

Coping With an Infertility Diagnosis

Understanding the Diagnosis, Protecting Your Relationship, Managing Emotional Stress and Moving Forward With Hope

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Introduction

When I tell a patient or a couple that their investigations suggest infertility, I am very conscious that I am not simply discussing a laboratory report.

I am speaking about something connected with their dreams, marriage, family, expectations, emotions and future.

For many couples, hearing words such as **“low sperm count,” “blocked tubes,” “poor ovarian reserve,” “anovulation,” “azoospermia,” “PCOS,” “endometriosis,”** or even **“unexplained infertility”** can be emotionally overwhelming.

Some patients become silent.

Some immediately ask:

“Doctor, will we ever have a child?”

Others begin blaming themselves.

A husband may secretly think:

“I have failed my wife.”

A wife may think:

“Perhaps I am responsible for everything.”

Family members may unintentionally increase the pressure by repeatedly asking when the couple will have a baby.

My first message to such patients is very important:



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An infertility diagnosis is medical information. It is not a judgment about your worth, masculinity, femininity, marriage or value as a human being.

Infertility is a recognised reproductive-health condition affecting millions of people worldwide. According to the World Health Organization, approximately **one in six people of reproductive age experience infertility at some point during their lifetime.**

The WHO issued its first comprehensive global guideline for the prevention, diagnosis and treatment of infertility in November 2025. Importantly, modern fertility care is not limited to medicines, procedures and laboratory tests. WHO also emphasises respectful, people-centred care and the importance of psychological and social support when it is required.

In this article, I want to speak directly to patients and couples who have recently received an infertility diagnosis.

I want to explain:

what an infertility diagnosis actually means,
why infertility occurs,
why both partners should be evaluated,
how infertility can affect emotional and sexual health,
how husbands and wives can support each other,
how to handle family and social pressure,
when counselling should be considered,
how fertility treatment decisions can be approached,
what role lifestyle plays,
how the Unani system views reproductive health,
where Unani treatment may contribute,
and how we approach infertility at Saira Health Care.

Above all, I want patients to understand that receiving a diagnosis is **the beginning of understanding the problem—not automatically the end of the possibility of parenthood.**

What Is Infertility?



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The World Health Organization defines infertility as a disease of the male or female reproductive system characterised by failure to achieve pregnancy after **12 months or more of regular unprotected sexual intercourse**.

Infertility is generally described as:

Primary infertility

Pregnancy has never previously been achieved.

Secondary infertility

Pregnancy has occurred previously, but the individual or couple is currently unable to achieve another pregnancy.

A previous pregnancy therefore does not guarantee that conception will always occur easily in the future.

Secondary infertility deserves the same serious evaluation as primary infertility.

Infertility Is More Common Than Many Couples Realise

One reason patients feel isolated is that infertility is rarely discussed openly.

Couples see pregnancies, births and children's photographs around them, while very few people publicly discuss unsuccessful attempts at conception.

This can create the false impression:

“Everyone is becoming pregnant except us.”

The reality is very different.

WHO estimates that approximately **17.5% of adults—around one in six people worldwide—experience infertility during their lifetime**.

Therefore, a couple facing infertility is certainly not alone.

Infertility Is Not Automatically a Female Problem

This is one of the most important misconceptions that I try to correct.

In many communities, whenever pregnancy does not occur, investigation begins with the woman and sometimes stops with the woman.

That is medically inappropriate.

Infertility can result from:



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male factors,

female factors,

factors involving both partners,

or no clearly identifiable cause despite appropriate investigation.

WHO recognises both male and female reproductive causes of infertility. In men, problems may involve sperm production, sperm movement, sperm shape, semen delivery or reproductive anatomy. In women, causes may involve ovulation, the ovaries, fallopian tubes, uterus, endocrine system or other reproductive disorders.

For this reason, I strongly encourage couples to think:

“We are being evaluated as a couple.”

not:

“Which one of us is defective?”

That difference in thinking can protect a relationship.

Both Partners Should Be Evaluated

Modern fertility guidance supports simultaneous evaluation of both partners when appropriate.

ASRM guidance recommends that when a male partner contributes sperm, evaluation of the male and female partners should begin at the same time. Male assessment commonly includes reproductive and medical history and semen analysis.

At Saira Health Care, I consider this principle especially important.

Suppose the wife has PCOS.

It would still be inappropriate to assume that PCOS is the entire explanation without considering the husband.

Similarly, if the husband's semen analysis shows reduced sperm count, we should not automatically assume that the female partner has no additional fertility factor.

