

Low Sperm Motility (Asthenozoospermia): Causes, Diagnosis, Treatment, Fertility Options and the Role of Unani Medicine

By Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care

Focused Practice in Sexual Disorders & Infertility

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

Medical literature reviewed and updated: September 2026

Introduction: “Doctor, My Sperm Count Is Good but Motility Is Low. Can I Still Become a Father?”

One of the most common semen-analysis problems I see in men undergoing infertility evaluation is:

Low Sperm Motility

also commonly called:

Asthenozoospermia or Asthenospermia

A patient may come to me and say:

“Doctor, my sperm count is 50 million, but progressive motility is only 20%. Does this mean I am infertile?”

Another may ask:

“My report says 70% sperm are immotile. Are all those sperm dead?”

Another man may have:

- a reasonable sperm count,
- acceptable morphology,
- normal sexual function,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

but pregnancy has still not occurred.

He may ask:

“If sperm are present but cannot swim properly, what treatment can improve their movement?”

These are very important questions.

Sperm motility refers to the ability of sperm to:

- move,
- move forward,
- navigate through the female reproductive tract,
- approach the egg,
- and participate in fertilization.

However, the first thing I explain to patients is:

A low motility percentage does not automatically mean permanent infertility.

Semen analysis is not a simple pass-or-fail examination.

Current European Association of Urology guidance emphasizes that no individual semen parameter—including sperm count, motility or morphology—can by itself distinguish every fertile man from every infertile man. Fertility must be interpreted using the complete semen profile together with the reproductive health of both partners.

Many causes of reduced sperm motility can potentially be:

- identified,
- improved,
- treated,
- or bypassed using assisted reproduction.

At **Saira Health Care**, my approach is therefore not:

“Motility is low—take one sperm medicine.”

My approach is:

Confirm the result, identify why motility is low, correct reversible factors, support sperm health through individualized Unani and lifestyle care, treat medical causes appropriately, and select IUI, IVF or ICSI when required.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

What Is Sperm Motility?

Sperm motility means the ability of spermatozoa to move.

A healthy sperm cell has:

- a head carrying genetic material,
- a midpiece containing mitochondria that help generate energy,
- and a flagellum or tail that produces movement.

The tail does not simply shake randomly.

It is a highly specialized biological structure containing:

- microtubules,
- motor proteins,
- ion channels,
- signaling proteins,
- and energy-producing systems.

A major 2025 scientific review of human asthenozoospermia highlighted that effective motility depends on the normal development and functioning of the sperm flagellum, together with ion channels and molecular pathways required for sperm activation and hyperactivation.

Why Does Sperm Need to Move?

After ejaculation into the female reproductive tract, sperm have a long biological journey.

They must:

1. leave the semen,
2. progress through cervical mucus,
3. travel through the uterus,
4. enter the fallopian tube,
5. undergo functional changes known as capacitation,
6. develop a special form of vigorous movement called hyperactivation,
7. interact with the egg,
8. participate in fertilization.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Therefore, movement is an important part of natural fertility.

But sperm motility is only **one** component.

Successful conception also depends on:

- sperm number,
- morphology,
- sperm DNA integrity,
- ejaculation,
- intercourse timing,
- ovulation,
- egg quality,
- fallopian tubes,
- female age,
- ovarian reserve,
- uterine health.

What Is Asthenozoospermia?

Asthenozoospermia is the term commonly used when sperm motility is below the expected reference range.

The sixth edition of the WHO semen manual, published in 2021 and still the current international laboratory reference in 2026, provides distributions derived from fertile men.

The lower fifth-percentile reference points are approximately:

- **Total motility: 42%**
- **Progressive motility: 30%**

The current EAU guideline reproduces these WHO 2021 values.

However, patients should understand:

30% and 42% are not magical fertility cut-offs.

WHO reference values represent the lower fifth percentile observed among men whose partners achieved natural pregnancy.

They do not mean:



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

29% progressive motility = infertile

and:

30% progressive motility = fertile.

The entire reproductive situation must be considered.

Understanding the Different Types of Sperm Movement

Modern semen analysis classifies sperm movement into several categories.

Rapid Progressive Motility

Sperm move actively forward at a good speed.

Slow Progressive Motility

Sperm still move forward but less rapidly.

Non-Progressive Motility

The sperm are moving, but they are not making meaningful forward progress.

They may:

- move in small circles,
- vibrate,
- or move their tails without travelling effectively.

Immotile Sperm

No movement is observed.

The WHO sixth edition again distinguishes rapid and slow progressive sperm because the quality of forward movement may have clinical importance.

Progressive Motility Is Especially Important

When patients show me a semen report, they sometimes focus only on:

“Total motility.”

But I also look closely at:

progressive motility.

A sperm that moves energetically but remains almost in the same location is biologically different from a sperm moving forward toward the egg.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Therefore, good interpretation of semen analysis requires more than simply:

“How many sperm are moving?”

We also want to understand:

“How effectively are they moving?”

Is an Immotile Sperm Always Dead?

No.

This is a very important point.

An immotile sperm may be:

- alive but unable to move,
- or genuinely dead.

This distinction is determined by:

Sperm Vitality Testing

Current EAU guidance recommends vitality assessment particularly when more than **60% of sperm are immotile**.

This helps distinguish:

Asthenozoospermia

from:

Necrozoospermia

where an abnormally high proportion of sperm are dead.

These conditions may require different evaluation and fertility strategies.

Total Motile Sperm Count: Often More Informative Than Motility Percentage Alone

Imagine two men.

Man A

Sperm concentration: 80 million/mL

Progressive motility: 25%

Man B

Sperm concentration: 4 million/mL

Progressive motility: 25%

Both have the same percentage of progressive motility.

But their actual number of usable motile sperm is very different.

Therefore, clinicians may consider:

Total Motile Sperm Count – TMSC

which takes into account:

- semen volume,
- sperm concentration,
- and motility.

This can be particularly useful when deciding whether:

- natural conception,
- IUI,
- IVF,
- or ICSI

is more realistic.

Low Sperm Motility Is Not the Same as Low Sperm Count

These terms are commonly confused.

Oligozoospermia

Means low sperm concentration or total sperm number.

Asthenozoospermia

Means reduced sperm motility.

Teratozoospermia

Means an increased proportion of abnormally shaped sperm.

Sometimes all three occur together:

Oligo-Asthen-Teratozoospermia – OAT

A man can also have isolated low motility while:



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- sperm concentration is normal,
- morphology is normal.

Each pattern needs its own interpretation.

Symptoms of Low Sperm Motility

Most men with asthenozoospermia have:

No physical symptoms.

You cannot feel:

- 20% progressive motility,
- 40% progressive motility,
- or poor flagellar movement.

The most common clinical presentation is:

Difficulty achieving pregnancy

despite regular unprotected intercourse.

A man may otherwise have:

- normal libido,
 - normal erection,
 - normal ejaculation,
 - normal orgasm,
 - normal-looking semen.
-

Low Sperm Motility Does Not Mean Sexual Weakness

This is a misconception I frequently correct.

