Infertility and Marital Intimacy

Understanding Sexual Performance Anxiety, Loss of Desire, Erectile and Ejaculatory Problems, Relationship Stress, Emotional Health and the Integrative Unani Approach

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Introduction

When a couple comes to me because pregnancy is not happening, the discussion usually begins with questions such as:

“Is the sperm count low?”

“Is ovulation normal?”

“Are the fallopian tubes open?”

“Is there a hormonal problem?”

These questions are important. But after speaking with the couple in detail, I often discover another problem that may never have been mentioned during their previous fertility consultations:

their intimate relationship has changed.

Sex that was once spontaneous has become scheduled.

The fertile window has become a deadline.

The husband may begin worrying:

“What if I cannot get an erection tonight when it is the most important day?”

The wife may feel:

“We are no longer being intimate because we want each other. We are doing it only because the ovulation test says today is the day.”

After repeated unsuccessful cycles, sexual activity can gradually become associated with pressure, disappointment and fear rather than pleasure and emotional closeness.

The detailed background material supplied for this article appropriately identifies this change as one of the most important but often overlooked consequences of infertility: the pursuit of pregnancy can transform intimacy from an affectionate, spontaneous part of a relationship into a medically regulated task, while psychological distress can interact with sexual dysfunction and relationship strain.

This is no longer a minor issue in fertility medicine.

The **World Health Organization's first global infertility guideline, published in November 2025**, specifically emphasizes that infertility can cause substantial distress, stigma, anxiety, depression and social isolation, and states that psychosocial support should be available as part of fertility care.

So when I assess infertility, I do not consider only:

egg + sperm + tube + uterus.

I also consider:

sexual function + emotional wellbeing + relationship health + lifestyle + the couple's experience of treatment.

That is the difference between merely investigating reproduction and providing comprehensive fertility care.

What Is Infertility?

The World Health Organization defines infertility as a disease of the male or female reproductive system characterized by failure to achieve pregnancy after **12 months or more of regular unprotected sexual intercourse**. WHO's latest figures indicate that approximately **one in six people of reproductive age worldwide experience infertility during their lifetime**.

Infertility is generally described as:

Primary infertility

A pregnancy has never previously been achieved.

Secondary infertility

At least one previous pregnancy has occurred, but a subsequent pregnancy is not being achieved.

Infertility may result from a female factor, a male factor, a combination of both, or sometimes remain unexplained despite appropriate testing.

The 2024 AUA/ASRM male-infertility guideline notes that male factors contribute wholly or partly to approximately **half of infertile couples**, which is why fertility assessment should never automatically focus only on the woman.

This is one of the first messages I give couples:

Infertility is a couple's health problem. It should not automatically become the woman's blame or the man's shame.

When Should a Couple Seek Fertility Evaluation?

The standard WHO clinical definition uses 12 months of regular unprotected intercourse.

However, evaluation may appropriately begin earlier in certain circumstances.

ASRM recommends evaluation after approximately **12 months when the female partner is younger than 35**, after **6 months when she is 35 or older**, and more immediately in women over 40 or where there is already a known condition associated with infertility. Evaluation of the male and female partners should occur in parallel.

Earlier assessment may also be reasonable when there is a known history of significant reproductive disease, absent or very irregular periods, previous pelvic disease, significant testicular problems, sexual dysfunction preventing intercourse, or another condition likely to impair fertility.

Infertility Is Not Only a Reproductive Diagnosis

When fertility treatment is discussed only in terms of:

ovulation, sperm count, morphology, motility, ovarian reserve, follicular size and tubal patency,

we risk forgetting that the couple experiencing infertility are human beings rather than reproductive laboratory values.

Infertility can affect:

identity, confidence, masculinity, femininity, sexual desire, body image, emotional health, relationships with family members and the couple's relationship with each other.

The most recent WHO infertility guidance therefore places **people-centred care and ongoing psychosocial support** alongside biological diagnosis and treatment.

How Infertility Changes the Meaning of Sex

One of the deepest changes occurs when intercourse stops being:

"We want to be close."

and becomes:

"Today is day 14, therefore we have to have intercourse."

The supplied clinical background describes this transition from spontaneous intimacy to calculated, fertility-focused intercourse in considerable detail.

A 2024 qualitative synthesis of sexual experiences among people with infertility similarly found major themes involving changed meanings of sexuality, altered sexual behaviour, attempts to cope with sexual problems and unmet needs for sexual-health information.

And a 2026 qualitative study of couples living with infertility described experiences such as diminished sexual pleasure and **"prescribed instead of pleasurable sex."**

This is why I tell couples:

Do not allow the fertility journey to consume the entire intimate relationship.

The Fertile Window: Useful Biology, but It Can Become Psychological Pressure

For natural conception, timing does matter.

The fertile period extends for several days before ovulation because sperm can survive in the female reproductive tract, while the ovum remains fertilizable for a much shorter period after ovulation.

ASRM describes the fertile window for counselling purposes as approximately the **six-day interval ending on the day of ovulation**, with the greatest probability of conception generally occurring close to ovulation.

Ovulation-prediction tests can therefore be useful.

A Cochrane review involving seven randomized trials and 2,464 women or couples found that timed intercourse based on urinary ovulation testing probably modestly increases pregnancy and live-birth chances in women under 40 who had been trying to conceive for less than 12 months. If pregnancy probability without prediction was approximately 18%, it was estimated at roughly 20–28% with urinary ovulation prediction.