Infertility management is most effective when we investigate the couple rather than search for someone to blame.

When Should a Couple Seek Fertility Evaluation?



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Traditionally, fertility evaluation is generally considered after approximately 12 months of regular unprotected intercourse without conception.

However, waiting a full year is not appropriate for every patient.

NICE's updated 2026 guidance recommends earlier specialist consideration in certain situations, including when the female partner is older or when a known or suspected fertility factor is already present.

ASRM guidance similarly recommends evaluation after approximately:

12 months when the woman is younger than 35,

6 months when she is 35 or older,

and potentially more immediate evaluation in women over 40 or when a recognised infertility-related condition is already present.

Earlier evaluation may also be appropriate when there is:

irregular or absent menstruation,

suspected ovulation disorder,

known endometriosis,

previous pelvic infection,

suspected blocked fallopian tubes,

previous reproductive surgery,

known male infertility,

erectile or ejaculatory difficulty,

previous chemotherapy or radiation,

genetic reproductive conditions,

azoospermia,

severe oligospermia,

significant testicular abnormalities.

Receiving the Diagnosis Can Feel Like a Shock

I have seen many patients who suspected that something might be wrong but still felt emotionally unprepared when a diagnosis was confirmed.



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Before testing, there is uncertainty.

After testing, there may suddenly be a name:

“Low ovarian reserve.”

“Bilateral tubal blockage.”

“Azoospermia.”

“Severe oligoasthenoteratozoospermia.”

“Anovulatory infertility.”

“Unexplained infertility.”

Putting a medical name on the problem can be helpful because it guides treatment.

Emotionally, however, the same diagnosis may initially feel frightening.

Patients may move through different emotions.

There is no single “correct” emotional response.

Common Emotional Reactions After an Infertility Diagnosis

Shock

Even couples who have been trying to conceive for several years may feel shocked when a medical explanation is found.

The thought changes from:

“Perhaps it will happen next month.”

to:

“There really is a fertility problem.”

That transition can be difficult.

Sadness and Grief

Infertility can involve a form of grief.

The couple may not be grieving a person who has died.

They may instead be grieving:

the pregnancy they expected,



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the child they imagined,
their expected family timeline,
the belief that conception would occur naturally,
or their previous confidence about the future.

The ASRM Mental Health Professional Group recognises that long-term difficulty conceiving can create profound feelings of loss and significant emotional upheaval.

This grief deserves respect.

Anger

Some patients ask:

“Why us?”

They may feel angry toward:

themselves,

their partner,

their body,

doctors,

relatives,

or even toward people who become pregnant easily.

Experiencing anger does not make someone a bad person.

It may simply be part of adjusting to a difficult diagnosis.

What matters is how that anger is handled.

Guilt and Self-Blame

A man with abnormal semen parameters may think:

“My wife is suffering because of me.”

A woman with diminished ovarian reserve may think:

“I waited too long.”

Someone with a previous infection may repeatedly revisit the past.



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This type of self-blame rarely helps treatment.

Medicine should ask:

“What factors are present, and what can we do now?”

rather than:

“Who should be blamed?”

Anxiety

Infertility naturally creates uncertainty.

Patients may worry about:

whether treatment will succeed,
whether sperm count will improve,
whether ovulation will occur,
whether the tubes are open,
whether IVF will be necessary,
whether they can afford treatment,
whether pregnancy will occur,
whether pregnancy will continue successfully,
and how long everything will take.

Research consistently demonstrates significant levels of anxiety, depression and psychological distress among people experiencing infertility. Systematic reviews also show that male infertility can substantially affect men's psychological health, self-esteem and quality of life.

Infertility Can Affect Men More Than They Admit

Male infertility is often discussed medically but not emotionally.

When a man's report shows:

low sperm concentration,
reduced motility,
abnormal morphology,



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azoospermia,

low testosterone,

varicocele,

or another reproductive problem,

he may experience the diagnosis as an attack on his masculinity.

Some men become quiet.

Others become irritable.

Some avoid discussing the report.

Others refuse repeat testing because they are afraid of confirming the result.

A systematic analysis of men diagnosed with male-factor infertility found increased symptoms of psychological distress, including anxiety, depression, reduced self-esteem and impaired aspects of quality of life compared with fertile controls.

I therefore tell my male patients:

Sperm count is a laboratory measurement. It is not a measurement of manhood.

A semen analysis cannot measure:

character,

strength,

intelligence,

love,

responsibility,

sexual worth,

or the quality of a husband.