A man can have:

excellent sexual performance + poor sperm motility.

Another man may have:

erectile dysfunction + perfectly normal sperm.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Sexual performance and male fertility are connected parts of reproductive health but they are not interchangeable.

At Saira Health Care, because my focused clinical work includes both **sexual disorders and infertility**, I deliberately evaluate these conditions separately.

Can Semen Look Normal When Motility Is Poor?

Yes.

You cannot judge sperm motility by looking at semen.

Semen may appear:

- thick,
- white,
- normal in volume,
- completely healthy to the naked eye,

while laboratory testing shows severely reduced progressive movement.

Likewise:

watery semen does not automatically mean low sperm motility.

Only microscopic semen analysis can evaluate sperm movement.

Causes of Low Sperm Motility

Low motility can result from many different factors.

Sometimes there is one clear cause.

In other patients, several smaller factors act together.

In some men:

no specific cause is identified.

This is called:

Idiopathic Asthenozoospermia.

1. Normal Biological Variation and Semen-Test Variability

Before diagnosing a permanent sperm problem from one report, we must remember:



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

semen parameters naturally vary.

Motility may be influenced by:

- period of abstinence,
- illness,
- fever,
- incomplete collection,
- sample transport,
- laboratory technique,
- temperature,
- delay before analysis.

This is one reason current EAU guidance strongly recommends **at least two consecutive semen analyses when the baseline test is abnormal.**

I rarely advise a major fertility decision from one borderline semen report alone.

2. Improper Semen Collection or Delayed Laboratory Processing

Sperm are living cells.

If semen is:

- collected incorrectly,
- exposed to inappropriate temperature,
- contaminated with ordinary lubricants,
- transported for too long,
- or analyzed too late,

motility may appear worse than it really is.

Patients should follow laboratory instructions carefully.

The complete ejaculate should ideally be collected because different portions of semen may contain different concentrations of sperm.

3. Recent Fever or Significant Illness

The testes are temperature-sensitive.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

A significant febrile illness can temporarily affect:

- sperm production,
- motility,
- morphology,
- and sometimes concentration.

Because sperm development takes several weeks, the effect may remain visible for some time even after the fever has resolved.

Therefore, when I see an unexpectedly abnormal semen report, I ask:

“Did you have high fever or a major illness during the last few months?”

A transient abnormality should not automatically be labelled permanent infertility.

4. Varicocele

Varicocele is one of the most important potentially correctable conditions associated with abnormal semen.

It is an enlargement of veins around the testicle.

Possible effects include:

- increased scrotal temperature,
- oxidative stress,
- altered testicular function,
- sperm DNA damage.

Current EAU evidence confirms that clinically important varicocele can be associated with male subfertility and abnormal semen. Repair in appropriately selected infertile men may improve several semen parameters, including progressive motility in some analyses.

However:

Every ultrasound-detected varicocele does not need surgery.

Repair is generally considered when there is:

- a clinical/palpable varicocele,
- infertility,
- abnormal semen,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- and an appropriate couple-level fertility situation.
-

5. Genital-Tract Infection and Inflammation

Conditions such as:

- epididymitis,
- prostatitis,
- urethritis,
- sexually transmitted infections,

can affect semen quality.

Current EAU guidance notes that organisms such as:

- *Chlamydia trachomatis*,
- *Ureaplasma*,
- *Mycoplasma*

may be associated with reduced sperm density, motility or other sperm abnormalities in selected men.

However:

low sperm motility alone does not prove that an infection is present.

Antibiotics should not be prescribed simply because a semen report shows poor movement.

Treatment should be directed at an actual diagnosed infection.

6. Oxidative Stress

Oxidative stress is an important mechanism in male infertility.

Sperm membranes contain large amounts of polyunsaturated fatty acids.

This makes them vulnerable to:

lipid peroxidation

from excessive reactive oxygen species.

Oxidative stress may affect:

- tail function,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- mitochondrial energy production,
- membrane integrity,
- sperm motility,
- acrosome function,
- and sperm DNA.

Current EAU guidance recognizes oxidative stress as an important contributor to impaired sperm function, while also noting that routine clinical ROS testing remains experimental.

7. Smoking and Tobacco

Smoking is one of the lifestyle factors I take seriously in an infertile man.

Tobacco exposure can increase:

- oxidative stress,
- toxic chemical exposure,
- inflammation.

It has been associated with poorer semen quality.

The WHO's 2025 infertility guideline identifies tobacco as an important preventable infertility risk factor and recommends tobacco cessation as part of fertility-promoting lifestyle care.

On **8 September 2026**, WHO also released an updated technical summary specifically addressing tobacco and infertility, reflecting the continuing importance of this issue in reproductive health.

8. Excessive Alcohol and Recreational Drugs

Heavy alcohol intake may interfere with:

- hormonal health,
- testicular function,
- sexual function,
- liver metabolism,
- semen quality.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Recreational drugs may also impair fertility.

The practical advice is straightforward:

A man trying for pregnancy should minimize avoidable reproductive toxins.

9. Obesity, Diabetes and Metabolic Disease

Obesity can alter:

- testosterone,
- estrogen,
- insulin sensitivity,
- inflammatory activity,
- scrotal temperature.

Diabetes may affect:

- hormones,
- sexual function,
- ejaculation,
- oxidative stress,
- overall sperm quality.

The relationship between body weight and fertility is complex, but metabolic optimization is an important part of comprehensive infertility care.

WHO currently includes:

- healthy diet,
- regular physical activity,
- and reduction of lifestyle risk factors

in its fertility recommendations.

10. Heat Exposure

The testes are located outside the abdomen for an important biological reason:

normal sperm production requires a cooler environment.

Potential excessive heat sources include:

- frequent prolonged hot tubs,
- repeated high-temperature sauna exposure,
- intense occupational heat,
- untreated varicocele.

This does not mean a man needs to live in fear of ordinary warm weather.

The goal is simply to avoid:

unnecessary chronic testicular overheating.

11. Hormonal Abnormalities

Sperm production depends on a properly functioning:

Hypothalamic-Pituitary-Testicular Axis

Important hormones include:

- GnRH,
- FSH,
- LH,
- testosterone.

Hormonal disease may affect overall spermatogenesis and consequently motility.

Potential problems include:

- hypogonadotropic hypogonadism,
- pituitary disease,
- hyperprolactinemia,
- severe testosterone deficiency,
- thyroid disorders in selected cases.

Hormone testing should be based on the complete fertility picture.

Testosterone Therapy: A Major Fertility Warning

Men sometimes take testosterone because they believe:



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

“Higher testosterone must produce better sperm.”

This can produce exactly the opposite effect.

External testosterone suppresses:

- FSH,
- LH,
- intratesticular testosterone,

and may reduce sperm production dramatically.

AUA/ASRM guidance states clearly:

Testosterone monotherapy should not be prescribed to men interested in current or future fertility.

Bodybuilding anabolic steroids can have similar fertility-suppressing effects.

12. Testicular Disease or Previous Injury

Motility may be affected when testicular function has been damaged by:

- undescended testes,
- torsion,
- trauma,
- orchitis,
- previous surgery,
- testicular cancer,
- chemotherapy,
- radiation.

