Male Counselling for Achieving Pregnancy: A Complete Modern and Unani Approach to Male Fertility, Sexual Health and Preparation for Fatherhood

A Comprehensive Guide to Sperm Health, Semen Analysis, Intercourse Timing, Lifestyle, Emotional Well-Being, Unani Principles and Responsible Fertility Care

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Introduction

When a couple is trying to achieve pregnancy, attention is very often directed almost entirely toward the woman. She is asked about her menstrual cycle, ovulation, hormones and fallopian tubes, while the male partner may be told simply to “keep trying.”

This is not an adequate approach to modern fertility care.

I frequently explain to couples at **Saira Health Care** that pregnancy is a shared reproductive process. Healthy ovulation and functioning fallopian tubes are important, but so are sperm production, sperm transport, ejaculation, erectile function, frequency and timing of intercourse, and the overall reproductive health of the male partner.

The World Health Organization estimates that approximately **one in six people of reproductive age experience infertility during their lifetime**. Male infertility may result from problems with semen ejaculation, absence or reduced numbers of sperm, abnormal sperm movement or morphology, reproductive-tract obstruction, hormonal problems and testicular dysfunction.

The AUA/ASRM male-infertility guideline specifically recommends **concurrent assessment of both partners** during an infertility evaluation. Initial male evaluation should include a reproductive history and one or more semen analyses.

Male counselling therefore has two important roles. Before pregnancy, it helps optimize **fertility, sexual health, lifestyle and appropriate investigation**. After pregnancy occurs,

counselling can help a man adjust emotionally to fatherhood, support his partner, communicate effectively and prepare responsibly for childbirth and family life.

As a physician focused on **sexual disorders and infertility**, I consider both aspects important.

What Is Male Counselling for Pregnancy?

Male counselling for pregnancy is a structured process of educating, evaluating and supporting a man before conception, during infertility treatment and, when relevant, throughout his partner's pregnancy.

It should not be confused with simply telling a man to “reduce stress” or “eat healthy foods.”

Good counselling explores the man's reproductive history, sexual function, semen findings, previous illnesses, medications, lifestyle, tobacco and alcohol exposure, use of testosterone or anabolic steroids, occupational exposures, relationship concerns and emotional readiness for conception and fatherhood.

It can also identify problems that a man may hesitate to discuss openly, such as erectile dysfunction, premature ejaculation, inability to ejaculate inside the vagina, reduced sexual desire or anxiety related to timed intercourse.

The WHO's first global infertility guideline, released in November 2025, emphasizes fertility education, lifestyle measures, diagnosis of both male and female causes, progressive evidence-based treatment and continuing psychosocial support.

For me, this makes counselling a genuine component of fertility treatment—not an optional conversation after all medical treatments have failed.

Why Male Counselling Is Important

A semen analysis may identify an abnormality, but it cannot tell us everything about the man.

Two men may both have reduced sperm motility but require completely different approaches.

One may smoke heavily. Another may have a clinical varicocele. Another may have uncontrolled diabetes. Another may be using testosterone injections from a gym. Another may have had an undescended testicle or previous testicular surgery. Another may have a genetic cause that cannot be corrected simply with vitamins or herbal medicines.

This is why counselling begins with **understanding the cause rather than immediately prescribing a sperm tonic**.

The AUA/ASRM guideline notes that male fertility evaluation can identify potentially correctable causes, irreversible conditions that may still be managed with assisted reproduction, genetic abnormalities, important lifestyle factors and occasionally significant underlying health conditions.

Male Fertility Is Not the Same as Sexual Power

This distinction is extremely important.

A man may have excellent erections, strong sexual desire and normal ejaculation but still have a very low sperm count.

Another man may have erectile dysfunction but completely normal sperm production.

Sexual performance and sperm production are related to some common hormonal and health factors, but they are **not the same biological function**.

At Saira Health Care, I frequently see men who assume:

“My sexual strength is good, therefore my fertility must also be good.”

That conclusion cannot be made without proper evaluation.

Likewise, a man should not assume he is infertile simply because his erection is weak or because his semen looks thin.

The Role of the Male Partner in Achieving Pregnancy

To achieve natural pregnancy, the male reproductive system must successfully perform several functions.

The testes must produce sperm. The epididymis must allow sperm maturation and transport. The vas deferens and ejaculatory ducts must remain sufficiently functional. Seminal fluids must combine with sperm. The man must usually be able to achieve intercourse and deposit semen in the vagina at an appropriate time.

Even when all these steps appear normal, sperm must still have sufficient functional capacity to reach and fertilize the egg.

Male fertility therefore cannot be judged from appearance, physical strength, sexual desire or semen consistency alone.

When Should the Male Partner Be Evaluated?

If a couple meets criteria for infertility, both partners should ideally be evaluated at approximately the same time.

WHO defines infertility as failure to achieve pregnancy after **12 months or more of regular unprotected sexual intercourse**.

However, the timing of evaluation also depends strongly on the female partner's age and medical history. ASRM recommends earlier evaluation after about six months when the female partner is 35 years or older and more immediate assessment in certain higher-risk circumstances.

