more vulnerable to certain foodborne infections. Higher-risk foods include raw or undercooked meat, seafood and eggs, unpasteurised dairy products, and unwashed produce. CDC recommends four basic food-safety steps: clean, separate, cook, and chill.

Clean

- [ ] Wash your hands before preparing food.
- [ ] Wash fruits and vegetables under clean running water.
- [ ] Clean knives, boards, counters, and utensils.
- [ ] Use safe water for cooking and drinking.

Separate

- [ ] Keep raw meat, poultry, fish, and eggs away from ready-to-eat foods.
- [ ] Use separate boards or clean them thoroughly between tasks.
- [ ] Do not place cooked food back on a plate that held raw meat.

Cook

- [ ] Cook meat and poultry thoroughly.
- [ ] Cook eggs until the whites and yolks are firm, unless using a pasteurised product in an approved recipe.
- [ ] Cook fish until properly done.
- [ ] Reheat leftovers thoroughly.

Chill

- [ ] Refrigerate perishable foods promptly.
- [ ] Do not leave cooked rice, stew, meat, or fish at room temperature for long periods.
- [ ] Freeze food you will not eat soon.
- [ ] Throw away food with signs of spoilage.

Do not use smell alone as the only safety test. Some harmful germs do not change a food's smell or appearance.

The Green, Yellow, and Red Kitchen Audit

Walk through your pantry, refrigerator, freezer, supplement shelf, and drink cabinet.

Place each item into one of the following categories.

GREEN: Keep and Use Regularly

These foods can form the foundation of your routine, according to your allergies, medical needs, and preferences.

- [ ] Clean drinking water
- [ ] Vegetables
- [ ] Whole fruit
- [ ] Beans, lentils, and peas
- [ ] Eggs
- [ ] Lower-mercury fish
- [ ] Chicken, lean meat, tofu, or another protein
- [ ] Oats, millet, sorghum, rice, yam, plantain, or another staple
- [ ] Nuts and seeds
- [ ] Avocado
- [ ] Unsweetened dairy where tolerated
- [ ] Measured amounts of suitable cooking oil
- [ ] Properly stored leftovers
- [ ] A reviewed prenatal or folic acid supplement

Green items I need to buy

YELLOW: Limit, Check, or Review

These products are not automatically forbidden, but they need attention.

- [ ] Coffee, tea, cola, or another caffeine source
- [ ] Sugary drinks
- [ ] Energy drinks
- [ ] Processed meats
- [ ] Deep-fried foods
- [ ] Highly salted snacks
- [ ] Very sugary cereals or pastries
- [ ] Large quantities of seasoning powder or cubes
- [ ] Fish whose species I cannot identify
- [ ] Herbal teas
- [ ] Several overlapping supplements
- [ ] A product with an incomplete label
- [ ] Leftovers whose storage time is uncertain
- [ ] Medication not yet reviewed for pregnancy

Yellow items requiring action

Item

Why it needs review

My action

RED: Stop, Remove, or Seek Support

- [ ] Alcohol while planning pregnancy
- [ ] Cigarettes or tobacco
- [ ] Vaping products
- [ ] Marijuana or recreational drugs
- [ ] Nonmedical anabolic steroids or testosterone
- [ ] Unlabelled fertility mixtures
- [ ] Products claiming guaranteed pregnancy
- [ ] Vaginal douches
- [ ] Vaginal steaming products
- [ ] Soap, lime, alum, herbs, or antiseptic for internal vaginal use
- [ ] Raw or undercooked meat, eggs, or seafood
- [ ] Unpasteurised dairy products

- [ ] High-mercury fish
- [ ] Spoiled or improperly stored food
- [ ] A supplement that has caused a serious reaction

Red items I am removing

Support I need

Your 48-Hour Kitchen Reset

Do not attempt to rebuild the entire kitchen in one afternoon.

Complete these actions within the next 48 hours.

Action 1: Remove one clear risk

I will remove or stop:

Action 2: Review one uncertain product

The medicine, supplement, herb, or fish I will investigate is:

Action 3: Prepare one safe meal

My meal will include:

Protein: _____:

Vegetables: _____:

Carbohydrate: _____:

Healthy fat: _____:

Drink: _____:

Action 4: Improve storage

- [ ] Label one container with the cooking date.
- [ ] Freeze food I will not eat soon.
- [ ] Separate raw meat or fish from ready-to-eat food.
- [ ] Discard spoiled or uncertain leftovers.

- [ ] Clean the refrigerator shelf.

Action 5: Prepare for a review

- [ ] Photograph my medicine labels.
- [ ] Photograph my supplement labels.
- [ ] Write down my caffeine intake.
- [ ] Record alcohol, smoking, or drug exposure honestly.
- [ ] Book the necessary appointment.

Before You Close This Chapter

A safe preconception kitchen is not a kitchen without rice, yam, tomatoes, chicken, seasoning, or cold water.

It is a kitchen where:

- Food is varied and prepared safely
- Alcohol and smoking are taken seriously
- Caffeine is measured rather than feared
- Medicine is reviewed rather than stopped carelessly
- Unlabelled fertility mixtures are questioned
- Vaginal products are not used to manipulate pH
- Fish is selected thoughtfully
- Sugary and heavily processed foods do not dominate every meal

You do not need to become afraid of your cupboard.

You need to become more intentional about what enters your body and why.

Complete the Green, Yellow, and Red Kitchen Audit before moving forward.

> **In the next chapter, we will turn everything you have learned into a complete 21-day meal calendar with weekly market lists, meal-preparation instructions, flexible African food combinations, and a daily progress tracker.**

Reference Notes for Chapter 5

- American Society for Reproductive Medicine. Optimizing Natural Fertility: A Committee Opinion.
- American Society for Reproductive Medicine. Tobacco or Marijuana Use and Infertility: A Committee Opinion.
- American College of Obstetricians and Gynecologists. Prepregnancy Counseling.
- American College of Obstetricians and Gynecologists. Alcohol and Pregnancy.
- American College of Obstetricians and Gynecologists. Moderate Caffeine Consumption During Pregnancy.
- National Center for Complementary and Integrative Health. Dietary and Herbal Supplements.
- Office on Women's Health. Douching.
- United States Food and Drug Administration. Advice About Eating Fish.
- Centers for Disease Control and Prevention. Safer Food Choices for Pregnant Women.
- World Health Organization. Healthy Diet.



CHAPTER 6

The 21-Day African Preconception Meal Calendar

> *Evidence base: See the chapter's Reference Notes; key clinical recommendations also carry parenthetical source anchors.*

You now understand what a balanced preconception plate looks like.

The next challenge is consistency.

It is easy to plan one beautiful meal after reading a guide. It is harder to decide what to eat on a busy Tuesday morning when you are late for work, the beans are still hard, and the only thing available nearby is bread and a sugary drink.

This 21-day calendar removes some of that daily decision-making.

It is not a fertility treatment, detox, hormone-reset diet, or pregnancy guarantee. It is a structured introduction to eating more regularly, improving food variety, preparing meals safely, and building habits you can continue beyond three weeks.

The World Health Organization recommends a varied diet built around nutrient-dense foods such as vegetables, fruits, legumes, nuts, seeds, whole grains, and suitable animal-source foods. Preconception care also involves more than food. It includes reviewing medicines, managing health conditions, addressing modifiable risks, and preparing safely for pregnancy.

Before You Begin

The meals in this calendar are examples, not compulsory prescriptions.

Change them when necessary because of:

- Food allergies
- Religious or cultural preferences
- Vegetarian eating
- Diabetes or blood-sugar concerns
- Kidney, liver, digestive, or other medical conditions
- Pregnancy-related advice

A clinician's dietary recommendations

Your budget and local food availability

Do not force yourself to eat foods you cannot tolerate simply because they appear in this guide.

Do not copy portions from another woman's plate and assume they are correct for you.

Your hunger, body size, activity level, health conditions, and nutritional needs matter.

Your Simple Portion Guide

Use this as a starting point when serving a main meal:

- Protein: approximately one palm-sized portion
- Carbohydrate: approximately one cupped-hand portion

- Vegetables: one or two fists
- Concentrated fat: approximately one thumb-sized portion
- Fruit: one moderate whole fruit or roughly one fist-sized serving

These are flexible visual guides, not medical measurements.

Eat slowly enough to notice when you are comfortably satisfied. If you remain hungry, increase the meal thoughtfully rather than trying to survive on an unnecessarily small portion.

The Daily Structure

Most days will include:

Breakfast

Lunch

Dinner

One optional snack

One practical action

You do not have to eat at exact clock times.

Try not to wait until you are exhausted, dizzy, or extremely hungry before deciding what to eat. Regular meals can make it easier to choose balanced food instead of grabbing whatever is fastest.

Drink clean water throughout the day.

Continue any prenatal or folic acid supplement recommended for you. For most average-risk people who may become pregnant, guidance recommends 400 micrograms of folic acid daily beginning before conception, although some people require a different prescribed dose.

WEEK ONE

Establish the Foundation

The first week is not about perfection.

It is about learning the plate structure, reducing meal confusion, and preparing enough food to make the next day easier.

Week One Shopping List

Adjust quantities according to household size.

Vegetables

- [ ] Ugu, spinach, ewedu, cabbage, or another leafy vegetable
- [ ] Carrots
- [ ] Tomatoes
- [ ] Peppers
- [ ] Onions
- [ ] Okra or another available vegetable
- [ ] Cucumber or garden eggs

Fruit

- [ ] Oranges or tangerines
- [ ] Pawpaw, banana, watermelon, or another seasonal fruit

Protein

- [ ] Eggs
- [ ] Beans
- [ ] Sardines, mackerel, tilapia, or another suitable fish
- [ ] Chicken or another preferred protein
- [ ] Unsweetened yoghurt where tolerated

Carbohydrates

- [ ] Oats or millet
- [ ] Rice
- [ ] Yam or sweet potato
- [ ] Plantain
- [ ] Whole-grain bread where available

Healthy fats

- [ ] Groundnuts
- [ ] Avocado where available
- [ ] Seeds or nuts
- [ ] Suitable cooking oil

Other essentials

- [ ] Clean drinking water
- [ ] Food-storage containers
- [ ] Folic-acid or prenatal supplement already reviewed for you
- [ ] Spices and seasonings

Week One Preparation Session

Set aside approximately 45-60 minutes.

Complete as many of these tasks as possible:

- [ ] Sort and soak beans.
- [ ] Boil a batch of eggs.
- [ ] Wash and cut vegetables.
- [ ] Prepare tomato and pepper sauce.
- [ ] Cook beans or divide soaked beans for later cooking.
- [ ] Boil yam or sweet potato for one or two meals.
- [ ] Grill, boil, or stew fish or chicken.
- [ ] Wash fruit and place it where you can see it.
- [ ] Portion groundnuts or nuts into small containers.
- [ ] Fill water bottles.
- [ ] Label refrigerated or frozen food with the date.

Day 1: Observe Before Changing Everything

Breakfast

Oats prepared with water or milk where tolerated

One boiled egg

One piece of fruit

Water

Lunch

Rice and beans

Mixed vegetables

Fish or chicken where desired

Water

Dinner

Boiled yam

Egg and vegetable sauce

Water

Optional snack

Orange, pawpaw, or a small portion of groundnuts

Day 1 action

Write down everything you eat and drink without judging yourself.

Do not try to impress the tracker. Record the sweet drink, extra bread, late-night snack, or meal you skipped.

You need an honest starting point.

Day 2: Add Protein to Breakfast

Breakfast

Choose one:

- Whole-grain bread with egg and tomato
- Moi-moi with fruit
- Oats with yoghurt and groundnuts
- Boiled sweet potato with egg sauce

Lunch

Bean porridge

Ugu or another vegetable

Fish where desired

Water

Dinner

Grilled fish

Plantain

Cabbage and carrot mixture

Water

Optional snack

Banana or unsweetened yoghurt

Day 2 action

Identify your usual breakfast protein.

Write it here:

If your breakfast normally consists only of tea, bread, pap, cereal, or a pastry, decide which protein you can add most often.

Day 3: Add Two Colours

Breakfast

Egg, tomato, and spinach scramble

Bread, yam, or sweet potato

Fruit

Water

Lunch

Rice

Chicken or beans

Carrot, cabbage, and green vegetable

Water

Dinner

Vegetable-rich soup

Moderate swallow portion

Fish, chicken, lean meat, or beans

Water

Optional snack

Garden eggs with a small portion of groundnuts

Day 3 action

Add two visibly different colours of vegetables or fruit to at least one meal.

Example:

- Green ugu
- Orange carrot
- Red tomato

Colour is not a fertility test. It is simply an easy way to encourage variety.

Day 4: Replace One Sugary Drink

Breakfast

Millet or oat porridge with minimal added sugar

Egg

Fruit

Lunch

Beans and plantain

Vegetable sauce

Water

Dinner

Sweet potato

Sardine or fish sauce

Cucumber and tomato

Water

Optional snack

Fruit

Day 4 action

Replace one soft drink, sweetened juice, energy drink, or heavily sweetened tea with:

- Water
- Unsweetened tea

A lightly sweetened homemade drink

- Sparkling water without added sugar

Do not compensate by drinking several glasses of fruit juice. Whole fruit generally provides more fibre and is easier to portion.

Day 5: Build a Bean-Based Meal

Breakfast

Moi-moi

Fruit

Water

Lunch

Rice and beans

Mixed vegetables

Fish where desired

Dinner

Lentil, bean, or pea stew

Yam, plantain, or another carbohydrate

Vegetables

Optional snack

Unsweetened yoghurt or groundnuts

Day 5 action

Prepare enough beans or lentils for at least two meals.

Freeze one portion if you will not use it within a safe storage period.

Day 6: Prepare Fish Safely

Breakfast

Oats

Boiled egg

Pawpaw or another fruit

Lunch

Grilled or stewed fish

Yam or rice

Vegetable sauce

Water

Dinner

Whole-grain bread

Sardine, egg, or bean filling

Tomato and cucumber

Water

Optional snack

Fruit or nuts

Day 6 action

Check the fish you buy.

Ask:

Do I know what type it is?

Was it stored properly?

Does it appear fresh?

Am I varying the species I eat?

Have I cooked it thoroughly?

Day 7: Repeat What Worked

Breakfast

Repeat your easiest balanced breakfast from Days 1-6.

Lunch

Use safe leftovers to build a balanced plate.

Dinner

Choose the meal you enjoyed most during the week.

Optional snack

Fruit, yoghurt, egg, or nuts.

Day 7 action: Weekly review

Complete:

The easiest breakfast was: _____:

The meal that kept me satisfied longest was: _____:

The vegetable I enjoyed most was: _____:

The food that was difficult to prepare was: _____:

The item I wasted was: _____:

The change I will make next week is: _____:

WEEK TWO

Improve Variety and Nutrient Density

Week two builds on the meals you already managed.

You do not need 21 completely different dishes. Repetition can save money and reduce stress.

The goal is to rotate food groups and improve the quality of familiar meals.

Week Two Shopping List

Before shopping, check what remains from Week One.

Buy only what you need

- [ ] One or two leafy vegetables
- [ ] Two other vegetables
- [ ] Two seasonal fruits
- [ ] Beans, lentils, peas, or soy food
- [ ] Eggs
- [ ] Fish or another protein
- [ ] Two staple carbohydrates
- [ ] Nuts, seeds, or avocado
- [ ] Clean water and storage supplies

Day 8: Include a Folate-Rich Meal

Breakfast

Moi-moi

Orange

Water

Lunch

Beans

Ugu or spinach

Plantain

Fish where desired

Dinner

Rice

Lentil or bean stew

Mixed vegetables

Optional snack

Pawpaw

Day 8 action

Include a dark-green leafy vegetable or beans today.

Continue your recommended folic acid supplement. Food folate is useful, but eating vegetables does not automatically replace the established preconception supplement recommendation.

Day 9: Add Nuts or Seeds Thoughtfully

Breakfast

Oats

Banana

Small portion of groundnuts or seeds

Egg where needed

Lunch

Yam and fish sauce

Vegetables

Dinner

Beans and rice

Cabbage or leafy vegetables

Optional snack

Fruit

Day 9 action

Measure one small portion of nuts or seeds.

Do not eat directly from a large bottle or bag.

My portion was: _____:

Day 10: Improve the Carbohydrate, Not Eliminate It

Breakfast

Millet, oats, or whole-grain bread

Egg or yoghurt

Fruit

Lunch

Ofada, brown, parboiled, or ordinary rice in a moderate portion

Beans or fish

Vegetables

Dinner

Sweet potato

Chicken, egg, or lentils

Vegetable sauce

Optional snack

Cucumber, garden egg, or fruit

Day 10 action

Choose one less-refined carbohydrate today, or improve a refined-carbohydrate meal by adding protein and vegetables.

You are not required to remove rice, yam, plantain, or bread completely.

Day 11: Make Fruit Convenient

Breakfast

Egg and vegetable sauce

Yam, bread, or sweet potato

Lunch

Rice and beans

Vegetables

Water

Dinner

Fish

Plantain

Vegetable salad or cooked greens

Optional snack

Whole fruit

Day 11 action

Wash and place tomorrow's fruit somewhere visible.

If you leave home early, put one portion in your bag tonight.

Day 12: Prepare a Vegetable-Rich Soup or Stew

Breakfast

Oats with egg and fruit

Lunch

Vegetable-rich soup

Moderate swallow portion

Fish, chicken, meat, or beans

Dinner

Safe leftover soup with yam, rice, or another suitable carbohydrate

Optional snack

Fruit or yoghurt

Day 12 action

Use vegetables as a substantial part of the meal rather than decoration.

Write the vegetables used:

Day 13: Review Caffeine and Alcohol

Breakfast

Whole-grain bread

Egg or sardine

Tomato and cucumber

Lunch

Beans and plantain

Vegetables

Dinner

Grilled chicken or fish

Rice or yam

Vegetables

Optional snack

Fruit or nuts

Day 13 action

Record every caffeinated and alcoholic drink consumed this week.

Coffee or tea servings: _____:

Soft or energy drinks: _____:

Alcohol: _____:

My adjustment: _____:

People planning pregnancy should avoid alcohol. Caffeine intake also deserves attention, particularly from large coffees, energy drinks, and products containing additional stimulants.

Day 14: Repeat and Prepare

Breakfast

Repeat your most practical breakfast.

Lunch

Use one safely stored prepared meal.

Dinner

Cook a double portion of a balanced meal for Day 15.

Day 14 action: Midpoint review

Score each area from 1 to 5.

1 = needs major attention

5 = going consistently well

Regular meals: _____

Protein intake: _____

Vegetable variety: _____

Fruit intake: _____

Water intake: _____

Meal preparation: _____

Food safety: _____

Energy level: _____

Do not interpret the score as a fertility measurement.

It is a habit review.

WEEK THREE

Build a Routine You Can Continue

Week three is about sustainability.

The programme is not successful if you eat perfectly for 21 days and then abandon everything on Day 22.

You need meals that fit your job, household, budget, and energy.

Day 15: Build a Low-Cost Market List

Breakfast

Pap, oats, or millet porridge with minimal added sugar

Moi-moi or egg

Fruit

Lunch

Rice and beans

Vegetables

Dinner

Yam

Egg or sardine sauce

Leafy vegetables

Optional snack

Seasonal fruit

Day 15 action

Build a market list around affordable staples.

Low-cost proteins

- [ ] Beans
- [ ] Eggs
- [ ] Sardines
- [ ] Groundnuts
- [ ] Moi-moi ingredients
- [ ] Another local option: _____

Low-cost vegetables

- [ ] Ugu, ewedu, cabbage, okra, or seasonal greens
- [ ] Carrots
- [ ] Tomatoes and peppers
- [ ] Another option: _____

Low-cost carbohydrates

- [ ] Rice
- [ ] Yam
- [ ] Plantain
- [ ] Oats
- [ ] Millet
- [ ] Sweet potato
- [ ] Another option: _____

Day 16: Prepare Two Proteins

Breakfast

Egg with vegetables

Bread or sweet potato

Fruit

Lunch

Beans

Plantain

Vegetables

Dinner

Fish or chicken

Rice

Mixed vegetables

Day 16 action

Prepare two protein options for the next three days.

Example:

- Cooked beans
- Boiled eggs
- Or:
- Grilled fish
- Moi-moi

Day 17: Plan for a Busy Workday

Breakfast

Choose a meal that takes fewer than ten minutes:

- Boiled egg, bread, tomato, and fruit
- Overnight oats with yoghurt and nuts
- Reheated moi-moi with fruit
- Sweet potato prepared the previous night with egg
- Packed lunch
- Rice and beans with vegetables
- Yam and fish sauce
- Whole-grain sandwich with egg or sardine and vegetables
- Safe leftovers in a suitable container

Dinner

Choose a simple one-pot meal:

- Bean porridge with vegetables
- Rice, beans, and vegetables
- Fish stew with yam
- Vegetable soup from the freezer

Optional snack

Fruit

Nuts

Yoghurt

Boiled egg

Day 17 action

Prepare tomorrow's breakfast and lunch before sleeping.

Breakfast prepared: _____:

Lunch packed: _____:

Water bottle filled: Yes / No

Day 18: Prepare a Shared Meal

Breakfast

Oats or millet

Egg

Fruit

Lunch

Beans or lentils

Rice or plantain

Vegetables

Dinner

Prepare with your partner:

- Fish, chicken, beans, or eggs
- Rice, yam, plantain, or another staple
- Two vegetables
- Water

Day 18 action

Ask your partner to choose and prepare one part of the meal.

Fertility preparation should not become another responsibility placed entirely on the woman.

Discuss:

Which healthy meal does your partner enjoy?

What habit can you both improve?

Which food-shopping task can your partner handle?

Does your partner need a health or medication review?

Day 19: Review Medicines and Supplements

Breakfast

Egg and vegetable sauce

Bread, yam, or sweet potato

Lunch

Fish

Rice

Vegetables

Dinner

Beans

Plantain

Vegetable sauce

Optional snack

Fruit or yoghurt

Day 19 action

Place every medicine and supplement in one location.

Complete:

- Product
- Dose
- Reason

Reviewed?

_____

_____

_____

Yes / No

_____

_____

_____

Yes / No

_____

_____

_____

Yes / No

_____

_____

_____

Yes / No

Do not discontinue prescribed medication independently. Preconception care includes reviewing medicines and weighing their risks and benefits with an appropriate professional.

Day 20: Build Your Four-Meal Rotation

Breakfast

Repeat your easiest breakfast.