But there is another side.

The same Cochrane review acknowledges that ovulation tracking may involve:

stress, time, cost and psychological burden, while evidence about its effect on stress and quality of life remains uncertain.

Therefore, more timing is not automatically better care.

Do Couples Need to Have Sex at an Exact Hour?

Usually not.

This is an important recent sexual-medicine message.

The **2026 International Consultation for Sexual Medicine recommendations** advise couples trying to conceive that frequent intercourse at their convenience during the fertile week is sufficient; extremely precise instructions about frequency can unnecessarily increase performance pressure.

The same recommendations specifically state that couples do not need to restrict sexual frequency in order to “save” or “conserve” semen.

I often explain this very simply:

The fertile period matters. The exact minute does not.

That small change in thinking can protect intimacy.

How Timed Intercourse Can Produce Sexual Performance Anxiety in Men

A man who normally has no difficulty with erections may suddenly experience problems when intercourse becomes compulsory.

He may know:

“Tonight is the fertile night.”

He knows his wife is waiting.

He knows another month may be lost if intercourse does not happen.

He starts monitoring himself:

“Am I becoming hard enough?”

“What if I lose the erection?”

“What if I cannot ejaculate?”

This self-monitoring increases anxiety.

An erection normally depends on coordinated neural and vascular responses that are favoured by sexual arousal and relative relaxation.

Performance anxiety increases sympathetic nervous-system activity—the body's alert or "fight-or-flight" system—which can oppose the relaxed vascular conditions required for a dependable erection.

The supplied research appropriately highlights the connection between fertility-related performance pressure, sympathetic activation and situational erectile difficulty, although some of its neurohormonal wording is more absolute than current evidence permits.

Timed Intercourse and Erectile Dysfunction: What Does the Research Show?

A frequently cited prospective study followed 439 men undergoing timed-intercourse protocols.

It reported newly developed erectile dysfunction in **42.8%** and ejaculatory dysfunction in approximately **5.9%** of the participants, with anxiety increasing as timed-intercourse exposure increased.

This study is important, but it should be interpreted carefully.

It was not proof that every man undergoing ovulation-timed sex will develop ED.

It does show something clinically important:

the psychological pressure of conception can itself become a sexual-health problem.

Modern guidance now explicitly recognizes this.

ASRM states that erectile dysfunction, ejaculatory problems and low libido should be actively assessed in men presenting for infertility evaluation because conception-related stress can worsen sexual dysfunction.

The Latest 2026 Recommendations on Male Sexual Dysfunction and Infertility

The Fifth International Consultation for Sexual Medicine published dedicated recommendations in January 2026.

Its central conclusion is extremely relevant:

sexual dysfunction and infertility frequently coexist and may be either a cause or a consequence of each other.

The panel strongly recommends incorporating a detailed sexual history into infertility assessment.

Possible male problems include:

erectile dysfunction, reduced sexual desire, premature ejaculation, delayed ejaculation, anejaculation and difficulty consummating intercourse.

These disorders should be treated rather than simply telling a couple to “try harder.”

Infertility Does Not Mean Impotence

This misunderstanding creates enormous unnecessary shame.

Male infertility and erectile dysfunction are not the same condition.

A man can have:

excellent erections with severely abnormal sperm,

or

normal sperm with erectile dysfunction,

or

both conditions,

or neither.

Similarly:

fertility does not measure masculinity.

A low sperm concentration does not make a man less masculine.

It is a reproductive-health finding that deserves medical assessment.

Erectile Dysfunction Can Also Contribute to Infertility

Although infertility itself may create ED, the relationship can work in the opposite direction.

If a man repeatedly cannot achieve sufficient erection for penetration during the fertile period, sperm may not be deposited in the vagina.

This can reduce the possibility of natural conception.

The 2026 ICSM recommendations therefore treat situational ED in infertility as a genuine clinical problem rather than an embarrassing side issue.

Can ED Medicines Be Used While Trying for Pregnancy?

For appropriately selected men, yes.

The 2026 International Consultation specifically concludes that oral **PDE5 inhibitors**, the drug class containing medicines such as sildenafil and tadalafil, may be used in couples trying to conceive and that current evidence does not show that these medicines reduce fertility or live-birth rates.

They still require appropriate medical assessment because they have contraindications and potential interactions—particularly with nitrate medicines.

The important point is that a man should not be frightened into thinking:

"If I need temporary ED treatment while trying for a baby, I will damage my sperm."

That is not supported by current evidence.

Exogenous Testosterone Is Different—and Can Reduce Fertility

This is one of the most important warnings for men trying to conceive.

A man with fatigue, low libido or erectile problems may obtain testosterone injections or gels because he believes they will improve fertility.

External testosterone can actually suppress pituitary hormones responsible for stimulating sperm production and may significantly reduce or even temporarily stop spermatogenesis.

The 2026 ICSM recommendations strongly advise against exogenous testosterone replacement in men who wish to preserve fertility.

This is why any hormonal treatment in an infertile man requires careful assessment.

Ejaculatory Dysfunction and Fertility

Fertility also requires semen to be deposited appropriately.

Premature ejaculation usually does **not** prevent natural conception if ejaculation occurs inside the vagina.

However, if ejaculation consistently occurs before penetration, conception may become difficult.