A man also deserves earlier evaluation when there is a known fertility concern such as previous undescended testis, testicular injury, chemotherapy, radiotherapy, significant genital surgery, azoospermia, severe sexual dysfunction or another condition that may impair fertility.

There is little benefit in repeatedly investigating one partner while leaving an obvious risk factor in the other unexamined.

Semen Analysis: The Foundation of Male Fertility Evaluation

A **semen analysis** is the basic laboratory investigation used to evaluate male fertility.

It assesses features including semen volume, sperm concentration, total sperm number, motility and morphology.

However, I always explain something important to patients:

A semen report is not simply a “fertile” or “infertile” certificate.

The AUA/ASRM guideline states that individual semen parameters above or below reference limits do not, by themselves, perfectly predict fertility or infertility. The significance becomes greater when multiple important abnormalities are present.

Semen parameters also vary naturally from one sample to another.

For this reason, if an initial semen analysis is abnormal, repeat testing is commonly useful before making major conclusions. AUA/ASRM guidance notes that at least two analyses, ideally separated in time, can be particularly important when the first result is abnormal.

Understanding Sperm Count

Sperm concentration describes how many sperm are present in a given volume of semen.

A reduced concentration is commonly referred to as **oligozoospermia**.

Complete absence of sperm from the ejaculate is called **azoospermia**.

Azoospermia does not always mean that the testes produce no sperm. In some men, sperm are produced but cannot reach the ejaculate because of an obstruction.

The distinction between **obstructive azoospermia and impaired sperm production** is therefore very important.

Current AUA/ASRM guidance recommends using clinical examination, semen characteristics and FSH among the initial tools for differentiating these mechanisms.

Azoospermia should never be managed simply by repeatedly prescribing medicines intended to “increase semen.”

Sperm Motility

Motility refers to sperm movement.

Sperm must travel through the female reproductive tract to reach the egg, so movement is biologically important.

Reduced sperm motility is called **asthenozoospermia**.

However, motility should not be interpreted alone. Total sperm number, morphology and other clinical factors matter, as does the fertility status of the female partner.

The couple's probability of conception cannot be calculated accurately from one semen parameter in isolation.

Sperm Morphology

Morphology describes sperm shape.

Men sometimes become extremely worried when a report shows a relatively low percentage of normally shaped sperm.

Morphology is important, but interpretation requires caution.

Current male-infertility guidance emphasizes that individual semen abnormalities do not independently diagnose infertility in most situations. Multiple abnormalities and the clinical context carry greater meaning.

A man should therefore not assume fatherhood is impossible solely because one morphology value appears abnormal.

“Thin Semen” Does Not Automatically Mean Weak Sperm

This is particularly relevant in Unani and South Asian sexual-health practice.

Many patients say:

“Doctor, my semen has become thin. Does that mean my sperm count is low?”

The visual thickness of semen does not tell us how many sperm are present.

A man can have apparently thick semen with severe oligozoospermia, while another may perceive his semen as thinner and still have a satisfactory sperm concentration.

The correct investigation is semen analysis.

Traditional terminology can help describe the patient's complaint, but modern laboratory testing is needed to determine sperm concentration, motility and morphology objectively.

How Frequently Should Intercourse Occur to Achieve Pregnancy?

This is one of the most common questions couples ask me.

The answer is simpler than many people expect.

The fertile window is generally considered the **six-day interval ending on the day of ovulation**, with the highest probability of conception occurring close to ovulation, especially during the preceding days.

ASRM concludes that reproductive efficiency is highest when intercourse occurs **every one to two days during the fertile window**. However, intercourse approximately two to three times per week can produce nearly comparable opportunities for many couples.

Therefore, intercourse does not need to occur at an exact clock time, nor does a couple need to abstain for many days in order to “save sperm.”

Does Daily Intercourse Reduce Sperm Count?

This is another widespread misconception.

ASRM notes that frequent ejaculation does **not** appear to reduce fertility in men with normal semen quality. In studies of men with normal semen parameters, concentration and motility remained satisfactory even with daily ejaculation.

Long abstinence is not necessarily beneficial either.

Couples should therefore not be instructed to avoid intercourse for many days solely to increase the sperm available for conception.

The best frequency is one that provides good coverage of the fertile period **without turning sexual intimacy into an exhausting medical obligation**.

Timed Intercourse and Performance Anxiety

Timed intercourse can be useful, but it can also create psychological pressure.

A man may begin thinking:

“Tonight is the ovulation day. I must perform.”

That expectation can itself contribute to erectile difficulty, delayed ejaculation or loss of sexual desire.

ASRM specifically recognizes sexual dysfunction as an important issue in infertile men and notes that the stress of trying to conceive may significantly worsen erectile, ejaculatory or libido problems.

In such cases, the solution is not simply to tell the man to “try harder.”

The couple may benefit from less rigid scheduling, counselling, treatment of underlying sexual dysfunction and appropriate fertility-awareness guidance.