Women May Carry a Heavy Emotional and Social Burden

Women experiencing infertility may face repeated questions such as:

“Any good news?”

“How many years have you been married?”

“Why don't you have children?”



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Sometimes they may even face insensitive advice from people who know nothing about their medical situation.

Research shows substantial levels of anxiety, depression, stress and impaired quality of life among women facing infertility. A systematic review also found that social support and socioeconomic circumstances can meaningfully influence psychological well-being.

This is why fertility care should not end after prescribing medicine.

The emotional environment of the patient matters too.

Husband and Wife May Cope Differently

One partner may want to talk constantly about infertility.

The other may want to avoid discussing it.

One may research every test online.

The other may say:

“Whatever happens, happens.”

One may cry openly.

The other may become quiet.

Different coping styles do not necessarily mean that one partner cares more than the other.

They may simply process stress differently.

The important thing is to avoid interpreting every difference as rejection.

Do Not Turn Infertility Into “Your Problem”

I often encourage couples to change their language.

Instead of:

“Your sperm count is low.”

say:

“We have found a male fertility factor that we need to manage.”

Instead of:

“Your tubes are blocked.”

say:

“We now understand one reason we have been having difficulty conceiving.”

This may seem like a small change.

It is not.

Language can either unite couples or divide them.

Protect Your Marriage From the Diagnosis

Infertility can gradually occupy every conversation.

Morning:

“Did you take the medicine?”

Afternoon:

“When is the ultrasound?”

Evening:

“Which day is ovulation?”

Night:

“We have to try today.”

A relationship that once contained humour, friendship and spontaneous intimacy can slowly begin to feel like a fertility project.

Do not allow this to happen completely.

Continue to have parts of your relationship that have nothing to do with conception.

Go for a walk.

Eat together.

Talk about work.

Watch something you enjoy.

Visit somewhere.

Celebrate occasions.

Remain husband and wife—not only two people undergoing fertility treatment.



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Infertility Can Affect Sexual Intimacy

This is particularly important in my clinical practice because I work with both **sexual disorders and infertility**.

When intercourse becomes scheduled only around ovulation, sex may begin to feel like a medical task.

The man may develop:

performance anxiety,

erectile difficulty,

loss of sexual confidence,

delayed ejaculation,

difficulty ejaculating during the fertile period.

The woman may experience:

reduced desire,

anxiety,

vaginal dryness,

painful intercourse,

resentment toward scheduled sex,

fear of another unsuccessful month.

A couple can therefore begin with infertility and later develop a secondary sexual difficulty caused partly by pressure.

If this happens, please discuss it with your doctor.

Sexual dysfunction is relevant to fertility assessment and should not be hidden because of embarrassment. ASRM specifically includes sexual dysfunction among factors that can justify prompt fertility evaluation.

The Monthly Cycle of Hope and Disappointment

Many couples describe fertility treatment as living month to month.

Menstruation begins.



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There is disappointment.

Then medicines start.

Follicles are monitored.

Hope increases.

Ovulation occurs.

The waiting period begins.

Every sensation is interpreted:

“Could this mean pregnancy?”

A pregnancy test is performed.

If negative, grief begins again.

This repeated cycle can be emotionally exhausting.

Knowing that this pattern is common can help couples recognise why they may feel unusually tired, anxious or emotionally sensitive during treatment.

How Can You Cope After an Infertility Diagnosis?

There is no single technique that works for everyone.

However, I recommend several principles.

1. Give Yourself Time to Process the Diagnosis

You do not need to make every treatment decision on the same day that you receive difficult results.

Ask your doctor:

What exactly does the report mean?

How certain is the diagnosis?

Does the test need repeating?

What additional investigation is required?

What are our treatment options?

Is this condition reversible, manageable or permanent?

How urgent is treatment?



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Understanding the diagnosis reduces fear created by uncertainty.

2. Understand Your Reports—Do Not Become Frightened by One Number

A common problem today is that patients receive a laboratory report on their phone before speaking with their doctor.

They search the internet.

Within an hour they are terrified.

For example, semen analysis is more complex than simply saying:

“My sperm count is below normal, therefore pregnancy is impossible.”

Semen characteristics vary, and abnormal results often require clinical interpretation and sometimes repeat testing. AUA/ASRM guidance specifically notes the biological variability of semen parameters and recommends appropriate repeat assessment where indicated.

Similarly:

AMH is not a pregnancy test,

ovarian reserve is not identical to egg quality,

one abnormal cycle does not explain everything,

one ultrasound does not always determine reproductive potential.

Reports should be interpreted in context.