The medical history is therefore an important part of infertility evaluation.

13. Epididymal Dysfunction

Sperm are produced in the testis but gain important functional characteristics while passing through the:

epididymis.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

The epididymis contributes to:

- sperm maturation,
- membrane changes,
- acquisition of motility.

Therefore, significant epididymal inflammation, injury or obstruction can contribute to abnormal sperm function in selected men.

14. Abnormal Semen Liquefaction or High Viscosity

Semen normally changes from a gel-like state after ejaculation to a more fluid state.

Abnormal:

- liquefaction,
- or viscosity

may interfere with the release and movement of sperm in laboratory assessment and potentially in natural conception.

This should be distinguished from a primary defect of the sperm tail.

15. Antisperm Antibodies

In some men, antibodies may bind to sperm and interfere with:

- movement,
- mucus penetration,
- sperm interaction.

However, antisperm-antibody testing is **not required routinely for every patient with low motility**.

Current EAU guidance notes the lack of evidence-based universal reference limits for commonly used sperm-antibody tests.

Testing should therefore be selective.

16. Genetic Causes of Severe Asthenozoospermia

This is one of the most important scientific advances of recent years.

Most mild low motility is **not** caused by a single identifiable genetic mutation.

But severe or almost complete immotility may occasionally result from inherited abnormalities involving:

- sperm-tail proteins,
- dynein motors,
- ion channels,
- mitochondrial function,
- signaling pathways.

A major 2025 review describes rapidly expanding knowledge of genes causing both structural and functional asthenozoospermia.

Multiple Morphological Abnormalities of the Sperm Flagella – MMAF

One severe genetic phenotype is:

MMAF

Sperm may show:

- absent tails,
- very short tails,
- bent tails,
- coiled tails,
- irregular flagella.

This can result in profound:

- asthenozoospermia,
- and teratozoospermia.

Modern genetic studies have identified many genes involved in MMAF, including several affecting dynein and flagellar structural proteins.

In these patients, ordinary lifestyle advice alone cannot correct the structural genetic defect.

Primary Ciliary Dyskinesia and Low Sperm Motility

Another important condition is:



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Primary Ciliary Dyskinesia – PCD

The structures responsible for sperm-tail movement are biologically related to motile cilia elsewhere in the body.

Therefore, a man with:

- severe or total sperm immotility,
- chronic sinus problems,
- recurrent respiratory infections,
- bronchiectasis,

may require consideration of a ciliary disorder.

The 2025 asthenozoospermia review notes that most men with PCD develop severe or total asthenozoospermia because of ciliary/flagellar dysfunction.

This is one reason:

“0% motility” deserves more investigation than simply prescribing antioxidants.

When Should a Genetic Cause Be Suspected?

I become particularly interested in possible genetic evaluation when there is:

- almost complete or total sperm immotility,
- repeated severe asthenozoospermia,
- characteristic tail abnormalities,
- a family history of male infertility,
- parental consanguinity,
- respiratory symptoms suggesting PCD,
- a clear MMAF pattern.

Genetic testing is not necessary for every man whose progressive motility is mildly reduced.

Diagnosis of Low Sperm Motility

The diagnostic process should answer several questions:

1. Is the low motility real and persistent?
2. Are the sperm alive?



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

3. Is sperm concentration also reduced?
 4. Is morphology abnormal?
 5. Is there varicocele?
 6. Is there an infection?
 7. Is there hormonal disease?
 8. Is there a testicular problem?
 9. Is the condition severe enough to suggest a genetic defect?
 10. What is the fertility status of the female partner?
-

Step 1: Repeat the Semen Analysis

Current EAU guidance recommends:

at least two consecutive semen analyses when the first analysis is abnormal.

This is one of the most important practical recommendations in the entire article.

Before a patient is told:

“Your sperm are weak,”

the abnormality should first be confirmed properly.

Step 2: Use a Good Andrology Laboratory

Sperm motility is particularly vulnerable to poor laboratory handling.

The laboratory should follow standardized WHO methodology.

The current WHO sixth-edition manual remains the primary international standard for semen examination and laboratory quality control.

Step 3: Interpret the Whole Semen Report

I do not read only one line.

I assess:

- semen volume,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- concentration,
- total sperm number,
- progressive motility,
- total motility,
- morphology,
- vitality where necessary,
- liquefaction,
- viscosity,
- leukocytes or other findings when relevant.

Current WHO lower fifth-percentile reference values include approximately:

- 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%**
- normal morphology: **4%**.

Again, these are reference distributions—not absolute fertility cut-offs.

Step 4: Perform Vitality Testing When Motility Is Very Low

When more than 60% of sperm are immotile, current EAU guidance recommends assessing vitality.

This answers:

Are these sperm alive but motionless—or are they dead?

That distinction can be very important for:

- diagnosis,
- prognosis,
- ART planning.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Step 5: Take a Detailed Medical and Reproductive History

I ask about:

- duration of infertility,
- previous pregnancies,
- sexual intercourse,
- fever,
- infection,
- varicocele,
- childhood undescended testes,
- surgery,
- trauma,
- smoking,
- alcohol,
- recreational drugs,
- testosterone,
- anabolic steroids,
- medications,
- occupational exposures,
- chemotherapy,
- radiation,
- family history.

Current EAU guidance emphasizes these factors in the evaluation of infertile men.

Step 6: Physical Examination

A male fertility examination may include assessment of:

- testicular size,
- testicular consistency,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- epididymis,
- vas deferens,
- clinical varicocele,
- secondary sexual characteristics,
- other scrotal abnormalities.

This can identify conditions that a semen report cannot.

Step 7: Hormonal Testing When Indicated

Depending on the semen profile and examination, I may consider:

- FSH,
- LH,
- morning testosterone,
- prolactin,
- estradiol,
- thyroid testing

when clinically relevant.

Hormonal treatment should be based on a diagnosed abnormality rather than giving hormones to every man with low motility.

Step 8: Scrotal Ultrasound When Appropriate

Ultrasound may be useful when there is:

- testicular abnormality,
- uncertain examination,
- suspected varicocele,
- mass,
- other scrotal disease.

A Doppler scan is particularly useful for selected varicocele evaluation.

But an ultrasound is not necessary solely because progressive motility is mildly low.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Step 9: Infection Testing When Indicated

Testing may include:

- urinalysis,
- urine culture,
- STI testing,
- semen culture

according to symptoms and clinical findings.

Antibiotics should be used for:

documented or strongly suspected infection

rather than as routine “sperm motility medicine.”

Step 10: Sperm DNA Fragmentation in Selected Couples

Sperm DNA fragmentation is not a routine replacement for semen analysis.

Current EAU guidance recommends considering SDF particularly in:

- recurrent pregnancy loss,
- failure of assisted reproduction,
- unexplained male infertility.

A man with isolated mild low motility does not automatically need this test.

Treatment of Low Sperm Motility

There is no one treatment called:

“the motility medicine.”

Treatment depends on the cause.