Lunch

Repeat your most affordable lunch.

Dinner

Repeat your favourite vegetable-rich dinner.

Day 20 action

Choose four meals you can continue preparing after the programme.

Meal 1: Fast breakfast

Meal 2: Affordable lunch

Meal 3: Vegetable-rich dinner

Meal 4: Emergency meal

An emergency meal is something balanced you can prepare when tired.

Examples:

- Boiled egg, bread, tomato, and fruit

- Sardines, rice, and frozen vegetables
- Moi-moi with fruit
- Beans from the freezer with plantain
- Oats, yoghurt, nuts, and fruit

Day 21: Review, Continue, and Escalate Where Needed

Breakfast

Choose your favourite breakfast from the programme.

Lunch

Build a plate using the formula without checking the guide.

Dinner

Prepare a meal you could confidently repeat next week.

Day 21 action

Complete the full progress review below.

The 21-Day Meal and Habit Tracker

Use one line each day.

Day

Balanced main meal

Vegetables or fruit

Protein at two meals

Water prepared

Supplement taken

Notes

1

- [ ] _____

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- [ ] _____

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The supplement column applies only to a product that has been recommended or reviewed for you.

Do not use this tracker to compare your body with another person's.

The Meal and Symptom Log

Complete this when you need to identify patterns.

Date: _____:

Breakfast: _____:

Lunch: _____:

Dinner: _____:

Snacks and drinks: _____:

Water intake: _____:

Supplements and medicines: _____:

How I felt

Hunger before meals: Low / Moderate / Very high

Energy: Low / Moderate / Good

Bloating: None / Mild / Moderate / Severe

Nausea: None / Mild / Moderate / Severe

Bowel symptoms: _____:

Pelvic pain: None / Mild / Moderate / Severe

Other symptoms: _____:

This tracker does not measure hormone balance or egg quality.

It helps you notice practical patterns and prepare useful information for a clinician or dietitian.

When Money Is Tight

A nourishing routine does not need to include salmon, imported yoghurt, chia seeds, berries, quinoa, or costly fertility powders.

Build around affordable combinations:

- Beans and rice
- Beans and plantain
- Moi-moi and fruit
- Eggs and sweet potato
- Sardines and rice
- Yam and egg sauce
- Oats and egg
- Vegetable soup with fish
- Groundnuts and fruit
- Seasonal vegetables and fruit

- Save money by:
- Buying seasonal produce
- Planning meals before shopping
- Checking the kitchen before buying more
- Cooking beans in larger batches
- Using eggs and legumes as affordable proteins
- Freezing safe portions
- Reducing food waste
- Carrying meals instead of buying food daily
- Avoiding supplements with unsupported promises

Do not spend your food budget on a fertility product while skipping proper meals.

Your Day 21 Review

Nutrition

The habit I maintained most consistently: _____:

The meal I will continue: _____:

The food group I need to improve: _____:

The product I stopped or reduced: _____:

Preparation

My most useful preparation habit: _____:

The day I will shop each week: _____:

The day I will prepare food: _____:

Health and safety

☐ My folic acid or prenatal supplement has been reviewed.

- [ ] My medicines have been reviewed or an appointment is booked.
- [ ] I have stopped unlabelled fertility mixtures.
- [ ] I have reduced or stopped alcohol.
- [ ] I have addressed smoking, vaping, or drug exposure.
- [ ] I prepare and store food more safely.

Medical follow-up

The symptom or concern I need to discuss: _____:

The person I will contact: _____:

My appointment deadline: _____:

Before You Close This Chapter

You have completed 21 days of structured nourishment.

Do not measure the programme only by whether you are pregnant.

A positive pregnancy test is not an outcome that a meal calendar can guarantee.

Instead, look at what you can now control:

You can build a balanced plate.

You can shop with a clear list.

You can prepare food before you become extremely hungry.

You can identify protein, vegetables, carbohydrates, and healthy fats.

You can question unsafe supplements.

You can plan meals around your budget.

You can recognise when medical care is still necessary.

These are meaningful results.

Continue the meals that worked. Adjust those that did not. Take your records to a qualified healthcare professional where you need individualised support.

In the next chapter, we will move from the kitchen to the menstrual cycle.

You will learn how the fertile window works, why ovulation does not always occur on Day 14, how to observe useful signs, and how to track without turning every day into a source of anxiety.

Reference Notes for Chapter 6

- World Health Organization. Healthy Diet. Updated January 26, 2026.
- American College of Obstetricians and Gynecologists. Prepregnancy Counseling.
- American College of Obstetricians and Gynecologists. Reducing Risks of Birth Defects.
- American College of Obstetricians and Gynecologists. Interpregnancy Care.
- International Evidence-Based Guideline for the Assessment and Management of Polycystic Ovary Syndrome. 2023.



CHAPTER 7

Understanding Your Fertile Window

> *Evidence base: See the chapter's Reference Notes; key clinical recommendations also carry parenthetical source anchors.*

Many women have been taught to treat ovulation like a one-day examination.

You open your calendar, count fourteen days from the beginning of your period, and circle one date. When that date arrives, you and your partner feel pressured to have sex whether you are tired, upset, travelling, unwell, or emotionally disconnected.

If pregnancy does not happen, you may assume that you missed the exact hour.

That is not how the fertile window works.

Pregnancy does not depend on catching one perfect moment. There are several days during each ovulatory cycle when intercourse can lead to conception.

This chapter will show you how to identify those days without allowing tracking to control your life.

You will learn:

- How to count a menstrual cycle correctly
- Why ovulation does not always happen on Day 14
- What the fertile window means
- How cervical mucus changes
- How ovulation-predictor kits work
- What basal-body temperature can and cannot tell you
- Why calendar applications are estimates
- How to track irregular cycles
- When tracking should give way to medical evaluation
- Start With Day 1

Day 1 of your menstrual cycle is the first day of proper menstrual bleeding.

It is not usually the day you notice one tiny brown spot when wiping. If light spotting becomes a proper menstrual flow the following day, that following day is generally recorded as Day 1.

Write the date clearly.

My current cycle

> The first day of proper bleeding was: _____:

That date is Cycle Day 1.

The cycle continues until the day before your next period begins. When the next period starts, a new cycle begins.

For example:

- Period begins on January 3
- Next period begins on January 31

The cycle length is 28 days

A menstrual cycle does not need to last exactly 28 days to be real or potentially ovulatory. The timing of ovulation varies between women and can also vary between cycles in the same woman. Ovulation often occurs around 10 to 16 days before the next period rather than on one universal cycle day.

What Ovulation Means

Ovulation is the release of an egg from an ovary.

After the egg is released, it enters a fallopian tube. Pregnancy becomes possible when sperm is already present or arrives while the egg remains capable of being fertilised.

The egg remains available for only a relatively short time after ovulation. Sperm can survive inside the female reproductive tract for several days under suitable conditions. This is why intercourse before ovulation is often more useful than waiting until you believe ovulation has already occurred.

You are not trying to make sperm arrive after the door is closing.

You are trying to have sperm available before or around the time the egg is released.

The Fertile Window Is Wider Than One Day

For practical fertility guidance, the fertile window is usually described as the six-day period ending on the day of ovulation.

It includes:

The five days before ovulation

The day of ovulation

The highest probability of conception is generally associated with intercourse during the final days before ovulation, particularly within the two days before the egg is released.

This means you do not need to know the exact minute of ovulation.

You need to identify a reasonable range of days and have intercourse regularly enough during that period for sperm to be present.

A simple example

Imagine that ovulation occurs on Cycle Day 16.

The estimated fertile window would include:

Day 11

Day 12

Day 13

Day 14

Day 15

Day 16

This does not mean pregnancy will occur if you have sex on those days.

It means those are the days during which intercourse could potentially lead to conception in that cycle.

How Often Should You Have Sex?

Intercourse every one to two days during the fertile window provides the highest pregnancy rates in the available evidence.

However, intercourse two or three times per week throughout the cycle may achieve results that are nearly equivalent for many couples. ASRM advises that couples should not be told to limit intercourse because of the belief that frequent ejaculation automatically weakens sperm.

A practical pattern may be:

- Every other day during the likely fertile window
- Every two to three days throughout the month
- Daily during the fertile window when both partners prefer it

Do not create a schedule that makes intimacy unbearable.

If every-other-day intercourse is realistic, use it. If a less rigid two-to-three-times-per-week pattern is better for your relationship, that can still provide regular opportunities.

One act of intercourse on one predicted ovulation day is more likely to miss the fertile window than intercourse spread across several days.

Why Day 14 Can Mislead You

Day 14 became popular because it fits a textbook 28-day cycle.

But not every woman has a 28-day cycle.

Even women who usually have regular cycles may ovulate on different days from one month to another. Illness, travel, sleep disruption, breastfeeding, hormonal conditions, age, significant changes in energy intake, and other factors can affect cycle timing.

Consider these examples:

- Example 1: A 28-day cycle

Estimated ovulation may occur around Day 14.

Example 2: A 31-day cycle

Estimated ovulation may occur later, perhaps around Day 17.

Example 3: A 24-day cycle

Estimated ovulation may occur earlier, perhaps around Day 10.

These dates are estimates, not guarantees.

The time between ovulation and the next period often falls within a range of approximately 10 to 16 days, which is why counting backward from the next period is more biologically sensible than assuming every woman ovulates on the fourteenth day.

The difficulty is that you do not know the date of your next period in advance.

That is why calendar tracking works best as one clue rather than the only method.

Method One: The Calendar

The calendar method uses previous cycle lengths to estimate when ovulation and the fertile window may occur.

To use it:

Record the first day of every period.

Count the length of each cycle.

Review at least three to six cycles where possible.

Identify your shortest and longest cycles.

Use the pattern to estimate when ovulation may occur.

Combine the estimate with cervical mucus or another method.

Three-cycle example

Cycle

First day

Next period

Cycle length

1

January 3

January 31

28 days

2

January 31

March 1

29 days

3

March 1

March 28

27 days

This person's cycles appear to fall within a relatively narrow range.

She may use a calendar to estimate her fertile period, but she should still avoid treating the application's predicted ovulation day as a laboratory result.

When the calendar becomes less useful

The calendar is less reliable when cycles vary widely.

For example:

- 25 days
- 37 days
- 29 days
- 42 days

A phone application may still produce a neat green fertile window, but the body is not required to follow the application's calculation.

ASRM reports that calendar-based applications can perform poorly when predicting the precise day of ovulation because they assume cycle timing is more consistent than it actually is. In one comparison, the best-performing applications predicted the exact ovulation day correctly in only 21 percent of cycles.

Use applications to store information.

Do not treat them as proof.

Method Two: Cervical Mucus

Cervical mucus changes in response to hormonal activity during the menstrual cycle.

Away from the fertile window, you may notice:

- Little or no discharge
- Sticky discharge
- Thick or creamy discharge
- As ovulation approaches, cervical mucus may become:
- Wetter
- Clearer
- Slippery
- Stretchy
- Similar in appearance to raw egg white

Slippery, clear mucus is associated with the period of highest fertility, although pregnancy can still occur when a woman does not notice textbook egg-white mucus.

How to observe it

You may notice mucus:

- On toilet tissue before urinating
- At the vaginal opening
- On underwear
- As a slippery sensation when walking or wiping

You do not need to insert fingers deeply into the vagina.

At approximately the same time each day, record the most fertile-quality mucus you observed.

Simple mucus categories

Dry: No noticeable discharge or sensation.

Sticky: Thick, tacky, pasty, or crumbly.

Creamy: Smooth, cloudy, lotion-like, or moist.

Watery: Thin and noticeably wet.

Slippery or stretchy: Clearer, lubricative, and able to stretch between the fingers.

When mucus becomes wetter, clearer, or more slippery, the fertile window may be approaching.

Things that can confuse mucus tracking

Discharge may be affected by:

- Semen after intercourse
- Sexual arousal fluid
- Vaginal infection
- Lubricants
- Vaginal medicines
- Breastfeeding
- Hormonal medication
- Individual differences

Do not assume every wet sensation means ovulation.

Seek medical advice for discharge accompanied by:

- Strong or unpleasant odour
- Itching
- Burning
- Pelvic pain
- Painful urination
- Green, grey, or unusual colour
- Bleeding outside the expected period

Method Three: Ovulation-Predictor Kits

Ovulation-predictor kits test urine for luteinising hormone, commonly called LH.

A rise or surge in LH occurs before ovulation. A positive result generally suggests that ovulation may occur within approximately the next one to two days.

The kit does not see the egg.

It detects a hormonal signal associated with the body preparing to release one.

How to use an ovulation test

Follow the manufacturer's instructions because products differ.

General steps may include:

Estimate when your fertile window may begin.

Start testing several days before expected ovulation.

Test at approximately the same time daily.

Avoid drinking an excessive amount of water immediately before testing.

Compare the result exactly as the instructions describe.

Record the result as negative, high, peak, or positive according to the product.

Some guidance notes that midday or evening urine may correlate better with the LH surge than relying only on the first urine of the morning, but the instructions supplied with your specific product should take priority.

What a positive result means

A positive result suggests that an LH surge has been detected.

It does not prove that:

The egg was successfully released

The egg is healthy

The fallopian tubes are open

- Sperm is healthy
- Fertilisation will occur

- Pregnancy will result

It is one useful clue.

PCOS and false positives

Some women with PCOS have persistently elevated or irregular LH levels. This can lead to repeated positive or confusing ovulation-test results even when ovulation does not follow in the expected way.

If you repeatedly see positive tests, never see a clear surge, or have highly irregular cycles, discuss the pattern with a clinician.

Buying more test strips may not solve the underlying question.

Method Four: Basal-Body Temperature

Basal-body temperature is your resting temperature taken immediately after waking, before getting out of bed or beginning normal activity.

After ovulation, progesterone can cause a small sustained temperature rise.

A chart showing lower temperatures followed by a consistently higher range may suggest that ovulation has already occurred.

That last word matters.

Already.

Basal-body temperature is better at suggesting that ovulation happened than predicting it early enough to time intercourse.

ASRM describes daily basal-body-temperature tracking as inexpensive but often unreliable. Some women who ovulate do not produce an easily interpreted two-phase chart, and daily testing can become tedious. It is not routinely recommended as the main method for evaluating ovulation.

If you choose to use it

Use a basal thermometer

Take your temperature at the same time each morning

Measure before getting out of bed

Record illness, alcohol use, poor sleep, late waking, or travel

Look for a pattern across several days

Do not panic over one unusual reading

Temperature can be affected by:

- Fever
- Interrupted sleep
- Alcohol
- Shift work
- Travel
- Different testing times
- Room temperature
- Medication
- Incorrect technique

Do not use one temperature reading to declare that you did or did not ovulate.

Which Tracking Method Should You Choose?

You do not need every available device.

Simple approach

Use:

- Period dates
- Cervical mucus
- Intercourse dates
- More detailed approach
- Use:
- Period dates
- Cervical mucus
- Ovulation-predictor kits

- Intercourse dates
- Optional retrospective approach

Add basal-body temperature when you enjoy detailed tracking and understand its limitations.

Clinical approach

Seek professional evaluation when:

- Cycles are absent
- Cycles are highly irregular
- Ovulation tests are repeatedly confusing

You have reached the recommended infertility-evaluation timeline

You have severe pain or other concerning symptoms

You have a known condition affecting ovulation

Tracking should not become a substitute for care.

Your Complete Cycle and Fertile-Window Tracker

Use one page for each cycle.

Cycle information

Cycle number: _____:
Date proper bleeding began: _____:
Date next period began: _____:
Total cycle length: _____:
Average cycle length from previous cycles: _____:

Bleeding record

Cycle day

Date

None

Spotting

Light

Moderate

Heavy

Pain 0-10

1

_____

_____

2

_____

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Add another line if bleeding continues.

Daily fertility record

Cycle day

Date

Cervical mucus

Ovulation test

Intercourse

Temperature

Symptoms or notes

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Continue on another page if the cycle is longer.

How to Complete the Mucus Column

Use one code per day:

- D: Dry
- S: Sticky
- C: Creamy

- W: Watery
- SL: Slippery or stretchy
- U: Uncertain
- I: Possible infection symptoms

Record the most fertile-quality mucus you observed that day.

How to Complete the Ovulation-Test Column

Use:

- N: Negative
- H: High, where the device uses this category
- P: Peak or positive
- U: Unclear
- NT: Not tested

Do not invent a result when the test is difficult to read.

Write "unclear" and repeat according to the instructions.

Your Estimated Fertile Window

After reviewing your calendar, mucus, and test results, write:

Likely fertile window began: _____:

Peak-type mucus appeared: _____:

Positive LH test appeared: _____:

Estimated ovulation period: _____:

Intercourse occurred during this range: Yes / No

Remember that this remains an estimate.

End-of-Cycle Review

Complete this when your next period begins or when pregnancy is confirmed.

Cycle pattern

Cycle length: _____:

Shortest cycle in the last six months: _____:

Longest cycle in the last six months: _____:

The cycles vary by: _____:

Ovulation clues

- [ ] I observed wetter or slippery mucus.
- [ ] I had a positive ovulation test.
- [ ] My temperature rose and stayed higher.
- [ ] I experienced mild mid-cycle discomfort.
- [ ] I did not identify a clear ovulation pattern.

Symptoms requiring attention

- [ ] Period absent
- [ ] Cycle highly irregular
- [ ] Severe pelvic pain
- [ ] Very heavy bleeding
- [ ] Bleeding between periods
- [ ] Bleeding after sex
- [ ] Persistent unusual discharge
- [ ] Repeated positive ovulation tests
- [ ] No positive ovulation tests across several cycles
- [ ] Other: _____

My next step

- [ ] Continue tracking.

- [ ] Use fewer tracking methods to reduce stress.
- [ ] Discuss possible irregular ovulation.
- [ ] Take my records to a clinician.
- [ ] Arrange a fertility evaluation.

Tracking With Irregular Cycles

Irregular cycles can make fertile-window prediction more difficult.

You may need to test for longer, observe mucus more carefully, or have intercourse regularly throughout the cycle rather than waiting for an application's predicted dates.

However, do not spend endless months trying to decode highly irregular or absent periods.

A history of infrequent or absent menstruation can be sufficient evidence that ovulation may not be occurring regularly and should prompt investigation into the underlying cause.

Possible causes cannot be identified from a tracker alone.

Evaluation may consider PCOS, thyroid conditions, prolactin-related disorders, hypothalamic causes, ovarian insufficiency, medication effects, and other factors depending on your history.

Your tracker helps tell the story.

It does not replace the investigation.

When Tracking Creates More Pressure Than Clarity

Tracking should serve you.

You should not become a servant to your application, thermometer, discharge, or test strip.

Fertility-awareness methods can help some couples time intercourse, but ASRM also recognises that strict scheduling may increase stress, reduce sexual satisfaction, and decrease intercourse frequency for some couples.

Signs that you may need to simplify include:

- Testing several times daily despite clear instructions
- Feeling unable to have sex outside predicted fertile days
- Fighting with your partner about timing

- Checking discharge repeatedly throughout the day
- Believing one missed day has destroyed the entire cycle
- Spending more than you can afford on devices
- Feeling intense fear when the application changes a date
- Avoiding medical care because you want more tracking data first

You are allowed to stop using a method that is making the process emotionally unmanageable.

A simpler plan of regular intercourse every two to three days may be more sustainable.

Fertile-Window Myths

Myth 1: I must have sex only on ovulation day.

False.

Intercourse during the days before ovulation is important because sperm can already be present when the egg is released.

Myth 2: My application knows exactly when I ovulate.

False.

Applications estimate ovulation based mainly on previous cycle patterns. They do not directly observe the ovary releasing an egg.

Myth 3: Clear discharge guarantees ovulation.

False.

Slippery, clear mucus can be a useful fertility sign, but it does not prove that ovulation occurred or guarantee pregnancy.

Myth 4: A positive ovulation test proves I released an egg.

False.

It detects an LH surge associated with impending ovulation. False-positive and false-negative results can occur.

Myth 5: Every woman must ovulate on Day 14.

False.

Ovulation timing depends on cycle length and can vary from month to month.

Myth 6: If we miss one day, the cycle is wasted.

False.

The fertile window spans several days. Regular intercourse across that range is more practical than chasing one exact date.

Myth 7: More tracking always produces better results.

False.

Tracking can help with timing, but too much monitoring may increase pressure and reduce intimacy for some couples.

Before You Close This Chapter

Your body is not a clock that must perform on Day 14.

Your fertile window is a range, not one perfect hour.

You can use your period dates, cervical mucus, ovulation-predictor tests, and optional temperature tracking to better understand your pattern. But every method has limitations.

The most useful approach is the one that gives you information without taking away your peace.

Your action from this chapter is to begin one Cycle and Fertile-Window Tracker.

Record:

The first day of proper bleeding

Your daily cervical mucus

- Ovulation-test results where used
- Intercourse dates
- Important symptoms

After the cycle, review the pattern rather than judging each day separately.

In the next chapter, we will discuss intimacy.

You will learn how to create a low-pressure plan that supports regular intercourse without sperm-retention rituals, compulsory sexual positions, or the feeling that every intimate moment must produce a pregnancy.

Reference Notes for Chapter 7

- American Society for Reproductive Medicine. Optimizing Natural Fertility: A Committee Opinion.
- American Society for Reproductive Medicine. Fertility Evaluation of Infertile Women: A Committee Opinion.
- American College of Obstetricians and Gynecologists. Fertility Awareness-Based Methods of Family Planning.
- American College of Obstetricians and Gynecologists. Evaluating Infertility.
- National Health Service. Periods and Fertility in the Menstrual Cycle.



CHAPTER 8

The Low-Pressure Intimacy Plan

> *Evidence base: See the chapter's Reference Notes; key clinical recommendations also carry parenthetical source anchors.*

Trying to conceive can quietly change the meaning of sex.

What was once spontaneous begins to revolve around dates, discharge, test strips, and reminders from an application. You may find yourself calculating whether tonight is "the night" while your partner feels as though he has been given an assignment.

When the fertile window opens, both of you may feel pressure to perform.

When it closes, disappointment begins.

Over time, intimacy can start feeling less like connection and more like a monthly medical procedure.

This chapter will help you create a plan that gives you regular opportunities for conception without allowing the process to damage your comfort, consent, or relationship.

There will be no compulsory sexual position.

There will be no sperm-retention ritual.

There will be no instruction to raise your legs, remain frozen in bed, achieve orgasm on command, or manipulate your vaginal pH.

