Male Infertility and Sperm Health: Complete Modern and Unani Understanding of Low Sperm Count, Motility, Morphology, DNA Fragmentation, Varicocele and Sexual Dysfunction

A Comprehensive Guide to Semen Analysis, Causes, Diagnosis, Treatment, Lifestyle, Sexual Health and Responsible Integrative Unani Care

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Introduction

When a couple has been trying for pregnancy without success, one of the most important messages I give them is that **infertility is not automatically a woman's problem**.

Male reproductive health deserves the same systematic attention as female fertility.

A man can have completely normal sexual desire, a strong erection and apparently normal semen and still have an important sperm problem. Conversely, a semen report containing one mildly abnormal value does not automatically mean that a man is infertile.

This distinction is essential.

The World Health Organization defines infertility as failure to achieve pregnancy after **12 months or more of regular unprotected sexual intercourse**. Globally, approximately **one in six people of reproductive age experience infertility during their lifetime**. WHO's 2025 infertility guideline reports that male factors contribute wholly or partly to a substantial proportion of infertility and emphasizes that male evaluation is an essential component of couple-based fertility care.

The detailed material prepared for this article appropriately identifies **semen analysis as the basic investigation in male reproductive medicine** and discusses sperm count, motility, morphology, DNA integrity, sexual dysfunction, varicocele and the Unani understanding of reproductive health.

However, modern evidence requires us to distinguish carefully between established treatments, promising supportive approaches and traditional claims that have not yet been confirmed in high-quality clinical studies.

As a physician working with sexual disorders and infertility, my aim at **Saira Health Care** is therefore not simply to "increase a sperm number." I want to understand **why the semen parameters are abnormal, whether natural conception remains realistic, whether the problem is reversible, whether sexual dysfunction is contributing, and where modern and Unani medicine can be integrated responsibly.**

What Is Male Infertility?

Male infertility means that a factor involving the male reproductive system is contributing to difficulty achieving pregnancy.

WHO identifies several broad causes. A man may have difficulty producing adequate sperm; sperm may be abnormal in concentration, movement or morphology; reproductive ducts may be obstructed; ejaculation may be impaired; or hormonal disorders may interfere with normal sperm production. Medical treatments such as chemotherapy, genital infections, varicocele, anabolic steroids and several lifestyle or environmental factors can also contribute.

Importantly, male fertility exists on a spectrum.

Except in specific situations such as confirmed azoospermia, semen analysis rarely provides a simple "fertile versus infertile" answer.

Fertility ultimately concerns **a couple**, because pregnancy also depends on the female partner's age, ovulation, fallopian tubes and reproductive health.

Male Factors May Be Present Even When Sexual Function Is Normal

Many men think:

"My erection is good and my sexual power is good, so my sperm must also be normal."

This is not necessarily true.

Erection is mainly a vascular, neurological and psychological process.

Sperm production occurs inside the testes and is regulated by hormonal, genetic and local testicular mechanisms.

A man can therefore have normal erections and severe oligozoospermia—or even azoospermia.

The opposite is also possible. A man may have erectile dysfunction while producing a perfectly adequate number of sperm.

For this reason, **sexual strength should never be used as a substitute for semen analysis** when infertility is being evaluated.

How Sperm Are Produced

Sperm production takes place inside the seminiferous tubules of the testes through a complex process called **spermatogenesis**.

The hypothalamus in the brain releases gonadotropin-releasing hormone. This stimulates the pituitary gland to produce FSH and LH.

LH stimulates Leydig cells in the testis to produce testosterone.

FSH, testosterone and Sertoli-cell function together support sperm development.

Developing sperm then pass through the epididymis, where further maturation occurs, before travelling through the vas deferens and eventually joining secretions from the prostate and seminal vesicles to form semen.

This means an abnormal semen report may originate from several different levels: hormonal signalling, the testicle itself, sperm maturation, reproductive-tract obstruction, accessory gland function or ejaculation.

That is why **cause-based diagnosis matters**.

Unani Understanding of Semen Formation

Classical Unani medicine describes reproduction through a different historical physiological system.

According to the source prepared for this article, semen or *Mani* is traditionally regarded as a highly refined product of nutrition and the successive stages of digestion involving the gastrointestinal system, liver, circulation and organs.

The Unani framework also evaluates the individual's **Mizaj**, or temperament, and the balance of *Dam*, *Balgham*, *Safra* and *Sauda*.

Traditional concepts such as **Quwwat-e-Tanasuliya**, *Quwwat-e-Muwallida*, *Qillat-e-Mani* and *Riqqat-e-Mani* are used to describe reproductive strength and semen-related disturbances.

These concepts have genuine historical and traditional importance.

However, they should not be interpreted as direct equivalents of testosterone concentration, sperm concentration, DNA fragmentation or another modern laboratory measurement.