The most successful strategy is:

Cause-Specific Treatment

1. Correct Lifestyle Factors



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Current WHO infertility guidance recommends:

- healthy diet,
- physical activity,
- tobacco cessation

for couples planning or attempting pregnancy.

For men with low motility, I commonly advise:

- stop tobacco,
- avoid anabolic steroids,
- reduce excessive alcohol,
- maintain healthy body weight,
- control diabetes,
- exercise appropriately,
- sleep adequately,
- reduce unnecessary heat,
- follow a nutritious diet.

These measures are especially useful when poor motility is partly related to:

- oxidative stress,
- metabolic disease,
- unhealthy lifestyle.

How Long Should Lifestyle Changes Be Given?

Patients sometimes repeat semen analysis after:

10 or 15 days

and become disappointed.

Sperm development is a long biological process.

For many interventions, clinically meaningful changes are better judged after:

approximately one full spermatogenic cycle or more

rather than after a few days.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

A practical follow-up period is often around:

three months

although timing should be individualized.

2. Treat a Clinically Significant Varicocele

If a man has:

- infertility,
- palpable clinical varicocele,
- persistently abnormal semen,

varicocele repair may be considered.

Current EAU guidance strongly recommends treatment in selected infertile men with a clinical varicocele and abnormal semen parameters when the couple's overall reproductive circumstances are appropriate.

AUA/ASRM provides similar guidance.

However:

subclinical varicocele visible only on imaging should not routinely be repaired for infertility.

3. Treat Infection Properly

If low motility accompanies a confirmed genital infection:

- appropriate antibiotic,
- STI management,
- partner treatment where necessary,
- follow-up

may improve the reproductive environment.

But antibiotics are not sperm stimulants.

They should not be given repeatedly when no infection exists.

4. Treat Hormonal Disease

One of the most treatable male-fertility endocrine disorders is:

Hypogonadotropic Hypogonadism

where the pituitary/hypothalamic hormonal signals required for spermatogenesis are deficient.

AUA/ASRM states that these men should be evaluated for the cause and treated accordingly; gonadotropin therapy can restore spermatogenesis in many appropriately selected patients.

This is very different from giving empirical hormones to a man with normal endocrine function.

5. Avoid Testosterone Monotherapy

I repeat this because it is so important:

Testosterone injections are not sperm treatment.

External testosterone may reduce sperm dramatically or stop sperm production altogether.

Men currently or potentially interested in biological fatherhood should not use testosterone monotherapy as infertility treatment.

6. Antioxidants and Nutritional Supplements

Because oxidative stress may affect sperm motility, a very large market has developed around:

- CoQ10,
- carnitine,
- vitamins C and E,
- selenium,
- zinc,
- lycopene,
- herbal antioxidants,
- combination fertility supplements.

Some individual studies report improvements in semen parameters.

However, current AUA/ASRM guidance states:



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

The benefits of supplements such as antioxidants and vitamins are of questionable clinical utility, and existing evidence is insufficient to recommend specific agents universally.

Therefore:

supplements should support a diagnostic treatment plan—not replace one.

7. IUI – Intrauterine Insemination

IUI may be useful in selected couples with:

- mild male-factor infertility,
- reasonable motile sperm numbers after semen processing,
- appropriate female reproductive factors.

During IUI:

- the semen is processed,
- the most useful motile sperm are concentrated,
- they are placed directly into the uterus near ovulation.

But very low total motile sperm count reduces the chance of success.

AUA/ASRM notes that when fewer than approximately **5 million motile sperm remain after processing**, the chance of pregnancy with IUI is limited.

This is not an absolute cut-off, but it is useful for counselling.

8. IVF

IVF may be appropriate when there is:

- significant male-factor infertility,
- female-factor infertility,
- failed simpler treatment,
- age-related fertility urgency,
- other indications.

Sperm and eggs are brought together in the laboratory.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

9. ICSI – Intracytoplasmic Sperm Injection

ICSI has transformed the management of severe male infertility.

During ICSI:

one selected viable sperm is injected directly into the egg.

This can bypass many problems related to:

- low sperm number,
- poor motility,
- abnormal morphology.

AUA/ASRM notes that ICSI can largely overcome the adverse effect of abnormal sperm concentration, motility and morphology when adequate viable sperm are available for injection.

Therefore, severe asthenozoospermia does not automatically mean biological fatherhood is impossible.

What If Sperm Are Alive but Completely Immotile?

This is a specialized situation.

If sperm are:

- immotile,
- but viable,

specialized embryology techniques can sometimes help identify living sperm for ICSI.

The fertility laboratory may use vitality-based or functional selection approaches.

However, severe total immotility should also prompt consideration of:

- genetic flagellar disease,
- primary ciliary dyskinesia,
- MMAF,

rather than simply proceeding without understanding the diagnosis.

What If Sperm Are Both Immotile and Dead?

If a very high proportion of sperm are non-viable, the condition may represent:

Necrozoospermia

rather than isolated asthenozoospermia.

Potential causes and treatment strategy may differ.

This is why vitality testing matters.

The Unani Concept of Low Sperm Motility

In Unani medicine, male reproductive disorders are approached through a broad individualized framework involving:

- **Mizaj – temperament**
- **Akhlat – traditional humoral balance**
- reproductive-organ strength,
- digestion,
- nutrition,
- lifestyle,
- sleep,
- physical activity,
- general vitality.

Classical Unani medicine developed long before:

- computer-assisted semen analysis,
- motility percentages,
- electron microscopy,
- genetic sequencing.

Therefore:

there is no classical Unani term that should be presented as an exact microscopic equivalent of modern asthenozoospermia.

Traditional concepts can help guide whole-person treatment, while:

modern semen analysis defines the motility abnormality objectively.

The Four Traditional Humors



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Classical Unani theory discusses:

- **Dam**
- **Balgham**
- **Safra**
- **Sauda**

and understands health in relation to their traditional balance and the patient's Mizaj.

Modern medicine, by contrast, evaluates:

- sperm movement,
- sperm concentration,
- hormones,
- flagellar structure,
- genetics,
- oxidative stress.

I believe these frameworks should be discussed respectfully but not artificially equated.

For example:

Balgham is not progressive motility, and humoral imbalance is not a sperm-tail mutation.

How Unani Medicine Can Be Useful in Low Sperm Motility

The most valuable role of Unani treatment is its:

individualized and holistic approach.

Instead of treating only one semen percentage, the practitioner evaluates:

- diet,
- digestion,
- obesity,
- weakness,
- sleep,
- physical activity,
- stress,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- sexual health,
- semen parameters,
- general medical conditions.

This is particularly useful in men whose low motility coexists with:

- poor lifestyle,
- general nutritional weakness,
- metabolic problems,
- mild idiopathic semen abnormalities,
- sexual-health concerns.

Major Unani Therapeutic Approaches

Traditional Unani treatment can broadly include:

Ilaj-bil-Ghiza

Dietotherapy

Ilaj-bit-Tadbir

Regimenal therapy

Ilaj-bid-Dawa

Pharmacotherapy

Ilaj-bil-Yad

Surgical treatment

This is an important concept.