Likewise, severe delayed ejaculation or complete anejaculation can prevent semen deposition even when erection is normal.

Current ICSM guidance recognizes these conditions and recommends cause-specific management, which can range from counselling and psychosexual treatment to medical approaches and assisted-reproduction techniques.

Sexual Lubricants When Trying to Conceive

Some couples need lubrication because intercourse has become frequent, stressful or uncomfortable.

This is not a failure.

However, couples trying to conceive should preferably use lubricants that are compatible with sperm.

The 2026 ICSM recommendations specifically advise couples to use **fertility- or sperm-compatible lubricants** when lubrication is needed.

How Infertility Affects Women Sexually

Women experience a different but equally important form of sexual pressure.

A woman may spend each month monitoring:

period dates, ovulation tests, ultrasound appointments, medications and pregnancy tests.

She may begin viewing her body primarily as a reproductive project.

Sex may cease to feel like intimacy and start feeling like another fertility procedure.

The supplied background research discusses how this “reproductive labour” can replace spontaneous affection and contribute to reduced desire, arousal and sexual satisfaction.

Research supports the broader concern.

A systematic review and meta-analysis found that women with infertility have a greater likelihood of sexual dysfunction, with lubrication, orgasm and sexual satisfaction among commonly affected domains.

Desire Can Decline During Infertility Treatment

Reduced desire may develop because:

sexual activity feels compulsory,

pregnancy repeatedly fails,

the woman is physically tired from treatment,

intercourse has become associated with disappointment,

or the relationship itself has become strained.

This does not necessarily mean that she has lost attraction to her partner.

Sometimes she has lost attraction to the **pressure surrounding sexual activity**.

That distinction can save a relationship from unnecessary misunderstanding.

Orgasm and Sexual Satisfaction

Some women stop focusing on pleasure because the entire sexual encounter becomes organized around ejaculation and sperm deposition.

The thought becomes:

“Did we do it on the right day?”

rather than:

“Are we enjoying intimacy?”

Over time, reduced sexual pleasure can lead to:

less initiation, reduced arousal and lower overall sexual satisfaction.

A comprehensive 2023 systematic review concluded that infertility is associated with increased risks of sexual difficulties in both men and women and recommended addressing sexuality throughout the infertility-treatment pathway.

Painful Intercourse Should Not Be Ignored During Fertility Treatment

Some women attempting pregnancy also experience:

vaginal dryness, pelvic-floor tightening, endometriosis, vaginismus or another cause of painful intercourse.

If intercourse hurts, telling a couple to increase frequency can worsen both the pain and the relationship.

Pain should be assessed and treated separately.

Where penetrative intercourse itself is difficult or impossible, a sexual-health assessment can be as important as hormone testing.

Infertility Can Affect Both Partners at the Same Time

A common pattern is:

the wife becomes anxious about missing ovulation,

the husband becomes anxious about erection,

his erection becomes less reliable,

she interprets that as lack of interest,

he interprets her distress as criticism,

she becomes more urgent,

he becomes more anxious,

and intercourse becomes even more difficult.

Neither partner intended this cycle.

They are both responding to pressure.

A couple-centred approach tries to interrupt that cycle before resentment becomes established.

Mental Health and Infertility

The emotional burden of infertility deserves the same seriousness as the reproductive diagnosis.

A 2024 systematic review and meta-analysis involving **44 studies and more than 53,000 women with infertility** estimated major depressive disorder at approximately 22.9%, broader depression symptoms at 31.6% and generalized anxiety at 13.3%, although estimates varied substantially among studies.

More recent analyses have also reported high levels of anxiety and depression in women undergoing infertility care, though exact prevalence varies considerably according to population and measurement methods.

Men are also affected.

A 2024 systematic review estimated anxiety symptoms in approximately **21% of infertile men**, again with wide variation according to the assessment instrument used.

During assisted reproductive treatment specifically, a 2025 meta-analysis found substantial anxiety, depression and stress in both women and men.

So the emotional burden should never automatically be considered “only a women's problem.”

Why Women Often Carry More Visible Blame

WHO specifically notes that even though both men and women can experience infertility, women in heterosexual relationships are frequently blamed regardless of where the underlying reproductive factor actually lies.

Possible consequences include:

stigma, anxiety, depression, loss of self-esteem, relationship disruption and—in some settings—violence or abandonment.

The supplied research also describes substantial family and social pressure in parts of India, where infertility may become a public family issue rather than remaining a private medical matter.

My position in clinical practice is clear:

Do not investigate only the wife because pregnancy has not occurred.

Both partners deserve evaluation.

Male-Factor Infertility Should Not Be Hidden

Sometimes a husband avoids semen analysis because he associates fertility with masculinity.

Meanwhile, the wife undergoes repeated:

blood tests, scans, hormonal medicines and procedures.

This is medically inappropriate.

AUA/ASRM guidelines strongly recommend concurrent evaluation of both partners and at least one semen analysis during initial male assessment.

A semen test is not a test of manhood.

It is a reproductive investigation.

Semen Collection Can Itself Be Stressful

Some men have no difficulty ejaculating at home but struggle to produce a semen specimen in a clinic.

They may feel:

embarrassed, rushed, observed or frightened that the sample will reveal a serious abnormality.

This should not be treated as weakness.

Clinical teams should provide privacy, clear instructions and reasonable flexibility according to laboratory requirements.