The goal is regular, comfortable intercourse during the fertile window while protecting the emotional relationship around it.

You Do Not Need One Perfect Night

The fertile window is not limited to one exact hour.

Sperm can remain capable of fertilisation inside the female reproductive tract for several days, while an egg remains available for a much shorter period after ovulation. This creates a fertile window of approximately six days rather than one perfect moment.

For the best opportunity, ACOG and ASRM recommend intercourse every day or every other day during the fertile window. Intercourse every one to two days produces the highest pregnancy rates, but couples do not need to force daily sex when it becomes stressful or uncomfortable.

This means you do not need to save all your hope for one predicted ovulation day.

A practical approach may be:

- Intercourse every other day during the likely fertile window
- Intercourse every two to three days throughout the cycle
- Daily intercourse during the fertile window when both partners genuinely prefer it

A clinician-directed schedule when fertility treatment requires specific timing

Choose the pattern you can follow without resentment, pain, or exhaustion.

More Sex Is Not Always a Better Plan

Some couples receive the instruction to have sex every day throughout the month.

That may be comfortable for some people. It may be emotionally and physically exhausting for others.

The goal is not to reach a particular number.

The goal is to have regular intercourse during the period when pregnancy is biologically possible.

Having intercourse every one to two days during the fertile window provides several opportunities without depending on one predicted ovulation date.

If daily intercourse is causing arguments, pain, loss of sleep, or erection difficulties, forcing yourselves to continue may make the situation worse.

A realistic plan that you can follow is better than an intense plan you both begin to avoid.

Your Low-Pressure Timing Options

Choose one option for the next cycle.

Option A: Every Other Day During the Fertile Window

Use your cycle pattern, cervical mucus, or ovulation tests to identify the likely fertile period.

Plan intercourse every other day across that range.

Example:

- Monday
- Wednesday
- Friday
- Sunday, where still relevant

This option provides repeated opportunities without requiring intercourse every day.

Option B: Two or Three Times Each Week

Choose this option when detailed tracking increases anxiety.

Have intercourse every two to three days throughout the cycle rather than waiting for a perfect date.

This approach may be useful when:

Your application keeps changing its prediction

Your cycles are somewhat variable

- Tracking has become emotionally exhausting
- One partner travels or works irregular hours

You want a simpler routine

- Option C: Daily During the Most Fertile Days

Choose this option only when both partners are comfortable with it.

You might use daily intercourse for two or three days when cervical mucus is especially slippery or an ovulation test becomes positive.

Daily intercourse is not compulsory.

Option D: Clinician-Directed Timing

Use the schedule provided by your fertility team when taking ovulation medication, receiving an ovulation-trigger injection, undergoing insemination, or following another clinical treatment plan.

Do not replace medical instructions with the general calendar in this guide.

Complete Your Timing Plan

First day of my last period: _____:

My likely fertile window: _____:

The tracking method I will use: _____:

- ☐ Period dates
- ☐ Cervical mucus
- ☐ Ovulation-predictor tests
- ☐ Clinician monitoring
- ☐ A simple every-two-to-three-days approach

Our chosen timing option: A / B / C / D

The days that appear realistic for us: _____:

A backup day if plans change: _____:

The person responsible for checking the calendar: _____

The final question matters.

The woman should not be expected to track everything, send reminders, plan the meals, prepare the supplements, and manage the emotional atmosphere alone.

Remove the Performance Test

Fertility pressure affects both partners.

A woman may feel that she has to be relaxed, lubricated, enthusiastic, and ready at the correct time.

A man may feel that he has to produce an erection and ejaculate on demand because the application says ovulation is approaching.

These expectations can create a cycle:

The fertile day approaches.

Both partners feel pressure.

Desire decreases.

Erection, lubrication, or orgasm becomes more difficult.

One person feels blamed.

The next attempt carries even more pressure.

The solution is not to demand better performance.

The solution is to reduce the feeling that intimacy is an examination.

Say This Before the Fertile Window

"The fertile window is approaching, but I do not want either of us to feel tested. Let us agree on a few realistic days and allow ourselves to adjust if one of us is tired, uncomfortable, or emotionally overwhelmed."

Say This When Plans Change

"Tonight is not working for us. Missing one evening does not mean the entire cycle is lost. Let us choose another day without blaming each other."

Say This When One Partner Feels Pressured

"I want us to protect our relationship while we are trying. Tell me what is making intimacy feel stressful and what would make it feel safer or more natural."

Say This After an Unsuccessful Cycle

"This month did not give us the result we hoped for, but neither of us failed. Let us decide what support we need before the next cycle."

The Couple Conversation

Set aside 15 minutes when neither person is already expecting sex.

Do not begin this conversation in bed.

Each partner should answer the following questions without interruption.

Question 1: What has trying to conceive changed about sex for you?

Partner one: _____:

Partner two: _____:

Question 2: What currently creates the most pressure?

- ☐ Being reminded at the last minute
- ☐ Feeling responsible for producing a pregnancy
- ☐ Having sex when tired
- ☐ Lack of privacy
- ☐ Fear of another disappointment

- [ ] Pain or dryness
- [ ] Erection or ejaculation difficulty
- [ ] Strict tracking
- [ ] Family pressure
- [ ] Relationship conflict
- [ ] Another concern: _____

Question 3: What would make the next fertile window easier?

- [ ] Agreeing on days in advance
- [ ] Using less cycle tracking
- [ ] Sharing the tracking responsibility
- [ ] Creating more private time
- [ ] Addressing pain or dryness
- [ ] Seeking medical support
- [ ] Having affectionate time that does not have to lead to intercourse
- [ ] Taking a temporary emotional break from tracking
- [ ] Another change: _____

Our agreement

During the next fertile window, we will:

We will not:

If either person feels pain, pressure, or distress, we will:

Consent Still Matters During the Fertile Window

Trying to conceive does not remove the need for consent.

Marriage does not make intercourse compulsory.

Ovulation does not create an obligation.

Both partners should be able to say:

- "I need more time."
- "I am in pain."
- "I am too tired tonight."
- "I do not feel emotionally safe."
- "Can we choose another day?"
- "I need us to slow down."
- "I would like affection without intercourse."

Consent should be active and ongoing.

A person who initially agreed can still change their mind.

Using guilt, silence, anger, threats, religious pressure, or reminders about age to force intercourse is not a healthy fertility strategy.

There Is No Best Sexual Position for Pregnancy

Many couples are told that one position sends sperm closer to the cervix.

Common advice includes:

The woman must lie underneath

A pillow must be placed beneath the hips

- Deep penetration is compulsory

The woman must not stand afterward

The legs must remain raised

- Certain positions are necessary for a tilted uterus

Evidence does not show that one sexual position improves natural fertility.

Sperm can enter the cervical canal very quickly after ejaculation. ASRM states that sexual position and post-intercourse routines do not affect fertility.

Choose a position based on:

- Mutual comfort

- Consent
- Physical mobility
- Pain level
- Personal preference
- Emotional connection

Do not continue a position that causes pain simply because someone called it a fertility position.

You Do Not Need to Raise Your Legs

You may notice fluid leaving the vagina after intercourse.

This is normal.

The fluid may contain seminal fluid, vaginal secretions, lubricant, and some sperm. It does not mean every sperm cell has fallen out or that the attempt has failed.

You do not need to:

- Place your legs against the wall
- Remain in bed for 30 minutes
- Sleep without washing externally
- Insert tissue or another object to block the vagina
- Hold your urine for hours
- Avoid walking
- Keep a pillow beneath your hips

ASRM reports that sperm may be found in the cervical canal within seconds after ejaculation and that positions or post-intercourse routines have no demonstrated effect on fertility.

You may remain lying down for a few minutes because it feels comfortable.

Do it for comfort, not because pregnancy depends on it.

Orgasm Is Not a Fertility Requirement

Orgasm can be pleasurable and may contribute to intimacy.

It is not a test of whether your body is ready to conceive.

Some fertility claims describe a female orgasm as creating a suction effect that pulls sperm toward the egg. ASRM notes that although orgasm may theoretically influence sperm transport, no relationship between orgasm and fertility has been demonstrated.

You do not need to fake an orgasm to protect your partner's feelings.

You do not need to become anxious when orgasm does not happen.

Pregnancy can occur without female orgasm.

Sexual pleasure deserves attention because it matters to wellbeing and the relationship, not because it must perform a reproductive function.

Do Not Try to Change Vaginal pH

The vagina maintains its own biological environment.

Do not insert substances to make it more alkaline or "friendly" to sperm.

Avoid:

- Lime or lemon
- Baking soda
- Salt water
- Alum
- Herbs
- Yoghurt
- Soap
- Antiseptic solutions
- Perfumed products
- Vaginal steaming
- Unprescribed pH products

These practices can cause irritation or disrupt the normal vaginal environment.

A healthy cervical environment naturally changes around ovulation. You do not need to reproduce that change with a homemade mixture.

Persistent unusual discharge, smell, burning, itching, pain, or bleeding should be assessed rather than covered with an internal wash.

Lubrication and Trying to Conceive

Some couples need lubricant because of dryness, discomfort, anxiety, medication effects, prolonged intercourse, or personal preference.

Do not continue painful intercourse without support.

Laboratory studies have found that some common lubricants, saliva, and certain oils can reduce sperm movement. However, studies of couples using lubricant during intercourse have not consistently shown reduced chances of pregnancy.

A sensible approach is:

- Allow enough time for arousal
- Choose a product labelled as fertility-friendly or sperm-compatible when lubricant is needed
- Follow the product instructions

Do not use saliva as your regular fertility lubricant

Do not insert household oils or products not intended for vaginal use

- Seek care when dryness or pain continues

A fertility-friendly label does not mean the lubricant increases fertility.

It means the product is designed to be less harmful to sperm under laboratory conditions.

When Dryness or Pain Needs Attention

Food cannot be promised to produce immediate vaginal lubrication.

Dryness and painful intercourse may be connected to:

- Inadequate arousal
- Stress or fear
- Hormonal changes
- Breastfeeding
- Menopause or perimenopause

- Medication
- Infection
- Skin conditions
- Endometriosis
- Pelvic-floor tension
- Previous surgery or childbirth
- Relationship factors
- Other medical conditions

ACOG recommends measures such as allowing enough time, communicating with the partner, using lubricant, and choosing activities that do not cause pain. Persistent pain deserves professional evaluation.

Vaginal dryness may also be associated with certain medicines, hormonal changes, inadequate arousal, diabetes, or the use of perfumed washes and douches.

Stop and seek guidance when you experience:

- Persistent pain during penetration
- Burning or stinging
- Deep pelvic pain during sex
- Bleeding during or after sex
- Unusual discharge
- Strong or unpleasant odour
- Itching
- Pain while urinating
- Pelvic pain outside intercourse
- Involuntary tightening that prevents penetration
- Dryness that continues despite adequate arousal and suitable lubricant

Unusual bleeding during or after sex should be checked because it has several possible causes.

Do Not Push Through Pain for Pregnancy

Pain is not proof that intercourse is "deep enough."

It is not evidence that sperm has reached the correct place.

It is not a sacrifice you must make to become a mother.

Repeatedly continuing painful intercourse can increase fear, muscle tension, avoidance, and emotional distress.

When pain begins:

Stop or slow down.

Communicate clearly.

Add an appropriate lubricant where dryness is the issue.

Change position.

Choose non-penetrative affection where desired.

Arrange an assessment if pain continues.

Possible sources of support include:

A gynaecologist

A primary-care clinician

A sexual-health clinic

A pelvic-floor physiotherapist

A qualified sex therapist

A couples therapist

A fertility specialist

The correct professional depends on the cause.

Erection or Ejaculation Difficulties

Men also experience fertility-related performance pressure.

Occasional erection difficulty can occur because of fatigue, stress, alcohol, relationship tension, or the pressure to have intercourse on demand.

Persistent problems may also relate to medication, cardiovascular health, diabetes, hormonal issues, neurological conditions, or other medical factors.

Do not shame your partner or interpret the problem as a lack of attraction.

Use a calm statement:

"I know this process has placed pressure on both of us. This does not make you less of a man. Let us get the right support instead of pretending it is not happening."

Seek professional guidance when:

- Erection difficulty occurs repeatedly
- Ejaculation is persistently delayed or absent
- Ejaculation occurs before penetration so often that conception attempts are affected
- There is pain during erection or ejaculation
- Semen does not appear to be released
- Sexual difficulties are causing significant distress
- Protect Intimacy Outside the Fertile Window

When every affectionate moment is expected to lead to intercourse, one or both partners may begin avoiding touch.

Create forms of connection that do not carry a reproductive expectation.

These may include:

- Holding hands
- Sitting together without phones
- Hugging

A back or foot massage

- Sharing a meal
- Taking a walk
- Praying together
- Watching something you both enjoy

- Talking about a subject unrelated to fertility
- Non-penetrative sexual affection where mutually desired

Agree clearly that some affectionate moments will not have to end in intercourse.

This can help touch feel safe again.

Your Seven-Day Low-Pressure Intimacy Plan

Use this during the likely fertile window.

Day 1: Check In

Ask:

- "How are you feeling about this cycle?"

Do not correct the answer.

Day 2: Affection Without an Assignment

Spend at least 15 minutes together without discussing fertility.

Day 3: Planned Intimacy

Choose a realistic time with enough privacy and less exhaustion.

Avoid waiting until both partners are almost asleep.

Day 4: Rest and Connection

No compulsory intercourse.

Talk, rest, or share another form of affection.

Day 5: Planned Intimacy

Adjust the plan when there is pain, illness, fatigue, or emotional distress.

Day 6: No Symptom Interrogation

Do not repeatedly ask whether discharge, pain, or ovulation signs "look right."

Day 7: Close the Window Gently

Say:

- "We have done what was reasonable for us this week. We do not need to keep analysing every moment."

This schedule is an example.

Change the days to match your fertile window and your relationship.

The Fertile-Window Agreement

Complete this together.

This cycle, we plan intercourse approximately: _____:

Our preferred frequency is: _____:

We will use this fertility sign: _____:

We will avoid last-minute pressure by: _____:

Our preferred lubricant, if needed: _____:

If sex becomes painful, we will: _____:

If erection or ejaculation becomes difficult, we will: __

One affectionate activity unrelated to conception: _____

Our appointment plan if a problem continues: _____:

The Pressure Check

At the end of the fertile window, each partner should privately rate the following from 1 to 5.

1 means not at all.

5 means extremely.

Statement

Partner 1

Partner 2

I felt pressured to perform

___

___

I felt heard by my partner

___

___

I felt able to say no or slow down

___

___

Sex was physically comfortable

___

___

Tracking controlled our relationship

___

___

We shared responsibility

___

___

We maintained affection outside intercourse

___

___

Discuss only two questions:

What should we keep?

What should we change?

Do not use the scores to attack each other.

Intimacy Myths

Myth 1: The woman must lie still after sex.

False.

Post-intercourse routines have not been shown to improve natural fertility.

Myth 2: Fluid leakage means the sperm has been lost.

False.

Leakage after intercourse is normal and does not mean that every sperm cell has left the reproductive tract.

Myth 3: One position is best for conception.

False.

There is no evidence that a particular sexual position improves fertility.

Myth 4: Female orgasm is required.

False.

No relationship between female orgasm and fertility has been demonstrated.

Myth 5: Intercourse must happen on one exact ovulation day.

False.

The fertile window spans several days.

Myth 6: Having sex every day is compulsory.

False.

Daily or every-other-day intercourse during the fertile window may provide the best opportunity, but the schedule should remain realistic and mutually acceptable.

Myth 7: Pain is normal when trying to conceive.

False.

Persistent painful intercourse should be assessed.

Before You Close This Chapter

You do not have to turn your bedroom into a fertility clinic.

You do not need a special position, raised legs, compulsory orgasm, or sperm-retention ritual.

You need a realistic understanding of the fertile window, regular opportunities for intercourse, mutual consent, physical comfort, and honest communication.

Your relationship deserves protection even while you are hoping for pregnancy.

Complete the Fertile-Window Agreement with your partner before the next likely fertile period.

Choose a schedule.

Discuss pressure.

Agree on what will happen if one person is tired or uncomfortable.

Decide where you will seek help if pain, dryness, erection difficulty, or ejaculation problems continue.

> **In the next chapter, we will examine vaginal comfort more closely.**

You will learn what vaginal pH actually means, how to respond to dryness, how to choose a lubricant, which intimate-care products to avoid, and which symptoms require medical attention.

Reference Notes for Chapter 8

- American Society for Reproductive Medicine. Optimizing Natural Fertility: A Committee Opinion.
- American College of Obstetricians and Gynecologists. Trying to Get Pregnant? Here's When to Have Sex.
- American College of Obstetricians and Gynecologists. Prepregnancy Counseling.
- American College of Obstetricians and Gynecologists. When Sex Is Painful.
- American College of Obstetricians and Gynecologists. Your Sexual Health.
- National Health Service. Vaginal Dryness.
- National Health Service. Vaginal Bleeding Between Periods or After Sex.



CHAPTER 9

Vaginal Comfort, Lubrication, and pH

> *Evidence base: See the chapter's Reference Notes; key clinical recommendations also carry parenthetical source anchors.*

Your vagina does not need to be scrubbed, tightened, dried, perfumed, steamed, or made more alkaline before you can conceive.

It does not need lime, alum, salt, herbs, yoghurt, antiseptic, or a special fertility wash.

Many women use these products because they are trying to feel clean, improve discharge, please a partner, or create what a seller calls a "sperm-friendly environment." Unfortunately, some of these practices can irritate delicate tissue and disturb the natural balance that helps protect the vagina.

This chapter will help you care for your body without fear.

You will learn:

- What vaginal pH means
- Why the vagina does not need internal cleaning
- What may cause vaginal dryness
- How to choose a lubricant while trying to conceive
- Why painful sex should not be ignored
- Which products to remove
- Which symptoms need medical attention
- How to prepare for a useful clinical conversation

The Vagina and Vulva Are Not the Same

The vulva is the external genital area you can see.

It includes structures such as the labia and the opening of the vagina.

The vagina is the internal muscular passage.

This distinction matters because gentle external washing is different from inserting water, soap, herbs, or another product into the vagina.

The vagina is self-cleaning.

Normal vaginal secretions help carry away cells and maintain the internal environment. You may wash the external vulval area gently, but you do not need to wash inside the vagina.

What Vaginal pH Actually Means

The vagina normally maintains an acidic environment supported by its natural bacteria.

This environment helps protect against irritation and infection. Douching can alter the balance of bacteria and natural acidity within the vagina.

The vagina does not remain chemically identical throughout every stage of life.

Hormones, menstruation, semen, infections, medication, pregnancy, breastfeeding, and menopause may influence vaginal conditions.

That does not mean you should try to control pH with homemade mixtures.

A product marketed as alkaline, detoxifying, cleansing, tightening, or fertility-enhancing may not solve the cause of your symptoms. It may hide an infection temporarily, create irritation, or delay proper treatment.

The Fertile Environment Is Created Naturally

Around the fertile window, cervical mucus may become wetter, clearer, and more slippery.

This mucus is produced naturally in response to hormonal changes. It can help sperm move through the cervix.

You do not need to make the vagina alkaline to imitate fertile cervical mucus.

You also do not need to test your vaginal pH every morning unless a qualified healthcare professional has given you a specific medical reason.

Home pH strips cannot tell you:

- Whether you ovulated
- Whether your eggs are healthy
- Whether sperm has reached the fallopian tube
- Whether your tubes are open
- Whether implantation will occur
- Whether you will become pregnant

A pH result may sometimes form part of a clinical assessment for certain vaginal conditions, but it is not a home fertility score.

Why Douching Is Not a Fertility Strategy

Douching means washing or flushing inside the vagina with water or another liquid.

Some women douche after menstruation, after sex, or when they notice discharge. Others believe it removes old blood, sperm, odour, or spiritual and physical "dirt."

Most doctors advise against douching because it can disturb the normal bacterial balance and acidity within the vagina. It has also been linked with conditions such as bacterial vaginosis and may contribute to bacteria travelling upward into the reproductive tract.

Do not douche with:

- Plain water
- Salt water
- Lime or lemon water
- Vinegar
- Baking soda
- Alum
- Antiseptic solution
- Herbal water
- Soap
- Perfumed wash
- Yoghurt
- Any fertility mixture

The fact that a mixture is homemade does not make it gentle.

The fact that it stings does not mean it is killing infection.

The fact that discharge reduces temporarily does not mean the underlying problem has been treated.

Vaginal Steaming Is Still Internal Exposure

Vaginal steaming may be presented as a traditional way to clean the womb, regulate periods, tighten the vagina, increase fertility, or remove infection.

Steam cannot clean the uterus through the vagina.

The cervix is not an open pipe through which steam can travel to wash the womb.

Hot steam may irritate or burn sensitive vulval and vaginal tissue. Herbs used in steaming may also trigger irritation or allergic reactions.

Do not sit over boiling water or herbal steam to prepare for conception.

Where there is unusual discharge, pelvic pain, itching, odour, or bleeding, seek an assessment instead of trying to steam the symptom away.

Normal Discharge Versus a Possible Problem

Vaginal discharge is not automatically a sign of infection.

Normal discharge may change in amount and texture during the menstrual cycle. It may become wetter or more slippery near the fertile window.

You should pay attention when the discharge becomes noticeably different from what is normal for you.

Possible symptoms of vaginitis or another vaginal condition include:

- Itching or soreness
- Discharge with a different colour, smell, or thickness
- Vaginal dryness
- Pain when urinating
- Pain during sex
- Light bleeding or spotting
- Swollen, sore, or cracked vulval skin

Do not diagnose an infection by colour alone.

Different conditions can cause similar symptoms. Treating every discharge as yeast may result in repeated use of medication that does not address the actual cause.

What Can Cause Vaginal Dryness?

Vaginal dryness is not always caused by low fertility.

It may be related to:

- Insufficient arousal
- Anxiety or fertility pressure
- Hormonal changes
- Breastfeeding
- Perimenopause or menopause
- Some medicines
- Irritating soaps or scented products

A vaginal or vulval condition

- Diabetes or another health problem
- Previous cancer treatment
- Relationship or sexual difficulties

Dryness may cause burning, irritation, soreness, or pain during intercourse. It may also occur alongside urinary symptoms or repeated urinary infections.

Food cannot be promised to produce immediate natural lubrication.

Eating well supports general health, but persistent dryness requires attention to its actual cause.

First Steps for Mild Dryness

When dryness is occasional and there are no warning symptoms, begin with simple changes.

