



Post Natal Care in Unani Medicine: A Holistic Approach to Maternal Health

¹Ramsha Anwar, ²Ibtisam Anwar, ³Suboohi Irshad, ⁴Aquil Ahmad Khan

¹Department of Ilmul Qabalat wa Amraz e Niswan, Ayurvedic and Unani Tibbia College and Hospital, Karol Bagh, New Delhi-110005

²Department of Amraze Jild wa Tazeeniyat, State Unani Medical College and Hospital, Prayagraj-211016

³Department of Ilmul Qabalat wa Amraz e Niswan, Ayurvedic and Unani Tibbia College and Hospital, Karol Bagh, New Delhi-110005

⁴Department of Ain Uzn Anaf Halaq wa Asnan, Aligarh Unani Medical College and ACN Hospital, Aligarh-202001

ABSTRACT :

Women's health throughout pregnancy, childbirth, and postpartum is called maternal health. The World Health Organization reports that pregnancy and delivery problems claim the lives of about 810 women per day. Therefore, all mothers should have access to high-quality healthcare throughout their pregnancy, delivery, and postpartum period. The thorough description of perinatal and postnatal care is "*Tadabeer-i-Wiladat*" in several Unani literature. In Unani medicine, maternal concerns are addressed systemically, and various therapeutic regimens can provide a better answer for both mother and child health difficulties. This review study provides a quick overview of many of these treatment plans that provide a better way to deal with pregnancy-related issues.

Keywords: Unani medicine, post-natal care, *tadabeer-e-wiladat*, *zamana-i-nifas*

Introduction :

The health of women throughout their pregnancies, deliveries, and postpartum periods is known as maternal health.¹ Women's health is one of the most essential concerns facing society because they need to be in good physical, mental, and emotional health before they can dedicate themselves to serving their families and thinking about other significant social issues. While pregnancy and childbirth are natural occurrences and wonderful periods in a woman's life, they can also occasionally turn into nightmares for her, especially for those living in rural or hilly places or lower socioeconomic groups.² Together, women in the reproductive age range of 15 to 49 make up over 63 per cent of the world's population, which is more than 22 per cent of the global population. Of the 2.6 billion women on the planet, half are in the 15–49 age range. Children and women in the reproductive stage are particularly susceptible to health issues and services.³ The WHO estimates that 810 women lost their lives in 2014 due to various pregnancy and childbirth-related factors. Countries with low and lower middle incomes account for 94% of all maternal deaths.⁴ For the medical community, managing pregnancy and parturition has always been difficult. India is a large country, and the vast majority of its people live in rural areas with limited access to healthcare facilities. Ancient Unani literature makes clear that the entire Unani System of Medicine addresses maternity and child health issues methodically.^{5,6} About 810 women died in 2017 from pregnancy and childbirth-related avoidable causes, according to WHO estimates. Countries with low and lower middle incomes account for 94% of all maternal deaths. Compared to other mothers, young adolescents (ages 10 to 19) are more likely to experience pregnancy-related problems and even die. It is commonly acknowledged that the Maternal Mortality Ratio (MMR) and Infant Mortality Rate (IMR) are imprecise measures of a nation's or region's general health situation. According to the Indian Sample Registration System, the current MMR for 2014–2016 was 130 per 100,000 live births, with most deaths taking place in the 20–24 age range. From 2017 to 2019, the IMR is 33 per thousand live births.⁷ The "Maternal and Child Health Programme" in India aims to accomplish certain goals, including lowering maternal, perinatal, infant, and child mortality and morbidity, promoting reproductive health, and fostering the physical and mental development of children. MCH services are ultimately focused on promoting lifelong health.⁸ With broad aims and objectives, the National Health Mission program now encompasses all of India's health initiatives. Among the seven goals of NHM are the revitalization of regional health customs and the mainstreaming of AYUSH (Ayurveda, Yoga, Unani, Siddha, and Homeopathy). For this reason, we must work together to make the country stronger.⁹ The largest health concern in the current environment is maternal health. For the medical community, managing pregnancy and parturition has always been difficult. Given the severity of the issue, the author decided to start a review paper on the subject. Unani medicine, which is the science of life, offers a variety of treatment plans that can improve the health of both mothers and children. Here is a brief outline of many of the treatment plans that can provide a better answer to pregnancy-related issues.

Postpartum Programme:

In 1969, the All-India Hospital Postpartum Programme (AIHPP) was launched. It is a maternity-centred, hospital-based method of family planning. Through MCH and the family welfare program, which includes prenatal, neonatal, and postnatal services; vaccination programs for women and children; and prophylactic measures against anaemia and blindness, the postpartum program's main goal is to promote the health of the mother and children.¹⁰

Aetiology of MMR and IMR⁴

Complications during and after pregnancy and childbirth cause many women to pass away. The following are the main problems that cause about 75% of all maternal deaths:

- Severe bleeding, usually following childbirth.
- Infections, typically following childbirth.
- Pregnancy-related hypertension (pre-eclampsia and eclampsia).
- Delivery complications.
- Unsafe abortion.