Erectile Dysfunction and Fertility

Erectile dysfunction can directly interfere with natural conception if vaginal penetration or ejaculation cannot reliably occur.

It may have psychological causes, medical causes or a combination.

Diabetes, hypertension, cardiovascular disease, obesity, certain medicines, hormonal abnormalities and anxiety are among factors that deserve consideration.

ASRM recommends assessing erectile dysfunction, ejaculatory dysfunction and reduced libido when men present for infertility evaluation.

At Saira Health Care, this is particularly important because my work involves **sexual disorders and infertility together**.

Treating the couple's fertility problem may sometimes require treating sexual function first.

Premature Ejaculation and Pregnancy

Premature ejaculation does not automatically cause infertility.

If ejaculation consistently occurs inside the vagina, sperm are still deposited within the reproductive tract.

However, very severe premature ejaculation—particularly when ejaculation happens before penetration—may interfere with natural conception.

This should be discussed confidentially rather than treated as a source of embarrassment.

A man may require sexual counselling and evidence-based management according to the actual pattern of his symptoms.

Delayed Ejaculation and Failure of Ejaculation

Some men achieve erections normally but cannot ejaculate during intercourse.

Others experience retrograde ejaculation, where semen passes into the bladder rather than emerging normally.

These are legitimate fertility conditions.

ASRM guidance recognizes ejaculatory dysfunction as an important component of male fertility evaluation and notes that specific forms can sometimes be managed medically or through sperm-retrieval strategies depending on the cause.

Therefore, the fertility history should include not only “How often do you have intercourse?” but also **whether ejaculation is actually occurring effectively**.

Male Hormonal Evaluation

Not every infertile man requires every hormone test.

AUA/ASRM recommends hormonal assessment including **FSH and testosterone** particularly when there is oligozoospermia, azoospermia, impaired libido, erectile dysfunction, small or atrophic testes, or other evidence suggesting hormonal abnormality.

Additional testing may be selected according to those results and the clinical picture.

A hormone panel should therefore answer a specific clinical question rather than simply being included in every fertility package.

Testosterone: A Very Important Fertility Warning

One of the most important pieces of male fertility counselling concerns **testosterone treatment**.

Some men take testosterone injections, gels or other preparations because they feel tired, want increased muscle mass or were told that higher testosterone will improve fertility.

This can have the opposite effect.

External testosterone suppresses the hormonal signals from the brain and pituitary gland that are necessary for sperm production. Sperm concentration can decline dramatically and may even reach azoospermic levels.

AUA/ASRM guidance states clearly that **testosterone monotherapy should not be prescribed to men who are interested in current or future fertility**.

Anabolic steroid use can similarly suppress spermatogenesis.

Men attempting conception should therefore tell their doctor about all testosterone injections, bodybuilding hormones and anabolic steroids.

Male Fertility and Smoking: Important 2026 Evidence

Tobacco is one of the clearest lifestyle issues I discuss with male fertility patients.

On **8 September 2026**, WHO published a new evidence summary specifically addressing tobacco and infertility.

A review involving more than **60,000 men across 44 studies** found smoking to be associated with reproductive dysfunction, including semen abnormalities and sexual dysfunction. WHO highlighted associations with erectile dysfunction, ejaculatory problems, reduced sperm motility, abnormal sperm morphology and other reproductive abnormalities.

WHO also warns that second-hand tobacco smoke may affect fertility.

Therefore, if a man asks me:

“Which supplement should I take to improve sperm?”

and he is still smoking every day, stopping tobacco deserves higher priority than searching for another antioxidant capsule.

Alcohol, Recreational Drugs and Fertility

Excessive alcohol and recreational drug use can negatively affect general and reproductive health.

WHO identifies excessive alcohol consumption among lifestyle factors that can influence fertility.

ASRM likewise advises discouraging smoking and recreational drug use among people trying to conceive and minimizing excessive alcohol exposure.

Counselling should be non-judgmental.

Men are more likely to disclose substance use when they believe the information will be used to help them rather than criticize them.

Obesity, Diabetes and Metabolic Health

Male reproductive health is closely connected to general health.

Obesity may contribute to hormonal disturbances and is associated with metabolic disease. Diabetes can affect erections, ejaculation and other reproductive functions.

Male counselling should therefore include weight, blood pressure, blood sugar and general medical health rather than focusing exclusively on sperm.

ASRM's sexual-dysfunction guidance recommends considering conditions such as diabetes, hypertension and cardiovascular disease during evaluation of infertile men with sexual complaints.

Improving metabolic health may also improve the man's long-term health irrespective of whether his semen parameters change.

Heat Exposure and Sperm

Sperm production is temperature-sensitive.

Research continues to suggest that prolonged or repeated increases in testicular temperature may adversely influence semen parameters. A 2026 scoping review of 135 human studies found that higher temperature exposure was generally associated with reduced semen parameters, although the authors emphasized substantial methodological limitations in the available evidence.

In practical counselling, I advise moderation with **frequent prolonged hot-tub or sauna exposure and significant occupational heat exposure**, particularly in a man who already has abnormal semen findings.