Allow more time

Do not rush directly into penetration because the fertile-window application says tonight is important.

Spend enough time on affection and arousal.

Communicate

Tell your partner when you need to slow down, change position, add lubricant, or stop.

Remove irritating products

Avoid:

- Scented wipes
- Perfumed soaps
- Deodorant sprays
- Harsh antiseptics
- Douches
- Warming or cooling products that cause irritation
- Flavoured products where you are sensitive

ACOG advises avoiding harsh soaps, douches, wipes, scented products, and other possible irritants where vulval discomfort is present.

Use lubricant where needed

Lubricant reduces friction during intercourse.

Needing it does not mean your body has failed, you do not love your partner, or you are infertile.

Choosing Lubricant While Trying to Conceive

Laboratory research has found that some common water-based lubricants, saliva, olive oil, and certain other products can reduce sperm movement under laboratory conditions.

However, studies of couples using lubricant during intercourse have not consistently demonstrated lower pregnancy rates.

A practical approach is to choose a product specifically labelled:

- Fertility-friendly
- Sperm-friendly
- Sperm-compatible

This does not mean the lubricant increases fertility.

It means it has been designed and tested to interfere less with sperm than some conventional products.

A suitable lubricant should ideally be:

- Intended for vaginal intercourse
- Clearly labelled
- Within its expiry date
- Used according to the instructions
- Free from ingredients that have previously irritated you
- Compatible with condoms where condoms are being used
- Sperm-compatible when conception is the goal
- Avoid using the following as lubricant:
- Saliva

- Body lotion
- Petroleum-based cosmetic products not intended for vaginal intercourse
- Cooking oil
- Herbal oil
- Soap
- Shampoo
- Hair conditioner
- Raw egg white
- Yoghurt
- Honey
- An unlabelled fertility gel

Do not place raw egg white inside the vagina because somebody says it resembles cervical mucus.

A similar appearance does not make two substances biologically interchangeable.

Lubricant Selection Checklist

Take this checklist when buying a product.

Product details

Product name: _____:
Manufacturer: _____:
Expiry date: _____:
Where it was purchased: _____:

Label review

- [ ] It is intended for vaginal intercourse.
- [ ] The ingredient list is visible.
- [ ] It is labelled sperm-compatible or fertility-friendly.
- [ ] It does not promise to make me pregnant.

- [ ] It has not previously caused burning or itching.
- [ ] The packaging is sealed.
- [ ] The instructions are clear.
- [ ] I understand how much to use.

After use

- [ ] It reduced friction.
- [ ] It did not cause burning.
- [ ] It did not cause itching.
- [ ] It did not cause swelling.
- [ ] It did not produce unusual discharge.
- [ ] It made intercourse more comfortable.

Stop using the product and seek advice if it causes persistent burning, swelling, rash, pain, or unusual discharge.

Lubricant and Vaginal Moisturiser Are Different

A lubricant is usually used around the time of sexual activity to reduce friction.

A vaginal moisturiser is generally used on a schedule to provide longer-lasting relief from dryness.

They are not the same product.

Some people with ongoing dryness may benefit from a moisturiser or prescribed treatment, depending on the cause. ACOG notes that lubricants and vaginal moisturisers can help with vaginal dryness and painful intercourse in appropriate situations.

Do not begin hormonal vaginal treatment without discussing your symptoms, reproductive plans, and medical history with a qualified clinician.

A treatment suitable for someone after menopause may not be the correct solution for a younger person with an infection, pelvic-floor problem, medication side effect, or inadequate arousal.

Pain During Sex Is Not a Required Sacrifice

Some women continue painful intercourse because they are afraid of missing the fertile window.

They bite their lip, remain silent, and hope the pain will produce a pregnancy.

Pain does not move sperm closer to the egg.

Pain does not prove that penetration is deep enough.

Pain does not improve conception.

Painful intercourse may be related to:

- Dryness
- Infection or inflammation
- Vulval skin conditions
- Pelvic-floor muscle tightening
- Endometriosis
- Ovarian or pelvic conditions
- Previous childbirth, surgery, or injury
- Hormonal changes
- Emotional distress
- Fear following previous painful experiences

ACOG advises that persistent or frequent pain during sex should be discussed with a healthcare professional. Treatment depends on the underlying cause and may include changes in products, medication, vaginal moisturisers, lubricants, pelvic-floor therapy, counselling, or other individualised care.

Where Do You Feel the Pain?

The location of pain may help a clinician understand what requires investigation.

Pain at the opening

This may feel like:

- Burning
- Stinging
- Tearing
- Tightness

- Inability to tolerate penetration
- Pain deeper inside

This may feel like:

A sharp pelvic pain

- Pressure
- Pain in certain positions
- Pain that continues after intercourse
- Pain on the external skin

This may feel like:

- Soreness
- Itching
- Rawness
- Burning when touched
- Pain from clothing or pads

Do not use this list to diagnose yourself.

Use it to describe your experience more clearly.

Your Vaginal Comfort Assessment

Complete this privately.

Dryness

- ☐ I experience dryness only occasionally.
- ☐ Dryness happens during most attempts at intercourse.
- ☐ Dryness began after starting a medicine.
- ☐ Dryness began during breastfeeding.
- ☐ Dryness occurs with itching or burning.
- ☐ Dryness continues despite adequate arousal and lubricant.

Pain

- [ ] Pain occurs at the vaginal opening.
- [ ] Pain feels deep inside the pelvis.
- [ ] Pain occurs only in one position.
- [ ] Pain continues after intercourse.
- [ ] Pain is becoming worse.
- [ ] Pain causes me to avoid intercourse.
- [ ] Penetration is sometimes impossible.

Discharge and irritation

- [ ] My discharge has changed in colour.
- [ ] My discharge has changed in smell.
- [ ] My discharge has changed in thickness.
- [ ] I experience itching.
- [ ] I experience burning.
- [ ] I experience pain when urinating.
- [ ] The vulval skin is swollen, cracked, or sore.

Bleeding

- [ ] I bleed during intercourse.
- [ ] I bleed immediately after intercourse.
- [ ] I experience spotting between periods.
- [ ] The bleeding has happened more than once.

Bleeding between periods or after sex has several possible causes. It is often not serious, but it should still be checked by a healthcare professional.

The Stoplight Comfort Guide

Use this guide to decide your next action.

GREEN: Continue With Gentle Adjustments

This may apply when:

- Dryness is occasional
- There is no unusual discharge
- There is no bleeding
- There is no persistent pain

A suitable lubricant resolves the discomfort

- There are no sores, swelling, or urinary symptoms

Your actions

- [ ] Allow more time for arousal.
- [ ] Use an appropriate sperm-compatible lubricant.
- [ ] Remove scented products.
- [ ] Communicate with your partner.
- [ ] Record whether symptoms return.

- YELLOW: Arrange a Routine Medical Review

This may apply when:

- Dryness happens repeatedly
- Lubricant does not solve the problem
- Sex is frequently painful
- There is recurring itching or burning
- Discharge has changed

You repeatedly treat yourself for infection

You have urinary discomfort

- Symptoms began after a medicine
- Penetration is becoming difficult
- Symptoms are affecting your relationship

Your actions

- [ ] Book an appointment.
- [ ] Stop using irritating products.
- [ ] List all medicines and supplements.
- [ ] Record symptoms before the visit.
- [ ] Avoid repeatedly buying treatment without confirming the cause.

- RED: Seek Prompt Care
- Seek timely medical attention when you experience:
- Severe pelvic pain
- Fever with pelvic or vaginal symptoms
- Fainting or significant weakness
- Heavy bleeding
- Bleeding after sex
- Pain with a possible pregnancy
- New sores, blisters, or ulcers
- Foul-smelling discharge with pain
- Severe swelling
- Possible exposure to a sexually transmitted infection
- Pain that is suddenly much worse

Urgent assessment may be particularly important where pain, bleeding, or faintness occurs with a positive pregnancy test because complications such as ectopic pregnancy must be excluded.

Your Intimate-Product Audit

Collect every product used around the vulva or inside the vagina.

This includes:

- Soap
- Shower gel

- Feminine wash
- Wipes
- Powder
- Perfume
- Deodorant spray
- Lubricant
- Vaginal moisturiser
- Infection treatment
- Herbal product
- Tightening product
- Steaming mixture
- pH product
- Antiseptic
- Douching bottle

Complete the table.

Product

External or internal use?

Why I use it

Causes irritation?

Keep, review, or remove

_____

_____

_____

Yes / No

_____

_____

_____

_____

Yes / No

_____

_____

_____

_____

Yes / No

_____

_____

_____

_____

Yes / No

_____

_____

_____

_____

Yes / No

_____

Remove immediately

- [ ] Douching products
- [ ] Vaginal steaming mixtures
- [ ] Lime, alum, or salt mixtures
- [ ] Antiseptic used inside the vagina
- [ ] Perfumed internal washes
- [ ] Unlabelled tightening products
- [ ] Raw food inserted as a fertility remedy
- [ ] Products that repeatedly cause burning or swelling

Your Seven-Day Comfort Tracker

Use this when symptoms are recurring.

Day

Dryness 0-10

Pain 0-10

Itching or burning

Discharge change

Product used

Intercourse comfortable?

1

___

___

Yes / No

Yes / No

_____

Yes / No

2

___

___

Yes / No

Yes / No

_____

Yes / No

3

___

___

Yes / No

Yes / No

_____

Yes / No

4

___

___

Yes / No

Yes / No

_____

Yes / No

5

___

___

Yes / No

Yes / No

_____

Yes / No

6

___

___

Yes / No

Yes / No

_____

Yes / No

7

___

___

Yes / No

Yes / No

_____

Yes / No

Additional notes

Bleeding: _____:

Odour: _____:

Pain when urinating: _____:

Pelvic pain outside intercourse: _____:

New medicine or supplement: _____:

Menstrual-cycle day: _____:

This tracker is not a diagnosis.

Take it to an appointment so you can describe your symptoms accurately.

Preparing for the Appointment

Write down your answers before seeing the clinician.

Symptoms

My main symptom is: _____:

It began on: _____:

It happens: Occasionally / Often / Every time

The pain is located: _____:

The pain feels like: _____:

What makes it better: _____:

What makes it worse: _____:

Products

Lubricant used: _____:

Soap or wash used: _____:

Vaginal medicines used: _____:

Herbs or home remedies used: _____:

Reproductive information

First day of last period: _____:

Possibility of pregnancy: Yes / No / Unsure

Trying to conceive: Yes / No

New sexual partner: Yes / No

Possible STI exposure: Yes / No / Unsure

Questions to ask

Could this be an infection, skin condition, pelvic-floor issue, or hormonal problem?

Do I need an examination or test?

Is my lubricant suitable while trying to conceive?

Could one of my medicines be contributing?

Should my partner be tested or treated?

Would pelvic-floor physiotherapy help?

Which products should I stop using?

What symptoms would require urgent care?

Vaginal Comfort Myths

Myth 1: A healthy vagina must have no smell.

False.

The vagina can have a mild natural scent. A strong new or unpleasant odour accompanied by discharge or discomfort deserves attention, but using perfume internally is not the solution.

Myth 2: Discharge means the vagina is dirty.

False.

Normal discharge is part of vaginal function and may change during the menstrual cycle.

Myth 3: Douching after sex improves fertility.

False.

Douching does not help sperm reach the egg and may disturb the normal vaginal environment.

Myth 4: The vagina must be made alkaline.

False.

The vagina normally maintains an acidic environment. Homemade pH manipulation is not an evidence-based fertility treatment.

Myth 5: Painful sex is normal when trying to conceive.

False.

Persistent pain should be assessed.

Myth 6: Needing lubricant means a woman is not attracted to her partner.

False.

Dryness has many possible causes, including hormones, medication, irritation, anxiety, insufficient arousal, and health conditions.

Myth 7: A fertility-friendly lubricant makes pregnancy happen.

False.

A sperm-compatible product is designed to interfere less with sperm than certain other lubricants. It cannot guarantee fertilisation or pregnancy.

Myth 8: Bleeding after sex can always be ignored.

False.

Bleeding after sex has several possible causes and should be checked.

Before You Close This Chapter

Your vagina does not need aggressive care.

It needs gentle care.

Wash externally. Do not douche. Do not steam. Do not insert homemade mixtures. Use a suitable lubricant when needed, and never continue painful intercourse simply because the fertile window is open.

Pay attention to persistent dryness, pain, discharge changes, urinary symptoms, irritation, and bleeding.

These symptoms are not proof that your body is infertile.

They are information.

Complete the Intimate-Product Audit today. Remove products that are unnecessary or irritating. Use the Seven-Day Comfort Tracker when symptoms continue, and take the record to a qualified healthcare professional.

> **In the next chapter, we will discuss PCOS, irregular cycles, and the phrase "hormone imbalance."**

You will learn why hormone problems cannot all be treated in the same way, how lifestyle support fits into PCOS care, why medication is sometimes necessary, and which questions to take to your next appointment.

Reference Notes for Chapter 9

- American College of Obstetricians and Gynecologists. Experiencing Vaginal Dryness? Here's What You Need to Know.
- American College of Obstetricians and Gynecologists. When Sex Is Painful.
- American College of Obstetricians and Gynecologists. Your Sexual Health.
- American College of Obstetricians and Gynecologists. Vulvovaginal Health.
- American Society for Reproductive Medicine. Optimizing Natural Fertility: A Committee Opinion.
- Office on Women's Health. Douching.
- Office on Women's Health. Bacterial Vaginosis.
- National Health Service. Vaginal Dryness.
- National Health Service. Vaginitis.
- National Health Service. Vaginal Bleeding Between Periods or After Sex.



CHAPTER 10

PMOS (formerly PCOS), Irregular Cycles, and "Hormone Balance"

> *Evidence base: See the chapter's Reference Notes; key clinical recommendations also carry parenthetical source anchors.*

TERMINOLOGY

UPDATEIn May 2026, a global consensus process renamed polycystic ovary syndrome (PCOS) as polyendocrine metabolic ovarian syndrome (PMOS). Because many readers, clinics, search tools, and the 2023 international guideline still use PCOS, both terms appear in this chapter. The name changed; the need for individual assessment did not. (Global Name Change Consortium, 2026)

"Hormone imbalance" has become an explanation for almost everything.

If your period comes late, somebody says your hormones are imbalanced. If you have acne, facial hair, painful periods, weight changes, low desire, or difficulty becoming pregnant, you may be told to balance your hormones with one tea, seed mixture, supplement, or restrictive diet.

But "hormone imbalance" is not one diagnosis.

Your menstrual cycle depends on signals travelling between the brain, pituitary gland, ovaries, thyroid, adrenal glands, and other parts of the body. Different disruptions can produce similar symptoms, but they do not all require the same treatment.

PCOS is one possible cause of irregular ovulation.

It is not the only cause.

This chapter will help you understand what PCOS means, what proper assessment may involve, how food and lifestyle support fit into treatment, and why medication should not be treated as failure.

What Is PMOS (formerly PCOS)?

Polyendocrine metabolic ovarian syndrome (PMOS), formerly called polycystic ovary syndrome (PCOS), is a complex endocrine, metabolic, and reproductive condition. The name changed through a global consensus process in May 2026; many existing guidelines and healthcare records still use PCOS during the transition. (Global Name Change Consortium, 2026)

It may affect:

- Menstrual regularity
- Ovulation
- Androgen levels
- Hair and skin
- Blood-sugar regulation
- Weight management
- Fertility
- Emotional wellbeing

- Long-term health

The experience is not identical for every woman.

One woman may have irregular periods and facial hair. Another may have acne, difficulty ovulating, and metabolic concerns. Another may have PCOS without being overweight.

PCOS should not be reduced to appearance.

You cannot confirm or exclude it by looking at a woman's body.

PCOS Does Not Simply Mean Ovarian Cysts

The name can be misleading.

The structures seen on a PCOS ultrasound are usually numerous small follicles rather than dangerous cysts that must be removed.

A woman does not always need visible polycystic ovarian morphology to be diagnosed. Current international guidance uses three main features in adults:

- Clinical or laboratory evidence of elevated androgen activity
- Irregular ovulation or menstrual cycles

Polycystic ovarian morphology on ultrasound, with AMH available as an alternative marker in the adult diagnostic pathway

After other possible causes are excluded, the presence of two of these features may support a diagnosis. AMH should not be used as a stand-alone PCOS test.

This means:

You can have PCOS without large ovarian cysts.

You can have polycystic-looking ovaries without having PCOS.

One high AMH result does not diagnose PCOS.

One irregular period does not diagnose PCOS.

Acne alone does not diagnose PCOS.

Proper assessment matters.

Common PCOS Features

Possible features include:

- Periods that come infrequently
- Long or unpredictable menstrual cycles
- Months without a period
- Difficulty identifying ovulation
- Difficulty becoming pregnant because of irregular ovulation
- Increased facial or body hair
- Acne
- Thinning hair on the scalp
- Darkened skin in body folds
- Metabolic concerns such as insulin resistance
- Weight gain or difficulty managing weight
- Anxiety, depression, or body-image distress

Not every woman will experience every symptom.

PCOS can also change over time. Menstrual and skin symptoms may look different during adolescence, after pregnancy, after weight changes, or as a woman approaches menopause.

Irregular Periods Do Not Always Mean PCOS

This is one of the most important lessons in this chapter.

Periods may become absent or irregular for several reasons, including:

- Pregnancy
- PCOS
- Thyroid disorders
- Elevated prolactin
- Functional hypothalamic amenorrhoea
- Primary ovarian insufficiency
- Significant under-eating

- Rapid weight loss
- Excessive exercise
- Some medicines
- Breastfeeding
- Perimenopause
- Uterine scarring or other anatomical conditions
- Certain pituitary, adrenal, or ovarian conditions

ASRM advises that the first consideration when a period is late or absent should be pregnancy. Where menstruation has stopped for more than three months in someone whose cycles were previously regular, or six months in someone whose cycles were already irregular, investigation is recommended.

Do not assume that every missing period needs weight loss.

Do not assume it needs weight gain either.

The treatment depends on the cause.

When Your Period Stops After Dieting or Exercise

Some women enter fertility preparation believing that becoming thinner as quickly as possible will improve their chances.

They begin fasting for long periods, remove most carbohydrates, reduce portions drastically, and exercise every day.

Then the period disappears.

Functional hypothalamic amenorrhoea can occur when signals between the brain and reproductive system are disrupted. Low energy availability, weight loss, heavy exercise, emotional stress, or a combination may contribute, but the diagnosis should only be made after other conditions have been excluded.

A missing period is not proof that your detox is working.

It can be a sign that your body is not receiving or perceiving enough available energy for normal reproductive function.

Arrange an assessment when:

Your period stopped after significant dietary restriction

You exercise intensely and menstruation has become absent

You have lost a large amount of weight quickly

You feel dizzy, weak, unusually cold, or exhausted

You are frightened of increasing food intake

You regularly binge, purge, or compensate for eating

You have a history of an eating disorder

Your heart rate or blood pressure is unusually low

Do not try to correct prolonged amenorrhoea by adding one fertility food while continuing the behaviour that may be contributing to it.

How PCOS Is Assessed

There is no single universal blood test called a "hormone-balance test."

Assessment begins with your history.

A clinician may ask about:

The age your periods began

Your usual cycle length

- How often periods are missed
- Pregnancy history
- How long you have been trying to conceive
- Acne, facial hair, or scalp-hair changes
- Weight history
- Diet and physical activity
- Medicines and supplements
- Family history of PCOS or diabetes
- Symptoms of thyroid or prolactin disorders
- Previous laboratory or ultrasound results

- Depending on your symptoms, testing may include:

A pregnancy test

- Thyroid testing
- Prolactin
- Androgen-related tests
- FSH, LH, and estradiol in selected cases
- Blood-sugar assessment
- Cholesterol or lipid testing
- Blood pressure
- Pelvic ultrasound
- Other tests needed to exclude alternative conditions

ASRM identifies pregnancy testing, menstrual and medical history, reproductive hormone assessment, and selected imaging as important parts of evaluating absent periods. Thyroid disease, elevated prolactin, PCOS, hypothalamic causes, ovarian insufficiency, medicines, and anatomical conditions may need consideration.

You may not need every test on this list.

Testing should respond to your symptoms rather than becoming an expensive package of unrelated laboratory checks.

AMH Is Not a Fertility Score

AMH is often discussed online as if it tells a woman exactly how many fertile years she has left.

In PCOS, AMH may be elevated because of the number of developing follicles. Current guidance allows AMH to contribute to the assessment of polycystic ovarian morphology in adults, but it should not be used as the only test for diagnosing PCOS.

AMH cannot tell you:

- Whether you will conceive this month
- Whether your egg quality is good
- Whether your fallopian tubes are open
- Whether your partner's sperm is healthy

- Whether an embryo will implant
- Whether you will have a healthy birth

Do not allow one number to become your entire fertility identity.

Ask why the test was ordered and how the result changes your care.

PCOS and Fertility

PCOS can make conception more difficult when ovulation occurs infrequently or unpredictably.

That does not mean women with PCOS cannot become pregnant.

Some conceive without fertility treatment. Others need lifestyle support, medication to induce ovulation, treatment for additional fertility factors, or assisted reproductive care.

A PCOS diagnosis should not end the fertility investigation.

The evaluation may still need to consider:

- Semen analysis
- Fallopian-tube patency
- Uterine health

Age

Duration of trying

Previous pregnancy history

Other medical conditions

ASRM recommends evaluating ovulation, the structure and openness of the female reproductive tract, and the male partner's semen, with both partners assessed in parallel where applicable.

Do not allow every fertility concern to be blamed on PCOS without checking the rest of the picture.

What Lifestyle Support Can Do

Lifestyle management is an important part of PCOS care.

It can support:

- Metabolic health
- Blood-sugar regulation
- Cardiovascular health
- Physical fitness
- Energy
- Sleep
- Emotional wellbeing
- Sustainable weight management where relevant
- General preparation for pregnancy

The international PCOS guideline recommends physical activity and healthy eating for women with PCOS, particularly for improving metabolic health.

This is valuable.

But it does not mean every woman can cure PCOS by eating perfectly.

A woman may follow a balanced meal plan and still require medication. Another may improve her cycle but still have a partner-related or tubal fertility factor.

Lifestyle is treatment support, not a moral test.