Health and Disease Management :

Ancient Unani literature makes clear how the comprehensive Unani System of Medicine methodically addresses these problems, as evidenced by the variety of medications and treatment plans accessible. *Ilaj bit Tadbir* (Regimenal therapy), *Ilajbil Ghiza* (Dietotherapy), *Ilaj bid Dawa* (Pharmacotherapy), and *Ilaj bil Yad* (Surgery) are the four types of treatment that are available in Unani medicine. Under the speciality of *Ilaj bit Tadbir*, several therapy modalities are employed for particular and complex illnesses. Preventive, promotional, curative, and rehabilitative are the four parts of the treatment. The Unani method places a strong emphasis on the six essential factors for life (*Asbab-e-Sitta Zarooria*) to prevent illness and promote health.⁵

Possible Ways of Health Promotion¹¹

- Improvement of *tabiyat* (Immunomodulation)
- Restoration of balanced temperament.
- Maintenance of balance in the quality and quantity of humours.
- Moderation of *Asbab e Sitta Zarooria* (six essential factors for life).
- Regimental therapy.

Six essential factors for life¹²

For the preservation of excellent health, there are six important components. According to Unani Medicine, to maintain optimum health, these elements should be balanced in terms of quality, quantity, and sequence. The following are these crucial elements:^{11,13}

- *Hawae Muheet* (Pure air)
- *Makol wa mashroobat* (Food and Beverages)
- *Harkat wa sukoon e badnia* (Physical movement and Rest)
- *Harkat wa sukoon e nafsania* (Psychic movement and Rest)
- *Naum wa yaqzah* (Sleep and Wakefulness) and
- *Ehtibas wa istafragh* (Retention and Evacuation).
- ***Ilaj bit-Tadbir* (Regimental therapy)**
- *Riyadat* (Exercise), *Nutool* (Irrigation), *Hammam* (Turkish bath), *Dalak* (Massage).²

Mother and child healthcare in Unani Medicine

In Unani medicine, the primary goals of mother and child health care are to protect women's health before conception, prevent and treat common pregnancy-related illnesses, prevent obstetric complications, provide perinatal and postnatal care (*tadabeer-i wiladatwa baadaz wiladat*), and provide care for newborns, infants, and children. The topic of discussion is reproductive health care, which aims to prevent and treat illnesses affecting the female reproductive system.³

Mother and child health care can be broadly divided into the following aspects.^{14,15}

- *Tadabeer-i Haamla* (Ante natal care)
- *Tadabeer-i Wiladat* (Peri natal Care)
- *Tadabeer-i baadazWiladat* (Post natal care)
- Nursing and Breast feeding.

Under the following headings, Unani physicians have mentioned several medications and treatment plans that help manage wiladat (labour).

Tasheel-I Wiladat wa Tadbeer-I Ushr Wiladat (To facilitate labour and regimen for dystocia)

- *Ikhraj al-Janeen* (Expulsion of foetus)
- *Ikhraj al-Masheema* (Removal of placenta)

According to *Ibn Sina*, if labour pain begins and is felt in the abdomen, the delivery would go well; but, if labour pain is accompanied by backache, this could be a sign of complications during delivery.¹⁶

Instruments used in obstetrics and gynaecology as described in Unani literature³

- *Lawlab* (Speculum) for the opening of the vagina and vaginal examination.
- *Midfa* (Thruster) designed to get a grip on the foetal neck and thus to push out the rest of the body.
- *Kalalib* (forceps)
- *Mibda* (scalpel) or perforator
- *Miqass* (scissor)
- *Sinnara* (midwifery hook or crotchet) is used to fasten in various parts of a dead fetus to draw it out.
- *Al-Qam* (Funnel) is used to irrigate the uterus.
- *Mishdakh* (Cephalotribe) for crushing the foetal head.

Tadabeer-I baadaz Wiladat (Post natal care)³

The first six to eight weeks after the baby is born are referred to as *Tadabeer-i baadaz Wiladat* (postnatal care). The modifications that take place during pregnancy return to their pre-pregnancy state during this time. During the first two weeks, the cardiovascular system returns to normal. The vaginal wall quickly regains its tone after initially appearing bloated, blue, and pouting. After the placenta is expelled, the uterus reaches the size of a 20-week pregnancy and then shrinks by 1 finger-breadth per day until it is impossible to palpate on the 12th day. It is just somewhat bigger than it was before pregnancy by the conclusion of the puerperium. Unani medicine refers to the postpartum period as *Tadabeer-i Niffas*, the women during this time as *Nifsaand*, and the puerperium as *Zamana-i Nifas*.^{3,14} According to *Ibn Sina*, *zamana-iniffas* can last for at least 30 to 40 days after the baby is delivered. According to *Jurjani*, the puerperal stage lasts for 25–30 days after the delivery of a male child and 30–35 days after the delivery of a female child.¹⁵ Women require extra medical attention during this time because certain issues could arise and cause serious, distant repercussions. Frequent puerperal issues include fever, mastitis, constipation, septicemia, excessive or insufficient lochia discharge, and others.^{3,13,14,16}