A properly integrated Unani approach does not mean:

“Only herbal medicine should ever be used.”

If:

- varicocele repair,
- infection treatment,
- hormone therapy,
- IVF,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- or ICSI

is medically appropriate, it can be incorporated into the patient's fertility pathway.

Ilaj-bil-Ghiza: Dietotherapy for Male Reproductive Health

No food can guarantee an increase in sperm motility.

However, a healthy diet can improve:

- metabolic health,
- antioxidant intake,
- micronutrient status,
- body weight,
- general reproductive health.

I commonly emphasize:

- vegetables,
- fruits,
- pulses,
- whole grains,
- nuts and seeds,
- appropriate protein,
- healthy fats,
- adequate hydration.

I reduce:

- tobacco,
- excessive sugar,
- ultra-processed foods,
- excessive alcohol,
- repeated deep-fried food.

This is fertility support rather than a miracle diet.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Ilaj-bit-Tadbir

Regimenal and lifestyle management may include:

- regular appropriate exercise,
- healthy sleep,
- weight management,
- stress reduction,
- minimizing avoidable heat,
- correcting sedentary habits.

These measures overlap considerably with current modern reproductive-health recommendations.

Ilaj-bid-Dawa: Unani Pharmacotherapy

Traditional Unani pharmacotherapy may be selected based on:

- Mizaj,
- general reproductive health,
- semen analysis,
- associated symptoms,
- nutritional status,
- other medical conditions.

At Saira Health Care, one formulation particularly associated with male reproductive and semen-quality support is:

Dr. Qasmi's Spermogenic Powder

The current Saira Health Care Pharmacy page specifically lists **decreased sperm motility** among the conditions for which Spermogenic is used in the clinic's traditional treatment programme.

The public formulation information lists ingredients including traditional herbs such as:

- Asgand Nagori,
- Kaunch Beej,
- Khulanjan,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- Maror Phali,
- Satawar,
- Musli Safed,
- Salab preparations,
- Darchini,

among other ingredients.

How I Position Spermogenic in My Treatment Approach

I do not believe Spermogenic should be described as:

“a universal medicine that cures all low sperm motility.”

At Saira Health Care, it may be considered as part of:

an individualized Unani male-fertility programme

after assessing:

- semen concentration,
- motility,
- morphology,
- vitality,
- varicocele,
- hormones,
- lifestyle,
- infection,
- and couple-level fertility factors.

The current Saira Health Care website also discusses Spermogenic and Dr. Qasmi's Nuskha No. 129 within its existing treatment material for reduced sperm motility and male infertility.

However:

A current pharmacy description or clinical experience should not be confused with an independently replicated randomized controlled trial.

I have not identified a high-quality peer-reviewed product-specific trial proving that Spermogenic reliably normalizes motility or increases live-birth rates in every man.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

That distinction is important for responsible medical publication.

What About Classical Spermogenic Unani Medicines?

Classical practice includes many medicines traditionally described as:

- Muqawwi-e-Bah,
- Muwallid-e-Mani,
- reproductive tonics,
- spermatogenic formulations.

The supplied traditional material mentions examples such as:

- Majun Salab,
- Habbe Mumsik,
- Safoof formulations,
- Jawarish preparations,
- and Kushta preparations.

These medicines should not be self-prescribed simply because:

“Motility is low.”

Their:

- composition,
- dose,
- indication,
- quality control,
- safety

matter.

Particular caution is appropriate with:

Kushta or mineral/metal-containing formulations

because quality, preparation and dose are extremely important.

They should only be used under qualified professional supervision where appropriate.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

What Does Published Unani Research Show?

There is some published research suggesting potential improvement in semen parameters with selected Unani formulations.

For example, a CCRUM-associated clinical study involving **30 men with oligospermia** reported improvement in mean sperm motility from approximately **21.7% before treatment to 46.6% after 60 days** with the studied formulation.

Another retrospective analysis involving **126 patients with idiopathic oligospermia** compared several Unani treatment groups and reported improvement in sperm motility in one group.

These findings are encouraging because they show that traditional Unani male-fertility treatment deserves further scientific study.

However, we must understand their limitations:

- they are older studies,
- sample sizes are limited,
- some are uncontrolled or retrospective,
- patients primarily had oligospermia rather than isolated asthenozoospermia,
- pregnancy and live-birth outcomes were not robustly established,
- they do not prove the efficacy of every modern commercial formulation.

Therefore:

Unani research provides encouraging preliminary evidence—not a universal cure claim.

Dr. Nizamuddin Qasmi's Special Individualized Approach to Low Sperm Motility

When a patient consults me for low sperm motility, I prefer a structured approach.

Step 1: Confirm the Report

I first ask:

“Is this one semen analysis or has it been repeated?”

If abnormality is based on one test, I often recommend confirmation according to standard laboratory methodology.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Step 2: Look at Progressive Motility, Not Just “Motile Sperm”

I examine:

- rapid progressive sperm,
- slow progressive sperm,
- non-progressive sperm,
- immotile sperm.

This gives a more meaningful picture.

Step 3: Check the Count and Morphology

Low motility with:

- 80 million sperm/mL

is not the same clinical problem as low motility with:

- 2 million sperm/mL.

Likewise, motility plus severe abnormal morphology may require a different strategy.

Step 4: Check Vitality When Many Sperm Are Immotile

If most sperm are motionless, I want to know:

Are they alive?

This helps distinguish asthenozoospermia from necrozoospermia.

Step 5: Look for Varicocele

A clinically significant varicocele is one of the important potentially correctable causes of abnormal semen.

I assess it clinically and use Doppler ultrasound when indicated.

Step 6: Search for Infection or Inflammation

If the patient has:

- burning urination,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- discharge,
- epididymal pain,
- prostatitis symptoms,
- significant leukocytes,

I investigate appropriately.

I do not prescribe antibiotics automatically.

Step 7: Review Hormones

Hormone testing is individualized.

If there are:

- severe semen abnormalities,
- small testes,
- reduced libido,
- low testosterone symptoms,
- abnormal physical findings,

I evaluate the endocrine system appropriately.

Step 8: Review Lifestyle and Medicines

I ask about:

- smoking,
- tobacco,
- alcohol,
- obesity,
- diabetes,
- sleep,
- physical activity,
- hot tubs,
- occupational heat,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- testosterone,
- anabolic steroids,
- recreational drugs.

Sometimes the most important “fertility medicine” is removing a harmful exposure.

Step 9: Identify Severe Genetic Phenotypes

If there is:

- 0–1% motility,
- repeated almost-complete immotility,
- severe tail abnormalities,
- chronic respiratory illness,
- family history,

I consider whether genetic or ciliary evaluation is required.

This prevents years of ineffective empirical medicine.

Step 10: Introduce Individualized Unani Care

Where appropriate, I may combine:

- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- Ilaj-bid-Dawa,
- lifestyle optimization,
- Spermogenic or other selected reproductive formulations

according to the patient's actual condition.

No one medicine is given simply because the report contains the word:

“asthenozoospermia.”