A contemporary Unani physician can preserve these traditional concepts while using modern semen analysis to determine objectively what is happening.

Semen Analysis: The Most Important First Laboratory Test

The WHO's **sixth edition Laboratory Manual for the Examination and Processing of Human Semen**, published in 2021, remains the international reference for standardized semen examination. It provides standardized procedures for basic, extended and advanced laboratory assessment.

A typical semen analysis evaluates semen volume, sperm concentration, total sperm number, motility, vitality and morphology.

But the numbers need careful interpretation.

WHO emphasizes that semen values should **not be treated as a rigid border between fertile and infertile men**. They describe distributions found in men whose partners achieved natural pregnancy.

This is one of the most important facts for patients to understand.

WHO 2021 Semen Reference Values

Current WHO sixth-edition lower fifth-centile values are approximately:

Semen parameter	WHO 2021 lower fifth centile
Semen volume	**1.4 mL**
Sperm concentration	**16 million/mL**
Total sperm number	**39 million per ejaculate**
Total motility	**42%**
Progressive motility	**30%**
Vitality	**54% live sperm**
Normal morphology	**4%**

These values are current reference figures used for laboratory interpretation, but they are **not absolute fertility cut-offs**. A man slightly below one value can still father a pregnancy, while a man above every threshold may still face fertility difficulty.

This corrects one detail in the supplied background, which lists sperm concentration as 15 million/mL. The current WHO sixth-edition fifth-centile value is approximately **16 million/mL**.

Why One Semen Report Should Not Define a Man

Semen parameters can vary substantially from sample to sample.

Fever, incomplete collection, abstinence duration, recent illness, laboratory technique and biological variation can influence the result.

WHO's 2025 infertility guideline now gives particularly practical advice: when one or more semen parameters are outside WHO reference ranges, it suggests **repeating semen analysis after at least 11 weeks**. When all parameters are within reference ranges, routine repetition is generally not suggested.

This interval is useful because sperm production takes time.

A man should therefore not panic after one borderline report, but a significantly abnormal finding should also not be ignored.

What Is Oligozoospermia?

Oligozoospermia means reduced sperm concentration.

The severity matters.

A man whose concentration is slightly below the WHO fifth centile is clinically very different from someone with only a tiny number of sperm detectable.

Severe oligozoospermia may warrant hormonal and genetic evaluation depending on the findings.

Possible causes include varicocele, testicular dysfunction, endocrine abnormalities, previous undescended testis, infection, toxic exposure, chemotherapy, certain drugs and genetic factors.

Sometimes no clear cause is identified.

This is called **idiopathic male infertility**.

What Is Azoospermia?

Azoospermia means that no sperm are detected in the ejaculate after appropriate laboratory examination.

It is a finding—not one single disease.

There are two major clinical mechanisms.

In **obstructive azoospermia**, sperm production may be relatively preserved but sperm cannot reach the ejaculate because of a blockage.

In **non-obstructive azoospermia**, sperm production inside the testes is severely impaired.

These conditions require very different management.

Therefore, a patient with zero sperm should **not** simply be given a general sperm-producing medicine for several months without identifying the mechanism.

Hormonal testing, examination, genetic investigation and specialized assessment may be required.

In selected men, sperm can sometimes be surgically retrieved and used with ICSI even when none are found in the ejaculated semen.

What Is Asthenozoospermia?

Asthenozoospermia refers to reduced sperm motility.

Sperm need appropriate forward movement to reach the egg naturally.

However, motility should never be interpreted by itself.

A man with 25% progressive motility but a very high total sperm number may have a very different reproductive potential from a man with 25% motility and an extremely low sperm concentration.

The clinically useful concept is therefore the **overall semen profile**, not one isolated number.

What Is Teratozoospermia?

Teratozoospermia refers to a low percentage of sperm with conventionally normal morphology.

Modern strict morphology criteria are demanding. The WHO lower reference figure is around **4% normal forms**, meaning it is perfectly possible for most sperm in a fertile man's sample to be classified as morphologically abnormal.

For this reason, men are often unnecessarily frightened by morphology reports.

Morphology is one component of semen assessment. It does not by itself determine whether pregnancy is possible.

The supplied background correctly identifies morphology as an important semen characteristic, but some of the very precise claims relating morphology percentages directly to fertilization or implantation should not be generalized to every couple.

Semen Volume Is Not the Same as Sperm Count

A man may produce a large amount of semen but have relatively few sperm.

Another may produce a smaller volume but have adequate sperm concentration and total sperm number.

Most ejaculate volume comes from accessory glands rather than directly from the testes.

Persistently very low semen volume can sometimes suggest incomplete collection, retrograde ejaculation, ejaculatory-duct obstruction or other reproductive-tract problems.

This is another reason appearance alone is unreliable.

Thin Semen Does Not Automatically Mean Weak Sperm

The Unani term **Riqqat-e-Mani** traditionally describes an abnormally thin semen pattern.