Care of the Mother During the Puerperium :***Hospital Care***¹

Blood pressure and pulse should be checked every 15 minutes for the first hour following birth, or more frequently if necessary. The fundus is palpated to make sure it is well-constricted, and the amount of vaginal bleeding is tracked. If there is evidence of relaxation,

To keep the uterus clenched, massage it through the abdominal wall. In certain cases, uterotonins must be added. Blood can build up inside the uterus without any visible bleeding. During the first few hours after delivery, fundal probing may reveal uterine enlargement, which could lead to an early detection of this. The uterus is continuously examined for at least an hour after delivery since, even in typical instances, the risk of major haemorrhage is highest right after delivery.

If regional analgesia or general anaesthesia is used for labour or delivery, the mother should be observed in an appropriately equipped and staffed recovery area.

Early Ambulation

After giving birth, women get out of bed within a few hours. For the first time at least, an attendant should be there in case the woman becomes syncopal. The numerous verified benefits of constipation and bladder issues are less common with early ambulation. The incidence of pulmonary embolism and puerperal venous thrombosis has decreased with early ambulation.¹

Perineal Care

The vulva should be cleaned from anterior to posterior, or toward the anus, according to the woman's instructions. If there is a laceration or an episiotomy, applying an ice pack to the perineum may assist minimize discomfort and oedema in the initial hours. The occasional administration of a topical anaesthetic spray also seems to provide some alleviation for the majority of women. Severe discomfort typically signals an issue, such as an infection after the third or fourth day and a hematoma within the first day or two. A thorough examination and probing are usually necessary when experiencing severe rectal, vaginal, or perineal pain. To lessen local discomfort, warm sitz baths with moist heat can be utilized starting about 24 hours after delivery. After a simple delivery, tub bathing is permitted. By the third week, the episiotomy incision is usually well-healed and almost asymptomatic.

Bladder Function

After delivery, bladder fullness may vary. Intravenous fluids are administered in the majority of units both throughout labour and for one hour following birth. In amounts that have an antidiuretic effect, oxytocin is frequently infused after giving birth, and bladder filling frequently occurs quickly. Furthermore, episiotomy, lacerations, instrumented delivery, and local or conduction analgesia can all impair bladder feeling and the ability to empty spontaneously. Urinary retention accompanied by overdistension of the bladder is therefore typical throughout the early stages of puberty. According to Ching-Chung and associates (2002), 4% of women who were delivered vaginally experienced retention.

According to Musselwhite and colleagues (2007), 4.7% of women who received labour epidural analgesia experienced retention. To prevent bladder overdistension, postpartum monitoring is necessary to make sure the bladder does not overflow and that it empties sufficiently with each voiding. Because the larger bladder raises the fundus above the umbilicus, it can be felt supra-pubically or seen indirectly from the abdomen.

The use of an automated sonography device to identify large bladder contents and, consequently, postpartum urine retention has been studied by Van Os and Van der Linden (2006).

A lady is probably unable to void if she hasn't done so within four hours of giving birth. She is also likely to experience additional difficulties if she has issues voiding at first. Haemostasis in the vaginal tract and perineum are examined. An indwelling catheter should remain in place in patients with an overdistended bladder until the retention-causing causes have subsided. It is generally advised to keep the catheter in place for at least 24 hours, even in the absence of a clear explanation. By doing this, recurrence is avoided and normal bladder tone and sensation can return.

The ability to void properly must then be demonstrated after the catheter is removed. A woman should have her urine volume assessed and catheterized if she is unable to void after four hours. More over 200 mL indicates that the bladder is not working well, and the catheter is put away for another day. The catheter can be taken out and the bladder checked again as explained if less than 200 mL of urine is collected. According to Harris and colleagues (1977), 40 per cent of these women experience bacteriuria; hence, following catheter removal, a single dosage or brief course of antimicrobial medication makes sense.¹

Subsequent Discomfort

The mother may have discomfort in the initial days following vaginal delivery for several causes, such as breast engorgement, episiotomy and cuts, afterpains, and even headaches from post-dural punctures.

During the first few days, mild analgesics that comprise codeine, aspirin, or acetaminophen—preferably in combination—are administered as often as once every three hours.¹

Depression¹

A few days after giving birth, it is quite typical for a mother to show signs of depression. Known as postpartum blues, this is probably the result of several circumstances, like as emotional disappointment that comes after the thrill and anxiety of pregnancy and childbirth, early puberty discomforts, exhaustion from lack of sleep, worry about how well one will be able to care for the baby, and issues with body image. Effective treatment for the majority of women involves awareness, expectation, and reassurance. Although it can occasionally linger for up to 10 days, this disease is typically moderate and self-limited for 2 to 3 days. If these feelings continue or get worse, a major depressive disorder examination is conducted.