There Is No Single PCOS Diet

You may have been told that PCOS requires:

A ketogenic diet

- No carbohydrates
- No fruit
- No dairy
- No gluten
- Intermittent fasting
- Vegan eating
- Blood-group eating
- Seed cycling

A fertility detox

- Imported supplements

Current international guidance states that there is no evidence supporting one particular diet composition over another for metabolic, hormonal, reproductive, psychological, or body-measurement outcomes in PCOS. It recommends sustainable healthy eating tailored to individual preferences and goals.

This means you can build your diet around the principles already covered in this guide:

Eat regularly enough to meet your needs.

Include protein.

Increase vegetables and fruit.

Choose higher-fibre carbohydrates more often.

Include beans and legumes.

Use suitable fats in sensible amounts.

Reduce frequent sugary drinks and heavily processed meals.

Adjust portions according to your needs.

Choose an approach you can maintain.

The diet should fit your culture.

You do not need to abandon Nigerian or African food to manage PCOS.

Carbohydrates and PCOS

You do not need to fear every carbohydrate.

The body's response to food is affected by the type of carbohydrate, the portion, the meal combination, physical activity, sleep, medication, and the individual's metabolic health.

You may improve a carbohydrate meal by adding:

Protein

Vegetables

Fibre

A moderate source of fat

For example:

Instead of: A large plate of white rice with little protein.

Try: A moderate rice portion with beans, fish, and mixed vegetables.

Instead of: Sweetened cereal and a sugary drink.

Try: Oats with egg, yoghurt, nuts, or fruit according to your needs.

Instead of: Several slices of bread alone.

Try: Bread with egg, sardines, beans, avocado, tomato, or cucumber.

Some women may need individualised carbohydrate advice because of diabetes, prediabetes, or other metabolic concerns.

That does not require labelling yam, rice, fruit, or plantain as poisonous.

PCOS in a Smaller Body

PCOS is often described as though every affected woman is overweight.

That is incorrect.

Women in smaller bodies can have irregular ovulation, androgen-related symptoms, fertility challenges, or metabolic risks associated with PCOS.

They may still benefit from:

- Balanced nutrition
- Regular physical activity
- Blood-pressure assessment
- Appropriate metabolic testing
- Medication where indicated
- Fertility evaluation
- Emotional support

Do not begin aggressive weight loss when a clinician has not established that it is appropriate.

Do not allow a normal or low body weight to prevent proper PCOS assessment either.

PCOS in a Larger Body

Weight stigma can delay good care.

A woman may visit a clinic because she has not menstruated for months and receive only one instruction: lose weight.

Weight management may be relevant for some people, but it should not replace evaluation.

The international PCOS guideline specifically emphasises awareness of weight stigma and recommends respectful, individualised care.

A useful care plan may include:

- Metabolic assessment
- Blood-pressure monitoring
- Nutrition support
- Physical activity
- Sleep support
- Behavioural strategies
- Medication
- Ovulation treatment
- Fertility investigation
- Mental-health support

Your body size should not become an excuse to ignore painful periods, absent periods, pregnancy losses, tubal factors, or sperm health.

Medication Is Not the Enemy

Fertility medication is sometimes described as artificial, dangerous, or evidence that a woman has failed to heal naturally.

That framing is harmful.

Medication is chosen because a particular problem may require a biological intervention that food cannot provide.

The correct question is not:

- "Is medication natural?"

The useful questions are:

What is the medicine treating?

What evidence supports it?

What are the benefits?

What are the risks?

How will I be monitored?

What alternatives exist?

How long should I use it?

What happens if it does not work?

Do not stop prescribed medication because a seller claims that it scatters hormones.

Letrozole

For women with PCOS who are not ovulating and have no other identified infertility factor, the international guideline recommends letrozole as the preferred first-line medication for ovulation induction.

Letrozole does not guarantee pregnancy.

It is intended to improve the likelihood of ovulation in appropriate patients.

The prescribing clinician should consider your full fertility picture, local availability, contraindications, and the monitoring required.

Do not buy it informally or copy another woman's dose.

Clomiphene

Clomiphene citrate, often known by the brand name Clomid, is another ovulation-induction medication.

It has helped many women ovulate and become pregnant, but it may not be the preferred first option in every PCOS case under current guidance.

It can have side effects and may increase the chance of multiple pregnancy, which is one reason appropriate prescribing and monitoring matter.

Clomiphene does not "destroy the hormonal ecosystem."

It is a medication with a specific purpose, potential benefits, limitations, and risks.

Metformin

Metformin is commonly used in PCOS, particularly where metabolic concerns such as insulin resistance or abnormal glucose regulation are relevant.

The international guideline recommends considering it for metabolic outcomes in appropriate adults with PCOS. It may also have a role in selected fertility-treatment plans, but it should not automatically be treated as a universal fertility medicine.

Common gastrointestinal effects can occur.

Do not increase or stop the dose independently. Discuss side effects, formulation, timing, and monitoring with the prescriber.

Birth-Control Pills and Trying to Conceive

Combined hormonal contraceptives may be prescribed for cycle management, acne, or excessive hair growth when pregnancy is not currently desired.

They prevent pregnancy while being taken as directed, so they are not used to induce conception.

A clinician may recommend them at one stage of PCOS management and change the plan when pregnancy becomes the goal.

Tell every prescriber clearly:

- "I am currently trying to conceive."

This changes which treatments may be appropriate.

Weight-Loss Medicines

Some people with PCOS use prescription weight-management medicines, including GLP-1 receptor agonists.

Pregnancy planning must be discussed with the prescriber because current PCOS guidance advises effective contraception while using GLP-1 receptor agonists when pregnancy is possible, due to insufficient pregnancy-safety data.

Do not continue, stop, or change a weight-loss medicine based on social-media instructions.

Ask:

When must this medicine be stopped before conception attempts?

What contraception is required while taking it?

What should I do if pregnancy occurs unexpectedly?

How will weight and metabolic health be managed afterward?

Your PCOS Symptom and History Map

Complete this before your appointment.

Menstrual history

Age when periods began: _____:

Usual cycle length: _____:

Shortest recent cycle: _____:

Longest recent cycle: _____:

Number of periods in the last 12 months: _____:

Longest time without a period: _____:

First day of last period: _____:

- ☐ My periods have always been irregular.
- ☐ They became irregular recently.
- ☐ They changed after weight loss.
- ☐ They changed after weight gain.
- ☐ They changed after starting medication.
- ☐ They changed after pregnancy or breastfeeding.

Androgen-related symptoms

- ☐ Facial hair growth
- ☐ Chest, abdominal, or back hair growth
- ☐ Persistent acne
- ☐ Scalp-hair thinning
- ☐ Rapid worsening of hair growth
- ☐ Deepening voice
- ☐ Major unexplained muscle or body changes

Rapidly progressing androgen-related symptoms require timely assessment because causes other than PCOS may need to be excluded.

Metabolic and general health

- ☐ Family history of diabetes
- ☐ Previous high blood sugar

- [ ] High blood pressure
- [ ] Darkened skin around the neck, armpits, or groin
- [ ] Sleep problems or possible sleep apnoea
- [ ] Major weight change
- [ ] Restrictive eating
- [ ] Very intense exercise
- [ ] History of an eating disorder
- [ ] Thyroid symptoms
- [ ] Milky breast discharge when not breastfeeding

Fertility history

How long we have been trying: _____:

Previous pregnancies: _____:

Previous pregnancy losses: _____:

Ovulation treatment used: _____:

Has my partner had a semen analysis? Yes / No

Have my tubes been assessed? Yes / No / Unsure

Has my uterus been assessed? Yes / No / Unsure

Your PCOS Appointment Preparation Sheet

Take this page to the appointment.

My three main concerns

Tests I have already completed

Test

Date

Result

What I was told

Medicines and supplements

Product

Dose

Reason

Still taking?

_____

_____

_____

Yes / No

_____

_____

_____

Yes / No

_____

_____

_____

Yes / No

_____

_____

_____

Yes / No

Questions for diagnosis

Which diagnostic features of PCOS do I have?

Which other causes have been excluded?

Do I need an ultrasound?

Is AMH necessary in my situation?

Could thyroid or prolactin problems explain my symptoms?

Could under-eating, weight change, or exercise be affecting my cycle?

Do my symptoms require more urgent investigation?

Questions for metabolic health

Should my blood pressure be checked?

Do I need glucose testing?

Do I need cholesterol testing?

How often should these be repeated?

Is there a sleep concern that needs assessment?

Would a dietitian be useful?

Questions for fertility

Am I likely to be ovulating?

Do I need medication to induce ovulation?

Is letrozole appropriate for me?

What are the alternatives?

Does my partner need a semen analysis?

Do my fallopian tubes need assessment?

How will treatment be monitored?

When should I be referred to a fertility specialist?

Questions for medication

What is this medication intended to treat?

What side effects should I expect?

How long should I take it?

Can it be used while trying to conceive?

What should I do if I become pregnant?

Does it interact with my supplements?

Must I stop it gradually?

Your PCOS Care Plan

Complete this after the appointment.

Diagnosis

My diagnosis or working diagnosis: _____:

Other conditions excluded: _____:

Further tests required: _____:

Nutrition

My first food goal: _____:

The support I need: _____:

- [ ] General healthy eating
- [ ] Blood-sugar management
- [ ] Weight-management support
- [ ] Help with under-eating
- [ ] Vegetarian planning
- [ ] Digestive support
- [ ] Eating-disorder support

Physical activity

Activity I can perform safely: _____:

Frequency agreed: _____:

Any medical restrictions: _____:

Medication

Medicine: _____:

Purpose: _____:

Dose: _____:

Monitoring: _____:

Fertility

- [ ] Continue trying naturally for an agreed period.
- [ ] Begin ovulation treatment.
- [ ] Arrange semen analysis.

- [ ] Arrange tubal or uterine evaluation.
- [ ] Refer to a fertility specialist.
- [ ] Another step: _____

Follow-up

Next appointment date: _____:

What must be completed first: _____:

PCOS Myths

Myth 1: Every irregular period is PCOS.

False.

Irregular or absent periods can result from several hormonal, medical, nutritional, medication-related, and reproductive causes.

Myth 2: You must have ovarian cysts to have PCOS.

False.

Diagnosis is based on a combination of defined features after excluding other causes. Ultrasound findings are only one possible feature.

Myth 3: One AMH result diagnoses PCOS.

False.

AMH should not be used as a stand-alone diagnostic test.

Myth 4: Every woman with PCOS must stop eating carbohydrates.

False.

No single diet composition has been shown to be best for every hormonal, metabolic, reproductive, or psychological PCOS outcome.

Myth 5: PCOS only affects women in larger bodies.

False.

PCOS can occur across body sizes.

Myth 6: Weight loss is the only PCOS treatment.

False.

Care may include lifestyle support, metabolic monitoring, cycle management, fertility medication, dermatological treatment, and psychological support.

Myth 7: Clomid and letrozole scatter hormones.

False.

They are prescribed ovulation-induction medicines with evidence-based roles, potential risks, and monitoring requirements. Letrozole is the preferred first-line pharmacological fertility treatment for appropriate women with PCOS and anovulatory infertility under the current international guideline.

Myth 8: Metformin is a natural-fertility replacement.

False.

Metformin is a prescription medicine with specific metabolic and selected reproductive roles. It does not treat every cause of infertility.

Myth 9: A perfect diet will cure PCOS.

False.

Healthy eating is important, but PCOS is a complex condition and may require ongoing clinical care.

Myth 10: PCOS means pregnancy is impossible.

False.

Women with PCOS can become pregnant naturally or with appropriate treatment. The plan depends on ovulation and any additional fertility factors.

Before You Close This Chapter

You do not need to spend the next year trying to balance unnamed hormones.

You need to identify what is actually happening.

Is ovulation irregular?

Is PCOS present?

Could the thyroid, prolactin, energy intake, exercise, medicine, or another condition be affecting the cycle?

Does your partner need evaluation?

Are your fallopian tubes and uterus relevant to the fertility picture?

Once the problem is defined more clearly, your choices become more useful.

Nutrition can support PCOS care.

Movement can support metabolic health.

Sleep and emotional support matter.

Medication can also be necessary.

These options do not compete with one another. They can form one complete care plan.

Your action from this chapter is to complete the PCOS Symptom and History Map and the Appointment Preparation Sheet.

Do not enter the next consultation saying only:

- "My hormones are not balanced."

Bring dates, symptoms, medicines, previous results, and specific questions.

> **In the next chapter, we will focus on stress, sleep, movement, and emotional wellbeing. You will learn how these areas can support your health without being told that you caused infertility by worrying too much.**

Reference Notes for Chapter 10

- International Evidence-Based Guideline for the Assessment and Management of Polycystic Ovary Syndrome. 2023.
- American Society for Reproductive Medicine. Current Evaluation of Amenorrhea: A Committee Opinion. 2024.
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- Global Name Change Consortium. Polyendocrine Metabolic Ovarian Syndrome, the New Name for Polycystic Ovary Syndrome: A Multistep Global Consensus Process. The Lancet. 2026.
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CHAPTER 11

Stress, Sleep, Movement, and Emotional Wellbeing

> *Evidence base: See the chapter's Reference Notes; key clinical recommendations also carry parenthetical source anchors.*

You have probably heard the sentence:

- "Just relax. It will happen."

Sometimes it comes from a friend who means well.

Sometimes it comes from a relative who has never experienced the monthly cycle of hope, waiting, testing, and disappointment. Sometimes it comes after you have spent money on consultations, answered painful questions, and watched another period arrive.

The statement sounds simple, but it can feel like blame.

It suggests that pregnancy has not happened because you are worrying too much. It makes you feel responsible not only for your medical condition, but also for every anxious thought that enters your mind.

Let us correct that idea.

Emotional stress can affect sleep, appetite, sexual desire, relationships, and daily functioning. In some situations, severe stress combined with inadequate energy intake or excessive exercise may contribute to menstrual disruption. But infertility has many possible causes, and relaxation cannot open fallopian tubes, correct a significant sperm problem, reverse reproductive ageing, or guarantee pregnancy.

You do not need to become perfectly peaceful before you deserve fertility care.

The purpose of this chapter is to help you feel and function better while you continue making informed medical decisions.

Infertility Can Be Emotionally Heavy

Trying to conceive can affect far more than your menstrual calendar.

It may affect:

Your confidence

Your relationship with your body

Your marriage or partnership

Your sex life

Your finances

Your faith

Your ability to attend social events

Your relationship with pregnant friends

Your willingness to visit family

Your concentration at work

Your sleep

The World Health Organization recognises that infertility can cause distress, stigma, anxiety, depression, social isolation, relationship strain, and financial hardship. Its 2025 infertility guideline emphasises people-centred care and psychosocial support as part of fertility care. (WHO, 2025)

Your emotional response is not evidence that you are weak.

It is a human response to uncertainty, loss of control, social pressure, and repeated disappointment.

Stress Is Not Proof That You Caused Infertility

Stress is a broad word.

It may describe:

- Worry about becoming pregnant
- Work pressure
- Financial difficulty
- Grief
- Relationship conflict
- Sleep deprivation
- Food insecurity
- Caregiving
- Physical overtraining
- Trauma
- Fear of another miscarriage
- Anxiety about fertility treatment

These experiences do not affect every person in the same way.

Stress can make intercourse more difficult by reducing desire, increasing muscle tension, or contributing to erection, ejaculation, or lubrication problems. Infertility-related psychological distress can also contribute to sexual difficulties in men and women.

However, this does not mean you can think yourself into or out of infertility.

You may benefit from stress support because you deserve relief, clearer thinking, better sleep, and a healthier relationship.

Do not use relaxation as another treatment you must perform perfectly.

When Stress, Under-Eating, and Exercise Affect the Cycle

There is one important area where emotional and physical stress deserves specific attention.

Functional hypothalamic amenorrhoea can occur when communication between the brain and reproductive system is disrupted. It is often associated with inadequate energy availability, weight loss, excessive exercise, psychological stress, or a combination of these factors.

The Endocrine Society recommends correcting the energy imbalance through increased food intake, improved nutrition, reduced exercise where necessary, and psychological support.

This does not mean every late period results from stress.

Functional hypothalamic amenorrhoea is a diagnosis made after other causes of missing periods have been considered.

Arrange a medical review when:

Your periods stopped after restrictive dieting

You lost weight rapidly

You train intensely most days

You regularly skip meals

You are afraid to increase food intake

You frequently feel dizzy, cold, weak, or exhausted

You have gone several months without a period

You have a history of an eating disorder

The solution may require more nourishment and less exercise, not another fertility supplement.

Your Five-Minute Stress Inventory

Complete this without trying to appear strong.

Rate each area from 0 to 3:

- 0: Not affecting me
- 1: Mild
- 2: Moderate
- 3: Strongly affecting me

Area	Score
Fear that pregnancy may not happen	___
Monthly disappointment	___
Pressure from relatives	___
Financial pressure	___
Conflict with my partner	___
Fertility-related sexual pressure	

___

Fear after pregnancy loss

___

Work or business pressure

___

Poor sleep

___

Social-media comparison

___

Difficulty attending baby-related events

___

Feeling blamed or ashamed

___

Medical appointments and treatment

___

Spiritual guilt or confusion

___

Lack of emotional support

___

My highest-scoring areas

The area I can address first

This inventory is not a mental-health diagnosis.

It helps you identify the part of the experience that currently requires support.

The Ten-Minute Nervous-System Pause

Use this exercise when your thoughts are racing, after receiving difficult news, before an appointment, or when fertility tracking begins to feel overwhelming.

It is not intended to make pregnancy happen.

Its purpose is to create a noticeable change in physical tension and mental organisation.

Minutes 1-2: Put the phone away

Turn your phone face down.

Close fertility applications, forums, and social media.

Sit with both feet supported.

Minutes 3-4: Slow your breathing

Breathe in gently through your nose.

Allow the breath to leave slowly.

Do not force extremely deep breathing if it makes you dizzy.

Repeat at a comfortable rhythm.

Minutes 5-6: Release physical tension

Notice:

Your jaw

Your shoulders

Your hands

Your stomach

Your pelvic muscles

Allow each area to soften slightly.

Minutes 7-8: Name what is happening

Complete these statements:

Right now, I feel: _____:

The thought disturbing me most is: _____:

The fact I know for certain is: _____:

The part I cannot control tonight is: _____:

Minutes 9-10: Choose one action

Select only one:

- ☐ Eat a proper meal.
- ☐ Drink water.
- ☐ Go for a short walk.
- ☐ Contact my partner or trusted person.

- [ ] Prepare questions for my appointment.
- [ ] Stop fertility research for the evening.
- [ ] Take prescribed medication.
- [ ] Go to bed.
- [ ] Arrange professional support.

Before and after

Tension before the exercise, 0-10: _____:

Tension after the exercise, 0-10: _____:

A reduction of even one or two points is useful.

The goal is not to eliminate every emotion.

Sleep Is Part of General Health, Not an Egg-Quality Test

Sleep affects mood, attention, appetite, physical recovery, and overall health.

Most adults should aim for at least seven hours of sleep within each 24-hour period, although individual needs vary. Helpful sleep habits include maintaining a regular schedule, reducing evening screen exposure, avoiding caffeine later in the day, and keeping the bedroom quiet and comfortable.

Poor sleep does not prove that you are infertile.

One late night does not damage your eggs.

However, regularly sleeping too little can make it harder to manage emotions, prepare meals, exercise safely, communicate with your partner, and attend appointments with a clear mind.

Your Seven-Day Sleep Reset

Do not attempt to force sleep.

Create conditions that make sleep more likely.

Step 1: Select a consistent wake time

My wake time: _____:

Try to keep it reasonably consistent, including on non-working days.

Step 2: Count backward

Choose a bedtime that gives you sufficient opportunity for sleep.

My target bedtime: _____:

My target sleep duration: _____:

Step 3: Create a 30-minute closing routine

Choose three:

- [ ] Dim the lights.
- [ ] Stop work.
- [ ] Put the phone away.
- [ ] Prepare clothes for tomorrow.
- [ ] Take a warm shower.
- [ ] Read something calming.
- [ ] Pray or reflect.
- [ ] Complete slow breathing.
- [ ] Write tomorrow's tasks on paper.
- [ ] Prepare breakfast.

Step 4: Review common disruptors

- [ ] Caffeine in the afternoon or evening

- [ ] Alcohol
- [ ] Heavy late meals
- [ ] Late-night fertility research
- [ ] Work messages in bed
- [ ] Television or phone in bed
- [ ] Noise
- [ ] Heat
- [ ] Pain
- [ ] Urinating repeatedly
- [ ] Anxiety
- [ ] Snoring or breathing difficulty

My first sleep change

CDC guidance recommends a consistent bedtime and wake time, switching off electronic devices before bed, avoiding large meals and alcohol near bedtime, and limiting afternoon or evening caffeine.

When Sleep Problems Need Medical Attention

Arrange a review when:

You regularly need more than 30 minutes to fall asleep

You wake repeatedly for long periods

You are very sleepy during the day

You frequently fall asleep unintentionally

Your partner notices loud snoring, choking, or pauses in breathing

- Pain or urinary symptoms repeatedly disturb sleep
- Anxiety keeps you awake most nights

You depend on alcohol or unreviewed medication to sleep

Persistent sleep difficulty can have medical, psychological, behavioural, or environmental causes. A clinician may need to assess medication, pain, mood, breathing, work schedules, or another health condition.

Do not begin sleeping tablets, herbal sedatives, or high-dose supplements without checking their safety while trying to conceive.

Movement Without Punishment

Movement can support cardiovascular health, strength, mood, sleep, and metabolic health.

For general preconception health, ACOG recommends approximately 150 minutes of moderate physical activity each week, along with muscle-strengthening activity on two or more days where appropriate. Activity can be divided into shorter sessions.

This is a general target, not a fertility competition.

More exercise is not always better.

Your movement plan should consider:

Your current fitness

- Medical conditions
- Pain
- Energy intake
- Menstrual pattern
- Previous injuries
- Pregnancy possibility
- Clinical advice

The Movement Ladder

Choose the level that matches your current ability.

Level 1: Begin Gently

Suitable when you have been inactive or are recovering from illness.

Complete:

A 10-minute walk

- Gentle stretching
- Light household movement
- Comfortable mobility exercises

Days per week: _____:

- Level 2: Build Consistency
- Complete:
- 20-30 minutes of brisk walking
- Dancing
- Cycling
- Swimming
- Low-impact exercise
- Light strength exercises

Days per week: _____:

- Level 3: Maintain a Developed Routine
- Continue a suitable combination of:
- Moderate aerobic activity
- Strength training
- Mobility work
- Rest and recovery

Review the routine if pregnancy occurs or if a clinician identifies a reason for modification.