However, I do not frighten men about ordinary clothing, occasional warm baths or everyday laptop use because evidence for many individual lifestyle exposures remains inconsistent.

Current AUA/ASRM guidance itself emphasizes that data for many proposed male-infertility lifestyle and environmental risk factors remain limited.

Fever Can Temporarily Affect Sperm

A significant febrile illness can temporarily disturb sperm production because developing germ cells are sensitive to temperature and systemic illness.

This means that an abnormal semen analysis performed soon after a substantial fever may not always reflect the man's long-term baseline.

The clinical history should therefore include recent illnesses rather than treating a single abnormal report as permanent infertility.

Occupational and Environmental Exposure

Certain occupational exposures have been associated with impaired semen quality, including some solvents, heavy metals, pesticides and other environmental pollutants.

A 2023 systematic review found associations between biomonitored environmental or occupational pollutants and abnormalities involving sperm motility, concentration or morphology.

The strength of evidence differs according to the substance and exposure.

Therefore, I advise men to tell their physician about occupations involving significant chemicals, pesticides, welding, heavy metals, radiation or chronic heat so that the relevance can be assessed individually.

Varicocele and Male Fertility Counselling

A varicocele is enlargement of veins around the testicle.

It is common and does not automatically cause infertility.

In selected men, however, a **palpable clinical varicocele together with infertility and abnormal semen parameters** may be relevant. AUA/ASRM guidance states that surgical varicocele repair may be considered in appropriately selected men attempting conception.

Counselling is important because finding a small varicocele on ultrasound alone does not mean every man needs surgery.

Treatment should be based on the full reproductive picture.

Medicines Can Affect Male Fertility

Men often forget to tell their fertility physician about medicines they take for other conditions.

Some medications can influence hormones, ejaculation, erections or spermatogenesis.

AUA/ASRM recommends including medication use in the reproductive history and counselling patients when a medication may affect fertility.

The correct response is **not to stop important medicines independently**.

The physician should determine whether an alternative is appropriate and whether the suspected effect is supported by evidence.

Cancer Treatment and Fertility Preservation

This is one of the most important situations in which counselling must occur **before treatment begins**.

Chemotherapy, radiotherapy and certain surgeries can damage future sperm production.

ASRM's updated 2026 fertility-preservation guidance states that people facing therapies capable of impairing fertility should receive prompt counselling and referral. For postpubertal males, **sperm cryopreservation is an established fertility-preservation strategy and should ideally occur before gonadotoxic therapy begins**.

AUA/ASRM likewise recommends discussing the reproductive effects of gonadotoxic treatment and encouraging sperm banking beforehand when possible.

A young man should not first learn about fertility preservation after chemotherapy has already started.

Supplements and Antioxidants: More Is Not Always Better

The male fertility market contains hundreds of combinations of zinc, selenium, CoQ10, folate, vitamin C, vitamin E and other antioxidants.

Some studies show improvements in selected semen parameters.

However, the 2024 amended AUA/ASRM guideline states that the clinical usefulness of supplements such as antioxidants and vitamins in treating male infertility remains **questionable**, and available evidence is inadequate to recommend particular agents routinely.

This is important because patients often spend large amounts of money on supplements without first finding out why their sperm count is low.

Nutrition matters.

Deficiency should be corrected.

But a supplement cannot reopen an obstructed vas deferens or reverse every genetic cause of azoospermia.

Diet for Male Fertility

There is no single scientifically proven “sperm diet.”

A generally healthy dietary pattern containing vegetables, fruits, whole grains, pulses, nuts, appropriate protein and healthy fats is reasonable for reproductive and general health.

AUA/ASRM notes that evidence connecting specific diets to male fertility remains limited and generally of low quality.

Therefore, I prefer realistic dietary counselling rather than presenting one fruit, nut, herb or food combination as a guaranteed sperm treatment.

Sleep and Male Reproductive Health

Adequate sleep supports general endocrine and psychological health.

Poor sleep may be associated with hormonal, metabolic and reproductive disturbances, although the exact relationship between sleep duration and human fertility remains complex.

For practical counselling, I encourage men to maintain a reasonably regular sleep schedule and address significant insomnia or suspected sleep apnoea.

The aim is not to promise that eight hours of sleep will normalize sperm count.

It is to improve overall health in a way that may also support reproductive function.

Exercise and Male Fertility

Moderate physical activity is beneficial for cardiovascular and metabolic health.

Men who are sedentary, obese or insulin-resistant may benefit considerably from regular exercise.

However, exercise should not involve the use of anabolic steroids or unregulated testosterone boosters.

The AUA/ASRM guideline specifically recognizes ongoing anabolic-steroid use as a suppressor of spermatogenesis.

The healthiest body-building programme is not a fertility programme if it suppresses sperm production pharmacologically.

Male Age and Fertility

Male fertility generally declines more gradually with age than female fertility.

ASRM notes measurable changes in semen parameters after approximately the mid-thirties but states that male fertility is usually not appreciably affected to the same extent as female fertility until considerably later.