In a systematic review, Gavin and colleagues (2005) discovered that over 20% of postpartum women suffered from depression. Its prevalence ranges from 12 to 20 per cent in 17 states, according to a recent examination of the PRAMS database (Centers for Disease Control and Prevention, 2008). Low-income women with pregestational or gestational diabetes had a twofold increased risk of perinatal or postpartum depression, according to a New Jersey state-wide study (Kozhimannil and colleagues, 2009). The first month following childbirth is linked to a higher risk of mental readmission among women with previous psychiatric problems (Munk-Olsen and coworkers, 2009). Emergent treatment is used for suicidal or infanticidal ideas.

Given that at least 25% of women experience serious postpartum depression again in subsequent pregnancies, some advise starting pharmaceutical prophylaxis in late pregnancy or right away after giving birth (Wisner and colleagues, 2004).

Abdominal Wall Relaxation¹

In cases where the abdomen is abnormally swollen or protuberant, a standard girdle is frequently adequate. At best, an abdominal binder is a short-term solution. Abdominal wall tone-restoring exercises may be initiated at any time following a vaginal birth and as soon as the pain in the abdomen subsides following a caesarean section.

Diet

Women who have had vaginal deliveries are not subject to any dietary restrictions. If there are no difficulties, a woman should be permitted to eat for two hours following a typical vaginal delivery. With breastfeeding, the National Research Council's Food and Nutrition Board advises a modest increase in the number of calories and protein ingested during pregnancy.

The mother's nutritional needs are the same as those of a nonpregnant woman if she chooses not to breastfeed. In our hospitals, continuing iron supplementation is a normal procedure for a minimum of three months following delivery and to measure the hematocrit during the initial postpartum checkup.¹

Thromboembolic Disease

In recent years, there has been a decline in the incidence of pulmonary embolism and deep vein thrombosis that complicate pregnancy and the puerperium. Nearly 50% of pregnancy-related thromboembolic incidents occur during the puerperium. According to a recent study by Jacobsen and colleagues (2008), pulmonary embolisms are most common during the first six weeks after giving birth.¹

Neuromuscular and Joint Problems

Stretching or tearing damage from a normal or challenging delivery may be the cause of pain in the hips, lower limbs, or pelvic girdle.

Obstetrical Neuropathies

When the lumbosacral nerve plexus is under pressure during childbirth, complains of severe neuralgia or as soon as the head enters the pelvis, there are cramping sensations that travel down one or both legs. In addition to varying degrees of sensory loss or muscle paralysis, discomfort may persist after delivery if the nerve is damaged. In certain instances, footdrops may result from damage to the sciatic nerve, lumbosacral plexus, common fibular (peroneal) nerve, or lumbosacral root. The fetal head or forceps can compress parts of the lumbosacral plexus that cross the pelvic brim.

Legs placed in stirrups may externally compress the common fibular nerves, particularly if the second stage of labour is extended. Obstetrical neuropathy is a somewhat prevalent condition. About 1% of the almost 6000 women who were delivered consecutively at Northwestern University experienced a documented nerve injury, according to Wong and colleagues' 2003 evaluation.

The most prevalent were lateral femoral cutaneous neuropathies, which were followed by femoral neuropathies. A third of the injuries were accompanied by a motor deficit. Risk factors were nulliparity, protracted second-stage labour, and extended periods of pushing in the semi-Fowler position. The range of symptom duration was 2 weeks to 18 months, with a median of 2 months.

Muscle Injuries

Even with typical labour, the muscles and tendons in the hips or pelvis may be stretched, ripped, or detached. We have discovered that magnetic resonance imaging (MR) is instructive if nerve damage is ruled out. The majority of problems can be resolved with physical therapy and anti-inflammatory medications. Sokolov and colleagues (2007) report septic pyomyositis as an uncommon condition.

Pelvic Bone and Joint Problems

Pain and significant difficulty moving around may accompany the separation of the sacroiliac synchondroses or the symphysis pubis during childbirth. The range of estimates for their frequency is 1 in 600 to 1 in 30,000 births (Reis Taylor and Sonson, 1986; and associates, 1932). Symptomatic separations are rare in our experience. According to Snow and Neubert (1997), when they are symptomatic, the pain usually starts suddenly during birth, but symptoms can also appear antepartum or up to 48 hours after delivery. Typically, conservative treatment involves using a pelvic binder that fits properly and resting in a lateral decubitus position. In certain cases, surgery is required for symphyseal separations greater than 4 cm (Kharrazi and colleagues, 1997).

Given that recurrence rates in subsequent pregnancies exceed 50%, Culligan and colleagues (2002) advise considering caesarean delivery. In certain instances, sacrum fractures or even simple births can result in pubic ramus (Alonso-Burgos and colleagues, 2007). According to Cunningham (2005), the latter is more common in cases of osteoporosis linked to heparin or corticosteroid medication.

Immunizations¹

The D-negative 300 g of anti-D immune globulin is administered shortly after delivery to a woman who is not immunized and whose child is D-positive. Before being released from the hospital, women who are not already immune to rubella or rubeola measles are prime candidates for the combined measles-mumps-rubella vaccination. A diphtheria-tetanus toxoid booster shot is also administered to postpartum women at Parkland Hospital before their discharge unless it is contraindicated.