My movement plan

Activity: _____:

Duration: _____:

Days: _____:

Where it will happen: _____:

Who may join me: _____:

Signs That Exercise May Need Review

Speak with a healthcare professional when:

Your periods stopped after increasing exercise

You regularly train despite injury or exhaustion

You feel unable to take a rest day

You exercise to compensate for eating

You are losing weight rapidly

You experience faintness, chest pain, or unusual shortness of breath

You have severe pelvic pain during activity

You are pregnant and develop warning symptoms

When exercise contributes to an energy deficit and missing periods, the answer may involve reducing activity and increasing nutrition.

Fertility Grief Is Real

Grief does not occur only after a death.

You may grieve:

The timeline you expected

The pregnancy announcement you hoped to make

A pregnancy loss

A failed treatment cycle

The money spent

The ease other people appear to have

The version of your marriage before fertility pressure

The confidence you once had in your body

You do not need to explain this grief to everyone.

But you should not be expected to carry it alone.

WHO's infertility guidance identifies continued psychosocial support as an important part of care, while ASRM recognises the role of trained fertility counsellors in supporting individuals and couples experiencing fertility problems.

Build Your Support Circle

Write one name in each category where possible.

Medical support

> Clinician or clinic: _____:

Emotional support

> Friend, relative, counsellor, or therapist: _____:

Partner support

> The action I need from my partner: _____:

Practical support

Person who can help with transport, meals, work, or appointments:

Spiritual support

Trusted person who supports without blame: _____:

You do not need a large circle.

You need safe people.

Scripts for Difficult Conversations

When a relative asks about pregnancy

"We appreciate your concern, but we are keeping our reproductive plans private. We will share news when we are ready."

When someone recommends another remedy

"Thank you for thinking of me. I am following a structured plan with medical guidance, so I am not adding new fertility products."

When someone blames stress

"Stress support is important for my wellbeing, but infertility has many possible causes. I am addressing both my emotional health and the medical factors."

When you cannot attend a baby-related event

"I care about you and I am happy for you. I am not emotionally able to attend this event, but I would like to celebrate with you privately."

When your partner withdraws

"I do not need you to solve everything. I need us to talk honestly about how this is affecting both of us."

When you need professional support

"Trying to conceive is affecting my sleep, mood, and daily life. I would like help from someone experienced in fertility-related emotional wellbeing."

Create a Fertility-Free Zone

Your entire home and relationship should not revolve around conception.

Choose one period each week when you will not discuss:

- Ovulation

- Test results
- Pregnancy symptoms
- Fertility treatment
- Supplements
- Family questions
- Our fertility-free period

Day: _____:

Time: _____:

Activity: _____:

- Possible activities include:
- Going for a walk
- Watching a film
- Cooking together
- Visiting a calm location
- Playing a game
- Attending a non-fertility-related event
- Discussing future plans unrelated to children

This is not denial.

It is permission to remain a complete person while trying to conceive.

Your 21-Day Sleep, Stress, Movement, and Energy Tracker

Use a score from 1 to 5.

1: Very poor or very difficult

2: Difficult

3: Moderate

4: Good

5: Very good

Day

Sleep quality

Energy

Stress management

Mood

Movement

Meal consistency

Connection or support

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These scores do not measure fertility, hormones, ovulation, egg quality, or the likelihood of pregnancy.

They help you notice whether your daily routine supports your wellbeing.

Weekly Review

Week 1

My strongest area: _____:

My most difficult area: _____:

One adjustment: _____:

Week 2

My strongest area: _____:

My most difficult area: _____:

One adjustment: _____:

Week 3

My strongest area: _____:

The habit I will continue: _____:

The support I still need: _____:

When Emotional Support Becomes Urgent

Seek prompt professional help when:

- Anxiety or sadness is affecting most days

You cannot work or complete normal responsibilities

You are withdrawing from everyone

You regularly use alcohol or drugs to cope

You experience panic attacks

You feel hopeless or worthless

Your relationship has become threatening or violent

You think others would be better without you

You think about harming yourself

You begin planning how to die

Warning signs of suicide may include talking about wanting to die, intense guilt or shame, feeling like a burden, withdrawing, giving away important belongings, taking dangerous risks, extreme mood changes, or increased drug and alcohol use.

Do not remain alone with an immediate risk of self-harm.

Contact local emergency services, a crisis service, a trusted person, or the nearest emergency department. Ask someone to remain with you while help is arranged.

Emotional support is not a luxury added after fertility treatment.

It is part of responsible care.

Wellbeing Myths

Myth 1: Infertility happens because a woman worries too much.

False.

Infertility has many possible female, male, combined, and unexplained causes. Emotional support may improve wellbeing, but relaxation cannot treat every reproductive condition.

Myth 2: Stress has no effect on anything.

False.

Stress may affect sleep, appetite, sexual function, relationships, and daily functioning. In combination with energy deficiency or excessive exercise, it may contribute to functional hypothalamic amenorrhoea in susceptible individuals.

Myth 3: Exercise always improves fertility.

False.

Appropriate movement supports general health, but excessive exercise combined with inadequate energy intake may disrupt menstrual function.

Myth 4: More exercise produces faster results.

False.

Exercise should be appropriate for your health, nutrition, fitness level, and medical circumstances.

Myth 5: Sleeping badly for one night damages egg quality.

False.

Sleep supports general health, but one difficult night is not a fertility diagnosis.

Myth 6: Seeking therapy means your faith is weak.

False.

Counselling can provide practical support for grief, anxiety, relationships, treatment decisions, and coping. Fertility counselling is recognised as part of reproductive care.

Myth 7: You must remain positive throughout the journey.

False.

You are allowed to feel sadness, anger, jealousy, fear, hope, and exhaustion. Honest emotions do not cancel your possibility of pregnancy.

Before You Close This Chapter

You did not cause infertility by having difficult days.

You do not need to smile through every pregnancy announcement.

You do not need to perform peace while carrying fear.

Your responsibility is not to eliminate every stressful thought.

Your responsibility is to recognise when the emotional burden is becoming too heavy and to seek the right support.

Begin with four actions:

Complete the Stress Inventory.

Choose one sleep improvement.

Select a realistic movement level.

Identify one safe person or professional you can contact.

Continue the 21-Day Wellbeing Tracker without using it to judge your fertility.

> **In the next chapter, we will shift the focus from the woman to the couple.**

You will learn why fertility is a two-person health issue, what can affect sperm health, when semen analysis is needed, and how a partner can participate practically instead of leaving the entire process to the woman.

Reference Notes for Chapter 11

- World Health Organization. Guideline for the Prevention, Diagnosis and Treatment of Infertility. 2025.
- World Health Organization. Infertility Fact Sheet. Updated November 2025.
- American Society for Reproductive Medicine. Guidance on Qualifications for Fertility Counsellors.
- Endocrine Society. Functional Hypothalamic Amenorrhea Clinical Practice Guideline.
- American College of Obstetricians and Gynecologists. Good Health Before Pregnancy: Prepregnancy Care.
- Centers for Disease Control and Prevention. About Sleep.
- National Institute of Mental Health. Warning Signs of Suicide. Revised 2025.



CHAPTER 12

Fertility Is a Two-Person Health Issue

> *Evidence base: See the chapter's Reference Notes; key clinical recommendations also carry parenthetical source anchors.*

In many families, the woman becomes the fertility project.

She tracks the cycle.

She changes her diet.

She takes the supplements.

She visits the hospital.

She answers questions from relatives.

She is told to lose weight, gain weight, stop worrying, pray harder, drink another mixture, and try one more sexual position.

Meanwhile, nobody asks whether her partner has completed a semen analysis.

This is not fair, and it is not medically complete.

Infertility can involve female factors, male factors, a combination of both, or factors that remain unexplained after evaluation. The World Health Organization identifies common male causes such as problems with ejaculation, absent or low sperm levels, and abnormalities in sperm movement or shape.

A couple should therefore approach fertility as a shared health issue.

That does not mean blaming the man instead of the woman.

It means evaluating both partners with the same seriousness, honesty, and respect.

A Previous Pregnancy Does Not Clear Either Partner

Some couples assume that the man cannot have a fertility problem because he has previously fathered a pregnancy.

Others assume that the woman must be fertile because she has been pregnant before.

Fertility can change.

A person may experience secondary infertility after previously contributing to or carrying a pregnancy. Health conditions, age, infection, surgery, medication, environmental exposure, and other factors may change over time.

A previous pregnancy is useful medical history.

It is not a permanent fertility certificate.

Sperm Health Is Not the Same as Masculinity

A low sperm count does not make a man weak.

Abnormal sperm movement does not mean he is sexually inadequate.

A man can have:

A normal erection

- Strong sexual desire

- Regular ejaculation

A masculine appearance

- Previous children

and still have a sperm-related fertility problem.

Sexual performance and sperm production are connected to reproductive health, but they are not the same measurement.

A man may also have difficulty with erection or ejaculation while producing sperm normally.

This is why assumptions based on appearance, strength, libido, semen thickness, or sexual confidence are unreliable.

The correct next step is assessment, not shame.

How Sperm Is Produced

Sperm is produced inside the testicles through a biological process called spermatogenesis.

Hormonal signals from the brain and pituitary gland help regulate testosterone production and sperm development. Mature sperm then travel through the male reproductive tract and mix with fluids that form semen.

A problem can occur at several stages:

The testicles may produce too few sperm.

Sperm may not develop normally.

A blockage may prevent sperm from entering the semen.

Hormonal signals may be disrupted.

Sperm may move poorly.

Ejaculation may not occur normally.

Semen may travel backward into the bladder.

Sexual difficulties may prevent semen from being deposited in the vagina.

WHO identifies obstruction, hormonal disorders, testicular failure, medical treatments, varicocele, and abnormal sperm function as possible contributors to male infertility.

What a Semen Analysis Examines

A semen analysis is usually one of the first tests used to assess a male partner.

It may report:

- Semen volume
- Sperm concentration
- Total sperm number
- Sperm motility
- Sperm morphology
- Other laboratory observations where appropriate
- Semen volume

This is the amount of semen collected.

A low volume may result from several possible factors, including incomplete collection, ejaculatory problems, obstruction, or gland-related issues. It should be interpreted alongside the history and the rest of the laboratory findings.

Sperm concentration

This describes how many sperm are present in each measured amount of semen.

It is not the same as the total number of sperm in the whole sample.

Total sperm number

This estimates the number of sperm present across the full ejaculate.

Motility

Motility describes sperm movement.

The laboratory may distinguish sperm that move progressively forward from those that move without meaningful forward progression or do not move.

Morphology

Morphology refers to the shape and structure of sperm assessed according to defined laboratory criteria.

A morphology result does not mean that every sperm has been inspected. It is based on the sample and method used by the laboratory.

The CDC explains that semen analysis commonly assesses sperm concentration, movement, and shape. It also warns that a mildly abnormal result does not automatically mean the man is infertile.

A Semen Analysis Is Not a Pass-or-Fail Examination

Couples often receive the result and immediately search for a single word:

Normal or abnormal.

The reality is more nuanced.

One semen parameter above or below a laboratory reference value does not independently prove fertility or infertility. The findings become more clinically important when several significant abnormalities occur together.

A semen analysis cannot tell you with certainty:

- Whether natural pregnancy will occur
- How long conception will take
- Whether every sperm is healthy
- Whether fertilisation will happen
- Whether an embryo will implant
- Whether a pregnancy will continue
- Whether the female partner has another fertility factor

WHO states that semen analysis can help guide investigation and management, but it cannot confirm an individual man's fertility because the couple's full reproductive picture also matters.

Do not use one number to declare that pregnancy is impossible.

Take the complete result to an appropriate clinician.

Why a Test May Need to Be Repeated

Semen findings can vary between samples.

Illness, collection problems, the time since the previous ejaculation, laboratory processes, and biological variation may affect results.

AUA and ASRM guidance notes that semen parameters can vary substantially from one ejaculate to another. It recommends obtaining at least two analyses, ideally at least one month apart, particularly when the first result is abnormal.

This does not mean every man must repeat every normal test indefinitely.

It means one unexpected result should be interpreted carefully rather than becoming the final verdict.

After an abnormal result, ask:

Was the entire sample collected?

Were the laboratory instructions followed?

Was the sample delivered correctly?

Was the man recently ill or feverish?

Should the analysis be repeated?

Does the pattern require a male reproductive specialist?

Are hormonal or genetic tests indicated?

Is there a potentially correctable cause?

Preparing for a Semen Analysis

The laboratory should give exact instructions.

Follow them carefully because collection requirements may differ between centres.

Common preparation principles include:

Follow the laboratory's required period without ejaculation.

Collect the sample using the method and container provided.

Avoid ordinary lubricants unless the laboratory provides an approved collection product.

Try to collect the complete ejaculate.

Tell the laboratory if any portion was lost.

Record the collection time.

Deliver the sample according to the laboratory's timing and temperature instructions.

Do not hide difficulty producing the sample.

Do not collect semen into a random household container.

Do not add water, saliva, oil, lotion, or another substance.

If masturbation conflicts with personal or religious beliefs, ask the clinic whether it provides an approved alternative collection method.

Your Semen Analysis Preparation Sheet

Appointment information

Laboratory or clinic: _____:

Appointment date: _____:

Collection location: At clinic / At home / Other

Required abstinence period: _____:

Maximum delivery time: _____:

Contact person or number: _____:

Before collection

- [ ] I have read the laboratory instructions.
- [ ] I understand the required abstinence period.
- [ ] I have the correct sterile container.
- [ ] I know whether collection must occur at the clinic.
- [ ] I know the permitted delivery time.
- [ ] I know how the sample must be transported.
- [ ] I have asked about an approved collection method if needed.

After collection

Collection time: _____:

Was the complete sample collected? Yes / No / Unsure

Was any portion lost? Yes / No

Delivery time: _____:

Information given to the laboratory: _____:

Understanding the Result

Use this sheet during the medical review.

Measurement

Result

Laboratory range

Clinician's explanation

Semen volume

_____

_____

_____

Sperm concentration

_____

_____

_____

Total sperm number

_____

_____

_____

Progressive motility

_____

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Total motility

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Morphology

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Other finding

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Questions to ask

Is more than one parameter abnormal?

How significant are the abnormalities?

Should the analysis be repeated?

When should it be repeated?

Could collection problems have affected the result?

Does my partner need a physical examination?

Is referral to a reproductive urologist appropriate?

Are hormone tests required?

Are genetic tests required?

Is infection being considered?

Is there a possible blockage?

What treatment options are appropriate?

Does the female partner's age affect the treatment timeline?

When the Male Partner Should Be Evaluated

A male evaluation should not wait until the woman has completed every possible test.

ASRM recommends concurrent assessment of both partners during an initial infertility evaluation. A male reproductive history and at least one semen analysis should be obtained at the beginning of the evaluation when a male partner contributes sperm.

Do not delay male assessment when:

The couple has reached the recommended infertility-evaluation timeline.

There is difficulty with erection or ejaculation.

The man has a history of testicular injury.

He had undescended testicles.

He has had surgery involving the groin, testicles, bladder, prostate, or reproductive tract.

He has received chemotherapy or radiation.

He uses testosterone or anabolic steroids.

He has had a serious genital infection.

There is testicular pain, swelling, or a lump.

He has previously had an abnormal semen analysis.

There have been repeated fertility-treatment failures.

The couple has experienced two or more pregnancy losses.

AUA and ASRM guidance also recommends considering male evaluation in couples with recurrent pregnancy loss or failed assisted-reproduction cycles.

The Male Reproductive History

A complete evaluation involves more than handing over a semen sample.

The clinician may ask about:

- Previous pregnancies with any partner
- Duration of current conception attempts

- Childhood testicular conditions
- Undescended testicles
- Puberty and sexual development
- Testicular or groin injuries
- Genital infections
- Sexually transmitted infections
- Operations
- Cancer treatment
- Medication
- Testosterone or anabolic steroids
- Smoking, alcohol, and drug use
- Work-related exposures
- Erectile or ejaculation difficulties
- Family or genetic history

The initial male evaluation should include a reproductive history, semen analysis, and specialist assessment when abnormalities or suspected male infertility are present.

Complete the Male Fertility History Checklist

Previous fertility

- ☐ I have previously contributed to a pregnancy.
- ☐ I have never contributed to a known pregnancy.
- ☐ I experienced difficulty conceiving in a previous relationship.
- ☐ A previous partner required fertility treatment.

Testicular and surgical history

- ☐ Undescended testicle during childhood
- ☐ Testicular injury
- ☐ Groin or testicular surgery
- ☐ Hernia surgery
- ☐ Testicular torsion

- [ ] Varicocele
- [ ] Testicular infection
- [ ] Testicular pain, swelling, or lump
- [ ] Vasectomy or vasectomy reversal

General medical history

- [ ] Diabetes
- [ ] Hormonal disorder
- [ ] Pituitary condition
- [ ] Cystic fibrosis
- [ ] Autoimmune condition
- [ ] Kidney or liver disease
- [ ] Cancer
- [ ] Chemotherapy
- [ ] Radiation treatment
- [ ] High fever or serious recent illness
- [ ] Another long-term condition: _____

Sexual function

- [ ] Low sexual desire
- [ ] Repeated erection difficulty
- [ ] Ejaculation difficulty
- [ ] Very low semen volume
- [ ] No visible ejaculation
- [ ] Pain during erection or ejaculation
- [ ] Intercourse does not regularly result in ejaculation inside the vagina

Medication and substance use

- [ ] Prescribed testosterone
- [ ] Testosterone injections, gels, pellets, or boosters

- [ ] Anabolic steroids
- [ ] Gym or bodybuilding hormones
- [ ] Opioids
- [ ] Long-term medication
- [ ] Herbal sexual-performance products
- [ ] Smoking or vaping
- [ ] Marijuana or another recreational drug
- [ ] Heavy alcohol use

Occupational and environmental history

- [ ] Regular pesticide exposure
- [ ] Solvents or industrial chemicals
- [ ] Heavy metals
- [ ] Radiation exposure
- [ ] Frequent high-heat exposure
- [ ] Another workplace concern: _____

My priority concerns

Testosterone Can Reduce Sperm Production

This is one of the most important warnings in the guide.

A man may take testosterone because he has:

- Low energy
- Reduced sexual desire
- Erectile concerns

A gym or bodybuilding goal

A laboratory result described as low testosterone

A product marketed as a male booster

External testosterone can signal the brain and pituitary gland to reduce the hormones that stimulate sperm production inside the testicles. Sperm production may fall significantly or stop, sometimes resulting in no sperm being detected in the semen.

AUA and ASRM guidance states that testosterone monotherapy should not be prescribed to a man interested in present or future fertility.

This includes testosterone supplied as:

- Injections
- Gels
- Creams
- Pellets
- Patches
- Unregulated gym products
- Anabolic steroid cycles

Do not stop prescribed testosterone abruptly without medical guidance.

Instead, tell the prescriber clearly:

"We are trying to conceive, and I need to understand how this treatment may be affecting sperm production."

A male reproductive specialist may discuss alternative approaches depending on the diagnosis.

Anabolic Steroids Are Not Fertility Supplements

Anabolic steroids are sometimes used to increase muscle size, strength, or physical performance.

They can suppress natural sperm production and interfere with fertility.

A man may appear extremely fit while producing very few or no sperm.

Do not assume the product is safe because:

It came from a gym instructor.

Other men have used it.

It is called a cycle.

A post-cycle product was recommended.

It increased sexual desire.

The packaging says natural testosterone support.

The complete list of products should be shown to a qualified clinician.

Smoking, Alcohol, and Recreational Drugs

Smoking can contribute to fertility problems in men and women. CDC also identifies heavy alcohol use, anabolic steroids, illicit drugs, testicular trauma, testosterone exposure, and certain medical treatments as male fertility risks.

Evidence for the exact effect of many individual lifestyle exposures remains limited, and not every man who smokes or drinks will be infertile. However, this uncertainty is not a reason to ignore known health risks.

Shared action plan

- [ ] Stop smoking.
- [ ] Reduce second-hand smoke exposure.
- [ ] Seek help for heavy alcohol use.
- [ ] Stop recreational drug use with professional support where needed.
- [ ] Disclose all anabolic steroids and testosterone products.
- [ ] Review medications with a clinician.
- [ ] Address weight and metabolic health without crash dieting.

Heat and Sperm

The testicles are located outside the body partly because sperm production functions best within a controlled temperature range.

Frequent high-temperature exposure is listed by CDC as a possible male infertility risk.

This does not mean a single hot shower destroys fertility.

Avoid fear-based rules such as:

A laptop touched the lap once, so the sperm is damaged.

Wearing fitted trousers guarantees infertility.

One fever permanently destroyed sperm production.

Instead, review repeated or occupational exposure, such as:

- Frequent hot tubs or saunas
- Regular high-heat workplace conditions
- Prolonged heat directly around the testicles
- Recent high fever

Mention significant exposure to the clinician rather than buying a cooling supplement.

Varicocele

A varicocele is an enlargement of veins around the testicle.

Some men have no symptoms. Others may notice discomfort, heaviness, visible veins, or a difference in testicular size.

Not every varicocele requires treatment.

AUA and ASRM guidance recommends considering surgical repair in selected men who are trying to conceive, have a palpable varicocele, infertility, and abnormal semen parameters. It advises against surgery for a varicocele found only through imaging when it cannot be felt on examination.

Do not diagnose or treat a varicocele through an online photograph or supplement.

A proper physical examination matters.

Male Fertility Supplements

The market contains countless products promising:

- Higher sperm count
- Faster sperm
- Better morphology
- Stronger testosterone
- Immediate male fertility
- Protection from DNA damage

These products may contain vitamins, minerals, herbs, antioxidants, or hormones.

AUA and ASRM guidance states that the clinical usefulness of antioxidant and vitamin supplements for treating male infertility is uncertain, with insufficient evidence to recommend specific products as a substitute for evaluation and treatment. (AUA/ASRM, 2021)

This does not mean every supplement is dangerous.

It means a supplement should not replace:

- Semen analysis
- Physical examination
- Hormone testing where indicated
- Treatment of infection
- Review of testosterone use
- Assessment of obstruction
- Management of a clinical varicocele
- Appropriate fertility treatment
- Before buying a sperm supplement, ask:

What diagnosis is this treating?

Has my partner completed a semen analysis?

Are the ingredients and doses listed?

Could it interact with medication?

Does it contain a hormone or stimulant?

Has a clinician reviewed it?

Is the seller promising guaranteed pregnancy?