Step 11: Monitor Objectively

Treatment response should be assessed with:

- repeat semen analysis,
- progressive motility,
- total motile sperm count,
- sperm concentration,
- morphology,
- and where indicated, other fertility investigations.

Success should not be judged by:

- semen becoming thicker,
- increased libido,
- feeling more energetic.

Those may be welcome changes but:

they do not prove sperm motility has improved.

Step 12: Protect the Couple's Reproductive Time

This is one of the most important parts of my fertility practice.

If the wife is:

- older,
- has low ovarian reserve,
- has tubal disease,
- or another time-sensitive problem,

I do not believe a couple should wait indefinitely for semen percentages to improve.

IUI, IVF or ICSI may need to be discussed at the correct time.

When Should IUI Be Considered?

IUI may be reasonable when:

- the motility reduction is mild or moderate,
- sufficient motile sperm remain after processing,
- the female partner's reproductive factors are favorable.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

But AUA/ASRM notes that IUI success becomes limited when the post-processing total motile sperm count is below approximately:

5 million.

The final decision is couple-specific.

When Is ICSI Particularly Useful?

ICSI may be especially useful when there is:

- severe asthenozoospermia,
- very low total motile sperm count,
- severe combined semen abnormalities,
- repeated fertilization problems,
- genetic flagellar disease with viable sperm,
- other major male-factor infertility.

As long as an embryologist can identify:

a viable sperm suitable for injection,

poor swimming ability can often be bypassed through ICSI.

Does Better Motility Guarantee Pregnancy?

No.

Even a dramatic improvement from:

- 15% to 45%

does not guarantee pregnancy.

Pregnancy depends on:

- sperm number,
- sperm function,
- female age,
- egg quality,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- ovulation,
- fallopian tubes,
- uterus,
- timing,
- embryo development.

Therefore, fertility success should always be assessed at:

the couple level.

Can Sperm Motility Naturally Improve?

Yes, in some men.

This may occur after:

- recovery from fever,
- stopping tobacco,
- stopping anabolic steroids,
- treating infection,
- varicocele treatment,
- metabolic improvement,
- correcting nutritional deficiency,
- reducing excessive heat.

Other causes—particularly severe inherited flagellar defects—may not be medically reversible.

Can Low Motility Return After Improvement?

Yes.

Semen quality changes over time.

Temporary factors such as:

- illness,
- fever,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- lifestyle,
- medications,
- environmental exposure

may alter the result again.

This is why I focus on:

long-term reproductive health rather than chasing one laboratory number.

How Should We Define “Success” in Treatment?

Success may mean different things for different men.

For one man:

Progressive motility improves.

For another:

Total motile sperm count becomes sufficient for IUI.

For another:

Varicocele repair improves semen quality.

For another:

An infection is identified and treated.

For another:

A genetic cause is diagnosed, preventing years of ineffective medication.

For another:

ICSI produces pregnancy despite persistent severe asthenozoospermia.

All of these can represent successful fertility care.

Success Stories and Responsible Medical Communication

Patients naturally find successful fertility stories encouraging.

Saira Health Care has many educational materials discussing male-fertility treatment and sperm-quality improvement.

However, a scientifically responsible website should not invent or exaggerate case outcomes.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

A meaningful success story should ideally include:

- baseline semen report,
- progressive motility,
- sperm concentration,
- morphology,
- diagnosis,
- treatment period,
- follow-up report,
- pregnancy outcome where available,
- patient permission for publication.

I do not believe statements such as:

“This medicine improves sperm motility in 90% of patients”

should be published without reliable clinical data supporting that percentage.

Individual success can provide:

hope

but it should not be converted into:

a guaranteed success rate.

Common Myths About Low Sperm Motility

Myth 1: Low motility means all sperm are dead.

Fact: Immotile sperm may still be alive. Vitality testing helps distinguish the two.

Myth 2: A man with low motility is impotent.

Fact: Fertility and erection are different functions.

Myth 3: Thick semen means good motility.

Fact: Motility can only be assessed microscopically.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Myth 4: Watery semen means sperm cannot move.

Fact: Semen appearance does not reliably predict sperm motility.

Myth 5: One semen report permanently defines fertility.

Fact: Semen parameters fluctuate; current EAU guidance recommends repeat testing when results are abnormal.

Myth 6: Progressive motility below 30% means pregnancy is impossible.

Fact: WHO's lower reference point is not an absolute fertile/infertile boundary.

Myth 7: Every man with low motility needs antibiotics.

Fact: Antibiotics should treat an infection, not a motility percentage.

Myth 8: Every man needs antioxidant supplements.

Fact: AUA/ASRM considers supplement benefits of questionable clinical utility and cannot recommend one universal agent.

Myth 9: Testosterone injections increase sperm motility.

Fact: External testosterone can suppress sperm production and even produce azoospermia.

Myth 10: Every varicocele must be operated upon.

Fact: Intervention is generally directed at selected men with a clinical varicocele, infertility and abnormal semen.

Myth 11: Herbal treatment cannot contribute to male infertility.

Fact: Unani medicine provides established traditional approaches to diet, lifestyle and pharmacotherapy, and limited clinical studies have reported semen-parameter improvements. However, stronger evidence is still needed for specific products and live-birth outcomes.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Myth 12: One herbal powder cures every case of asthenozoospermia.

Fact: Low motility has many causes, including genetic flagellar disorders that cannot logically be corrected by one universal formulation.

Myth 13: 0% motility means ICSI is impossible.

Fact: If viable sperm can be identified, ICSI may still be possible in specialized fertility laboratories.

Myth 14: If ICSI is available, there is no reason to investigate the man.

Fact: Investigation may identify:

- varicocele,
- hormonal disease,
- infection,
- genetic disorders,
- health conditions

that matter beyond conception.

Frequently Asked Questions

What is low sperm motility?

It means that an abnormally low proportion of sperm move effectively, especially in a forward direction.

What is the current normal sperm motility reference?

WHO 2021 lower fifth-percentile values are approximately:

- total motility: **42%**
- progressive motility: **30%.**

These are reference points rather than absolute fertility cut-offs.

Is 25% progressive motility very bad?

It is below the WHO lower reference distribution, but prognosis depends on:

- sperm concentration,
- total sperm count,
- morphology,
- semen volume,
- female-partner factors.

A single percentage should not be interpreted alone.

Can low motility cause infertility?

Yes.

Poor progressive movement may reduce the probability of sperm reaching and fertilizing the egg naturally.

Can a man with asthenozoospermia become a father naturally?

Yes.

Natural conception remains possible in many mild or moderate cases.

Can low motility improve?

Yes, particularly when it is related to a reversible cause such as:

- lifestyle,
 - fever,
 - infection,
 - clinically important varicocele,
 - metabolic disease,
 - harmful exposures.
-

How long does sperm-motility treatment take?

Sperm development requires months.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

I generally evaluate meaningful semen changes over approximately several months rather than a few days.

Should semen analysis be repeated?

Yes when the baseline result is abnormal.

EAU recommends at least two consecutive analyses.