Drugs that increase *Quwwat-e-mana*'at (Immunomodulator drugs)

- **Single drugs:** Kalonji (Nigella sativa), Zafraan (Crocus sativus), Asgand (Withania somnifera), Marwareed (Margarata), Amla (Embllica officinalis), Zeharmohra (Serpentine), Ghikawar (Aloe barbadensis), Gilo (Tinospora cordifolia).
- **Compound formulations:** Majoon falasifa, Habb-e-jadwar, Dawa-ul-misk, Kushta tila kalan, Khamira marwareed, Murabba Amla.^{17,18}

Time of Discharge

Usually, hospitalization is not necessary for longer than 48 hours after an uncomplicated vaginal delivery. It is important to educate a woman about expected typical physiological puerperal alterations, such as milk letdown, diuresis-induced weight loss, and lochia patterns. Instructions regarding fever, heavy vaginal bleeding, leg pain, swelling, or soreness should also be given to her. Any chest pain or shortness of breath should be taken seriously right away.¹

Early Discharge

Federal law currently governs how long hospital stays are after labour and delivery. Hospital stays of up to 48 hours after an uncomplicated vaginal birth are currently the norm. (American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, 2007) and for up to 96 hours after an uncomplicated cesarean delivery. For carefully chosen ladies, an earlier hospital discharge is permissible if they so choose.

Contraception¹

A concentrated effort should be made to offer family planning education while the patient is in the hospital.

Menstruation typically resumes if a woman is not breastfeeding for six to eight weeks. However, clinically, it can occasionally be challenging to pinpoint the exact date of the first menstrual cycle following birth.

According to Hytten (1995), only 20% of women ovulate before their first menstrual cycle. A tiny percentage of women experience sporadic, mild to heavy bleeding that begins shortly after giving birth.

The average time for ovulation is seven weeks, although it can happen anywhere between five and eleven weeks (Perez and associates, 1972). However, it has been reported that ovulation occurs before 28 days (Hytten, 1995). Thus, the 6-week artificially determined puerperium is when conception is conceivable.

Contraception should be started by women who become sexually active throughout their puerperium and do not wish to become pregnant. Women do not always receive this message.

It is also not always followed. For instance, Kelly and colleagues (2005) found that only 80% of adolescents were taking contraception by the third month after giving birth, despite 58% of them having resumed sexual activity.

Breast Feeding and Ovulation

There are significant differences in the frequency of ovulation between breastfeeding and non-breastfeeding women. Women who are nursing may get their first menstrual cycle as early as the second or as late as 18 months following delivery. Campbell and Gray (1993) determined the time of ovulation in 92 women by analyzing daily urine collections. Breastfeeding generally delays the resumption of ovulation, as illustrated in Figure 30-5, though this is not always the case. Their study also revealed the following other findings:

- Resumption of ovulation was frequently marked by the return of normal menstrual bleeding
- Breast-feeding episodes lasting 15 minutes seven times each day delayed resumption of ovulation
- Ovulation can occur without bleeding
- Bleeding can be anovulatory
- The risk of pregnancy in breast-feeding women was approximately 4 percent per year

HOME CARE¹

Coitus

Regarding the continuation of coitus after birth, there are no evidence-based guidelines. Common sense seems to be the best option. Depending on comfort and desire, coitus may be resumed after two weeks.

According to Barrett and colleagues (2000), within six months, nearly 90% of 484 primiparous women had resumed sexual engagement. Furthermore, just 15% of those who reported issues spoke with a healthcare professional about them, even though 65% of them did.

Early sexual contact can be uncomfortable, if not downright painful, because of lacerations or the episiotomy's inability to fully heal. Additionally, there is minimal lubrication after sexual stimulation and a thin vaginal epithelium. This is probably caused by the hypoestrogenic state that lasts until ovulation starts up again after delivery.

Breastfeeding women who experience hypoestrogenicity for several months after giving birth may find it more troublesome (Palmer and Likis, 2003; Wisniewski and Wilkinson, 1991).

Topical estrogen cream in tiny doses can be administered to the vulvar and vaginal tissues every day for a few weeks as a treatment. Vaginal lubricants can also be used during coitus.

Late Maternal Morbidity

According to MacArthur and colleagues (1991), major and minor maternal morbidity are unexpectedly prevalent in the months after childbirth. A survey of 1249 moms in Britain revealed that 3 per cent needed to be readmitted to the hospital within 8 weeks for a maximum of 18 months (Glazener and co-workers, 1995). Eighty-seven per cent experienced milder health issues within the first eight weeks. Additionally, nearly three-fourths of them experienced a range of issues for up to 18 months. As a result, while reported issues decreased over time, this fall was slower than most people thought. Similar results were reported in later papers by Lydon-Rochelle (2001), McGovern (2006), Thompson (2002), and all of their colleagues. According to the

mentioned, postpartum maternal morbidity is frequent and, historically at least, has not received enough attention. According to these studies, women's demands throughout their postpartum recuperation should be better understood.

