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The Efficacy of Unani Medicine in Labour Induction: An Evidence-Based Review

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Abstract: ***Induction of labour is widespread in obstetric practice when continued pregnancy may cause harm. Unani medicine offers herbal regimens purported to facilitate labour, yet modern scientific assessment is limited. This review synthesizes available data on Unani interventions, focusing on mechanisms, clinical evidence, and safety. While early studies suggest polyherbal Unani formulas may reduce induction-to-delivery times and increase rates of vaginal birth, limitations—such as small samples and lack of controls—hinder definitive conclusions. Safety concerns persist, particularly with variable dosing and possible neonatal effects. Controlled trials and standardization are urgently needed.***

Keywords: Labour induction, Unani medicine, Herbal remedies, Cervical ripening, Obstetric safety

1. Introduction

Labour induction is commonly employed to optimize maternal and fetal outcomes, especially when pregnancy continuation is unsafe. While standard approaches such as prostaglandins, oxytocin, or mechanical methods are effective, they carry risks of uterine overstimulation, fetal compromise, or increased surgical deliveries. A significant proportion of pregnant women seek herbal alternatives, including Unani medicine, rooted in Greco-Arabic tradition and humoral theory(1-4). Unani formulations blend multiple botanicals believed to trigger or hasten labour, yet rigorous modern evaluation is scarce.

2. Methods

A broad review of the literature was performed using major electronic databases with a focus on clinical studies, systematic reviews, and pharmacological reports evaluating Unani interventions in labour induction. Studies were included if they addressed efficacy, safety, or mechanism of action, with quality assessed using established critical appraisal tools(.1) (2)

3. Mechanisms and Pharmacology

Unani protocols for labour traditionally utilize plants categorised by their effects on uterine function. Several key botanicals contain compounds that stimulate prostaglandin production or modulate uterine muscle sensitivity, including Peganum harmala, Gentiana lutea, and Euphorbia resinifera. Others, such as Cinnamomum tamala, facilitate cervical softening, while plants like Gossypium herbaceum exert estrogen-like influences, enhancing readiness for labour. These multi-ingredient regimens work by targeting various processes underlying parturition, although the magnitude and reliability of these effects remains to be fully established in clinical settings. (3)

4. Results/ Findings

Polyherbal Unani Regimens

The primary clinical study identified examined a combination of oral and vaginal Unani botanicals in women beyond 38 weeks of gestation. Labour onset after Unani intervention averaged 12 hours, with a high proportion of spontaneous vaginal births and minimal reported adverse outcomes. However, important limitations include the absence of control groups and the relatively small number of participants, limiting confidence in efficacy estimates. (3)

Evidence for Individual Herbs

Widely used natural products such as castor oil have mixed or insufficient evidence. Blue cohosh, another herb referenced in traditional practice, has been implicated in neonatal complications. Raspberry leaf is popularly recommended, yet clinical trial data do not confirm benefits in initiating labour or shortening its duration. These variations emphasise the necessity of individualised evaluation of common herbal agents. (1) (4)

5. Discussion

Although preliminary findings are encouraging, especially in resource-limited or culturally specific contexts, Unani medicine's role in labour induction remains unproven by contemporary research standards. Limitations in existing studies—including inadequate controls, small sample sizes, and inconsistent herbal drug quality—are compounded by potential safety concerns due to variability in herbal composition. The lack of consistent dosing and monitoring protocols further complicates risk assessment and hinders standardisation across patient populations. (3)

6. Conclusion

Unani-based induction regimens may offer a promising approach to labour onset, particularly for those seeking traditional or complementary care. Yet, due to substantial gaps in high-quality evidence, standardized production, and safety surveillance, these interventions should be considered experimental and used with caution. Large, controlled trials and systematic safety monitoring are strongly recommended to clarify their clinical value and safety. (1) (2) (3)

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