3. Focus on the Cause, Not Only the Label

“Infertility” is not one disease with one treatment.

It is an outcome that can arise from many different conditions.

Female-related causes can include:

ovulation disorders,

PCOS,

diminished ovarian reserve,

tubal blockage,

endometriosis,



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uterine abnormalities,
endocrine disorders,
age-related reproductive decline.

Male-related causes can include:

oligozoospermia,
asthenozoospermia,
teratozoospermia,
azoospermia,
varicocele,
hormonal disorders,
testicular dysfunction,
ejaculatory problems,
reproductive obstruction,
genetic abnormalities.

Sometimes both partners have contributing factors.

Sometimes appropriate investigations reveal no definite explanation; this may be classified as **unexplained infertility**.

Current WHO guidance recommends systematic diagnosis and cause-oriented treatment rather than indiscriminate testing or unproven interventions.

4. Do Not Compare Your Fertility Journey With Someone Else's

This is very important.

A relative may say:

“My friend took this medicine and became pregnant immediately.”

Another may say:

“Someone I know did IVF and failed.”

Someone else may say:

“You don't need treatment—just stop thinking about it.”

These stories cannot determine your medical outcome.



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A 28-year-old woman with PCOS and normal tubes is different from a 39-year-old woman with low ovarian reserve.

A man with mild reduced sperm motility is different from a man with non-obstructive azoospermia.

Treatment must be based on **your diagnosis**, not somebody else's story.

5. Control How Much You Search Online

Good health information can empower patients.

Uncontrolled searching can increase anxiety.

One website says one thing.

A social-media reel says something different.

A commercial clinic promises a miracle.

A supplement advertisement says pregnancy is guaranteed.

A patient's forum describes a frightening experience.

Soon the couple does not know whom to believe.

My recommendation is:

Use reliable medical sources and discuss major decisions with qualified healthcare professionals.

Do not allow an algorithm to become your fertility specialist.

6. Decide Who Needs to Know

You are not required to discuss your fertility diagnosis with everyone.

You may choose to tell:

parents,

siblings,

close friends,

or nobody beyond your partner and healthcare team.

There is no universal correct choice.

However, if relatives repeatedly ask about children, you can create a simple boundary:



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“We are dealing with this privately and will share news when we are ready.”

You do not owe everyone a detailed explanation of semen reports, ovulation studies or fertility treatment.

Privacy can sometimes protect mental peace.

7. Choose Supportive People Carefully

One genuinely supportive person can be more valuable than ten people giving unwanted advice.

Good support sounds like:

“I am here if you need me.”

Poor support sounds like:

“Just relax and it will happen.”

“Why don't you try this home remedy?”

“Whose problem is it?”

Choose people who listen without interrogating.

8. Take Breaks From Fertility Talk

It is perfectly reasonable for a couple to agree:

“Tonight we are not discussing reports or treatment.”

Your fertility journey is part of your life.

It does not need to become your entire identity.

9. Maintain Normal Daily Activities

As far as possible, continue:

work,

exercise,

hobbies,

friendships,

religious or spiritual practices if personally meaningful,



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family activities,

sleep routine,

recreational activities.

Structure helps prevent infertility from occupying every waking thought.

10. Protect Sleep

Chronic stress often damages sleep.

Then poor sleep increases emotional irritability and fatigue.

Create a regular sleeping schedule.

Avoid spending late nights repeatedly searching fertility stories online.

If anxiety is severely interfering with sleep for a prolonged period, discuss it with your healthcare professional.

11. Exercise, But Do Not Turn Lifestyle Into Punishment

Healthy physical activity supports general and reproductive health.

But after an infertility diagnosis, some patients become extreme.

They eliminate numerous foods.

They exercise excessively.

They purchase large numbers of supplements.

They blame every meal.

Lifestyle optimisation should support health—not become another source of anxiety.

The WHO's 2025 infertility guideline supports healthy diet, physical activity and tobacco cessation as part of fertility-health promotion.

12. Stop Smoking

Smoking can negatively affect reproductive health.

WHO highlighted in September 2026 that tobacco use is associated with infertility in women and can adversely affect sperm and sexual function in men; second-hand smoke may also be relevant to reproductive health.



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If either partner smokes, fertility treatment is an excellent reason to stop.

13. Do Not Blame Yourself for Every Lifestyle Imperfection

Lifestyle matters.

But infertility is frequently caused by complex biological conditions.

A patient should not think:

“I ate badly for several months, therefore I caused my infertility.”

or:

“If I had exercised more, this would never have happened.”