However, AUA/ASRM advises counselling couples regarding increased relative risks of certain adverse offspring outcomes with **advanced paternal age**, while recognizing that absolute risks for individual pregnancies remain relatively low.

This should be discussed without unnecessary alarm.

Female age remains a stronger predictor of couple fertility outcome.

Psychological Stress in Men With Infertility

Men are often expected to remain emotionally strong during infertility.

This expectation can prevent them from discussing anxiety, guilt, sexual performance concerns or fear of disappointing their partner.

Infertility itself can worsen sexual dysfunction. ASRM states that psychological distress associated with infertility contributes to male sexual problems and that erectile dysfunction is common and treatable.

I therefore consider it appropriate to ask men directly—but respectfully—how the fertility journey is affecting them.

Counselling is not an indication that the problem is “all in the mind.”

It is recognition that reproductive treatment can affect the whole person.

Relationship Counselling During Fertility Treatment

Infertility can change the way a couple communicates.

Intercourse may become scheduled. Every menstrual period can bring disappointment. One partner may want to continue treatment while the other becomes exhausted.

Men may withdraw emotionally because they do not know how to express fear.

Good counselling can help couples communicate without blame, discuss treatment decisions, preserve intimacy and understand each other's emotional responses.

WHO's 2025 infertility guideline specifically emphasizes ongoing psychosocial support because infertility can lead to **anxiety, depression and social isolation**.

Male Counselling After Pregnancy Is Achieved

Male counselling should not automatically end when the pregnancy test becomes positive.

The transition from infertility treatment or planned conception to fatherhood creates a different set of emotional and practical responsibilities.

Some men feel immediate happiness. Others feel happiness mixed with fear about the pregnancy, finances, their partner's health, childbirth or whether they will be a good father.

These emotions are legitimate.

A 2024 scoping review found that fathers frequently experience challenges related to their new role, relationship changes and limited access to father-focused antenatal and psychological support.

A more recent systematic review also found that paternal prenatal anxiety can persist into the postpartum period and is associated with factors such as depression, limited social support and maternal anxiety, supporting the value of family-centred psychosocial care.

Preparing Emotionally for Fatherhood

Counselling can help an expectant father discuss concerns that he may otherwise keep private.

These can include fear of pregnancy loss, uncertainty about paternity, financial pressure, changing sexual intimacy during pregnancy, fear of childbirth, work-life balance and uncertainty about caring for a newborn.

The counsellor's purpose should not be to tell a man how a father “should” feel.

It should provide a confidential and non-judgmental environment in which concerns can be explored and, when necessary, referred for more specialized psychological or medical care.

Supporting the Pregnant Partner

An expectant father can make an important contribution to pregnancy without attempting to become the woman's doctor.

Helpful involvement can include attending relevant antenatal appointments when welcomed, understanding important pregnancy precautions, assisting with practical responsibilities, supporting healthy habits and listening when his partner is anxious or uncomfortable.

Research on paternal perinatal mental health emphasizes that fathers function both as **partners and parents**, and their own wellbeing can influence family functioning.

Support should remain respectful of the pregnant woman's autonomy and preferences.

Communication and Sexual Intimacy During Pregnancy

Pregnancy often changes sexual desire and comfort.

Some couples unnecessarily stop all sexual contact because they fear intercourse will harm the pregnancy, while others experience mismatched desire and relationship tension.

In an uncomplicated pregnancy, sexual activity is generally possible unless an obstetric clinician has advised restrictions for a specific reason.

Male counselling can help the couple communicate about comfort, consent and intimacy rather than allowing fear or misinformation to create conflict.

Where pregnancy is high-risk or there is bleeding, placenta-related disease, ruptured membranes or another obstetric concern, the maternity team should guide sexual-activity advice.

Preparing for Birth and the Postpartum Period

The father's role does not begin in the delivery room.

During pregnancy, couples can discuss birth preferences, transportation to hospital, emergency contacts, family support, parental leave and responsibilities after the baby arrives.

After childbirth, the mother's recovery, feeding difficulties and sleep deprivation can place significant demands on the couple.

Male counselling can therefore include realistic expectations about shared newborn care and the possibility of postpartum emotional difficulties in **both parents**.

Paternal mental-health research increasingly supports father-inclusive rather than exclusively mother-focused perinatal support.

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Male Counselling According to Unani Medicine

The Unani system of medicine traditionally considers reproductive function within the broader health of the body.

Rather than focusing only on one semen value, classical Unani medicine evaluates **Mizaj**, nutrition, digestion, physical condition, psychological factors and reproductive faculties.

Male reproductive complaints may traditionally be discussed under terms such as **Qillat-i-Mani**, meaning scanty semen production within the Unani framework, and **Zu'f-i-Bah**, relating to diminished sexual capability.

Official CCRUM treatment guidance for *Qillat-i-Mani* describes traditional causes including general debility, insufficient nutrition and abnormal hot, cold, moist or dry temperamental states of the reproductive organs. Traditional principles include improving nutrition, supporting digestion and correcting the relevant temperamental disturbance.