It is useful as part of the patient's symptom history.

However, a man cannot determine sperm count or motility by looking at semen.

A watery appearance does not prove oligozoospermia.

Thick semen does not prove high fertility.

Modern semen analysis provides the objective answer.

At Saira Health Care, I therefore respect the traditional symptom description but combine it with laboratory evaluation whenever fertility is the concern.

What Is Sperm DNA Fragmentation?

Standard semen analysis evaluates sperm number, movement and appearance.

It does not directly measure the integrity of DNA carried inside sperm.

Sperm DNA fragmentation, or SDF, refers to breaks or damage within sperm DNA.

Elevated SDF has been associated with reduced natural conception and poorer reproductive outcomes in some populations, including recurrent pregnancy loss and some assisted-reproduction failures. Smoking, varicocele, infection, age and other factors may contribute.

But this does **not** mean every infertile man needs an SDF test.

DNA Fragmentation Testing Is Not a Routine First Test

The AUA/ASRM guideline specifically advises that sperm DNA fragmentation analysis **should not routinely be performed in the initial evaluation of an infertile couple**.

It may become useful in selected circumstances, such as unexplained infertility, recurrent pregnancy loss, repeated assisted-reproduction failure or particular clinical concerns.

EAU guidance similarly treats SDF as a more specialized investigation rather than a universal first-line test.

This is important because advanced tests can add considerable cost and anxiety without necessarily changing treatment.

A sophisticated test should be ordered because its result may influence a decision—not simply because it exists.

Oxidative Stress and Sperm

Sperm membranes contain lipids that are vulnerable to oxidative damage.

Reactive oxygen species at normal physiological levels have roles in sperm function, but excessive oxidative stress may interfere with sperm membranes, motility and DNA integrity.

Smoking, inflammation, varicocele and several metabolic or environmental conditions have been investigated as contributors.

The supplied background discusses “male oxidative stress infertility” and advanced oxidative-stress testing.

The concept is scientifically relevant, but testing and treatment are still evolving.

Oxidative stress should therefore not become a label used to sell every infertile man a large antioxidant package.

Do Antioxidants Improve Male Infertility?

This area is particularly important because antioxidant supplements are heavily marketed.

The latest **WHO infertility guideline, published in November 2025, did not make a recommendation either for or against antioxidant supplements** in infertile men with semen parameters outside the WHO reference ranges because the evidence was not sufficiently certain.

AUA/ASRM similarly states that the benefits of vitamins and antioxidants are of **questionable clinical utility**, and evidence is insufficient to recommend specific agents routinely.

EAU guidance also describes the evidence as conflicting and does not recommend routine antioxidant treatment for all men with idiopathic infertility.

This does not mean nutrition is unimportant.

It means that **food quality and correction of genuine deficiencies should not be confused with taking multiple high-dose antioxidant pills without a diagnosis**.

Natural Foods That Support Male Reproductive Health

A balanced diet containing adequate protein, vegetables, fruits, whole grains, pulses, nuts and healthy fats is sensible for general and reproductive health.

Traditional Unani dietotherapy—**Ilaj-bil-Ghiza**—also places strong emphasis on appropriate nourishment.

The supplied Unani material describes foods such as milk, eggs, nuts, dates, pomegranate and other nutrient-dense foods within traditional categories such as *Muwallid-e-Mani* and *Mughalliz-e-Mani*.

These foods can be useful components of a nutritious diet when suitable for the patient.

However, I do not tell men:

“Eat walnuts and your sperm count will definitely become normal.”

Nutrition provides biological support.

It cannot correct every genetic, hormonal, obstructive or testicular problem.

Unani Pharmacotherapy and Male Fertility

Unani medicine contains a substantial pharmacopoeia traditionally used for male sexual and reproductive disorders.

The supplied source discusses **Asgand (*Withania somnifera*), Tukhm-e-Konch (*Mucuna pruriens*), Kalonji (*Nigella sativa*) and Aqarqarha (*Anacyclus pyrethrum*)** in this context.

These plants contain biologically active compounds, and several have been studied experimentally or in small human trials.

However, promising biological activity does not mean they are established treatments for every type of male infertility.

Results may depend on preparation, dose, manufacturing quality, diagnosis and the population being studied.

At Saira Health Care, my preferred approach is therefore **individualized, physician-supervised Unani treatment after understanding the semen abnormality and likely cause**, rather than giving all men the same fertility herb.

Asgand and Male Fertility

Asgand or Ashwagandha has traditionally been used as a *Muqawwi-e-Bah* and reproductive tonic.

Some clinical research has reported changes in semen parameters or stress-related measures.

This is encouraging, but current international infertility guidelines do not regard Asgand—or any individual herbal supplement—as a proven universal treatment for oligozoospermia, asthenozoospermia or azoospermia.

