Low Libido (Reduced Sexual Desire): Causes, Diagnosis, Hormonal Factors, Modern Treatment and the Unani Approach

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Introduction: "Doctor, Why Have I Lost Interest in Sex?"

When a patient comes to me and says,

"Doctor, earlier my sexual desire was normal, but now I rarely feel interested in sex,"

I do not immediately assume that the patient needs a sexual stimulant.

I first try to understand **why the desire has changed**.

Low libido, or reduced sexual desire, is common in both men and women. It can occur temporarily because of stress, tiredness, illness, poor sleep or relationship circumstances, or it can persist because of hormonal, medical, psychological or medication-related factors.

One of the most important things I explain to patients is that **there is no medically correct frequency at which every healthy person must want sex**.

Sexual desire naturally differs from person to person. It also changes during different stages of life. The important clinical question is whether there has been a meaningful and persistent reduction from the person's usual level of desire and whether that change causes distress or affects the relationship.

Current European Association of Urology guidance describes sexual desire as the interaction of three broad components: **biological drive, psychological motivation and social or cultural influences**. It also emphasizes that low sexual desire can have many causes, including androgen deficiency, high prolactin, depression, anxiety, relationship conflict, cardiovascular and kidney disease, medications, erectile dysfunction and other health problems.

This is why my approach at Saira Health Care is not simply:

"Low libido = low testosterone = give a tonic."

Instead, I ask:

Is the problem hormonal, psychological, medical, relationship-related, medication-related—or a combination of several factors?

That distinction determines the treatment.

What Is Libido?

Libido means **sexual desire, sexual interest or the wish to engage in sexual activity**.

It may involve sexual thoughts, fantasies, interest in physical intimacy, desire for intercourse or other forms of sexual expression.

Libido is different from:

erection, ejaculation, orgasm and fertility.

These functions can influence one another, but they are not medically identical.

A man can have low libido but excellent erections.

Another man can have very strong desire but erectile dysfunction.

A woman can have sexual desire but avoid intercourse because it is painful.

A man can have excellent libido and completely normal sexual performance but still have a very low sperm count.

Understanding these differences prevents unnecessary and inappropriate treatment.

Low Libido Is Not Always a Disease

A person does not automatically have a sexual disorder because he or she wants sex less frequently than a partner.

Modern sexual medicine increasingly recognizes the concept of **sexual desire discrepancy**—a difference in desired frequency between partners.

The EAU notes that focusing on the discrepancy itself rather than automatically labelling the lower-desire partner as abnormal can reduce stigma and provide a more useful approach to relationship treatment.

This is something I consider extremely important.

If one partner wants intercourse three times a week and the other wants it once a week, it does not automatically mean one person is diseased.

A problem becomes clinically important when the reduced desire is persistent, unwanted and distressing.

Low Libido Versus Hypoactive Sexual Desire Disorder

The term **low sexual desire** describes a symptom.

The term **hypoactive sexual desire disorder (HSDD)** describes a more specific clinical condition.

In men, the EAU describes male HSDD as a persistent or recurrent deficiency or absence of sexual thoughts, fantasies or desire for sexual activity, interpreted in the context of age, general health and the individual's social circumstances.

In women, terminology has changed over time. HSDD remains widely used clinically and in pharmaceutical indications, while DSM-based terminology combines certain desire and arousal problems under **female sexual interest/arousal disorder**.

ACOG emphasizes that female sexual problems become disorders when they cause personal distress and may involve overlapping problems with desire, arousal, orgasm or pain. Its Female Sexual Dysfunction guidance was reaffirmed in 2025.

For the general public, the important message is simple:

Low libido should be treated when it is persistent, troubling to the person, or caused by an underlying health problem—not merely because someone does not meet another person's expectation of how often they "should" want sex.

Sexual Desire Can Be Spontaneous or Responsive

This concept is particularly important in women.

Not everyone begins sexual activity with a strong spontaneous urge.

ACOG explains that, for some women, desire may develop **after affectionate or sexual stimulation has already begun** rather than appearing beforehand.

This is called **responsive desire**.

A woman may initially feel neutral, but after emotional closeness, kissing, touch and arousal, sexual interest develops.

This can be entirely normal.

Therefore, a person should not automatically assume:

"I don't randomly think about sex during the day, so I must have a libido disorder."

The complete sexual response and associated distress matter more.

Common Causes of Low Libido

Possible Cause	How It May Affect Desire
Low testosterone	Reduced desire, spontaneous erections and energy in genuinely hypogonadal men
High prolactin	Can suppress reproductive hormones and sexual desire
Thyroid disease	May alter energy, mood, hormones and sexual function
Diabetes and metabolic disease	Can affect hormones, nerves, circulation, mood and energy
Depression	Reduces interest, pleasure and motivation
Anxiety and stress	Shifts attention away from erotic cues toward worry
Relationship conflict	Reduces emotional safety, attraction or motivation for intimacy
Sexual pain	Repeated painful intercourse naturally reduces desire
Erectile dysfunction	Fear of another erection failure may cause sexual avoidance
Medicines	Some antidepressants, opioids and hormone-altering drugs may reduce desire
Poor sleep and fatigue	Reduce energy, mood and sexual motivation
Pregnancy/postpartum changes	Hormonal change, breastfeeding, fatigue and pain may temporarily reduce desire
Menopause	Vaginal dryness, pain, sleep disruption and other changes can affect sexual interest
Chronic illness	Cardiovascular, renal, neurological and other diseases may reduce libido

Low Testosterone and Male Libido

Testosterone is important for male sexual desire.