Postpartum Follow-Up Care¹

Women who completed an easy course can return to most activities by the time they are discharged, such as driving, taking a shower, and doing home chores. Cross-cultural data on 202 societies from various international geographic locations was tabulated by Jimenez and Newton (1979). Most civilizations did not restrict work activities after childbirth, and around half of them anticipated returning to full-time duties in two weeks. By six weeks after giving birth, just half of mothers had returned to their prepartum energy levels, according to a later study by Tulman and Fawcett (1988). Compared to women who had a cesarean delivery, those who gave birth vaginally were twice as likely to have normal energy levels at this point. With the father's assistance, the mother should ideally be the one caring for and nurturing the child.

A postpartum visit between four and six weeks is advised by the American Academy of Pediatrics and the American College of Obstetricians & Gynecologists (2007). This has turned out to be rather adequate to start contraceptive procedures and detect anomalies outside of the immediate puerperium. Recent follow-up data from the Pregnancy Risk Assessment Monitoring System (PRAMS) database was released by the Centers for Disease Control and Prevention (2007c). While postpartum visit compliance was 90% overall, it varied between 65 and 80% among teenagers, women with low levels of education or income, and those who did not get prenatal care.

Management of Common Problems During *Zamana-i Nifas*

For abdominal swelling after delivery: Pills made from Mastagi (*Pistacia lentiscus* Linn.), Sakbeenaj (*Ferula persica* Willd.), and Saatar (*Satureja hortensis* Linn.) One portion each and 4.5 grams of honey is taken orally.³

Excessive lochia discharge: The lower and upper extremities are bound, and the abdomen is covered with vinegar-soaked cloth.

Diet: It is advised to follow a *Qabiz* (astringent) and *Muqawwi* (nutritive) diet that includes foods like milk, sumaqia, dates, meat gravy, and half-boiled egg yolks.

Following formulations are also useful:^{19,20}

- Gulnar (*Punica granatum* Linn.), Kehrubā (*Pinus succinifera*), Kundur (*Boswellia serrate* Roxb.), Gul Surkh (*Rosa damascena* Mill.), and Sharab (wine) were used to produce Shiyaf (vaginal pessary).
- AabBartang's (*Plantago major* Linn.) huqna (enema) is highly advantageous.
- Dry cupping, also known as dry hijama, is applied beneath the breast.

Scanty lochia discharge:^{3,19-21}

It is advised to use *Mudirrat-i Tams Advia* (Emenagogues), *Dhooni* (Fumigation), and *Atoos* (induced sneezing) along with *Fasd* (Venesection), a part of regimental therapy. Avoid the *mufatteh sudad wa ghaleez aghzia* (obstruent and less digestible diet).

- Ajmod (*Apium graveolens* Linn.), Hansraj (*Adiantum incisum* Forsk.), and Mushktaramushi (*Mentha spicata* Linn.) decoctions are administered orally with sugar crystals.
- *Mudirrat-i tams Advia* (emenagogues) such as karafs (*Apiumgra veolens* Linn.), Anisoon (*Pimpinella anisum* Linn.), Majeeth (*Rubia cordifolia*, Linn.), Afsanteen (*Artemisia absinthium*, Linn.), Turmus (*Lupinus albus* Linn.), Abhal (*Juniperus communis* Linn.), and Zarawand mudharij (*Aristolochia rotundus* Linn.) are helpful for uterine cleansing.¹⁵

Single medications such as Khardal (*Brassica nigra* (Linn.)), Muqil (*Commiphora mukul* Hook.), Harmal (*Peganum harmala* Linn.), and Ilak al-batam (*Pistacia lentiscus* Linn.) are helpful for *Dhooni* (Fumigation).¹⁵

Venesection of the saphenous vein, or *Fasd-i Safin*, is especially helpful in cases of endometritis and decreased puerperal discharge.

For uterine pain and endometritis.^{5,6}

- *Ma'a ul-Shaeer* (barley water) and *Ma'a ul-Asool* are administered orally for a few days.
- Decoction of salikha (*Cinnamomum zeylanicum* Blume), Izkhar, or Satar (*Saturejahortensis* Linn.) administered orally
- It is recommended to take a lukewarm *Aabzan* (Sitz bath).¹⁵
- Applying Lukewarm Roughan Banafsha on the abdomen¹⁶
- *Huqna-e- Mahbili* (Enemata per vaginum) is prepared by decocting either Salikha (*Cinnamomum zeylanicum* Blume) or Katan (*Linum itatissimum* Linn.).
- *Muqawwirahm* (Uterine tonic): **Single drugs:** Mazu (*Quercus infectoriaoliv*), Bhangra (*Eclipta alba*), Satawar (*Asparagus racemosus*), Kaat safaid (*Uncaria gambier*). **Compound formulations:** Majoon Muqawwi Rehm Sada. Majoon suparipak, Majoon mochras.²²

Mastitis and cracked nipple³

- These are typical puerperal and lactation issues. Mastitis can be brought on by an accumulation of milk in the breast, trauma sustained during nursing, or *Su'e Mizaj* of the breast (ill temperament). Using a sponge soaked in lukewarm water, hot fomentation is used to treat breast congestion and swelling.
- Roughan Gul, roti (chappati), and egg yolk are used to make zimad (paste), which is then put on the breast.