I therefore view it as a **potential supportive agent in appropriately selected patients**, not as a replacement for diagnostic evaluation.

Kalonji, Konch and Other Traditional Medicines

Kalonji contains thymoquinone and has antioxidant and anti-inflammatory properties of research interest.

Mucuna pruriens contains L-DOPA and has also been studied in male reproductive medicine.

But there is a major difference between saying that an herb has pharmacological activity and saying that it **reliably increases live-birth rates**.

The latter requires stronger clinical evidence.

This distinction is especially important in infertility because the final outcome is not merely an improved laboratory value—it is achieving a healthy pregnancy.

A Note About Dr. Qasmi's Individualized Unani Formulations

The supplied background discusses specialized formulations used in Dr. Qasmi's clinical practice for different male reproductive and sexual-health complaints.

At Saira Health Care, I believe such treatment should always remain **diagnosis-based**.

A formulation intended to support semen quality should not be represented as a proven cure for all forms of azoospermia.

A medicine intended to support erections does not automatically increase sperm count.

Treatment for premature ejaculation is not equivalent to infertility treatment.

The exact therapeutic objective therefore needs to be identified before treatment begins.

Testosterone: One of the Most Important Fertility Warnings

Some men take testosterone injections, gels or bodybuilding hormones because they believe more testosterone must produce more sperm.

The opposite can happen.

External testosterone suppresses pituitary LH and FSH and can significantly reduce or completely suppress sperm production.

AUA/ASRM clearly states that **testosterone monotherapy should not be prescribed to men who wish to preserve current or future fertility**.

Anabolic steroids can have a similar effect.

Any man planning a child should tell his fertility physician about testosterone injections, “muscle-building” hormones and performance-enhancing drugs.

This simple discussion can sometimes identify the cause of severe oligozoospermia or azoospermia.

Hormonal Testing in Male Infertility

Not every man requires a very large hormone panel.

Hormonal tests are selected according to semen findings, examination and symptoms.

FSH and testosterone are particularly useful when sperm concentration is markedly low or sperm are absent, and in men with symptoms suggesting endocrine disease.

Additional LH, prolactin or other endocrine tests may then be selected according to those findings.

The key principle is the same as elsewhere in fertility medicine:

test because there is a clinical question—not merely because a test is available.

Genetic Causes of Male Infertility

Some severe male infertility has a genetic basis.

Men with very low sperm production or azoospermia may require selected testing for chromosomal abnormalities or Y-chromosome microdeletions.

Men with congenital absence of the vas deferens may require testing involving the **CFTR gene**, because this can have implications for future children.

AUA/ASRM recommends CFTR-related testing in appropriate men with vasal agenesis or idiopathic obstructive azoospermia and partner testing when a relevant mutation is identified.

This is an important example of why fertility treatment is not simply about improving a semen report.

Sometimes the evaluation protects the future child as well.

Varicocele and Male Infertility

A **varicocele** is enlargement of veins within the pampiniform plexus surrounding the testicle.

It is common.

EAU reports that varicocele occurs in approximately 15% of the general male population and in a higher proportion of men presenting with abnormal semen parameters or infertility.

Possible mechanisms include increased scrotal temperature, disturbed testicular microenvironment and oxidative stress.

But not every varicocele causes infertility.

This is crucial.

What Kind of Varicocele Needs Treatment?

The latest WHO infertility guideline suggests **surgical or radiological treatment rather than expectant management for infertile men with a clinical varicocele**, particularly when semen parameters are abnormal. The recommendation is conditional because certainty of evidence is limited.

EAU gives a stronger recommendation for treatment when there is a **clinical varicocele, abnormal semen analysis and otherwise unexplained infertility**, provided the female partner has reasonable reproductive potential.

AUA/ASRM advises against varicocelectomy for a **non-palpable varicocele detected only on imaging**.

This is why treatment should not be decided solely because an ultrasound says “mild varicocele.”

The man, semen analysis and couple must all be considered.

Can Varicocele Be Permanently Treated With Medicines Alone?

Current international guidelines do **not** establish oral medicine, massage, yoga, cupping or leech therapy as methods that reliably correct the abnormal veins of a clinically significant varicocele.

The supplied document describes Irsal-e-Alaq, cooling measures, herbs and other traditional approaches for varicocele.

These descriptions are useful for understanding traditional practice, but they should not be presented as clinically equivalent to procedures that physically interrupt abnormal venous reflux.

The 2025 WHO infertility guideline specifically evaluates **surgical and radiological treatment** for infertility associated with clinical varicocele.

This does not mean supportive Unani treatment has no place.

Lifestyle counselling, symptom support and general reproductive-health optimization may be used where appropriate—but patients should understand the difference between **supporting symptoms and correcting abnormal veins**.

Scrotal Heat and Sperm Health

The testes are located outside the abdominal cavity partly because sperm production functions best at a temperature below core body temperature.