Health optimisation is valuable because it improves the conditions under which we pursue fertility—not because every fertility problem results from poor discipline.

14. Understand That Fertility Treatment Is Usually Stepwise

Some couples hear the word infertility and immediately imagine IVF.

That is not always necessary.

Treatment depends upon the diagnosis.

Depending on the cause, management may include:

education regarding the fertile window,

lifestyle modification,

treatment of a medical condition,

ovulation induction,

correction of selected hormonal abnormalities,

treatment of sexual dysfunction,

management of male reproductive disorders,

selected surgery,

intrauterine insemination,

IVF,

ICSI,



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or other reproductive technologies.

WHO's current infertility guideline recommends a progressive, evidence-based approach that considers clinical findings as well as individual preferences rather than automatically moving every patient directly to the most complex treatment.

Counselling Is Part of Fertility Care

Some patients hear the word “**counselling**” and think:

“Doctor, I am not mentally ill.”

Counselling does not mean that you are mentally ill.

It means you are dealing with a difficult life and medical situation, and professional psychological support may make that process easier.

NICE's fertility quality standard, updated in March 2026, states that people experiencing fertility problems should be offered counselling **before, during and after investigation and treatment**, because fertility problems and fertility treatment can cause emotional stress.

ESHRE also recognises psychosocial care as an important part of infertility and medically assisted reproduction.

Counselling can help with:

anxiety,

depression,

relationship difficulties,

treatment fatigue,

sexual problems,

grief,

repeated treatment failure,

pregnancy loss,

difficult treatment decisions,

family pressure,

social isolation.



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When Should I Strongly Consider Mental-Health Support?

Consider speaking with a psychologist, counsellor, psychiatrist or appropriately trained mental-health professional if you experience prolonged:

sadness,
persistent anxiety,
hopelessness,
frequent crying,
loss of interest in normal activities,
severe sleep disturbance,
social withdrawal,
relationship conflict,
inability to concentrate on anything except infertility,
panic symptoms,
inability to function normally at work,
extreme anger,
overwhelming guilt.

ASRM similarly identifies persistent depression, social withdrawal, relationship strain and being unable to think about anything except infertility as reasons to consider psychological counselling.

If you ever develop thoughts of harming yourself, feeling that life is no longer worth living, or harming another person, seek urgent professional or emergency mental-health assistance.

Infertility and Financial Stress

This subject deserves acknowledgement.

Fertility investigation and treatment can become expensive.

Repeated:

consultations,
blood tests,



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ultrasound scans,

medicines,

semen tests,

procedures,

IUI,

IVF,

travel,

can create substantial financial stress.

WHO's 2025 global guideline specifically recognises the financial burden associated with fertility care and the unequal access experienced by many patients worldwide.

Before starting expensive treatment, ask:

Why is this treatment recommended?

Is there a lower-cost evidence-based alternative?

What is the realistic expected benefit?

How many cycles are reasonable?

What additional costs may arise?

Good fertility care should include informed decision-making.

What If Treatment Fails?

A failed cycle hurts.

Whether it is:

unsuccessful ovulation induction,

unsuccessful IUI,

IVF with no pregnancy,

failed implantation,

biochemical pregnancy,

pregnancy loss,

patients may experience intense disappointment.



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Do not make major emotional decisions immediately after receiving a negative result.

Allow yourself time.

Then meet the treating doctor and ask:

What happened?

Was anything unexpected?

Has the diagnosis changed?

Should anything be investigated further?

Is repeating the same treatment reasonable?

Should the strategy change?

What are the alternatives?

A failed cycle provides medical information.

It does not necessarily predict every future cycle.

What About “Unexplained Infertility”?

Sometimes all basic investigations appear reasonably normal and pregnancy still does not occur.

This can be particularly frustrating because patients prefer a clear explanation.

They ask:

“Doctor, if everything is normal, why are we not conceiving?”

Reproduction involves many complex biological steps that routine clinical testing cannot measure perfectly.

Therefore, **unexplained infertility does not mean imaginary infertility.**

It means that the standard evaluation has not identified a definite cause.

Treatment decisions are then based on:

age,

duration of infertility,

previous pregnancy history,

ovarian reserve,

semen findings,



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prior treatment,

individual circumstances.

ESHRE and WHO both provide contemporary guidance for the management of unexplained infertility.

The Unani Understanding of Infertility

In the Unani system of medicine, infertility has traditionally been discussed under the concept of **Uqr**.

Classical Unani physicians considered reproductive capacity to depend not only upon reproductive organs but upon the broader state of health.