- Paste made with anti-inflammatory medications such as Mur (*Commiphora myrrha*), Katan (*Linum usitatissimum* Linn.), Khatmi (*Althaea officinalis* Linn.), and Hulba (*Trigonella foenum* Linn.). Arad Jau (barley flour), Roughan kunjud (sesame oil), Roughan Zaitoon (olive oil), or egg yolk, as well as Maweez (*Vitis vinifera* Linn.) and Barg Sarw (*Cypress ussempervirens* Linn.).^{19,20}
- Vinegar or a decoction of Hulba (*Trigonella foenum* Linn.), Katan (*Linum usitatissimum* Linn.), and Khatmi (*Althaea officinalis* Linn.) is used for hot fermentation.
- Zimad (paste) made of roti (chappati), water, vinegar, and Khajur (dates) is applied locally.^{19,20}
- When mastitis is present, breastfeeding should be avoided. Fever may accompany mastitis if the nursing woman has it as a result of milk retention. Adas (lentil) and vinegar are helpful for this.
- Oral administration of Tukhm Kahu (*Lactuca sativa* Linn) decoction.³
- Paste made from the leaves and seeds of Beekh Karnab (*Brassica oleracea* Linn.), Badrooj, and Sudab (*Rutagra veolens* Linn.).³

Qillat-i Laban (Lack of Breast milk)¹⁹

The breast produces less milk throughout the lactation phase in this disease. Malnutrition, blood shortages, mental stress, negligence toward the infant, and *Su'e Mizaj-i Pistan* (bad breast temperament) are the main reasons for decreased breast milk production. The following management techniques should be used for this:

- A healthy diet, or *Islah-i Ghiza*, is advised in terms of both quantity and quality.²³
- Milk, rice, chicken, egg, gram, starch, carrot, turnip, and other foods are provided to mothers as part of the *Jayyed al-Kaimoos* (good blood generating diet), *Haar-ratab Aghziya* (diet for hot and moist temperament), and *Muwallid-i Sheer Aghziya* (lactogenic diet).
- Sweet dishes like *halwa* and *hareerajat* are made with milk, sugar, and dry fruits.^{19,20}
- Galactagogue medicines are employed. Among the fixes are:
Taking 4 grams of powdered Tudri Surkh (*Lepidiumperis* Linn.) orally with 250 millilitres of cow's milk.³
- *Ma'a ul-Asl* is administered orally along with 2 grams of Shoneez (*Nigella sativa*) powder.
- Satavar (*Asparagus racemosus* Willd.), Zeera safed (*Cumin cyminum* Linn.), and Badiyan (*Foeniculum vulgare* Mill.) are used to make Safoof (powder), which is administered orally in a dose of 7gm with milk and sugar.³
- *Hijama* (cupping) beneath the breast area and *Nutool* (pouring) of lukewarm water over the breast are the methods used to treat *Su'e mizaj-i Pistan* (bad temperament of the breast).³
- Compound Drugs²¹
- Halwa Baiza Murgh 6-12 gms twice daily. HalwaNakhud QS
- Halwa-i Salab 12-24gm with milk in the morning²⁰

Muqawwi A'za-e-raisa: Single drugs: Jadwar, Zahar Mohra, Gazar, Qust, Zafraan, Gauzbaan, Marwarweed, Badam (*Prunus amygdalus*) Sandal (*Santalum album*). Compound formulations: Khamira Marwareed, Khamira Abresham, Habbe Jawahar, Habbe Zahar mohra, Khamira sadaf, Khamira khas.²⁴

Daf-e-zaghatuddam (Anti-hypertensive drugs): Asrol (small dose), Kishneez, Muqil, Gulqand, Itrifal Kishneezi, Sharbat Ahmad Shahi.²⁵

DISCUSSION AND CONCLUSION :

To cope with the challenges of the entire journey and to ensure a healthy mother and baby at the end of pregnancy, the patient requires the right care and support during pregnancy. An attempt has been made to concentrate on and emphasize the benefits of Unani medicine in prenatal and postnatal care through this study. The Unani medical system has a wealth of literature on maternal health and wellbeing; all that is required is the appropriate integration of the regimens into clinical practice, which will serve as a foundation for future research aimed at effectively managing maternal health. The comprehensive Unani System of Medicine takes a unique stance when explaining maternal health topics.