Reduced libido is one of the more specific symptoms associated with male hypogonadism. Other sexual symptoms include erectile dysfunction and decreased spontaneous or morning erections.

However, there is an important misunderstanding:

Sexual desire does not increase and decrease in exact proportion to the testosterone number.

The EAU specifically notes that although testosterone is important for male sexual desire, circulating testosterone levels and libido are not directly proportional in every patient, particularly in older men.

Therefore:

Low libido can be a symptom of testosterone deficiency, but low libido alone cannot diagnose low testosterone.

How Testosterone Deficiency Should Be Diagnosed

The current 2026 EAU guidance states that late-onset hypogonadism should be diagnosed from **compatible symptoms together with consistently low testosterone levels**.

Testosterone should generally be measured in a fasting state between approximately **7:00 AM and 10:00 AM**, and an abnormal result should be confirmed before treatment is started.

The guideline uses approximately **12 nmol/L (3.5 ng/mL)** as a practical threshold for late-onset hypogonadism when interpreted together with symptoms and the patient's overall clinical condition.

Depending on the result, I may also consider:

LH, FSH, prolactin, SHBG and calculated free testosterone.

Testing should be selected according to the patient rather than ordering every hormone for everyone.

Obesity, Diabetes and Low Testosterone

An important modern development is the recognition that a large amount of low testosterone in adult men is associated with **obesity and chronic metabolic disease rather than simply ageing**.

The current EAU guideline states that obesity, type 2 diabetes, metabolic syndrome and overall poor health are important contributors to late-onset hypogonadism. It describes obesity and associated comorbidities as major causes of functional hypogonadism.

This matters because some cases can improve through:

weight reduction, physical activity, diabetes management and treatment of associated conditions.

For an overweight man with diabetes and low libido, the best long-term strategy may therefore involve treating his metabolic health as well as his sexual symptoms.

Should Every Man With Low Libido Take Testosterone?

No.

This is one of the most important messages in this article.

Testosterone replacement can improve sexual desire in men who have **properly diagnosed testosterone deficiency**, and the EAU recommends testosterone therapy when low sexual desire occurs together with signs and symptoms of testosterone deficiency.

But testosterone should not be prescribed simply because a man is:

tired, older, unhappy with his sex life or worried about his masculinity.

The 2026 EAU guideline specifically advises against using testosterone merely to improve vitality or physical strength in ageing men without an appropriate indication.

A Major Fertility Warning About Testosterone

This is especially important in my male-infertility practice.

External testosterone suppresses the pituitary hormones LH and FSH.

Those hormones are required for sperm production inside the testes.

As a result, testosterone therapy can **reduce or even markedly suppress sperm production**.

Therefore, a man who wants to father a child should never casually start testosterone because his libido is low.

Fertility goals should always be discussed during the evaluation of hypogonadism. The current EAU guideline specifically emphasizes this principle.

A patient may feel sexually better while his fertility becomes worse.

That is why sexual medicine and infertility medicine must sometimes be considered together.

High Prolactin

Prolactin is another hormone that can affect sexual desire.

High prolactin can suppress the male reproductive hormone pathway and reduce libido.

The EAU lists **hyperprolactinaemia** among the common biological causes of low sexual desire and recommends prolactin testing when clinically appropriate.

In some patients, elevated prolactin can result from a pituitary adenoma.

If high prolactin is confirmed—especially with symptoms such as headaches, visual disturbances or severe hormonal abnormalities—further endocrine and pituitary evaluation may be needed.

This is a good example of why an aphrodisiac cannot substitute for diagnosis.

Thyroid Disease

Both hypothyroidism and hyperthyroidism may affect sexual well-being.

Hypothyroidism can produce:

fatigue, lethargy, depressed mood and hormonal changes.

Hyperthyroidism can produce:

anxiety, sleep problems, palpitations and other disturbances.

The EAU includes thyroid-hormone evaluation among investigations that may be appropriate when endocrine symptoms accompany low sexual desire, and recommends treating accompanying thyroid disease according to its diagnosis.

Traditional medicine may support general health in a thyroid patient, but necessary thyroid medication should not be stopped.

Diabetes

Diabetes can reduce sexual desire through several mechanisms.

It may cause:

fatigue, depression, erectile dysfunction, vascular disease, nerve damage and—in some men—functional hypogonadism.