Traditional assessment may consider factors such as:

Mizaj or individual temperament,

reproductive function,

menstrual health,

semen quantity and quality,

nutritional status,

digestive health,

physical activity,

sleep,

psychological state,

general strength and vitality.

The classical Unani approach also gives importance to **Asbab-e-Sitta Daruriyya**, or the six essential factors related to health, including environment, food and drink, physical activity and rest, psychological influences, sleeping and waking, and elimination and retention.

A 2026 review examining the Unani-biomedical interface in anovulatory infertility has specifically discussed these lifestyle principles in relation to reproductive health.

How I Approach Infertility Through Unani Medicine



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As a physician trained in Unani medicine with a focused practice in sexual disorders and infertility, I believe the greatest strength of a responsible Unani approach is **individualisation**.

I do not believe that every patient with infertility should be given the same medicine.

Two patients may both be labelled “infertile” while having completely different medical situations.

One may have:

PCOS with anovulation.

Another:

tubal obstruction.

Another:

diminished ovarian reserve.

Another couple:

male-factor infertility.

Another:

unexplained infertility.

Another:

sexual dysfunction preventing properly timed intercourse.

These conditions cannot responsibly be treated as though they are identical.

My first objective is therefore:

Understand the cause as clearly as possible.

Only then can an appropriate therapeutic plan be discussed.

Potential Role of Unani Care

In appropriately selected patients, Unani management may form part of a broader fertility-care programme.

Depending upon the individual's condition, the approach may focus on:

improving general health,

nutrition,



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digestive wellbeing,
sleep,
weight and metabolic health where appropriate,
menstrual regularity,
reproductive vitality,
sexual health,
stress management,
lifestyle regulation,
and individualized traditional pharmacotherapy.

However, I consider it essential that traditional medicine be practised responsibly.

Unani treatment should **not** prevent or unnecessarily delay:

investigation of blocked fallopian tubes,
evaluation of severe male infertility,
genetic testing when indicated,
treatment of significant endocrine disease,
surgery when clearly required,
or assisted reproduction when time-sensitive and medically appropriate.

What Does Research Say About Unani Treatment and Infertility?

Traditional Unani literature contains a substantial body of fertility-related therapeutics, but modern scientific validation is still developing.

There are some promising clinical studies.

For example, research published through CCRUM has evaluated Unani formulations in men with idiopathic oligospermia and reported improvements in several semen parameters in studied groups.

A randomized controlled study at the National Institute of Unani Medicine evaluated **Asparagus racemosus (Satavar)** in women with anovulatory infertility and examined follicular development and ovulation. The study was small and did not demonstrate superiority over the comparator, illustrating why larger studies are still necessary.

Other small studies and case reports have investigated Unani approaches for selected infertility conditions, but these studies are insufficient to conclude that any single Unani medicine can universally treat infertility or guarantee pregnancy.

This scientific distinction is very important.

Traditional experience can guide research.

Clinical evidence can refine traditional practice.

Neither should be exaggerated.

At Saira Health Care, I prefer to use Unani principles alongside appropriate modern diagnostic information rather than asking the patient to choose blindly between traditional and modern medicine.

Why Diagnosis Must Come Before Treatment

Consider three examples.

Patient A

A woman is not ovulating regularly.

Appropriate medical and lifestyle treatment may help restore ovulation.

Patient B

A woman has bilateral complete tubal blockage.

Simply prescribing medicines for “fertility strength” without acknowledging the mechanical obstruction would not be responsible.

Patient C

A man has azoospermia.

He requires proper classification to determine whether sperm production is impaired or sperm transport is obstructed.

These patients all have infertility.

But they do not have the same problem.

Therefore:

Treat the cause—not merely the word infertility.

Saira Health Care's Approach to Infertility



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At **Saira Health Care**, my approach to infertility is built around five important principles.

1. Detailed Evaluation

We begin with history.

For women this may involve:

menstrual cycles,

ovulation,

previous pregnancies,

miscarriages,

pelvic infection,

surgery,

PCOS,

endometriosis,

thyroid or hormonal disorders.

For men:

semen parameters,

sexual function,

previous fertility,

childhood testicular problems,

infections,

varicocele,

surgeries,

medicines,

lifestyle,

occupational exposures.

2. Couple-Based Care

Where applicable, I encourage evaluation of both partners.



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We try not to create a situation where one spouse carries all responsibility for a couple's fertility difficulty.

3. Integration of Sexual and Reproductive Health

Infertility and sexual health frequently overlap.