Repeated substantial heat exposure can adversely affect spermatogenesis in some men.

Varicocele itself may increase local testicular temperature.

Men with abnormal semen parameters may therefore be advised to avoid unnecessary prolonged high-heat exposure, particularly repeated hot tubs or extreme occupational heat.

However, fertility counselling should remain sensible.

There is no need to create fear around every warm shower or every pair of trousers.

The overall evidence for many everyday heat exposures is less certain than internet discussions often suggest.

Smoking and Male Fertility: Important New 2026 Evidence

This is one of the clearest modifiable issues.

On **8 September 2026**, WHO published an updated technical summary specifically on tobacco and infertility.

WHO reviewed evidence involving more than 60,000 men and reports associations between smoking and **semen abnormalities, erectile dysfunction, ejaculatory problems, poor sperm motility and abnormal morphology**. It also warns that second-hand smoke may negatively affect fertility.

If a man asks me:

“Which antioxidant should I take?”

but continues to smoke daily, stopping tobacco deserves far greater priority than searching for another supplement.

Smoking cessation is a genuine reproductive-health intervention.

Alcohol, Obesity and Physical Activity

WHO recognizes smoking, excessive alcohol consumption and obesity among lifestyle factors associated with infertility.

EAU similarly advises infertile men to address obesity, low physical activity, smoking and high alcohol intake because these factors are associated with poorer sperm quality and testosterone profiles.

This does not mean every abnormal semen report is caused by lifestyle.

But improving metabolic health, maintaining appropriate body weight, exercising regularly, reducing heavy alcohol consumption and avoiding tobacco can support both fertility and long-term cardiovascular health.

Male reproductive medicine should improve **the man's health**, not only his sperm count.

Sexual Dysfunction and Male Infertility

A couple may have reasonable sperm production but still fail to conceive naturally because intercourse is not occurring effectively.

This can happen with erectile dysfunction, severe premature ejaculation before penetration, delayed ejaculation, anejaculation or retrograde ejaculation.

Sexual dysfunction is therefore not separate from fertility medicine.

The supplied source correctly emphasizes that erectile and ejaculatory problems can create a mechanical and psychological barrier to conception.

Because my focused practice includes both **sexual disorders and infertility**, this relationship is especially important at Saira Health Care.

Erectile Dysfunction and Fertility

Erectile dysfunction means persistent difficulty achieving or maintaining an erection sufficient for satisfactory sexual activity.

It does not automatically mean the man is infertile.

But if vaginal intercourse cannot occur reliably, natural conception becomes difficult.

ED may be related to diabetes, vascular disease, medications, hormonal problems, neurological disease, relationship factors or performance anxiety.

A man seeking fertility treatment who also has ED deserves evaluation of both problems.

Simply prescribing a semen tonic would miss the main barrier to conception.

Premature Ejaculation and Fertility

Premature ejaculation usually does **not** reduce sperm quality.

If ejaculation takes place inside the vagina, conception remains possible.

However, extremely severe premature ejaculation occurring consistently before vaginal penetration can interfere with sperm deposition.

Timed intercourse can also worsen ejaculation problems because the man feels pressured to perform during the predicted fertile period.

The Unani term **Surat-e-Anzal** has historically been used for premature ejaculation, while classical concepts may relate it to altered temperament or impaired *Quwwat-e-Masika*.

Modern treatment adds behavioural, psychological and pharmacological approaches when indicated.

The best treatment depends on the individual man rather than simply trying to “thicken semen.”

The ED–PE–Infertility Cycle

Some men with erectile difficulty hurry intercourse because they fear losing the erection.

This can contribute to rapid ejaculation.

Other men with premature ejaculation deliberately reduce their level of arousal to delay climax and subsequently lose the erection.

When pregnancy is desired, ovulation schedules may add further psychological pressure.

This can create a cycle:

fertility pressure → sexual anxiety → poor sexual performance → unsuccessful intercourse → more fertility pressure.

Counselling can be extremely valuable here.

The objective is not to tell the man that the problem is imaginary.

It is to recognize that sexual physiology and psychological state interact.

Morning Erections and Male Health

Morning erections can provide some information about normal erectile physiology.

Frequent spontaneous erections during sleep suggest that vascular and neurological pathways remain functional.

However, the absence of a morning erection on some days does **not diagnose low testosterone, infertility or vascular disease**.

Sleep quality, stress, age and many other factors influence nocturnal erections.

The supplied material emphasizes morning erections as a potential clue to male sexual and vascular function.

I consider it one part of the clinical history—not a fertility test.

Unani Medicine and Male Sexual/Reproductive Health

The Unani system offers a highly individualized approach to male reproductive health.

Traditional assessment may consider **Mizaj**, *Quwwat-e-Bah*, *Quwwat-e-Muwallida*, semen characteristics, diet, digestion, sleep, emotional state and general constitution.