When collection problems recur, the clinician should assess whether the difficulty reflects:

anxiety, erectile dysfunction, delayed ejaculation, medication effects or another sexual problem.

In other words:

failure to produce a clinic sample does not automatically mean biological inability to ejaculate.

IVF, IUI and ART Can Further Medicalize Intimacy

When fertility treatment advances to assisted reproductive technology, the couple may spend months thinking about:

follicles, injections, egg retrieval, semen collection, embryo grading, transfer dates and pregnancy tests.

The bedroom can gradually begin to feel like another extension of the clinic.

This is why WHO's current infertility guidance emphasizes not only technical fertility treatment but also respectful, people-centred and psychosocial care.

The relationship deserves protection during treatment.

Infertility Should Not Become the Couple's Entire Identity

A couple may gradually stop talking about:

work, travel, humour, plans, affection or ordinary life.

Every conversation becomes:

“What did the doctor say?”

“When is ovulation?”

“What was the sperm count?”

“When do we test?”

Fertility treatment is important.

But a marriage needs areas of life that remain separate from infertility.

I often encourage couples to create deliberate periods when fertility discussion is put aside and they reconnect as partners rather than patients.

Sexual Communication During Infertility

One partner may be thinking:

“I feel pressured.”

while the other is thinking:

“I feel alone.”

If neither expresses this clearly, both may begin interpreting the other's behaviour negatively.

A better conversation sounds like:

“I know conception matters to both of us, but I feel anxious when every intimate moment becomes scheduled. I want us to find a way to protect our relationship too.”

This is not abandoning fertility treatment.

It is protecting the couple who are undergoing it.

Counselling Can Improve Marital and Sexual Satisfaction

This is not simply theoretical advice.

A systematic review and meta-analysis of randomized clinical trials found that counselling and psychological interventions improved marital and sexual satisfaction among couples dealing with infertility.

A 2025 systematic review focusing specifically on marital intimacy similarly concluded that infertility-related stress damages intimacy and that counselling approaches can help address emotional and marital consequences.

A newer 2026 systematic review and meta-analysis of interventions for sexual function in women with infertility also found significant improvements after treatment, with benefits seen from sex-therapy, psychotherapeutic, counselling and selected pharmacological or complementary interventions, although evidence quality and study design varied.

Cognitive Behavioural Therapy

CBT can help patients identify thoughts such as:

“If this cycle fails, everything is hopeless.”

“My husband cannot perform because he no longer wants me.”

“Low sperm count means I am not a real man.”

“My infertility means I have failed as a woman.”

These thoughts can intensify emotional and sexual distress.

CBT does not guarantee pregnancy.

Its purpose is to help individuals respond more adaptively to the psychological burden of infertility.

A 2025 meta-analysis of psychological interventions found meaningful improvements in anxiety, depression and wellbeing among women with infertility, with CBT and counselling among the more useful approaches.

Sensate Focus and Restoring Intimacy

The supplied material also discusses **sensate focus**, a classic psychosexual technique used to reduce performance pressure.

The central concept is useful:

temporarily shift attention away from erection, penetration, ejaculation, orgasm and conception as compulsory “goals” and rebuild comfortable physical closeness.

Under appropriate therapeutic guidance, couples may use gradually structured, non-demand touch to rediscover:

comfort, bodily awareness, communication and affection.

The objective is not a rigid internet protocol.

It is to teach the nervous system and the relationship:

“Physical closeness does not always have to end in a fertility performance test.”

Protect Affection That Is Not About Fertility

This can be surprisingly powerful.

A hug should sometimes remain a hug.

A kiss should not always mean:

“We need intercourse because today is fertile.”

Couples can preserve:

non-demand affection, conversation, shared leisure and emotional intimacy.

This prevents the entire physical relationship from becoming associated with pregnancy attempts.

Does Stress Cause Infertility?

This question requires careful wording.

Infertility clearly causes stress.

Stress can also influence:

sexual desire, intercourse frequency, sleep, relationship functioning and sexual performance.

However, it is usually inaccurate and unhelpful to tell a patient:

“You are infertile because you are stressed.”

That can create additional guilt.

Many infertile couples have identifiable reproductive causes such as:

ovulatory disorders, tubal disease, endometriosis, sperm abnormalities or reproductive-age factors.

Stress management is valuable because it improves wellbeing and can help sexual functioning and treatment adherence—not because relaxation is a guaranteed infertility cure.

Does Anxiety Directly Lower Testosterone?

The relationship between chronic stress and the reproductive endocrine system is complex.

The supplied source presents a relatively direct model in which elevated cortisol necessarily suppresses testosterone and creates infertility-related sexual dysfunction.

Stress physiology can interact with the hypothalamic-pituitary-gonadal axis, but this should not be simplified into:

“Anxiety always lowers testosterone.”

If symptoms suggest testosterone deficiency, it should be investigated appropriately rather than assumed from stress alone.

Diagnosing Infertility Properly

A responsible fertility evaluation aims to identify the cause before treatment.

For the female partner, evaluation may consider:

ovulatory function, menstrual history, age, ovarian factors, uterine anatomy and tubal patency according to the clinical situation.

For the male partner, initial assessment includes:

reproductive and medical history and semen analysis, with hormonal, genetic, imaging or specialist investigations added when indicated.

ASRM recommends that both partners be evaluated concurrently rather than completing the woman's entire investigation before assessing the man.