This is a useful historical and individualized framework, but it should not be treated as identical to modern oligozoospermia.

Modern sperm concentration can only be established through semen analysis.

Psychological Factors in Classical Unani Male Care

One aspect of Unani medicine that is particularly relevant to counselling is its recognition of psychological influences on sexual function.

CCRUM's standard guidance for **Zu'f-i-Bah** lists psychological factors among possible contributors and includes **Izala-i-'Awariz Nafsani**, or addressing psychological disturbances, among traditional treatment principles.

This is important because modern sexual medicine also recognizes the interaction between anxiety, relationship stress and erectile or ejaculatory dysfunction.

The terminology differs, but both approaches acknowledge that reproductive health cannot always be separated from emotional wellbeing.

Mizaj and Male Fertility

Mizaj, or temperament, is central to Unani assessment.

A traditional Unani practitioner may assess whether a man's constitution shows excessive heat, coldness, moisture or dryness and modify diet, lifestyle and treatment accordingly.

This can support individualized counselling.

However, *Mizaj* does not replace objective testing.

A man with azoospermia requires investigation to determine whether sperm production is impaired or a blockage is present.

A man with low libido may require assessment of testosterone, prolactin, diabetes, medications or psychological factors.

A traditional diagnosis should therefore be integrated with modern reproductive assessment when necessary.

Asbab-e-Sitta Zarooriya and Male Fertility Counselling

The **Six Essential Factors** of Unani medicine offer a useful framework for fertility counselling.

They address environment and air, food and drink, bodily movement and rest, mental activity and repose, sleep and wakefulness, and retention and elimination.

In modern practice, these principles can be translated into sensible reproductive-health goals: nutritious food, appropriate exercise, good sleep, tobacco avoidance, emotional balance and management of general health.

This is one of the areas where Unani preventive philosophy and modern lifestyle counselling fit naturally together.

Ilaj-bil-Ghiza: Dietotherapy

Unani medicine gives substantial importance to **Ilaj-bil-Ghiza**, or dietotherapy.

For a man with poor nutrition, obesity, metabolic disease or general debility, dietary improvement is clinically reasonable.

CCRUM's guidance for *Qillat-i-Mani* specifically includes **Taghziya**, or provision of nutrition, when nutritional insufficiency is considered relevant, as well as strengthening digestion within the traditional framework.

I regard this as useful supportive care.

But I would not tell a patient that milk, dates, almonds, walnuts or any other particular food will guarantee improved sperm count.

Food supports reproductive physiology; it is not a substitute for diagnosing serious male infertility.

Asgandh in Male Reproductive Health

Asgandh (*Withania somnifera*) has a long traditional history of use in reproductive and sexual health and has also been studied scientifically.

A systematic review and meta-analysis of infertile men found some improvements in semen parameters in the available studies, but the authors emphasized that only a small number of studies were available and that evidence was **too limited for robust conclusions**.

A 2026 systematic review of reproductive outcomes likewise described ashwagandha as a promising possible adjunct while emphasizing the need for additional evidence regarding long-term effects and dosing.

Therefore, I may consider such a plant within an individualized traditional treatment framework where suitable, but it should not be advertised as a guaranteed cure for male infertility.

Gokshura or Khar-e-Khasak

Tribulus terrestris, often known as Gokshura or Khar-e-Khasak in traditional systems, is frequently promoted for testosterone and fertility.

Clinical evidence is inconsistent.

A systematic review reported improvement in some semen parameters in several small studies, but an individual clinical study in men with unexplained infertility found **no significant improvement in testosterone, sperm concentration or motility**.

A more recent systematic review of Tribulus for male sexual function also found variable effects and methodological limitations.

For this reason, herbal medicines should not be selected merely because a social-media advertisement says they “boost testosterone.”

Unani Medicines Are Not a Substitute for Diagnosis

This is a principle I consider central to responsible Unani medicine.

If a man has a mildly abnormal semen analysis related to modifiable health factors, individualized diet and supportive Unani management may be useful.

But if he has azoospermia, severe testicular atrophy, obstruction, a genetic abnormality, significant hormonal disease or a clinical varicocele requiring specialist consideration, the treatment must address that cause.

Giving the same *Muqawwi-e-Bah* or *Muwallid-e-Mani* medicine to every male infertility patient is not truly individualized Unani practice.

Modern investigation actually allows the traditional physician to be **more precise**.

Sexual Strength Medicines and Fertility

Another important distinction is between a medicine intended to support libido or erection and a treatment intended to improve fertility.

Improved sexual desire can be useful if low libido prevents regular intercourse.

Improved erection can be important in erectile dysfunction.

But these effects do not necessarily increase sperm concentration or correct a reproductive obstruction.

A man may become sexually stronger without becoming more fertile.

Therefore, at Saira Health Care I try to identify whether the primary problem is **sexual function, sperm production, sperm transport, hormonal disease—or a combination of these**.