Therapeutic approaches may involve **Ilaj-bil-Ghiza** (dietotherapy), **Ilaj-bil-Dawa** (pharmacotherapy) and **Ilaj-bil-Tadbeer** (regimenal therapy).

I consider the holistic nature of this approach particularly valuable.

But a responsible twenty-first-century Unani physician should combine this framework with semen analysis, modern examination and appropriate investigations instead of treating traditional and modern diagnoses as interchangeable.

How Unani Medicine Can Be Very Useful in Male Infertility Care

The strongest contemporary role of Unani medicine is in **individualized supportive reproductive care**.

This may include optimization of diet and nutrition, correction of unhealthy lifestyle patterns, attention to sleep and digestion, management of general weakness, improvement of sexual wellbeing and carefully selected physician-supervised herbal or compound medicines according to the patient's traditional assessment.

For some men whose infertility involves modifiable lifestyle and functional factors, this type of comprehensive care can be especially useful.

But its limits must also be respected.

A herbal formulation cannot replace genetic counselling in a man with a major chromosome abnormality.

A sexual tonic cannot mechanically correct an obstructed reproductive duct.

No medicine should be promised to produce sperm in every man with non-obstructive azoospermia.

The true strength of Unani medicine lies in using it **where its supportive and individualized qualities can add value**.

Ilaj-bil-Tadbeer and Regimenal Therapies

Traditional Unani practice includes regimenal approaches such as Dalk, Hijama and other procedures.

The supplied material discusses these therapies for circulation, humoral balance and reproductive health.

These methods may have roles in traditional supportive care or general wellbeing.

However, current infertility guidelines do not establish cupping, massage or detoxification procedures as replacements for treatment of azoospermia, severe oligozoospermia or varicocele.

This distinction is important.

When regimenal therapy is used, it should be **adjunctive rather than a substitute for necessary andrological treatment**.

Why "Detoxifying Sperm" Is Not a Precise Medical Concept

The term "detox" is widely used in fertility marketing.

Modern male infertility may involve oxidative stress, infection, smoking, environmental exposures or metabolic disease, but these are specific biological conditions.

A general statement that "toxins are blocking sperm" is not sufficiently precise.

Similarly, the traditional Unani concept of eliminating abnormal humoral material should not automatically be translated into claims that a therapy has removed sperm DNA fragmentation or reactive oxygen species.

The systems use different concepts.

Responsible integration requires respecting that difference.

When Medicines Are Not Enough

There are situations in male infertility where procedures or assisted reproduction may be required.

An obstructive problem may require reconstructive treatment or surgical sperm retrieval.

Severe non-obstructive azoospermia may require specialized testicular sperm retrieval in selected men.

A clinically significant varicocele may be considered for surgical or radiological correction.

When usable sperm are available but natural fertilization is unlikely, IUI, IVF or ICSI may be considered depending on the entire couple's reproductive findings.

WHO's 2025 infertility guideline specifically emphasizes progressing fertility treatment according to **diagnosis, clinical findings and patient preferences** rather than using the same treatment for everyone.

When Is ICSI Useful?

Intracytoplasmic sperm injection, or **ICSI**, involves injecting one sperm directly into an egg during assisted reproductive treatment.

It can be extremely useful in selected severe male-factor infertility cases.

However, ICSI should not be viewed as evidence that male evaluation no longer matters.

Understanding the cause of severe male infertility may identify genetic implications, reversible conditions or health problems important to the man himself.

Sometimes treating the male factor may even reduce the intensity of reproductive treatment required by the female partner.

This is another reason comprehensive male evaluation remains important even in the era of IVF.

Preparing a Man Before Fertility Treatment

Before recommending treatment, I want to know whether the man smokes, drinks excessively, uses anabolic steroids, has diabetes or obesity, experiences significant heat exposure, has had previous genital surgery or infection, takes medicines affecting reproduction or has signs of a varicocele.

I also want to know whether intercourse is occurring effectively.

These factors may be as important as selecting another supplement.

Preconception fertility preparation should therefore involve **both partners**.

WHO's latest infertility guideline recommends healthy diet, physical activity and tobacco cessation as part of fertility promotion.

Psychological Effects of Male Infertility

A low sperm count can have a profound emotional effect on a man.

Some immediately interpret it as loss of masculinity.

Others withdraw from their partner.

Some become obsessed with semen volume, erection quality or repeated laboratory testing.

Infertility can cause anxiety, depression and social isolation, and WHO's 2025 guideline emphasizes ongoing psychosocial support for people affected.

Male infertility counselling should therefore explain very clearly:

Sperm count is not masculinity. Fertility is not sexual worth. And infertility is a medical problem—not a moral judgment.

This type of counselling can itself improve the couple's ability to cope with treatment.