Sexual History Should Be Part of Fertility History

A couple may have apparently normal fertility investigations yet intercourse occurs only once every few months.

Another couple may have severe vaginismus and never successfully complete penetration.

Another man may consistently ejaculate before vaginal penetration.

Another may be unable to ejaculate with intercourse.

A fertility work-up that never asks about sexual function can therefore miss the actual barrier to conception.

The 2026 International Consultation strongly recommends taking a sexual history as part of infertility care.

Lifestyle Matters for Fertility and Sexual Health

WHO's 2025 global infertility guideline recommends healthy lifestyle measures including:

healthy diet, appropriate physical activity and tobacco cessation for individuals and couples planning pregnancy.

Lifestyle management is useful because the same health problems that impair fertility may also impair sexual function.

For example:

obesity and diabetes can affect hormones and erection,

smoking can affect vascular and sperm health,

severe sleep disturbance can affect energy and desire,

and heavy alcohol use can impair both sexual performance and reproductive health.

The objective is not to promise that lifestyle correction will cure every infertility diagnosis.

It is to improve the biological environment and overall health.

The Unani Perspective on Infertility and Sexual Wellbeing

As a physician trained in Unani medicine, I find its **whole-person approach** particularly valuable when infertility has begun affecting both health and marital intimacy.

Classical Unani medicine considers health through concepts including:

Mizaj – individual temperament

and the four traditional humours:

Dam – blood
Balgham – phlegm
Safra – yellow bile
Sauda – black bile

These concepts belong to the traditional Unani explanatory framework.

They should not be equated directly with measurable modern variables such as:

testosterone, ovarian reserve, sperm DNA fragmentation or cortisol.

The purpose of responsible integrative care is not to pretend that the two systems use identical concepts.

It is to use the useful strengths of each appropriately.

Unani Medicine Recognizes Sexual and Psychological Factors

CCRUM's official guideline for **Zuf-i-Bah**, or sexual debility, specifically includes **Umūr Wahmiyya—psychological factors—**among traditional contributors to diminished sexual capability and desire.

This is particularly relevant in infertility.

A man with normal anatomy may develop situational ED.

A woman may lose sexual desire because sex has become associated with disappointment.

A couple may become emotionally disconnected.

Responsible Unani sexual healthcare should therefore consider **mind and relationship**, not merely prescribe an aphrodisiac.

Qillat-i Mani and Male-Factor Infertility in Unani Literature

CCRUM's Standard Unani Treatment Guidelines discuss **Qillat-i Mani**, traditionally corresponding broadly to reduced semen production or oligospermia, within the wider category of sexual debility.

Traditional management principles include attention to:

nutrition, general health, temperament and overall bodily function.

From my contemporary clinical perspective, these traditional ideas can guide a holistic assessment, but semen disorders should still be quantified through modern semen analysis.

A man should not be diagnosed as having low sperm count merely because his semen appears thin or because the quantity seems small.

Ilaj bil Ghiza – Dietotherapy

Dietotherapy is one of the useful components of Unani care.

In infertility practice, I consider nutritional status alongside:

body weight, diabetes, metabolic disease, micronutrient deficiency and general health.

A patient with obesity and insulin resistance needs a different diet from an undernourished patient.

The aim is not to feed every infertile man large quantities of sweet “sexual-strength” foods.

The aim is to build an appropriate nutritional environment for general and reproductive health.

Ilaj bit Tadbir – Regimenal and Lifestyle Care

Regimenal therapy can support:

physical activity, rest, sleep, stress management and regular daily habits.

This can be especially helpful for couples whose fertility journey has disrupted normal life.

A patient who is:

sleep deprived, chronically stressed, physically inactive and emotionally exhausted

may have poorer sexual wellbeing regardless of semen or ovulation results.

Here, traditional lifestyle principles and modern fertility care can work naturally together.

Asbab-e-Sitta Zarooriya

The Unani framework of **Asbab-e-Sitta Zarooriya**, or the Six Essential Factors, places importance on areas including:

air and environment, food and drink, movement and rest, psychological activity and repose, sleep and wakefulness, and retention/elimination.

These principles remind us that fertility does not occur in isolation from the person's general health.

For couples facing infertility, this encourages attention to:

nutrition, exercise, sleep, stress, emotional wellbeing and routine.

Those are valuable supportive interventions even though they do not replace fertility diagnosis or assisted reproduction where needed.

Ilaj bid Dawa – Unani Pharmacotherapy

Unani pharmacotherapy includes many single and compound formulations traditionally used for reproductive and sexual complaints.

However, treatment should follow the diagnosis.

A man with:

varicocele,

severe azoospermia,

genetic infertility,

pituitary disease,

or ejaculatory obstruction

does not simply need the same aphrodisiac medicine.

Likewise, a woman with:

bilateral tubal obstruction,

advanced endometriosis,

ovarian insufficiency,

or severe uterine disease

requires condition-specific care.

Traditional medicine is most useful when it is **individualized and medically integrated**.

What Does the Research Say About Unani Treatment for Oligospermia?

CCRUM's *Hippocratic Journal of Unani Medicine* published a comparative analysis involving **126 patients with idiopathic oligospermia** treated in several Unani studies. Improvements were reported in different semen parameters across treatment groups.

This is relevant because it shows that Unani infertility treatment has been subjected to clinical investigation.

However, the study was a **retrospective comparative analysis**, not a large modern multicentre placebo-controlled trial.