Safety of Herbal and Unani Treatment

“Natural” does not automatically mean harmless.

Herbal medicines may interact with prescription drugs or have metabolic effects of their own. Products may also vary in identity, purity and concentration.

Men should therefore disclose all herbal medicines and supplements they use.

This is particularly important in patients with diabetes, hypertension, liver disease, kidney disease or those taking multiple medicines.

Fertility treatment should improve health, not create a new medical problem.

What Male Counselling Should Cover Before Conception

In my view, a comprehensive male fertility counselling session should review **reproductive history, duration of infertility, previous children or pregnancies, testicular development or injury, genital surgery, infection history, erections and ejaculation, sexual frequency, semen testing, current medicines, testosterone or steroid use, tobacco, alcohol, recreational drugs, weight and metabolic health, occupational exposures, psychological wellbeing, and the fertility status and age of the female partner**.

This is not unnecessary questioning.

Each point can change the treatment plan.

Why Both Partners Should Attend Counselling When Possible

Couple-based counselling can prevent many misunderstandings.

The male partner can learn about the woman's fertile period.

The female partner can understand what semen parameters actually mean.

Both can discuss intercourse frequency and reduce performance pressure.

Treatment decisions can then be made together.

WHO's 2025 infertility framework specifically promotes patient-centred fertility care and emphasizes both clinical and psychosocial needs.

This is preferable to one partner carrying the entire emotional and treatment burden.

Special Approach of Dr. Nizamuddin Qasmi at Saira Health Care

When a man consults me regarding fertility, I do not begin by asking only:

“What is your sperm count?”

I want to understand his entire reproductive situation.

I review whether intercourse is occurring effectively, whether he has erectile or ejaculatory problems, whether semen has actually been tested appropriately, whether a previous result needs confirmation and whether there are clinical clues suggesting varicocele, endocrine disease, obstruction or testicular dysfunction.

I ask specifically about smoking, alcohol, anabolic steroids, testosterone and other medicines because these can materially change reproductive management.

When there is a female partner, I also consider her age and fertility findings because **male fertility cannot be interpreted in isolation from the couple's reproductive situation**.

If modern investigation identifies a significant abnormality, that condition receives appropriate evidence-based management or referral.

Alongside this, where suitable, I use the individualized principles of Unani medicine—particularly **Mizaj, nutrition, digestion, sleep, activity, psychological wellbeing and carefully selected supportive pharmacotherapy**.

This is what I mean by an integrative approach.

Contribution of Saira Health Care in Male Sexual Disorders and Infertility

At **Saira Health Care**, male fertility forms an important part of our broader work in sexual disorders and infertility.

One problem we repeatedly encounter is that men delay evaluation because infertility is assumed to be a female condition.

Another is that men focus only on sexual power and ignore semen testing.

Some take testosterone or bodybuilding hormones without realizing they may suppress sperm production.

Others spend months taking several supplements without identifying a treatable condition.

Our contribution is therefore not limited to prescribing medicines.

We aim to provide **confidential counselling, sexual-health assessment, interpretation of semen reports, identification of appropriate investigations, reproductive education, lifestyle counselling and individualized integrative care**.

Where urological, genetic, endocrine, surgical or assisted reproductive expertise is required, appropriate referral is part of responsible care.

Male Counselling When the Couple Has Already Conceived

Once pregnancy is achieved, the objective changes.

The man is no longer being counselled mainly as a fertility patient. He is preparing to become a father and to support his partner during pregnancy and postpartum recovery.

At this stage, I encourage men to communicate openly, learn about pregnancy, participate in appropriate medical appointments if their partner wants them there, understand warning signs and help create a practical plan for childbirth and newborn care.

Men should also be allowed to discuss their own anxiety.

Research increasingly shows that fathers may experience significant mental-health challenges during the transition to parenthood and that father-focused support remains limited in many maternity systems.

Seeking counselling in such circumstances is a responsible health decision.

Frequently Asked Questions

How often should we have intercourse to achieve pregnancy?

For couples without another fertility problem, ASRM reports that intercourse **every one to two days during the six-day fertile window** provides the highest reproductive efficiency. Intercourse two or three times per week is nearly comparable for many couples.

Does having sex every day weaken sperm?

Generally, no. In men with normal semen quality, frequent ejaculation does not appear to impair fertility, and couples do not need to restrict intercourse solely to “save sperm.”

Should a man abstain for many days before intercourse during ovulation?

No. Prolonged abstinence is not necessary for natural conception. Laboratory semen-analysis collection instructions are a separate matter and should follow the testing laboratory's protocol.

Is one semen analysis enough?

Sometimes one normal result provides useful reassurance, but semen parameters vary. When the first result is abnormal, repeat testing is commonly important before major decisions are made.

Does low sperm count mean pregnancy is impossible?

No. The probability depends on the severity of the abnormality, motility, morphology, female fertility factors and other clinical findings. Severe abnormalities deserve specialist evaluation.

Can a man be infertile despite normal sexual power?

Yes. Erection and libido do not measure sperm count or quality.

Does thin semen mean low sperm count?