Are 70% immotile sperm all dead?

No.

If more than 60% are immotile, vitality testing is particularly useful.

What is sperm vitality?

Vitality measures whether sperm are:

- alive,
- or dead.

Motility measures whether they move.

The two are related but different.

Does varicocele reduce motility?

It can in selected men.

Clinically significant varicocele may contribute to abnormal semen and oxidative stress.

Can varicocele surgery improve motility?

Some studies show improvement after repair, although current guideline evidence regarding the size of the motility benefit is mixed. Treatment is based on the complete fertility picture.

Can infection reduce sperm motility?

Yes, certain genital-tract infections and inflammatory conditions can impair sperm quality.

The infection should be properly diagnosed.

Does masturbation reduce sperm motility?

Normal masturbation is not considered a cause of chronic asthenozoospermia.

Very short or very long abstinence intervals may alter semen-analysis parameters temporarily.

Does smoking affect sperm motility?

Smoking is associated with poorer reproductive health and increased oxidative stress.

Stopping tobacco is strongly advisable when trying to conceive.

Does alcohol affect sperm?

Heavy alcohol consumption can adversely affect male reproductive and general health.

Can obesity affect sperm motility?

Obesity and metabolic dysfunction may adversely influence hormones and semen quality in some men.

Does mobile-phone use cause low motility?

Evidence remains inconsistent.

Avoiding prolonged direct heat exposure is more practical than becoming fearful of ordinary mobile-phone use.

Do hot baths affect sperm?

Repeated excessive testicular heat may temporarily impair semen quality in susceptible men.

Can Unani medicine help improve sperm motility?

Unani medicine can contribute through:

- individualized dietary management,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- regimenal care,
- lifestyle correction,
- supervised pharmacotherapy,
- general reproductive-health optimization.

Published small Unani studies have reported improvements in sperm motility, although stronger controlled evidence is needed.

What is Spermogenic?

Spermogenic is a Dr. Qasmi herbal formulation currently listed by Saira Health Care Pharmacy for male reproductive-health concerns including decreased sperm motility.

I consider its appropriate role to be within an individualized fertility programme rather than as a guaranteed cure.

Is Spermogenic scientifically proven to normalize motility?

The Saira Health Care pharmacy describes the formulation as researched and used for male fertility. However, I do not identify a high-quality independently published product-specific randomized controlled trial establishing universal normalization of motility or improved live-birth rates.

Therefore, treatment progress should be verified through objective semen analysis.

Can IUI work with low motility?

Yes in selected cases.

Success depends greatly on the total number of motile sperm available after processing.

AUA/ASRM notes that IUI chances are limited when post-wash total motile sperm count is below approximately 5 million.

Can IVF help?

Yes.

IVF may be recommended according to the severity of male and female factors.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Is ICSI better for severe low motility?

ICSI can bypass severe motility problems by injecting a viable sperm directly into the egg.

It is particularly useful in severe male-factor infertility.

Can totally immotile sperm be used in ICSI?

Sometimes yes, if viable sperm can be identified.

This requires an experienced embryology laboratory.

Should genetic testing be done for low motility?

Not routinely for mild asthenozoospermia.

It becomes more important with:

- near-total immotility,
 - severe sperm-tail defects,
 - MMAF,
 - suspected primary ciliary dyskinesia,
 - suggestive family history.
-

Latest Scientific Perspective: 2025–2026

Modern understanding of sperm motility has progressed significantly beyond simply counting moving sperm.

WHO's First Global Infertility Guideline – November 2025

WHO published its first comprehensive global infertility guideline in November 2025.

It emphasizes:

- evidence-based diagnosis,
- assessment of male and female factors,
- healthy lifestyle,
- tobacco cessation,
- appropriate progression to IUI or IVF,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- and psychological support.
-

Current 2026 EAU Male-Infertility Guidance

Current EAU recommendations emphasize:

- standardized WHO semen analysis,
 - repeat semen tests when baseline results are abnormal,
 - complete male evaluation,
 - selective use of advanced tests,
 - cause-specific treatment,
 - simultaneous evaluation of both partners.
-

Genetics Has Become Increasingly Important

A detailed 2025 review demonstrated the rapidly growing number of genes associated with:

- structural sperm-tail abnormalities,
- ion-channel defects,
- functional sperm activation disorders,
- primary ciliary dyskinesia.

This has changed the evaluation of men with:

severe or total asthenozoospermia.

2026 Genetic Research Continues to Expand

Recent 2026 research continues to identify new pathogenic mutations involving sperm-tail proteins.

For example, newly described FSIP2 mutations have been linked to severe flagellar abnormalities and male infertility.

These findings reinforce an important clinical point:

some low-motility conditions are structural genetic diseases, not nutritional deficiencies.

Supplement Evidence Remains Uncertain



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Despite enormous commercial interest in:

- antioxidant products,
- vitamin combinations,
- fertility powders,

AUA/ASRM continues to state that the clinical utility of supplements remains questionable and evidence is inadequate to recommend specific universal agents.

This does not mean supportive medicine has no role.

It means treatment should remain:

individualized, monitored and evidence-aware.

Dr. Nizamuddin Qasmi and Saira Health Care

I am **Dr. Nizamuddin Qasmi**, Founder and Chief Physician of **Saira Health Care**, with a focused specialist practice in:

Sexual Disorders & Infertility

My professional education and training include:

- **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**

Saira Health Care's public physician profile identifies my principal field of practice as sexual disorders and infertility and specifically includes **Asthenospermia** among the male-fertility conditions addressed in the clinic.

Current Saira Health Care educational material also identifies me as Founder and Chief Physician with a focused clinical practice in sexual disorders and infertility and lists the additional **Masters in Male Infertility – MasterHealthPro (HealthPro)** within the professional profile used on the website.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Saira Health Care's Contribution to Male Infertility and Low Sperm Motility

At Saira Health Care, I believe an important contribution is:

helping patients understand what their semen report actually means.

A patient may arrive terrified because:

“60% sperm are not moving.”

But his total motile sperm count may still be clinically useful.

Another man may have:

“30% motility”

but also have extremely low sperm concentration, creating a much more serious problem.

Another may have:

0% motility

and require vitality and genetic evaluation.

Another may simply be recovering from:

- high fever,
- infection,
- or steroid use.

They should not all receive the same prescription.

Our Integrative Philosophy

At Saira Health Care, I believe modern infertility medicine and Unani medicine should be used according to what each contributes best.

Modern fertility diagnostics help us identify:

- motility percentage,
- sperm concentration,
- morphology,
- vitality,
- hormones,
- varicocele,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- infection,
- genetic disease.

Unani medicine can contribute through:

- individualized Mizaj assessment,
- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- supervised traditional pharmacotherapy,
- lifestyle optimization,
- general reproductive-health support.

Modern reproductive treatment can provide:

- varicocele repair,
- appropriate hormonal therapy,
- IUI,
- IVF,
- ICSI

where required.

The patient should not have to choose between:

“traditional medicine”

and:

“scientific diagnosis.”

The better approach is responsible integration.