It also focused on semen parameters rather than definitive endpoints such as:

spontaneous pregnancy or live birth.

Therefore, the scientifically appropriate conclusion is:

Unani approaches to male infertility have clinically interesting evidence and deserve further high-quality research, but they should not be presented as universally proven fertility cures.

Semen Improvement Does Not Automatically Mean Pregnancy

This distinction is extremely important.

A treatment may improve:

sperm concentration, motility or morphology.

That is useful.

But pregnancy depends on both partners.

If the woman has bilateral tubal obstruction, improving sperm motility alone may not result in pregnancy.

If age-related ovarian reserve is severely reduced, waiting indefinitely for a male supplement to work can waste valuable reproductive time.

Therefore, treatment success should not be judged only by a semen report.

The couple's complete fertility picture matters.

Herbs, Antioxidants and "Natural Fertility Boosters"

Many botanical and nutritional products are marketed for fertility.

Some have preliminary research.

Some may influence sperm parameters.

But evidence quality varies substantially.

I avoid telling patients:

"This herb guarantees sperm production."

or

"This medicine opens blocked tubes naturally."

These statements exceed current evidence.

Traditional products should be:

properly identified, quality controlled and selected according to the patient rather than purchased indiscriminately.

What About Hijama or Wet Cupping?

The supplied research makes strong claims that Hijama can improve pelvic circulation, release toxins, rebalance hormones, treat anxiety and improve reproductive outcomes.

These claims need significant scientific qualification.

Hijama has a place within traditional Unani regimenal medicine, and some research has examined cupping for pain and general wellbeing.

However, a 2025 systematic review and meta-analysis of 72 randomized trials of cupping for pain found that **all included trials were judged to have a high risk of bias**. The review was about pain—not fertility—and does not establish that wet cupping increases sperm count, restores ovulation, raises pregnancy rates or improves live birth.

Therefore, I would not tell a fertility patient:

“Hijama will increase blood flow to the reproductive organs and cure infertility.”

Where a qualified Unani practitioner considers regimenal therapy appropriate for general wellbeing, it should remain an **adjunctive intervention**.

It must never delay evaluation of:

tubal disease, severe male-factor infertility, endocrine disease or other treatable reproductive conditions.

“Detoxification” Claims Require Caution

Another common claim is that wet cupping or herbal therapy “removes toxins” from the blood and thereby restores fertility.

There is currently no accepted clinical evidence that infertility in general is caused by an accumulation of unspecified toxins that can be physically extracted through the skin.

It is more scientifically accurate to focus on measurable risk factors:

smoking, alcohol, environmental exposures, obesity, diabetes, infection and medication effects.

Psychological Support Fits Naturally Within Integrative Unani Care

One area where I believe the holistic philosophy of Unani medicine is particularly compatible with modern infertility practice is psychological wellbeing.

A couple cannot be reduced to reproductive organs.

Stress, grief, fear, shame and relationship tension deserve attention.

CCRUM's recognition of psychological factors within sexual debility provides a traditional basis for discussing these issues, while modern evidence provides validated therapeutic methods such as counselling and CBT.

This is the kind of integration I consider clinically meaningful.

The Special Approach at Saira Health Care

At **Saira Health Care**, my aim is not to begin infertility treatment with the question:

“Which medicine should we give?”

I begin with:

“Why has pregnancy not occurred, and how is this fertility journey affecting both partners?”

My clinical approach considers both fertility and sexual health.

First: Evaluate Both Partners

I do not consider it appropriate to repeatedly investigate one partner while ignoring the other.

The woman's reproductive evaluation and the man's semen and reproductive evaluation should generally progress together.

This is consistent with contemporary ASRM/AUA guidance.

Second: Identify the Actual Fertility Factor

The goal is to determine whether the major contributor is:

ovulatory, tubal, uterine, male, sexual, mixed or unexplained.

That diagnosis determines treatment.

Third: Ask About Sexual Function

I specifically consider:

erection quality, ejaculation, sexual desire, intercourse frequency, penetration difficulty, pain during intercourse and whether conception pressure has changed the sexual relationship.

The newest 2026 international sexual-medicine recommendations strongly support including these questions in infertility care.

Fourth: Protect Mental Health

I ask about:

anxiety, depression, sleep, family pressure and the emotional effect of repeated unsuccessful cycles.

If significant psychological symptoms are present, counselling or mental-health referral should become part of the treatment plan.

WHO's latest infertility guideline explicitly supports ongoing psychosocial care.

Fifth: Reduce Unnecessary Performance Pressure

Couples should understand the fertile period without becoming prisoners of an exact timetable.

Frequent intercourse during the fertile week is generally more practical than creating an exact appointment with the bedroom.

For some couples, reducing pressure itself restores more normal sexual functioning.

Sixth: Treat Sexual Dysfunction Properly

A man with ED deserves an ED assessment.

A woman with painful intercourse deserves evaluation of the pain.

A patient with ejaculatory dysfunction deserves specific management.

Sexual disorders should not automatically be labelled:

“infertility stress”

without proper assessment.

Seventh: Integrate Unani Care Responsibly

Where appropriate, I consider:

Ilaj bil Ghiza, dietotherapy;

Ilaj bit Tadbir, lifestyle and regimenal management;

and **Ilaj bid Dawa**, appropriately selected Unani pharmacotherapy.