Additionally, it has a unique method for treating ailments associated with pregnancy, labour, and postpartum care. It takes a unique approach to conception, prenatal care, embryology, managing pregnancy-related issues, managing abortion, a normal delivery, and postpartum care. The treatment and management of maternal health and related disorders are specifically mentioned in the Unani classics. Its genesis and therapy have been extensively described by several Unani doctors. The most authentic Unani medical source for understanding maternal health is *Zakaria Razi's* book *Kitab al Hawi fi al Tib*, written in 925 A.D. We are interested in its ninth volume, "Gynecology and Midwifery."

The material on maternal health and wellness in the Unani medical system has been thoroughly reviewed. This review has discussed different treatment plans that are recommended in the system for various areas of maternal health. An otherwise comprehensive study would have been able to address them all in detail, but this has not been possible. Even though it is not particularly thorough, this study serves as a guide for scientists in the field and serves as a foundation for future research aimed at effectively managing maternal health and associated issues.

REFERENCES:

1. F. Gary Cunningham *et al.* The Puerperium. in *Williams Obstetrics* 654–660 (McGraw-Hill Medical, New York).
2. Khan Qutubuddin, Ahmed Waseem Mohammad & Imam Hashmat. Perceptions of maternal health and well-being in Unani system of medicine. *International Journal of Medical and Health Research* 6, 64–67 (2020).
3. Bashir Fouzia, Akhtar Jamal & Bi Salma. Tadabeer-iWiladatwa baadaz wiladat (Peri natal and post natal care): An approach through unani system of medicine. *Int J Herb Med* 105–108 (2020).
4. Say, L. *et al.* Global causes of maternal death: a WHO systematic analysis. *Lancet Glob Health* 2, e323–e333 (2014).

5. Anonymous. *Unani System of Medicine: The Science of Health and Healing*. (Ministry of Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy (AYUSH) Government of India, CCRUM, New Delhi, 2016).
6. Anonymous. *Qarabadeen e Sarkari*. (Central Council for Research in Unani Medicine, New Delhi, 2006).
7. Anonymous. SRS Bulletin. Sample Registration System, Office of the Registrar General, India. 52(1) 1–9 (2019).
8. Gupta MC & Mahajan BK. *Textbook of Preventive and Social Medicine*. (Jaypee Brothers medical publishers, New Delhi, 2005).
9. Park K. *Parks Textbook of Preventive and Social Medicine*. (Bnarsidas Bhanot Publishers, Jabalpur, India, 2009).
10. Park K. *Park's Textbook of Preventive and Social Medicine*. (Bhanot, Jabalpur, 2009).
11. Lone, A. H. *et al*. Perception of health promotion in Unani herbal medicine. *J Herb Med* 2, 1–5 (2012).
12. Tipo FA, Dr. Khan TN & Khanam B. Conceptual explanation of Asbab-e-Sitta Zarooriya (six essentials), their effect on vital heat and human health: A Unani perspective. *International Journal of Physiology, Nutrition and Physical Education* 4, 570–573 (2019).
13. Majoosi AA. *Kamil al Sana (Urdu Translation by Kantoori GH)*. vol. 2 (Lucknow Nawal Kishore; YNM).
14. Majoosi II. *Kamil. Us Sana. New Delhi. 2010; 54:190-260*. vol. 54 (Idara Kitabus-shifa, New Delhi, 2010).
15. Razi AMIZ. *KitabulHawi: (Urdu Translation by CCRUM)*. vol. 9 (CCRUM Ministry of H&FW, 2001).
16. Sina I. *Al Qanoon Fil Tib (Urdu Translation by Molvi Hakeem Sayed Ghulam Hasnain)*. vol. 2 (MushiNawal Kishore press, Lucknow YNM).
17. Majeed SF, Roqaiya M, Jahan D & Khan AA. Immunomodulatory herbs of Unani medicine: A review. *Int J Herb Med* 3, 19–21 (2015).
18. Saboo, S. Immunomodulator in Traditional Healthcare System. in *Alternative Medicine - Update* (IntechOpen, 2021). doi:10.5772/intechopen.94965.
19. Kabīr al-Dīn & Hakīm Muhammad. *Tarjama-i-Kabīr (Urdu Translation)*. vol. 3 (Daftar al-Masīh, Hyderabad Deccan, 2005).
20. Kabīr al-Dīn & Hakīm Muhammad. *Sharah Al-Asbāb (Urdu Translation)*. vol. 3 (Hikmat Book Depot, Hyderabad, 1916).
21. Abdul Bari & Alsharif. *Jamiul Advia*. (Faisal publication, Deoband, India, 2003).
22. Roqaiya M, Begum W, Majeed SF & Saiyed A. A Review on Herbs with Uterotonic Property. *The Journal of Phytopharmacology* 4, 190–196 (2015).
23. Anonymous. *Standard Unani Medical Terminology*. (CCRUM, New Delhi, 2012).
24. Anonymous. *National Formulary of Unani Medicine (Part-4)*. (Ministry of Health & Family Welfare, Government of India. Department of Indian Systems of Medicine and Homoeopathy. Central Council for Research in Unani Medicine, New Delhi, 2011).
25. Anonymous. *Qarabadeen e Sarkari* . vol. 4 (CCRUM, New Delhi, 2006).