Are we delaying a proper evaluation?

Food and Male Fertility

A balanced diet supports general health.

Men can use the same plate structure introduced earlier:

- Vegetables and fruit
- Beans and legumes
- Fish, eggs, poultry, or another protein
- Whole or minimally processed carbohydrates
- Suitable fats
- Water

Evidence linking specific diets to male fertility remains limited. AUA and ASRM note that lifestyle and dietary studies often provide low-quality or uncertain evidence, even though diets containing more fruit and vegetables and less excessive fat may be reasonable for general health.

Do not promise that a food will multiply sperm in seven days.

The useful goal is a sustainable health pattern.

Sexual Difficulties Deserve Care

Erection and ejaculation difficulties may interfere with conception even when sperm is present.

Possible concerns include:

- Difficulty obtaining an erection
- Difficulty maintaining an erection
- Ejaculation before penetration
- Delayed or absent ejaculation
- Painful ejaculation
- Semen travelling backward into the bladder
- Low sexual desire
- Fertility-related performance anxiety

These problems may be connected to stress, diabetes, cardiovascular health, medication, hormone disorders, neurological conditions, relationship strain, or other factors.

Do not shame the man.

Do not say:

- "You are not trying."
- "You are not attracted to me."
- "A real man should be able to perform."
- "You have wasted my fertile window."
- Use a calmer approach:

"This is affecting both of us, and it deserves proper support. Let us discuss it with someone who can identify the cause."

The Shared Preconception Checklist

Both partners should complete this page.

Woman or pregnancy-carrying partner

- ☐ Records menstrual dates
- ☐ Takes reviewed folic acid or prenatal supplementation
- ☐ Has reviewed medicines and supplements
- ☐ Has addressed irregular periods or severe pain
- ☐ Has arranged appropriate fertility evaluation
- ☐ Avoids smoking, alcohol, and recreational drugs

Male or sperm-contributing partner

- ☐ Has shared full reproductive history
- ☐ Has completed semen analysis where indicated
- ☐ Has disclosed testosterone and anabolic-steroid use
- ☐ Has reviewed medicines and supplements
- ☐ Has addressed erection or ejaculation difficulties
- ☐ Avoids smoking, heavy alcohol use, and recreational drugs

Shared responsibilities

- ☐ We understand the fertility-evaluation timeline.
- ☐ We attend important appointments together where possible.
- ☐ We share the financial planning.
- ☐ We share meal preparation and healthy habits.
- ☐ We do not blame one partner.
- ☐ We protect consent and comfort during intercourse.
- ☐ We discuss results respectfully.
- ☐ We agree on the next clinical step.

The Partner Appointment Preparation Sheet

Main reason for the appointment

Duration of conception attempts

Previous pregnancies contributed to

Previous semen analyses

Date

Main findings

Repeat advised?

_____

_____

Yes / No

_____

_____

Yes / No

Current medicines, hormones, and supplements

Product

Dose

Reason

Prescriber or source

Important history

- [ ] Undescended testicle
- [ ] Testicular injury
- [ ] Surgery
- [ ] Infection
- [ ] Varicocele
- [ ] Testosterone or steroid use
- [ ] Chemotherapy or radiation
- [ ] Erectile difficulty
- [ ] Ejaculatory difficulty
- [ ] Family or genetic condition

Questions for the clinician

Should the semen analysis be repeated?

Do the results show one or several abnormalities?

Is a physical examination needed?

Could testosterone or medication be contributing?

Are hormone tests indicated?

Is genetic testing indicated?

Could there be a blockage?

Is a varicocele present?

What can be treated?

What treatment timeline is appropriate?

Should we see a reproductive urologist?

How does the female partner's age affect urgency?

Male Fertility Myths

Myth 1: If a man can have sex, his sperm must be normal.

False.

Erection, ejaculation, and sperm quality are different aspects of reproductive function.

Myth 2: Thick semen means a high sperm count.

False.

The appearance or thickness of semen cannot replace laboratory analysis.

Myth 3: A previous child proves the man cannot have a fertility problem.

False.

Fertility can change, and secondary infertility can occur.

Myth 4: The woman should finish every test before the man is checked.

False.

Both partners should be assessed concurrently when infertility is evaluated.

Myth 5: One abnormal semen result proves permanent infertility.

False.

Semen parameters vary, and repeat testing may be needed.

Myth 6: Testosterone improves male fertility.

False.

External testosterone may suppress sperm production and should not be used as monotherapy by men seeking present or future fertility.

Myth 7: Gym steroids only affect muscles.

False.

Anabolic steroids can suppress sperm production and interfere with fertility.

Myth 8: A sperm supplement can replace testing.

False.

Evidence for many male fertility supplements is uncertain, and no product should replace proper evaluation.

Myth 9: Male infertility means pregnancy is impossible.

False.

Some causes can be treated medically or surgically. Other couples may use insemination, IVF, ICSI, sperm retrieval, or donor sperm depending on the diagnosis and their choices.

Myth 10: A male fertility problem should be hidden.

False.

Secrecy can delay treatment, create unnecessary costs, and place unfair responsibility on the female partner.

Before You Close This Chapter

The woman is not the fertility department of the relationship.

She should not carry the tracking, diet, testing, financial burden, family pressure, and emotional labour alone.

A complete fertility plan asks questions about both partners.

Does the woman ovulate?

Are the tubes and uterus appropriately assessed?

Is the male partner producing and delivering sperm normally?

Are there medicines, hormones, infections, surgeries, or lifestyle exposures affecting either person?

Your action from this chapter is to complete the Shared Preconception Checklist with your partner.

Where the fertility-evaluation timeline has been reached, arrange semen analysis at the same time as the female assessment rather than waiting until every other possibility has been exhausted.

In the next chapter, we will discuss the point at which food, tracking, and lifestyle changes are no longer enough.

You will learn when to seek fertility care, what an initial evaluation may include, which symptoms require earlier attention, and how to enter the appointment with an organised medical summary instead of another bag of unverified remedies.

Reference Notes for Chapter 12

- World Health Organization. Infertility Fact Sheet. Updated November 28, 2025.
- World Health Organization. WHO Laboratory Manual for the Examination and Processing of Human Semen, Sixth Edition.
- American Urological Association and American Society for Reproductive Medicine. Diagnosis and Treatment of Infertility in Men: Guideline Part I.
- American Urological Association and American Society for Reproductive Medicine. Diagnosis and Treatment of Infertility in Men: Guideline Part II.
- American Society for Reproductive Medicine. Fertility Evaluation of Infertile Women: A Committee Opinion.
- Centers for Disease Control and Prevention. Infertility: Frequently Asked Questions.
- Centers for Disease Control and Prevention. Cigarettes and Reproductive Health.



CHAPTER 13

When Food Is Not the Answer

> *Evidence base: See the chapter's Reference Notes; key clinical recommendations also carry parenthetical source anchors.*

There is a point where another meal plan will not give you the information you need.

You may be eating balanced meals, taking folic acid, tracking your fertile window, and having intercourse regularly. You may have reduced alcohol, reviewed your supplements, and involved your partner.

Yet pregnancy has not happened.

At that point, continuing to add more foods, herbs, tests, or fertility rituals may only delay the next useful step.

This does not mean nourishment has failed.

It means nutrition cannot answer every fertility question.

Food cannot show whether your fallopian tubes are open. A cycle application cannot examine the uterus. Cervical mucus cannot assess sperm. A supplement cannot determine whether you are ovulating consistently or why pregnancies are being lost.

Sometimes the most natural next step is proper medical investigation.

Seeking Help Is Not Giving Up

Many women delay fertility care because they are afraid of what the doctor might find.

Others believe that attending a fertility clinic automatically means they will be pressured into IVF.

Some have been told that medical treatment shows a lack of faith or that fertility medicine will damage their hormones.

These fears can keep couples trying the same unsupported remedies for years.

A fertility evaluation does not commit you to any particular treatment.

Its first purpose is to gather information.

The results may show:

A problem with ovulation

A sperm-related factor

A fallopian-tube issue

A condition affecting the uterus

A hormonal or medical condition

- More than one contributing factor
- No obvious cause after the initial tests

The information can help you decide whether to continue trying naturally, use medication, treat an identified condition, consider insemination or IVF, or explore another family-building path.

WHO's infertility guideline promotes a stepwise approach that moves from simpler management options to more complex treatments according to clinical findings, patient preferences, and available resources.

The Standard Fertility-Evaluation Timeline

For women younger than 35 with no known fertility risk, evaluation is generally recommended after 12 months of regular unprotected intercourse without pregnancy. (ASRM, 2021)

For women aged 35 or older, evaluation is generally recommended after six months. (ASRM, 2021)

For women older than 40, more immediate evaluation may be appropriate because fertility declines with age and delaying investigation may reduce the available treatment time. (ASRM, 2021)

Use the following guide:

- Younger than 35
- Seek an evaluation after:
- 12 months of regular unprotected intercourse without pregnancy
- Age 35 to 40
- Seek an evaluation after:
- Six months of regular unprotected intercourse without pregnancy
- Older than 40

Discuss fertility evaluation immediately rather than waiting six or twelve months.

These timelines apply when there is no known condition requiring earlier attention.

They are not instructions to ignore concerning symptoms until the deadline arrives.

Do Not Wait When a Known Concern Exists

ASRM recommends beginning evaluation without delay when medical history or physical findings are associated with infertility.

Seek earlier assessment when you have:

- Irregular or absent periods

- Cycles that are repeatedly very short or very long

A known ovulation disorder

- Suspected or diagnosed endometriosis
- Previous pelvic inflammatory disease

A history of ectopic pregnancy

- Previous pelvic or reproductive surgery
- Known or suspected fallopian-tube disease

A uterine condition that may affect fertility

- Previous chemotherapy or pelvic radiation

A condition associated with reduced ovarian function

- Persistent painful intercourse
- Significant sexual or ejaculation difficulty

A known or suspected male fertility factor

- Two or more pregnancy losses

You do not need to complete a 21-day food programme before making the appointment.

The guide can support your health while the evaluation is taking place.

Irregular or Missing Periods Need More Than Tracking

When periods are absent or highly irregular, waiting for twelve months of perfectly timed intercourse may not make sense.

A woman who rarely ovulates may not receive twelve meaningful opportunities to conceive within one year.

Irregular or absent menstruation can be associated with PCOS, thyroid conditions, elevated prolactin, hypothalamic dysfunction, primary ovarian insufficiency, medicines, pregnancy, breastfeeding, or other causes.

The correct treatment depends on what is disrupting the cycle.

Arrange an evaluation when:

You have gone three months without a period after previously regular cycles

Your periods have always been highly irregular

You regularly go many weeks or months between periods

Your cycle changed significantly without explanation

- Ovulation tests remain repeatedly confusing

Your period stopped after major weight loss, food restriction, or intense exercise

Do not rely only on an application's ovulation prediction when the underlying cycle is not functioning predictably.

Severe Pain Is Not a Fertility Sign

Some women are told that painful periods mean the womb is working hard or cleansing itself.

Severe pain should not be romanticised.

Seek assessment when menstrual or pelvic pain:

- Prevents you from working or sleeping
- Causes vomiting, faintness, or extreme weakness
- Is becoming progressively worse
- Occurs during sex
- Occurs outside menstruation
- Is associated with very heavy bleeding
- Began after surgery, infection, or pregnancy
- Is concentrated on one side
- Continues despite ordinary pain-relief measures

Pain may have several causes, including endometriosis, adenomyosis, fibroids, infection, ovarian conditions, gastrointestinal problems, or other pelvic conditions.

A vegetable soup cannot identify which one is present.

Do Not Delay After an Ectopic Pregnancy

An ectopic pregnancy occurs when a pregnancy develops outside the uterus, most commonly in a fallopian tube.

A previous ectopic pregnancy can be relevant to future fertility and pregnancy monitoring.

When pregnancy is possible, seek urgent medical attention for:

- Sudden or severe abdominal or pelvic pain
- Shoulder pain
- Weakness
- Dizziness
- Fainting
- Vaginal bleeding with significant pain

These may be signs of a ruptured ectopic pregnancy, which can cause dangerous internal bleeding.

Do not wait for a scheduled fertility appointment when these symptoms occur.

Seek emergency care.

Two Pregnancy Losses Deserve Evaluation

A miscarriage is not evidence that you ate the wrong meal, worried too much, had sex in the wrong position, or failed to keep the sperm inside.

Most isolated miscarriages are sporadic, and many are connected to genetic abnormalities in the pregnancy.

However, repeated pregnancy loss requires its own assessment.

ASRM's 2026 guidance defines recurrent pregnancy loss as two or more spontaneous pregnancy losses, excluding confirmed ectopic and molar pregnancies. Urine or blood pregnancy tests can be sufficient confirmation, so very early biochemical losses may count.

If you have experienced two losses, do not allow someone to dismiss them because:

- They were not consecutive
- One occurred very early
- No ultrasound was performed

You already have a living child

You were told to try again without discussion

You are still young

Recurrent pregnancy loss is distinct from infertility and has its own evaluation and management pathway.

Prepare this pregnancy-loss history

Pregnancy

Positive-test date

Loss date

Estimated gestation

Ultrasound completed?

Treatment or test results

1

_____

_____

_____

Yes / No

_____

2

_____

_____

_____

Yes / No

_____

3

_____

_____

_____

Yes / No

_____

4

_____

_____

_____

Yes / No

_____

Take photographs or copies of:

- Positive pregnancy tests
- Ultrasound reports
- Laboratory results
- Hospital discharge notes
- Pathology or genetic-testing reports
- Medication records

Your loss deserves to be documented accurately.

What a Basic Fertility Evaluation May Include

A fertility evaluation should respond to the couple's history rather than becoming a random package of tests.

ASRM states that the basic investigation should assess:

- Ovulation

The structure and openness of the female reproductive tract

The male partner's semen

Both partners should be evaluated in parallel where applicable.

Part One: Medical and Reproductive History

The clinician may ask about:

Your age

- How long you have been trying
- Frequency of intercourse
- Menstrual-cycle pattern
- Previous pregnancies
- Pregnancy losses
- Ectopic or molar pregnancies
- Pelvic pain
- Painful intercourse
- Previous infections
- Operations
- Medical conditions
- Medicines and supplements
- Cancer treatment
- Family history
- Smoking, alcohol, and drug exposure

Answer honestly.

The doctor cannot interpret the situation properly when important information is hidden because of embarrassment or fear of judgement.

Part Two: Ovulation Assessment

When cycles are regular and generally fall between 21 and 35 days, additional testing to prove ovulation may not always be necessary unless another clinical feature raises concern.

Where cycles are irregular, absent, or uncertain, assessment may include:

- Menstrual history
- Ovulation-test records
- Selected hormone tests
- Ultrasound
- Other investigations based on symptoms

Do not insist on one hormone test simply because it appeared in another woman's fertility report.

Tests should answer a clinical question.

Part Three: Semen Analysis

The male partner should not wait outside while the woman completes months of testing.

A semen analysis can assess sperm concentration, number, movement, shape, and other features. An abnormal result may need repetition because semen parameters can vary.

The result should be reviewed in the context of:

- Collection quality
- Medical history
- Medicines
- Testosterone or steroid use
- Previous surgery or infection
- Sexual function

The female partner's findings

Male and female evaluation should occur together rather than sequentially whenever possible.

Part Four: Fallopian-Tube Assessment

At least one functioning fallopian tube is generally needed for unassisted conception.

A clinician may recommend a hysterosalpingogram, commonly called an HSG, or an ultrasound-based procedure such as sonohysterography or another locally available method to evaluate whether the tubes appear open.

ASRM identifies HSG or sonographic methods as recommended approaches for evaluating tubal patency.

A tubal test may be especially relevant after:

- Ectopic pregnancy
- Pelvic inflammatory disease
- Certain sexually transmitted infections
- Pelvic surgery
- Endometriosis

A previous abnormal tubal test

- Prolonged infertility without another explanation

Food, herbs, massage, and steaming cannot confirm or reopen a blocked tube.

A claim that a supplement "unblocks tubes" should be treated as a warning sign.

Part Five: Uterine and Pelvic Assessment

Ultrasound or other imaging may be used to assess:

The shape of the uterus

- Fibroids
- Polyps
- Ovarian appearance

- Endometriomas
- Other pelvic findings

Additional procedures may be considered when the history or initial imaging identifies a reason.

Not every woman needs surgery or an invasive procedure during the first evaluation.

Not Every Test Is Necessary

A larger fertility-test package is not automatically a better evaluation.

ASRM recommends a systematic, cost-effective, and minimally invasive approach based on the couple's history and preferences.

Before agreeing to a test, ask:

What question will this test answer?

Is it recommended at this stage?

How will the result change treatment?

Is there a less invasive option?

What are the risks?

What will it cost?

Will it need to be repeated?

Does my partner need testing at the same time?

Do not feel pressured into an expensive group of immune, genetic, hormone, microbiome, or "implantation" tests simply because they are marketed as advanced.

Some specialised tests are appropriate for particular histories.

They are not automatically useful for everyone.

Which Professional Should You See?

Your starting point may depend on your symptoms, location, healthcare system, and available resources.

Primary-care clinician

May help with:

- General preconception health
- Medicine review

- Blood pressure
- Diabetes or thyroid concerns
- Referrals
- Obstetrician-gynaecologist
- May assess:
- Menstrual irregularity
- Pelvic pain
- Uterine or ovarian conditions
- Initial infertility concerns
- Pregnancy loss
- Preconception care
- Reproductive endocrinologist or fertility specialist
- May provide:
- Detailed infertility evaluation
- Ovulation induction
- Insemination
- IVF
- Fertility preservation
- Management of complex reproductive conditions
- Reproductive urologist or male fertility specialist
- May assess:
- Abnormal semen analysis
- Hormonal male infertility
- Varicocele
- Obstruction
- Testosterone or steroid-related suppression
- Erectile or ejaculation difficulties
- Surgical sperm retrieval
- Fertility counsellor or mental-health professional

- May support:
- Grief
- Anxiety
- Relationship strain
- Pregnancy loss
- Treatment decisions
- Donor conception
- Emotional preparation for treatment

You may need more than one professional.

Your Fertility-Evaluation Decision Checklist

Tick every statement that applies.

Timeline

- ☐ I am younger than 35 and have tried for 12 months.
- ☐ I am 35 or older and have tried for six months.
- ☐ I am older than 40 and planning pregnancy.

Menstrual and ovulation concerns

- ☐ My periods are absent.
- ☐ My cycles are highly irregular.
- ☐ I may not be ovulating.
- ☐ My cycle has changed significantly.

Medical and reproductive history

- ☐ I have endometriosis or severe pelvic pain.
- ☐ I have had an ectopic pregnancy.
- ☐ I have had pelvic infection or relevant surgery.
- ☐ I have received chemotherapy or radiation.
- ☐ I have a known uterine, ovarian, or tubal condition.

☐ I have experienced two or more pregnancy losses.

Partner factors

☐ My partner has an abnormal semen analysis.

☐ My partner has never been evaluated despite prolonged attempts.

☐ My partner uses testosterone or anabolic steroids.

☐ There is persistent erection or ejaculation difficulty.

☐ My partner has a history of testicular disease, injury, or surgery.

My result

If you ticked any box, write:

The clinician or clinic I will contact: _____:

The date I will make contact: _____:

The most important reason for the appointment: _____:

Your One-Page Doctor Visit Summary

Complete this before attending.

PERSONAL INFORMATION

Name: _____:

Date of birth: _____:

Age: _____:

Phone or contact details: _____:

TRYING-TO-CONCEIVE HISTORY

How long we have been trying: _____:

How often intercourse occurs: _____:

Cycle tracking method used: _____:

Previous fertility treatment: _____:

MENSTRUAL HISTORY

First day of last period: _____:

Average cycle length: _____:

Shortest cycle: _____:

Longest cycle: _____:

Periods per year: _____:

Bleeding duration: _____:

Pain level, 0-10: _____:

PREGNANCY HISTORY

Number of pregnancies: _____:

Number of births: _____:

Number of losses: _____:

Previous ectopic pregnancy: Yes / No

Previous molar pregnancy: Yes / No

Pregnancy complications: _____:

MEDICAL HISTORY

- [ ] PCOS
- [ ] Endometriosis
- [ ] Fibroids
- [ ] Adenomyosis
- [ ] Thyroid condition
- [ ] Diabetes or prediabetes
- [ ] High blood pressure
- [ ] Pelvic inflammatory disease
- [ ] Sexually transmitted infection
- [ ] Autoimmune condition
- [ ] Cancer treatment
- [ ] Relevant surgery

Other: _____:

CURRENT SYMPTOMS

- [ ] Irregular periods
- [ ] Missing periods
- [ ] Severe menstrual pain
- [ ] Pelvic pain
- [ ] Painful intercourse
- [ ] Heavy bleeding
- [ ] Bleeding between periods
- [ ] Vaginal dryness
- [ ] Unusual discharge
- [ ] Acne or increased hair growth
- [ ] Milky breast discharge when not breastfeeding

Other: _____:

MEDICINES AND SUPPLEMENTS

Product

Dose

Reason

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PREVIOUS TESTS

Test

Date

Main result

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PARTNER INFORMATION

Partner's age: _____:

Previous pregnancies contributed to: _____:

Semen analysis completed: Yes / No

Main result: _____:

Testosterone or steroid use: Yes / No

Relevant medical or sexual concerns: _____:

MY THREE MAIN QUESTIONS

Questions to Ask During the First Appointment

About the possible cause

Which factors appear most relevant in our situation?

Are we likely dealing with ovulation, sperm, tubes, uterus, age, or several factors?

Is the cause still unknown?

Does my history justify earlier or more specialised testing?

About testing

Which tests are essential first?

What will each test tell us?

Should both partners be tested now?

Do I need tubal assessment?

Does my partner need semen analysis or specialist review?

Are any suggested tests optional?

Which tests are not currently necessary?

About treatment

Can we continue trying naturally during testing?

Is ovulation medication appropriate?

Does an identified condition need treatment first?

What are the simplest evidence-based options?

When would insemination or IVF be considered?

How does my age affect the timeline?

What risks and costs should we understand?

About safety

Should any medicine or supplement be stopped or changed?

What should I do if I become pregnant during the evaluation?

Which symptoms require urgent care?

Who should I contact after office hours?

When You Cannot Afford Every Test

Fertility care can be expensive, and access remains unequal in many countries. WHO recognises that cost and availability prevent many people from receiving appropriate infertility services.