Why I Do Not Promise a Fixed Success Rate

Asthenozoospermia can result from:

- smoking,
- varicocele,
- fever,
- infection,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- obesity,
- hormonal disease,
- genetic tail disorders,
- idiopathic causes.

It is therefore impossible for one product to have the same result in every patient.

A man whose motility is low because of:

smoking

is biologically different from a man with:

inherited MMAF.

A professional infertility clinic must recognize that difference.

My Final Message to Patients With Low Sperm Motility

If your semen report says:

“Low Motility”

please do not panic.

But do not ignore it either.

Ask the right questions:

Was my semen analysis performed correctly?

Should it be repeated?

What is my progressive motility?

What is my total motility?

What is my total motile sperm count?

Are my immotile sperm alive or dead?

What is my sperm concentration?

What is my morphology?

Do I have a clinical varicocele?

Do I have infection or inflammation?

Did I recently have fever?



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Do I smoke?

Am I using testosterone or steroids?

Do I need hormone testing?

Is my motility so severe that a genetic flagellar disorder should be considered?

How is my wife's fertility?

Can we continue trying naturally?

Would IUI help?

Would IVF/ICSI give us a better chance?

These questions are far more useful than simply asking:

“Which medicine makes sperm run faster?”

Conclusion

Low sperm motility—commonly called **asthenozoospermia**—is an important form of male-factor infertility in which sperm have reduced ability to move effectively, particularly in a forward direction.

Current WHO 2021 semen-reference distributions include approximately:

- **42% total motility**
- and **30% progressive motility**

as lower fifth-percentile values among fertile reference populations.

These values should **not** be interpreted as strict fertile-versus-infertile boundaries.

The complete semen profile and the fertility of both partners must be considered.

Low motility usually causes no visible physical symptom.

Most men have:

- normal libido,
- normal erection,
- normal ejaculation,
- normal-looking semen.

The problem is usually discovered during:

infertility evaluation.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Potential causes include:

- temporary semen variation,
- improper sample handling,
- recent fever,
- varicocele,
- genital infection,
- oxidative stress,
- smoking,
- heavy alcohol,
- obesity,
- diabetes,
- excessive heat,
- hormonal disorders,
- epididymal disease,
- testicular injury,
- medications and anabolic steroids,
- and genetic flagellar or ciliary disorders.

Diagnosis begins with properly performed semen analysis.

Current EAU guidance recommends:

at least two consecutive semen analyses when the baseline result is abnormal.

When more than approximately 60% of sperm are immotile, **vitality testing** becomes particularly important to distinguish living immotile sperm from dead sperm.

Treatment should focus on the cause.

This may include:

- lifestyle optimization,
- tobacco cessation,
- metabolic-health improvement,
- treating infection,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- treating selected hormonal disease,
- varicocele repair in appropriately selected patients,
- avoiding testosterone and anabolic steroids,
- and assisted reproductive technologies.

Supplements and antioxidants may be used selectively, but current AUA/ASRM guidance considers their overall clinical benefit uncertain and does not recommend a universal specific product.

For selected couples with sufficient motile sperm:

IUI

may be considered.

However, AUA/ASRM notes reduced IUI success when post-processing total motile sperm count is below approximately **5 million**.

For severe male-factor infertility:

IVF with ICSI

can bypass much of the problem caused by poor sperm motility, provided suitable viable sperm can be identified.

The **Unani system of medicine** can make a useful contribution through:

- Mizaj-based individualized assessment,
- Ilaj-bil-Ghiza,
- Ilaj-bit-Tadbir,
- Ilaj-bid-Dawa,
- nutrition,
- lifestyle management,
- general reproductive-health optimization,
- and selected traditional medicines.

Published CCRUM-associated studies have reported improvement in sperm motility with selected Unani formulations, including one small 30-patient study in which mean motility increased substantially during treatment. These results are encouraging but should be interpreted as preliminary evidence rather than proof of universal efficacy.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

At Saira Health Care, Dr. Qasmi's **Spermogenic Powder** is used within selected individualized male-fertility programmes and is currently listed specifically for concerns including decreased sperm motility.

Its role should be understood as part of:

individualized integrative fertility management

rather than as a guaranteed cure for every cause of asthenozoospermia.

My treatment philosophy at Saira Health Care can therefore be summarized as:

Confirm the semen abnormality.

Repeat the test when required.

Look at progressive rather than total movement alone.

Check vitality when most sperm are immotile.

Assess sperm count and morphology together.

Look for varicocele, infection and hormonal causes.

Ask about smoking, obesity, fever, heat and medications.

Never use testosterone as a fertility medicine.

Consider genetic evaluation in severe or total immotility.

Use Unani medicine individually and responsibly.

Monitor improvement objectively through semen analysis.

Evaluate the female partner at the same time.

Use IUI, IVF or ICSI when the couple's fertility situation requires it.

And never promise pregnancy from one motility percentage, one supplement or one herbal formulation.

For every man who asks me:

“Doctor, my sperm are slow. Can I still become a father?”

my answer is:

In many cases, yes. Low sperm motility is an important fertility problem, but it is not automatically the end of biological fatherhood. The most important step is to identify why the sperm are moving poorly and choose the treatment according to that cause.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

About the Author

Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility

Professional Education & 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**

Saira Health Care's public professional profile identifies Dr. Nizamuddin Qasmi's focused work in sexual disorders and infertility and specifically includes **Asthenospermia, oligospermia, azoospermia, abnormal sperm morphology, varicocele and other male-fertility disorders** within the practice.

His clinical approach combines:

- Unani medical principles,
- male-infertility assessment,
- semen analysis,
- reproductive-hormone evaluation,
- lifestyle correction,
- fertility counselling,
- and appropriate referral for contemporary fertility treatment.

Medical Disclaimer

This article is intended for general medical education and reproductive-health awareness.

It is not a substitute for:

- individual medical consultation,



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

- physical examination,
- semen analysis,
- sperm vitality assessment,
- hormone testing,
- scrotal examination,
- genetic assessment,
- or personalized infertility treatment.

A diagnosis of low sperm motility should not be based solely on:

- semen appearance,
- sexual performance,
- one non-standard laboratory test,
- or self-assessment.

Do not independently start or stop:

- antibiotics,
- testosterone,
- anabolic steroids,
- hCG,
- FSH,
- clomiphene or other hormonal medicines,
- high-dose antioxidants,
- Unani medicines,
- Kushta preparations,
- herbal supplements,
- or fertility products

without appropriate professional advice.

Dr. Qasmi's Spermogenic Powder, Nuskha No. 129 or other traditional fertility formulations should not be interpreted as guaranteed cures for every case of low sperm motility.

Severe or complete sperm immotility may require:

- sperm vitality testing,
- specialist andrological evaluation,
- genetic testing in selected cases,
- and assisted reproduction.

Couples should not delay appropriate IUI, IVF or ICSI simply to wait indefinitely for sperm motility to improve when:

- female reproductive age is advancing,
- ovarian reserve is low,
- motile sperm numbers remain very poor,
- or another important fertility condition is present.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com