Dr. Nizamuddin Qasmi's Specialized Approach to Male Infertility

When a patient comes to me at **Saira Health Care** with an abnormal semen report, I do not immediately prescribe a single “sperm-increasing” medicine.

My first objective is to classify the problem properly.

Is the main issue concentration?

Motility?

Morphology?

Semen volume?

Azoospermia?

Sexual dysfunction?

Varicocele?

A hormonal abnormality?

Previous infection?

Medication or testosterone exposure?

Or is the semen report only mildly abnormal while a more important female fertility factor is present?

I also review the man's age, previous fertility, medical illnesses, genital surgery or injury, sleep, smoking, alcohol, physical activity, body weight and occupational exposures.

When appropriate, I evaluate hormone reports and recommend additional andrological or genetic assessment.

Only after understanding this background do I consider where **Unani treatment, nutrition, lifestyle modification or modern medical/surgical treatment** fits.

What "Special Treatment" Means at Saira Health Care

For me, special treatment means **personalized treatment rather than one medicine for everyone**.

A man with mild oligozoospermia, poor lifestyle and nutritional problems requires a different plan from a man with complete azoospermia.

A man with varicocele requires a different strategy from someone with an endocrine disorder.

A man whose primary problem is premature ejaculation requires different care from someone with severe spermatogenic failure.

A man taking external testosterone requires withdrawal and specialist endocrine/reproductive planning—not simply additional sperm tonics.

The Unani component of treatment can include individualized dietotherapy, lifestyle regulation and selected physician-supervised pharmacotherapy where suitable.

But modern investigation tells us **which problem we are actually trying to treat**.

That combination is central to my approach.

Contribution of Saira Health Care in Male Sexual Disorders and Infertility

Male reproductive disorders are frequently associated with embarrassment.

Many men delay consultation because they do not want to discuss semen, erections or ejaculation.

Others purchase medicines online because they are uncomfortable undergoing a semen test.

At **Saira Health Care**, our goal is to create a professional and confidential environment in which these problems can be discussed without judgment.

Our work in sexual disorders and infertility includes counselling regarding semen analysis, sperm concentration, motility and morphology; assessment of sexual dysfunction; fertility lifestyle education; review of relevant investigations; and individualized treatment planning.

Where Unani supportive treatment is suitable, it may be incorporated responsibly.

Where the patient requires hormonal, genetic, urological, surgical or assisted-reproductive evaluation, this should be recognized promptly.

The objective is not simply to keep prescribing medicine.

The objective is **to find the most realistic path toward conception**.

Important Scientific Clarifications About the Supplied Male-Fertility Material

The background document contains valuable traditional concepts and useful discussion topics, but several points should be modified before website publication.

The current WHO sixth-edition lower fifth-centile sperm concentration is approximately **16 million/mL rather than 15 million/mL**.

WHO semen figures should not be called strict fertile/infertile thresholds. WHO specifically emphasizes that semen analysis assists interpretation of male reproductive function but cannot alone define a couple as fertile or infertile.

Sperm DNA fragmentation is a specialized test and is **not recommended routinely in the initial infertility evaluation**.

The effectiveness of routine antioxidant supplementation remains uncertain; WHO did not make a recommendation for or against it in its 2025 infertility guideline.

Most importantly, traditional approaches such as **leech therapy, Hijama, purgation, yoga or herbs should not be presented as clinically validated substitutes for surgical or radiological treatment of infertility-associated clinical varicocele**. Current WHO, AUA/ASRM and EAU guidelines support appropriately selected procedural treatment for relevant clinical varicocele.

Making these distinctions improves the scientific credibility of an integrative Unani article rather than diminishing traditional medicine.

Frequently Asked Questions

What is the normal sperm count?

The WHO sixth-edition lower fifth-centile sperm concentration is approximately **16 million sperm/mL**, while the lower fifth-centile total sperm number is about **39 million per ejaculate**. These are reference values—not absolute fertile/infertile boundaries.

Is sperm concentration of 15 million automatically infertility?

No. Fertility depends on the entire semen profile and female factors as well. One value alone cannot determine fertility.

What is normal sperm motility?

WHO's lower fifth-centile values are approximately **42% total motility and 30% progressive motility**.

Is 4% normal morphology very bad?

Not necessarily. Approximately 4% normal forms is itself the WHO lower fifth-centile reference figure under strict morphology assessment. Morphology must be interpreted with sperm number, motility and the rest of the couple's findings.

Should an abnormal semen test be repeated?

Yes, in many cases. WHO's 2025 guideline suggests repeat semen analysis after **at least 11 weeks** when one or more semen parameters are outside WHO reference ranges.

Does thick semen mean high sperm count?

No. Semen consistency cannot tell you sperm concentration.

Can a man with low sperm count become a father naturally?

Yes, depending on the degree of abnormality, motility, total sperm number and the female partner's fertility. Severe cases deserve specialist evaluation.