But these interventions should fit the patient's diagnosis.

They should not substitute for necessary:

imaging, hormonal investigation, semen analysis, surgery or assisted reproduction.

Eighth: Know When Referral or ART Is Needed

A responsible integrative physician must also recognize the limits of conservative treatment.

Some patients need:

reproductive urology,

gynaecological surgery,

ovulation treatment,

IUI,

IVF,

ICSI,

genetic counselling,

or other specialist care.

The WHO 2025 guideline specifically recommends progressive treatment according to diagnosis, patient preferences and clinical circumstances—from basic fertility promotion to more advanced therapies where necessary.

Integration does not mean delaying effective care.

Saira Health Care's Contribution to Sexual Disorders and Infertility

The connection between infertility and sexual dysfunction is especially relevant to the clinical focus of Saira Health Care.

A fertility clinic should not simply produce:

semen reports, hormone reports and ultrasound reports.

The patient also needs explanations.

The couple needs education.

Sexual dysfunction needs recognition.

My aim at Saira Health Care is to support an approach that combines:

accurate reproductive assessment, sexual-health evaluation, lifestyle care, appropriate Unani principles, patient education and referral when advanced fertility treatment is required.

One of the most important contributions a clinician can make is reducing fear.

The couple should understand that:

infertility is not proof of sexual inadequacy.

Erectile dysfunction does not automatically mean infertility.

Low sperm count does not mean impotence.

Female infertility does not mean loss of femininity.

Needing IVF is not a moral or personal failure.

These messages can themselves protect the relationship.

Protecting the Marriage During Fertility Treatment

I encourage couples to remember that they were partners before they became fertility patients.

Treatment should not consume every part of the marriage.

Continue to have conversations that are not about fertility.

Maintain affection that does not have to end in intercourse.

Allow sexual intimacy to exist at times when conception is not the goal.

Avoid blaming language.

Do not disclose private fertility information to relatives without your partner's agreement.

And remember:

you and your partner are on the same side.

When Family Pressure Becomes Harmful

In many communities, relatives begin asking about pregnancy soon after marriage.

Repeated questions such as:

“When are you giving us good news?”

can become extremely painful for a couple already undergoing fertility treatment.

Sometimes pressure escalates into:

blaming the woman, blaming the man, threats of remarriage or interference in medical decisions.

WHO explicitly recognizes infertility-related stigma, divorce, violence and emotional distress as important global health concerns.

Couples may need to establish boundaries around what information is shared with extended family.

Faith and Cultural Values Can Be Sources of Support

For many patients, spiritual belief is an important coping resource.

A responsible clinician should respect this.

Faith can provide:

meaning, patience, hope and emotional stability.

At the same time, infertility should not be presented as punishment, personal failure or evidence that one partner is spiritually deficient.

Medical treatment and spiritual coping do not need to oppose each other.

Frequently Asked Questions

Can infertility reduce sexual desire?

Yes.

Infertility-related stress, relationship strain, scheduled intercourse, painful treatment experiences and repeated disappointment can all reduce libido.

Sexual dysfunction is more common among people with infertility than among many fertile comparison groups.

Can infertility cause erectile dysfunction?

Infertility does not always directly cause ED, but fertility-related performance pressure can precipitate situational erectile difficulty in susceptible men.

The 2026 international recommendations recognize this relationship and recommend appropriate counselling and treatment.

Can erectile dysfunction itself cause infertility?

It can contribute when erection difficulty repeatedly prevents vaginal penetration or ejaculation inside the vagina.

A man can still have normal sperm production while experiencing ED.

Does low sperm count mean sexual weakness?

No.

Sperm production and erection are different physiological functions.

A man can have very low sperm concentration with completely normal libido and erections.

Does infertility mean the woman is responsible?

No.

Male factors, female factors or both may contribute.

Current AUA/ASRM guidelines emphasize simultaneous assessment of both partners.

Is timed intercourse useful?

It can be useful.

Cochrane evidence suggests urinary ovulation prediction probably modestly improves pregnancy and live-birth chances in some couples, particularly women under 40 trying for less than 12 months.

But exact timing can create psychological pressure, so the couple should not become obsessed with one particular hour.

Should we have intercourse every day during ovulation?

Daily intercourse is not mandatory.

Current sexual-medicine guidance recommends frequent intercourse at the couple's convenience during the fertile week and warns that overly precise scheduling can produce unnecessary stress.

Should a man avoid frequent ejaculation to “save sperm”?

Routine semen conservation is generally unnecessary for natural conception.

The 2026 ICSM guidance specifically states that frequent intercourse does not need to be avoided simply to conserve semen.

Laboratories may still give specific abstinence instructions before a semen analysis; follow those instructions for the test.

Can sildenafil or tadalafil be used while trying for pregnancy?

When medically appropriate, current evidence indicates that PDE5 inhibitors can be used in couples trying to conceive and have not been shown to reduce fertility outcomes.

They should still be prescribed appropriately because contraindications exist.

Can testosterone injections improve fertility?

Usually the opposite.

External testosterone can suppress sperm production and should generally be avoided in men actively seeking fertility unless managed for a very specific specialist indication.

Can counselling really help infertility-related sexual problems?

Yes.

Systematic reviews report improvements in sexual and marital satisfaction from counselling and psychological interventions in couples with infertility.

Can sex therapy improve female sexual function during infertility?