No. Visual semen consistency cannot determine sperm concentration. Semen analysis is required.

Can smoking affect sperm?

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

Does heat reduce sperm quality?

Prolonged or substantial testicular heat exposure has been associated with poorer semen parameters, although evidence for many everyday exposures remains incomplete.

Can testosterone improve fertility?

External testosterone can actually **suppress sperm production** and should not be used as testosterone monotherapy in men wishing to preserve current or future fertility.

Do fertility vitamins improve sperm?

Evidence for routine antioxidant and vitamin supplements is uncertain. AUA/ASRM describes their clinical utility as questionable and states that evidence is inadequate to recommend particular agents routinely.

Can Asgandh improve male fertility?

Research is promising but still limited. Some studies report improved semen parameters, but systematic reviews conclude that stronger clinical trials are required before it can be considered a proven fertility treatment.

Can Gokshura increase testosterone and sperm count?

Evidence is inconsistent, and it should not be promoted as a guaranteed testosterone or fertility treatment.

Can Unani medicine be useful for male infertility?

Yes, it may provide valuable **individualized supportive care** through diet, lifestyle, sleep, psychological wellbeing, traditional Mizaj-based assessment and selected physician-supervised pharmacotherapy. It should not replace modern evaluation when a structural, hormonal, genetic or severe sperm-production problem is suspected.

Can counselling itself cure male infertility?

Counselling cannot reverse every biological cause of infertility. Its value lies in identifying problems, improving health behaviour, addressing sexual dysfunction and psychological distress, improving communication and guiding the couple toward the correct treatment.

Should men attend fertility appointments with their partners?

Whenever feasible and comfortable for the couple, this can be very useful because infertility evaluation should involve both partners rather than focusing exclusively on the woman.

Should a man bank sperm before chemotherapy?

Men facing chemotherapy, radiation or other potentially gonadotoxic treatment should receive fertility-preservation counselling before treatment. Sperm cryopreservation is an established option for postpubertal males.

My Final Message to Men Planning Fatherhood

When a man comes to me because his wife is not becoming pregnant, I do not want him to feel accused or ashamed.

I want him to understand that **evaluating male fertility is simply one half of evaluating the couple**.

Your sexual strength does not tell us your sperm count.

The thickness of your semen does not tell us whether sperm are moving normally.

A vitamin does not correct every fertility problem.

And taking testosterone to become physically stronger may actually make sperm production worse.

A responsible fertility plan begins with understanding the problem.

If semen testing is required, do it properly. If the first result is significantly abnormal, confirm and investigate it. If there is erectile or ejaculatory dysfunction, discuss it openly. If you smoke, quitting is one of the most worthwhile reproductive-health changes you can make. If you are taking testosterone or anabolic steroids, tell your physician. If you are going to receive chemotherapy or radiation, fertility-preservation counselling should happen **before treatment begins**.

At the same time, fertility is not only laboratory medicine.

My training in the **Unani system of medicine** teaches me to consider the man's *Mizaj*, nutrition, digestion, physical activity, sleep, emotional state and overall constitutional health. Formal Unani guidance also recognizes psychological factors in sexual debility and emphasizes nutritional and constitutional treatment principles in conditions traditionally described as *Qillat-i-Mani*.

I consider these principles useful when they are applied responsibly.

But I do not believe they should replace semen analysis, hormonal investigation, genetic testing, urological evaluation or assisted reproductive care when those are necessary.

At **Saira Health Care**, my aim is to bring these two perspectives together:

understand the man as a whole person, but diagnose his reproductive problem accurately.

Support his diet, sleep, lifestyle and psychological wellbeing.

Treat sexual dysfunction when it interferes with conception.

Use individualized Unani care where it can reasonably support reproductive health.

And when a modern medical, surgical or assisted reproductive treatment offers the better opportunity, explain it clearly rather than losing valuable reproductive time.

Once pregnancy occurs, counselling continues in a different form. A man becomes not only a partner in conception but a partner in pregnancy, childbirth and parenthood.

Being prepared emotionally, communicating with the mother, supporting her health and acknowledging one's own worries are all part of becoming a responsible father.

That is the broader meaning of **male counselling for achieving pregnancy and fatherhood**.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi
Founder & Chief Physician, Saira Health Care
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Dr. Nizamuddin Qasmi's clinical work at **Saira Health Care** focuses on sexual disorders and infertility, including male reproductive problems, semen abnormalities, sexual dysfunction, fertility counselling and individualized integrative management.

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Medical Disclaimer

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

Male infertility may have hormonal, genetic, anatomical, infectious, medical, sexual or lifestyle-related causes. Men with azoospermia, severely abnormal semen parameters, testicular abnormalities, infertility following chemotherapy or radiation, or persistent erectile or ejaculatory dysfunction should receive appropriate professional evaluation.

Unani medicines, herbs, sexual tonics and supplements should not be used to delay evidence-based investigation or treatment. Evidence for many herbal and antioxidant fertility interventions remains limited, and products should be selected under qualified professional supervision.