Can azoospermia be treated?

Sometimes. Treatment depends on whether azoospermia is obstructive or non-obstructive and on the underlying cause. Some men may have surgically retrievable sperm even when none appear in the ejaculate.

Can testosterone increase sperm count?

No. External testosterone can suppress spermatogenesis and should not be used as testosterone monotherapy in men wishing to preserve fertility.

Can smoking affect sperm?

Yes. WHO's September 2026 evidence review associates smoking with semen abnormalities and male sexual dysfunction.

Are antioxidants necessary for all infertile men?

No. Evidence remains uncertain. WHO did not recommend either for or against routine antioxidant supplementation because available evidence was insufficient.

Should every infertile man undergo sperm DNA fragmentation testing?

No. AUA/ASRM does not recommend SDF testing as part of the routine initial infertility evaluation. It may be useful in selected situations.

Does varicocele always require surgery?

No. Treatment depends on whether the varicocele is clinically palpable, whether semen is abnormal and on the couple's infertility situation. Imaging-only subclinical varicoceles generally should not be repaired solely for infertility.

Can Unani medicine help male infertility?

Yes, particularly as **individualized supportive treatment** involving diet, lifestyle, sexual health, constitutional assessment and selected physician-supervised Unani medicines. However, its role depends on the cause and it should not delay genetic, hormonal, surgical or assisted-reproductive care when needed.

Can Unani medicine treat erectile dysfunction and infertility together?

These conditions may coexist, and individualized treatment can address both. However, improving erection does not automatically improve sperm production, so each problem needs separate assessment.

Can Hijama or massage increase sperm count?

There is insufficient high-quality evidence to state that Hijama or massage reliably increases sperm concentration or live-birth rates. They should not replace proven male fertility evaluation.

Can leech therapy cure varicocele?

Current international infertility guidelines do not establish leech therapy as a method for correcting the abnormal venous reflux of varicocele. Appropriate clinical varicocele is managed according to evidence-based urological or interventional options.

My Final Message to Men With Fertility Problems

Whenever a man comes to me with a semen report, I tell him:

Do not judge your fertility from one number—and do not judge your masculinity from your sperm count.

If sperm concentration is low, we need to understand why.

If motility is poor, we need to look at the complete semen profile and the clinical history.

If morphology appears abnormal, we need to interpret it correctly rather than panic about a percentage.

If sperm are completely absent, we must determine whether the problem is obstruction or sperm production.

If you have a varicocele, we need to determine whether it is clinically significant.

If you smoke, stopping tobacco is one of the most valuable fertility interventions available.

If you are taking testosterone or anabolic steroids, tell your doctor because these can profoundly suppress sperm production.

If intercourse is difficult because of erectile dysfunction or premature ejaculation, address that problem openly rather than hiding it.

And if you have already spent months taking antioxidants or fertility tonics without knowing the cause, it may be time to investigate rather than simply add another product.

My Unani training teaches me to look beyond the laboratory report—to consider **Mizaj, diet, digestion, sleep, physical activity, psychological state, sexual health and the overall constitution of the patient**. The traditional material prepared for this article reflects this broad view, emphasizing the systemic nature of semen formation and the role of dietotherapy and pharmacotherapy in reproductive health.

Modern andrology gives us an equally important set of tools: standardized semen analysis, hormonal testing, genetic evaluation, ultrasound when indicated, treatment of clinical varicocele, sperm retrieval and assisted reproduction.

I believe the best care comes from understanding the strengths and limitations of both.

At **Saira Health Care**, my objective is therefore not simply to make the sperm count on a report appear larger.

My objective is to **identify the cause, improve reversible factors, treat associated sexual disorders, use individualized Unani supportive treatment where suitable, and guide the couple toward the safest and most realistic route to pregnancy.**

Male infertility is often treatable or manageable.

But successful treatment begins with the correct diagnosis.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi
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Dr. Nizamuddin Qasmi's work at **Saira Health Care** focuses on sexual disorders and infertility, including semen abnormalities, male reproductive problems, erectile and ejaculatory disorders, fertility counselling and individualized integrative treatment.

Medical Disclaimer

This article is intended for **general medical education and public awareness**. It does not constitute an individual diagnosis, prescription or guarantee of pregnancy.

Male infertility can result from hormonal, genetic, structural, infectious, testicular, sexual, lifestyle or unexplained causes. Treatment therefore needs to be individualized.

Unani medicines, herbal supplements, antioxidants, Hijama, massage, leech therapy or other complementary approaches should not be used to delay necessary hormonal, genetic, urological, surgical or assisted-reproductive evaluation.

Patients with azoospermia, severe oligozoospermia, testicular abnormalities, infertility-associated clinical varicocele, recurrent pregnancy loss, previous chemotherapy, significant endocrine disease or persistent sexual dysfunction should seek appropriate specialist assessment.