A fertility assessment may reveal:

erectile dysfunction,

premature ejaculation,

inability to ejaculate,

decreased libido,

painful intercourse,

performance anxiety,

incorrect understanding of fertile timing.

Because my focused clinical work includes both **sexual disorders and infertility**, I consider sexual function an important part of fertility history rather than an embarrassing side issue.

4. Individualised Unani Care

When suitable, Unani therapy is selected according to the patient's individual presentation rather than offering a single medicine to every infertile couple.

5. Responsible Referral

Good clinical care also means recognising when another specialist or reproductive technology is required.

Depending upon the problem, this may include:

gynaecology,

reproductive endocrinology,

urology,

andrology,



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genetics,

mental-health services,

IVF/ICSI services,

surgery.

Referring appropriately is not a failure of Unani medicine.

It is responsible medicine.

What I Want Every Couple to Remember

Infertility should never become a competition over who is suffering more.

The wife may have repeated injections and ultrasound examinations.

The husband may be struggling silently after an abnormal semen report.

Both experiences are real.

One person's suffering does not cancel the other's.

Try to say:

“We are going through this together.”

Do Not Let Treatment Destroy the Relationship You Are Trying to Build a Family Around

This is a sentence I consider extremely important.

The purpose of fertility treatment is to help build a family.

If the entire treatment process destroys trust, affection and communication between husband and wife, something important is being lost.

Protect your relationship while pursuing pregnancy.

Sometimes the partner beside you needs your attention just as much as the laboratory report in your hand.

Frequently Asked Questions

Does infertility mean we can never have children?

No.



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Infertility means there is difficulty achieving pregnancy according to the recognised medical definition.

It does not automatically mean that pregnancy is impossible.

Prognosis depends upon the underlying cause, age, duration of infertility and available treatment options.

Is infertility always permanent?

No.

Some causes are treatable or manageable.

Others may be more difficult or irreversible.

The answer depends completely on the diagnosis.

Is infertility usually the woman's fault?

No.

Infertility may involve male factors, female factors, both partners or unexplained factors.

Modern guidelines recommend assessment of both partners when appropriate.

Should the husband undergo testing even when the wife already has PCOS?

Usually, yes, when clinically appropriate.

Identifying one female factor does not exclude the possibility of an additional male factor.

Can stress cause infertility?

The relationship between stress and fertility is complicated.

Severe psychological stress can affect well-being, sexual activity and possibly some reproductive processes, but patients should not be told that infertility exists simply because they are “thinking too much.”

Such statements can increase guilt.



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Stress management is important for quality of life regardless of whether it directly changes pregnancy probability.

Does counselling mean I have a psychiatric disorder?

No.

Fertility counselling is part of comprehensive fertility care.

NICE recommends access to counselling before, during and after fertility investigation and treatment.

Should we stop trying naturally after being diagnosed?

Not necessarily.

That depends on the diagnosis.

Some couples should continue natural attempts while receiving treatment.

Other conditions may require IUI, IVF, ICSI, surgery or another intervention.

Your doctor should explain why a particular strategy is recommended.

Can Unani medicine help infertility?

It may have a supportive and therapeutic role in appropriately selected patients, particularly within individualized management of general health, lifestyle, sexual health, menstrual or ovulatory health and certain male fertility problems.

There is preliminary clinical research investigating Unani approaches to infertility-related conditions. However, current evidence is not sufficient to claim that Unani treatment can cure every form of male or female infertility or guarantee pregnancy.

Correct diagnosis should come first.

Can Unani treatment be combined with modern fertility investigation?

Yes, where clinically appropriate.

In my practice, I strongly support using modern investigations to understand the reproductive problem while considering responsible individualized Unani management for suitable patients.



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The two approaches need not be treated as enemies.

Does low sperm count mean pregnancy is impossible?

Not necessarily.

The clinical significance depends upon:

sperm concentration,

total sperm number,

motility,

morphology,

semen volume,

associated medical findings,

severity,

repeat results,

and the female partner's fertility.

A semen report should be interpreted by a qualified clinician.

What if no cause is found?

This may be classified as unexplained infertility after appropriate evaluation.

It is a recognised clinical situation and does not mean the symptoms are imaginary.

Treatment can still be planned based on age, duration of infertility and other factors.

Should we tell our family about infertility?

That is a personal decision.

You have the right to keep medical information private.

Share it with people who genuinely support you rather than people who increase your stress.

When Should You Seek Additional Help Urgently?