When money is limited, ask the clinician to prioritise.

Say:

"We cannot complete every investigation at once. Which tests are most important based on our history, and which can safely wait?"

A reasonable initial evaluation often focuses on:

- Whether ovulation is occurring
- Whether sperm findings are adequate
- Whether the uterus and fallopian tubes need assessment

These areas should be investigated according to the couple's history rather than spending the entire budget on supplements or unsupported test packages.

Ask for:

- Written test names

The reason for each test

- Prices
- Lower-cost laboratory options
- Which results can be reused
- Whether tests can be completed in stages
- Available public, charity, insurance, or employer support

Do not be ashamed to discuss cost.

A plan you cannot afford is not a complete care plan.

What to Do After the Appointment

Do not leave with only a collection of prescriptions.

Before leaving, write down:

Working diagnosis: _____:
Tests ordered: _____:
Why they were ordered: _____:
Medicine prescribed: _____:
How to use it: _____:
Possible side effects: _____:
Partner's next step: _____:
Follow-up date: _____:
When to seek urgent care: _____:

If something is unclear, ask the clinician to explain it again in ordinary language.

You have the right to understand your own care.

Medical-Care Myths

Myth 1: I must complete every natural remedy before seeing a doctor.

False.

Known fertility risks, concerning symptoms, age, and duration of attempts may justify immediate evaluation.

Myth 2: Going to a fertility clinic means I must undergo IVF.

False.

Evaluation comes before treatment decisions. Care may begin with education, timed intercourse, medication, surgery, insemination, or another appropriate option depending on the findings.

Myth 3: The woman must be tested first.

False.

Male and female partners should be evaluated concurrently where applicable.

Myth 4: Two miscarriages are not enough to investigate.

False.

ASRM defines recurrent pregnancy loss as two or more spontaneous pregnancy losses.

Myth 5: Regular periods prove the tubes are open.

False.

Menstrual regularity cannot establish fallopian-tube patency.

Myth 6: A normal ultrasound proves there is no fertility problem.

False.

Ultrasound provides useful information about pelvic anatomy, but it does not answer every question about ovulation, tubal function, sperm, fertilisation, or implantation.

Myth 7: Food can unblock fallopian tubes.

False.

Tubal patency requires appropriate clinical assessment.

Myth 8: All fertility tests must be completed at once.

False.

Testing should be systematic and guided by the couple's history.

Myth 9: Unexplained infertility means nothing is wrong.

False.

It means the standard evaluation has not identified a clear cause. It does not mean the couple imagined the difficulty.

Myth 10: Needing treatment means the 21-day programme failed.

False.

The programme is designed to support preconception habits, not replace fertility diagnosis or treatment.

Before You Close This Chapter

There is wisdom in knowing what food can do.

There is also wisdom in knowing what it cannot do.

A balanced diet can support your general and preconception health.

Cycle tracking can improve your understanding of timing.

Communication can reduce pressure.

None of these tools can replace an investigation when the timeline, symptoms, age, pregnancy history, or partner factors show that more information is needed.

Your action from this chapter is clear:

Complete the Fertility-Evaluation Decision Checklist.

Prepare the One-Page Doctor Visit Summary.

Gather previous results.

Include your partner.

Set a date for the appointment.

Do not wait for your body to become "perfect" before seeking care.

> **In the final chapter, you will turn everything you have learned into a sustainable 90-day maintenance plan. You will choose the habits to continue, set medical follow-up deadlines, and measure progress without using pregnancy as the only evidence that your efforts mattered.**

Reference Notes for Chapter 13

- American Society for Reproductive Medicine. Fertility Evaluation of Infertile Women: A Committee Opinion.
- American Society for Reproductive Medicine. Optimizing Natural Fertility: A Committee Opinion.
- American Society for Reproductive Medicine. Recurrent Pregnancy Loss: A Committee Opinion. 2026.
- American College of Obstetricians and Gynecologists. Evaluating Infertility.
- American College of Obstetricians and Gynecologists. Ectopic Pregnancy.
- World Health Organization. Guideline for the Prevention, Diagnosis and Treatment of Infertility. 2025.
- World Health Organization. Infertility Fact Sheet. Updated November 2025.



CHAPTER 14

After Day 21: Your 90-Day Maintenance Plan

> *Evidence base: See the chapter's Reference Notes; key clinical recommendations also carry parenthetical source anchors.*

You have reached Day 21.

You may feel proud of the changes you made. You may also feel that some areas still need work.

Perhaps you now prepare breakfast instead of surviving on tea until afternoon. You may be eating more vegetables, drinking more water, tracking your cycle more clearly, or asking your partner to share the responsibility.

You may also have discovered something that needs medical attention.

Your period may still be irregular. Intercourse may still be painful. A semen analysis may need to be completed. You may have reached the point where fertility evaluation should no longer be delayed.

All of these discoveries are useful.

The end of a 21-day programme should not create another moment of pressure where you ask:

- "Did it work?"

If by "work" you mean, "Did this guide guarantee pregnancy?" the answer must remain no.

Pregnancy depends on several biological factors that cannot be controlled by completing a meal calendar.

But if "work" means:

You understand your body more clearly

You make safer food choices

You have stopped using unverified fertility products

You know your likely fertile window

You have reduced pressure around intimacy

You have involved your partner

You know when to seek professional care

You have built habits that can continue

then the programme has already produced meaningful progress.

The next 90 days will help you protect that progress.

Why Continue for 90 Days?

Twenty-one days can help you begin a routine.

It is usually not enough time to know whether that routine is truly sustainable.

Over the next three months, you will have more opportunities to:

- Repeat balanced meals
- Observe several menstrual cycles
- Complete medical appointments
- Review medicines and supplements
- Build consistent sleep and movement habits
- Address partner-related factors
- Prepare for pregnancy safely
- Adjust the plan according to professional guidance

The 90-day plan is not based on a promise that eggs will be rebuilt within three months.

It is a practical maintenance period that allows you to move from short-term enthusiasm to long-term preparation.

You are building a system, not completing a fertility challenge.

Your Five Maintenance Areas

During the next 90 days, focus on five areas:

- Nourishment
- Preconception safety
- Cycle and intimacy awareness
- Partner participation
- Medical follow-up

You do not need to improve everything at once.

At the beginning of each month, select one priority action from each area.

Area One: Nourishment

Continue using the preconception plate:

- Vegetables and fruit

Protein

Whole or minimally processed carbohydrates

Suitable fats

Water

Your meals do not need to become more complicated after Day 21.

The best meals are often the ones you can prepare repeatedly without excessive cost or stress.

Your four-meal foundation

Choose four meals that worked well during the programme.

Fast breakfast

Affordable lunch

Vegetable-rich dinner

Emergency meal

An emergency meal should require little preparation.

Examples include:

- Boiled eggs, bread, tomatoes, and fruit
- Sardines, rice, and frozen vegetables
- Beans from the freezer with plantain
- Moi-moi with fruit
- Oats with yoghurt, nuts, and fruit
- Sweet potato with egg sauce
- Weekly nourishment targets
- Aim to complete most of these each week:

☐ Prepare at least one protein in advance.

☐ Prepare or purchase vegetables.

☐ Keep two affordable fruits available.

☐ Eat beans, lentils, or peas at least once.

- [ ] Include fish, eggs, poultry, dairy, soy, or another suitable protein.
- [ ] Drink water as the regular beverage.
- [ ] Limit frequent sugary drinks.
- [ ] Use measured amounts of cooking oil.
- [ ] Store leftovers safely.
- [ ] Plan at least one meal before a busy day.

These targets are flexible.

A difficult week does not mean the whole plan has failed.

Return to the next meal rather than waiting for another Monday or another month.

Your Weekly Meal Rotation

Use this template every weekend.

Breakfast options

Lunch options

Dinner options

Snacks

Preparation tasks

- [ ] Cook beans or lentils.
- [ ] Boil eggs.
- [ ] Prepare fish, chicken, or another protein.
- [ ] Wash and cut vegetables.
- [ ] Prepare tomato or vegetable sauce.
- [ ] Wash fruit.
- [ ] Portion nuts or seeds.
- [ ] Fill water bottles.
- [ ] Label refrigerated and frozen meals.

Area Two: Preconception Safety

A balanced diet is only one part of pregnancy preparation.

Continue reviewing the habits and exposures that may affect your health or a future pregnancy.

Maintain these actions

- [ ] Take the folic acid or prenatal supplement recommended for you.
- [ ] Check that you are not taking several products with overlapping ingredients.
- [ ] Keep your medicine list updated.
- [ ] Tell prescribers that you are trying to conceive.
- [ ] Avoid alcohol.
- [ ] Avoid smoking, vaping, and recreational drugs.
- [ ] Reduce second-hand smoke exposure.
- [ ] Avoid unlabelled herbal fertility mixtures.
- [ ] Do not douche or steam the vagina.
- [ ] Use safer food-handling practices.
- [ ] Choose lower-mercury fish.
- [ ] Review workplace or household exposures where relevant.

Your monthly supplement review

Complete this at the beginning of each month.

Product

Dose

Purpose

Still needed?

Reviewed professionally?

_____

_____

_____

Yes / No

Yes / No

_____

_____

_____

Yes / No

Yes / No

_____

_____

_____

Yes / No

Yes / No

_____

_____

_____

Yes / No

Yes / No

Remove expired products.

Do not add a new fertility supplement without understanding:

- Its complete ingredients

The dose

- Possible interactions
- Pregnancy safety

The problem it is intended to address

- Whether evidence supports its use
- Area Three: Cycle and Intimacy Awareness

Continue tracking only the information that remains useful.

You do not need to record every sensation indefinitely.

A simple monthly tracker may include:

- First day of proper menstrual bleeding
- Cycle length
- Cervical-mucus pattern
- Ovulation-test results where used
- Intercourse dates
- Significant pain
- Unusual bleeding
- Pregnancy-test result

- Questions for your clinician
- Simplify when tracking becomes stressful
- Reduce the number of methods when you notice that:

You check several times daily

You are fighting about intercourse timing

You feel unable to have sex outside the fertile window

You spend too much money on tests

- One missed day causes panic

The application controls your mood

You delay medical care to collect more data

A simple plan of intercourse every two to three days may be easier for some couples.

Monthly intimacy check-in

Complete this with your partner.

What felt comfortable this month?

What created pressure?

Was intercourse painful or physically difficult?

Did erection or ejaculation problems occur?

What should we change next cycle?

Do not continue painful intercourse for several months without seeking help.

Do not hide persistent sexual difficulties because they feel embarrassing.

These are health concerns, not personal failures.

Area Four: Partner Participation

The 90-day plan must not become another task completed only by the woman.

Your partner should have visible responsibilities.

Choose at least three

- [ ] Attend medical appointments.
- [ ] Complete semen analysis.
- [ ] Review medicines, testosterone, steroids, and supplements.
- [ ] Reduce smoking or alcohol.
- [ ] Prepare meals.
- [ ] Purchase groceries.
- [ ] Share fertility-tracking responsibility.
- [ ] Discuss sexual pressure.
- [ ] Contribute to treatment costs.
- [ ] Arrange transport.
- [ ] Complete a general health review.
- [ ] Support fertility-free time.

Our shared responsibilities

My responsibilities:

My partner's responsibilities:

Responsibilities we share:

Review this agreement monthly.

If one partner repeatedly carries everything, discuss it directly rather than allowing resentment to grow.

Area Five: Medical Follow-Up

The 90-day plan must include clear deadlines.

Do not continue "watching and waiting" without deciding what you are waiting for.

Complete your medical follow-up calendar

Appointment or task one

Task: _____:

Deadline: _____:

Person responsible: _____:

Appointment or task two

Task: _____:

Deadline: _____:

Person responsible: _____:

Appointment or task three

Task: _____:

Deadline: _____:

Person responsible: _____:

Possible tasks include:

- Medication review
- PCOS assessment
- Thyroid or prolactin testing
- Semen analysis
- Tubal assessment
- Pelvic ultrasound
- Fertility-specialist consultation
- Pregnancy-loss evaluation
- Pelvic-floor assessment

- Mental-health support
- Nutrition consultation

The 30-Day Review

At Day 30, focus on consistency and unfinished safety tasks.

Nourishment

- [ ] I regularly build balanced meals.
- [ ] I have at least four meals I can repeat.
- [ ] I eat vegetables or fruit most days.
- [ ] I include protein consistently.
- [ ] I prepare for busy days.

Safety

- [ ] My folic acid or prenatal supplement has been reviewed.
- [ ] My medicines have been reviewed.
- [ ] I have stopped unlabelled fertility products.
- [ ] I avoid alcohol.
- [ ] I have addressed smoking or drug exposure.
- [ ] I do not use vaginal douches or steaming products.

Cycle and intimacy

- [ ] I recorded the beginning of my period.
- [ ] I used a tracking method that felt manageable.
- [ ] We had regular intercourse without depending on one perfect day.
- [ ] I addressed dryness or discomfort.

Partner participation

- [ ] My partner completed agreed responsibilities.
- [ ] We discussed pressure without blame.
- [ ] A semen analysis was completed or scheduled where indicated.

Medical follow-up

- [ ] Required appointments are booked.
- [ ] Previous records are organised.
- [ ] I know the next clinical step.

My Day 30 summary

The habit that is working best:

The habit that needs adjustment:

The medical task still outstanding:

My priority for the next 30 days:

The 60-Day Review

At Day 60, look beyond enthusiasm.

Ask whether your plan fits your real life.

Food sustainability

The foods I repeatedly waste are:

The meals that cost too much are:

The meals that save me time are:

One budget adjustment:

Physical and emotional wellbeing

Rate each area from 1 to 5:

- Sleep quality: _____
- Energy: _____
- Meal consistency: _____
- Movement: _____
- Emotional support: _____
- Relationship connection: _____

- Fertility-related stress: _____
- Sexual comfort: _____

These ratings do not measure fertility.

They show where your routine needs support.

Cycle pattern

Number of periods recorded: _____:
Shortest cycle: _____:
Longest cycle: _____:
Ovulation signs identified: _____:
Symptoms that continue: _____:

Medical progress

- ☐ Evaluation completed.
- ☐ Tests still pending.
- ☐ Treatment started.
- ☐ Follow-up appointment scheduled.
- ☐ Partner evaluation completed.
- ☐ A second opinion is being considered.

My Day 60 decision

Choose one:

- ☐ Continue the current routine.
- ☐ Simplify the routine.
- ☐ Seek additional nutrition support.
- ☐ Escalate fertility evaluation.
- ☐ Address sexual pain or dysfunction.
- ☐ Seek emotional support.

- [ ] Review treatment with the clinician.

The 90-Day Review

Day 90 is not a final fertility examination.

It is a decision point.

You will review what has changed and determine what happens next.

Part One: Habits

Mark each statement.

Nourishment

- [ ] I can build a balanced plate without checking the guide.
- [ ] I have affordable meal options.
- [ ] I eat enough food for my needs.
- [ ] Vegetables, fruit, and protein appear regularly in my meals.
- [ ] I no longer depend mainly on supplements.

Safety

- [ ] My medication list is current.
- [ ] My supplements have been reviewed.
- [ ] I avoid unsafe vaginal practices.
- [ ] I prepare food safely.
- [ ] I have addressed alcohol, smoking, and drug exposure.

Fertility awareness

- [ ] I understand my cycle pattern more clearly.
- [ ] I know the limits of my fertility application.
- [ ] I do not depend on one exact ovulation day.
- [ ] Tracking has remained emotionally manageable.

Relationship

- [ ] Responsibility is shared.
- [ ] We can discuss fertility without constant blame.
- [ ] We have addressed painful intercourse or sexual difficulties.
- [ ] We maintain affection outside conception attempts.

Medical care

- [ ] I know whether evaluation is required.
- [ ] Important tests have been completed or scheduled.
- [ ] My partner has been assessed where indicated.
- [ ] I understand the current treatment plan.

Part Two: Symptoms

Circle every symptom that remains present:

- Absent periods
- Highly irregular cycles
- Severe menstrual pain
- Heavy bleeding
- Pelvic pain
- Painful intercourse
- Vaginal dryness
- Bleeding after sex
- Unusual discharge
- Repeated pregnancy loss
- Erection difficulty
- Ejaculation difficulty

Another concern: _____:

The symptom requiring the most attention

My next medical action

- Deadline

Part Three: Fertility Timeline

Complete:

My current age: _____:

Total time trying to conceive: _____:

Has pregnancy occurred? Yes / No

Have we reached the recommended evaluation timeline? Yes / No

Has evaluation begun? Yes / No

The next step agreed with the clinician is:

Do not restart another 90-day self-guided programme when professional evaluation is already due.

Lifestyle support can continue alongside care.

When Pregnancy Occurs

If you receive a positive pregnancy test, do not assume every product used during the trying-to-conceive period should continue.

Contact an appropriate healthcare professional.

Early-pregnancy action checklist

- ☐ Confirm the pregnancy according to local clinical guidance.
- ☐ Continue appropriate folic acid or prenatal supplementation.
- ☐ Review all medicines immediately.
- ☐ Review herbs and supplements.

- [ ] Avoid alcohol.
- [ ] Avoid smoking and recreational drugs.
- [ ] Continue safe food practices.
- [ ] Ask about fish choices.
- [ ] Discuss exercise.
- [ ] Arrange prenatal care.
- [ ] Report pain or bleeding.

Seek urgent medical attention for severe abdominal or pelvic pain, shoulder pain, fainting, significant weakness, or heavy bleeding, particularly where there is a previous ectopic pregnancy.

This guide becomes a preconception reference.

It does not replace prenatal care.

When Pregnancy Has Not Occurred

A negative pregnancy test at Day 90 does not mean you failed.

It also does not mean you should ignore the timeline and continue repeating the same routine indefinitely.

Ask:

Have we reached the recommended fertility-evaluation point?

Have both partners been assessed?

Are periods regular?

Is ovulation occurring?

Has semen analysis been completed?

Are the tubes and uterus relevant?

Is age increasing the urgency?

Have there been pregnancy losses?

Is treatment being delayed because of fear or cost?

Do we need a second opinion?

My decision

- ☐ Continue trying naturally for the period agreed with my clinician.
- ☐ Begin or continue fertility evaluation.
- ☐ Begin prescribed ovulation treatment.
- ☐ Complete partner testing.
- ☐ Seek a fertility-specialist referral.
- ☐ Review pregnancy losses.

- [ ] Seek a second opinion.
- [ ] Discuss assisted reproductive treatment.
- [ ] Take an agreed emotional break.

An emotional break does not mean stopping necessary medical care.

It may mean pausing intensive tracking, treatment cycles, or fertility discussions for a defined period after consulting the relevant professionals.

Your Monthly Maintenance Scorecard

Complete this every month.

Score each area from 0 to 2:

- 0: Not completed
- 1: Partly completed
- 2: Completed consistently

Area

Score

Balanced meals

___

Vegetable and fruit variety

___

Regular protein

___

Water intake

___

Supplement safety

___

Medication review

___

Smoking and alcohol avoidance

___

Cycle awareness

___

Comfortable intimacy

___

Partner participation

___

Medical follow-up

___

Sleep and wellbeing

___

Total score: _____ out of 24:

The score is not a fertility score.

A high score cannot guarantee pregnancy.

A low score does not mean you caused infertility.

Use it to choose one area for improvement.

My next-month priority

Your Personal Maintenance Contract

Complete and sign this page.

I will continue:

I will stop:

I will seek help for:

I will not blame myself for:

I will ask my partner to:

My next clinical deadline is:

Name: _____:

Signature: _____:

Date: _____:

Final Myths to Leave Behind

Myth 1: If pregnancy did not occur within 21 days, the programme failed.

False.

The programme supports preconception habits. It cannot guarantee the timing of pregnancy.

Myth 2: A balanced diet means medical care is no longer necessary.

False.

Nutrition cannot diagnose or treat every cause of infertility.

Myth 3: I must continue taking every fertility supplement after pregnancy occurs.

False.

All medicines, herbs, and supplements should be reviewed for pregnancy.

Myth 4: Tracking more information will always solve the problem.

False.

Tracking has limits. Fertility evaluation may still be required.

Myth 5: If my partner has fathered a child before, he does not need testing.

False.

Fertility can change, and both partners should be evaluated where indicated.

Myth 6: A negative pregnancy test means my body has failed.

False.

A negative result means pregnancy was not detected in that cycle. It does not define your value or explain the cause.

Myth 7: Needing fertility treatment means natural preparation was useless.

False.

Healthy preconception habits can remain valuable alongside evidence-based treatment.

Myth 8: I should keep trying the same approach for years.

False.

Age, symptoms, duration of attempts, partner factors, and pregnancy history determine when care should escalate.

A Final Word to You

You began this guide because you wanted to prepare your body for conception.

Perhaps you also wanted certainty.

You wanted to know that if you ate the correct foods, avoided the wrong ingredients, timed intercourse properly, and followed every instruction, pregnancy would happen.

I understand that desire.

When so much feels outside your control, a fixed protocol can feel safer than uncertainty.

But responsible fertility guidance must tell you the truth.

There is no meal that guarantees motherhood.

There is no sexual position that forces conception.

There is no supplement that can replace every fertility investigation.

There is no 21-day programme that can promise to rebuild every egg, balance every hormone, or prevent every miscarriage.

What you now have is something more useful than a false guarantee.

You know how to nourish yourself without fearing ordinary African foods.

You know how to build a balanced plate.

You know why folic acid matters.

You know how to question herbs and supplements.

You understand the fertile window.

You know that sex should remain comfortable and consensual.

You know that vaginal pH does not need homemade manipulation.

You understand that PCOS is not one simple hormone problem.

You know fertility belongs to both partners.

You know when food is no longer the answer.

Most importantly, you now have a plan.

Take the actions that belong to you.

Eat adequately.

Prepare safely.

Track what is useful.

Ask better questions.

Share the responsibility.

Attend the appointment.

Follow evidence-based treatment when it is needed.

Then release the blame.

Your fertility journey is not proof of your worth, your femininity, your faith, your discipline, or your ability to follow instructions.

You are not a failed project.

You are a person deserving nourishment, truthful guidance, compassionate care, and support at every stage of the journey.

Final 90-Day Commitment

Write one sentence you want to carry forward:

> During the next 90 days, I will _____

And one truth you will remember:

I will support my health without blaming myself for outcomes I cannot completely control.

The next stage is not another promise or a stricter protocol. It is the steady 90-day practice of nourishing yourself, sharing responsibility, keeping medical deadlines, and adjusting the plan when new information appears.

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