A 2026 systematic review and meta-analysis found improvement in sexual function following several interventions, with sex-therapy-based, counselling and psychotherapeutic approaches among those showing benefits.

Does stress itself make someone infertile?

Stress may affect sexual function, sleep, behaviour and general wellbeing, but it is usually inaccurate to say that stress alone explains infertility.

A complete fertility assessment remains necessary.

Can Unani medicine help infertility?

Unani medicine can make a meaningful **supportive and integrative contribution** through individualized diet, lifestyle regulation, sleep and stress management, general-health optimization and appropriately selected traditional pharmacotherapy.

CCRUM has also published clinical work investigating Unani treatments for oligospermia.

However, current evidence is not strong enough to claim that a particular Unani formulation universally cures male or female infertility or guarantees pregnancy.

Can Hijama cure infertility?

There is insufficient high-quality evidence to make that claim.

Hijama may be used within traditional regimenal practice for selected purposes, but available cupping research does not establish improved pregnancy or live-birth rates. A 2025 review of cupping studies for pain also found high risk of bias across the included trials.

It should not delay established fertility treatment.

Can Unani treatment improve sperm count?

Some Unani clinical research has reported improvements in semen parameters, including studies involving oligospermia.

But semen improvement should not automatically be interpreted as proven improvement in pregnancy or live-birth rates.

Is IVF the only treatment after infertility is diagnosed?

No.

Treatment depends on the cause.

WHO's 2025 guideline describes a progressive pathway from fertility education and simpler management through treatment of specific causes and, where necessary, IUI or IVF.

When Psychological Help Should Not Be Delayed

Infertility can be emotionally overwhelming.

Professional mental-health support should be considered promptly when a patient develops persistent depression or anxiety, repeated panic, severe insomnia, inability to function normally, major relationship breakdown, escalating conflict or hopelessness.

Thoughts of self-harm or suicide, threats or violence within the relationship require urgent professional help and safety support.

Seeking psychological care does not mean that infertility is “all in the mind.”

It means that mental health deserves treatment alongside reproductive health.

SAIRA HEALTH CARE
An ISO Certified Clinic
SEXUAL DISORDERS & INFERTILITY CENTER

A Message From Dr. Nizamuddin Qasmi

When a couple tells me:

“Doctor, trying for a baby has destroyed our sex life,”

I take that statement seriously.

It does not mean that the marriage is weak.

It often means that intimacy has been placed under enormous pressure.

The wife may be tired of monitoring every cycle.

The husband may be afraid that his erection will fail on the fertile day.

Both may be frightened by every negative pregnancy test.

Sex gradually stops feeling like closeness and begins feeling like an examination.

At that stage, simply prescribing another fertility medicine may not solve the entire problem.

I want to know:

What is the actual cause of infertility?

Have both partners been properly evaluated?

Is intercourse occurring frequently enough for conception?

Is there erectile or ejaculatory dysfunction?

Is the woman experiencing pain?

Has desire decreased?

Is the couple depressed or anxious?

Has family pressure become overwhelming?

Has intimacy become completely mechanical?

Only then can we build a complete treatment plan.

As a physician trained in Unani medicine, I value its emphasis on the **whole person**.

Diet matters.

Sleep matters.

Physical activity matters.

Psychological wellbeing matters.

Mizaj and individualized care are important within the traditional framework.

Ilaj bil Ghiza, Ilaj bit Tadbir and Ilaj bid Dawa may all contribute appropriately to an integrative treatment plan.

But responsible Unani practice also means understanding where modern reproductive medicine is essential.

A blocked tube cannot be wished open.

A significant genetic cause of azoospermia requires specialist evaluation.

A severely reduced ovarian reserve should not be ignored while months are lost on unsupported remedies.

A man seeking fertility should not unknowingly take testosterone and suppress his sperm.

And psychological distress should not be dismissed simply because laboratory reports are being treated.

At **Saira Health Care**, my objective is therefore broader than:

“Make the sperm count higher”

or

“Make ovulation happen.”

My goal is to understand the reproductive problem, protect sexual health, reduce unnecessary psychological burden and help the couple move through fertility treatment **together rather than against each other**.

Pregnancy is an important objective.

But preserving the couple's health, dignity, intimacy and relationship during that journey is equally important.

About the Author

Dr. Nizamuddin Qasmi

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BUMS – Hamdard University, Delhi
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Certificate in Infertility – MGBIMS, Delhi
Certificate in Urology – London, UK

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Integrated Sexual and Reproductive Health – ISRH, UNFPA

At **Saira Health Care**, the clinical focus includes individualized assessment of male and female infertility, sexual dysfunction and fertility-related relationship concerns, with an integrative approach that incorporates responsible Unani principles while recognizing the role of contemporary reproductive medicine, sexual medicine and psychological care.

Medical Disclaimer

This article is intended for **patient education and general health information**. It does not replace an individual fertility evaluation, semen analysis, gynaecological examination, hormonal investigation, mental-health assessment or personalized treatment plan.

Infertility can involve male, female, combined or unexplained factors. Both partners should be evaluated when appropriate.

Patients should not begin or discontinue hormonal fertility treatment, testosterone, erectile-dysfunction medicines or other prescription drugs without appropriate professional advice.

Unani medicines and other herbal or traditional therapies should be selected under qualified supervision. Evidence supporting individual traditional therapies varies considerably, and no responsible treatment should guarantee conception or live birth.