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Contact an appropriate healthcare professional when infertility is causing:

severe depression,

persistent inability to sleep,

panic attacks,

serious marital conflict,

complete social withdrawal,

inability to work,

sexual dysfunction that is worsening,

overwhelming hopelessness.

Urgent mental-health assistance is required if a person develops thoughts of self-harm, suicide or harming another person.

My Message to Couples Facing Infertility

If you have recently received an infertility diagnosis, I want you to remember something.

You are more than your fertility report.

A semen analysis does not define a husband.

An AMH level does not define a woman.

A blocked fallopian tube does not determine someone's value.

A failed IVF cycle does not mean you have failed as a person.

And an infertility diagnosis should not become a reason for husband and wife to turn against each other.

Use the diagnosis for what it is intended to do:

to guide us toward understanding the cause and choosing the most appropriate next step.

Ask questions.

Understand your reports.

Take care of your physical health.

Take care of your emotional health.

Protect your relationship.



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Choose treatment based on evidence and individual circumstances rather than fear.

And remember that asking for psychological support is not weakness.

The latest international fertility guidance increasingly recognises that high-quality fertility care must address not only reproductive biology but also the preferences, emotional well-being and social needs of individuals and couples.

A Balanced Path Forward

As a Unani physician with a specialized clinical focus on **sexual disorders and infertility**, my objective is to bring together three important elements:

Traditional Unani principles

Understanding the individual, lifestyle, nutrition, temperament, general health and reproductive function.

Modern reproductive diagnostics

Using appropriate semen analysis, hormonal assessment, imaging, ovulation evaluation, tubal assessment and other investigations where medically required.

Compassionate patient-centred care

Understanding that behind every report is a person—or a couple—who may be frightened, disappointed and uncertain about the future.

This combination is particularly important in infertility.

A patient is not simply:

“Sperm count 10 million.”

or:

“AMH 0.8.”

or:

“One blocked tube.”

He or she is a human being.

Medicine should never forget that.

About Dr. Nizamuddin Qasmi



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Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care

Focused Practice in Sexual Disorders & Infertility

Qualifications and Professional Training

BUMS – Hamdard University, Delhi

MD

CGO

Certificate in Infertility – MGBIMS, Delhi

Certificate in Urology – London, UK

Masters in Male Infertility – MasterHealthPro (HealthPro)

Integrated Sexual and Reproductive Health – ISRH, UNFPA

Dr. Nizamuddin Qasmi's focused clinical work at **Saira Health Care** involves male and female infertility, male sexual disorders and reproductive-health concerns, with particular attention to individualized Unani management supported by appropriate modern diagnostic evaluation.

Through Saira Health Care, the aim is also to improve public understanding of subjects that are frequently hidden because of embarrassment—especially male infertility, sexual disorders, erectile difficulties, semen abnormalities and reproductive-health concerns.

The objective is not merely to prescribe medicine but to help patients understand:

their diagnosis,

possible causes,

realistic treatment options,

lifestyle factors,

reproductive health,

sexual health,

and when referral or advanced fertility care is appropriate.

Final Words From Dr. Nizamuddin Qasmi

Whenever a couple sits in front of me after receiving an infertility diagnosis, I try to remind them:



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Do not allow one medical diagnosis to become the definition of your marriage.

The journey may be short for some people and longer for others.

Some conditions respond to relatively simple treatment.

Some require prolonged management.

Some require assisted reproductive technology.

Some require difficult decisions.

No responsible doctor can promise the same outcome to every couple.

But every couple deserves:

a correct diagnosis,

clear information,

respectful treatment,

emotional support,

and a scientifically responsible plan.

If you are facing infertility, do not spend months blaming yourself or your partner.

Understand the condition.

Investigate both partners where appropriate.

Discuss the available treatment options.

Take care of your health.

Seek support when you need it.

And move forward one sensible step at a time.

An infertility diagnosis gives us a problem to understand. It should never take away your dignity, your relationship, or your hope.

Medical Disclaimer

This article is intended for general education and patient awareness and does not replace an individual consultation, medical examination or fertility evaluation.

Infertility can result from many different male, female, combined and unexplained factors. Investigations and treatment should therefore be individualized.



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Unani medicine may be used as part of appropriate individualized and integrative care, but available scientific evidence does not support promising that any Unani, herbal, conventional or other treatment will guarantee conception or live birth.

Patients should not postpone medically indicated investigations, surgery, genetic evaluation or assisted reproductive treatment because of unproven claims.

Always discuss medicines, herbal preparations, supplements and fertility treatments with an appropriately qualified healthcare professional.



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