The EAU identifies diabetes and metabolic disease as important comorbidities in male hypogonadism.

Therefore, when a diabetic man tells me that his libido is low, I do not look only at testosterone.

I consider:

glucose control, erection quality, weight, cardiovascular health, medication and psychological well-being.

Cardiovascular and Kidney Disease

Sexual desire can also decline in people with chronic systemic disease.

The current EAU low-desire guideline lists **coronary disease, heart failure and renal failure** among recognized associated conditions.

A heart patient may become afraid of sexual activity.

A person with chronic kidney disease may experience fatigue and hormonal disturbances.

Another patient may be taking medicines that affect sexual response.

Treatment therefore requires understanding the complete medical condition.

Depression and Low Libido

Depression is among the most important causes of low sexual desire.

A depressed patient may lose interest not only in sex but also in:

hobbies, social contact, work, food and other pleasurable activities.

The EAU recognizes depression as an important cause of male low sexual desire and recommends assessing depressive symptoms during the diagnostic evaluation.

This is why I sometimes ask patients:

“Have you lost interest only in sex, or have you lost interest in many other things as well?”

The answer can be very informative.

Anxiety and Performance Pressure

Anxiety can suppress desire by redirecting attention away from pleasurable sexual cues.

A man may be thinking:

“Will my erection stay hard?”

“Will I ejaculate too quickly?”

“Will I satisfy my partner?”

A fertility patient may be thinking:

“Today is the fertile day—we must succeed.”

The EAU notes that anxiety, erection-related concerns, negative sexual thoughts and shame can all contribute to low desire in men.

Sex then becomes a performance examination rather than an intimate experience.

In these patients, reducing pressure may be more useful than increasing stimulation.

Erectile Dysfunction Can Cause Secondary Loss of Libido

Some men initially have normal desire but repeatedly experience erection failure.

After several unsuccessful encounters, they begin avoiding intimacy because they fear another failure.

Eventually they tell me:

“Doctor, now I don't even feel like having sex.”

The EAU includes erectile dysfunction among conditions associated with male low sexual desire.

In such patients, libido may improve once ED is appropriately treated and confidence returns.

Premature Ejaculation and Libido

Premature ejaculation and libido are also different functions.

However, severe PE may cause:

frustration, embarrassment, relationship tension and sexual avoidance.

Over time, desire may fall because the patient associates sex with anxiety rather than pleasure.

Therefore, PE should be treated when it is contributing to the low desire, rather than giving the patient only a general libido tonic.

Relationship Difficulties

Relationship factors can be extremely important.

The EAU specifically identifies relationship conflict as a common cause of male low sexual desire and notes that sexual satisfaction strongly influences desire within a couple.

Problems may include:

unresolved anger, mistrust, poor communication, different expectations, lack of emotional intimacy or fear of rejection.

When the relationship itself is the main cause, hormone treatment will not solve the entire problem.

Couple counselling may be much more appropriate.

Medications Can Reduce Libido

Medication history is an important part of my assessment.

The EAU specifically identifies **antidepressant therapy** as a recognized contributor to low sexual desire and recommends considering modification of chronic medicines that negatively affect desire where clinically possible.

Other medicines affecting reproductive hormones or the central nervous system can also influence libido.

A patient should never stop a prescribed medicine suddenly.

Instead, the clinician should determine whether:

the medicine is responsible, a different dose could help, an alternative drug is possible or the underlying condition itself is causing the sexual problem.

Antidepressants: A Special Situation

Depression itself can cause severe low libido.

But some antidepressants can also produce sexual adverse effects.

This creates a difficult clinical situation.

EAU guidance recommends treating depression appropriately while considering antidepressants with fewer sexual effects when possible; psychotherapy can also improve outcomes.

Stopping antidepressant treatment suddenly can cause withdrawal or relapse and should not be done without professional guidance.

Sleep, Fatigue and Overwork

In everyday clinical practice, sleep is often underestimated.

A person who consistently sleeps only four or five hours may experience:

physical fatigue, reduced mood, irritability, lower motivation and reduced sexual interest.

The same applies to excessive work stress.

Sometimes a patient says:

“My libido is gone.”

After detailed discussion, I discover that he is sleeping at 2 AM, waking at 6 AM and working under intense pressure seven days a week.

The sexual symptom may be part of a much broader exhaustion problem.

Low Libido in Women

Female low sexual desire requires the same respectful attention as male sexual dysfunction.

ACOG recognizes lack of desire as one of the major categories of female sexual problems and notes that desire difficulties can occur at any age.

The causes may include:

stress, fatigue, depression, anxiety, medication, hormonal changes, pregnancy, breastfeeding, menopause, relationship difficulties and painful sexual activity.

Importantly, women are less likely to volunteer sexual-health concerns unless clinicians ask sensitively.

Painful Intercourse Can Look Like “Low Libido”

If sexual activity repeatedly hurts, it is natural for desire to decrease.

A woman with vaginal dryness, vaginismus, vulvodynia, pelvic-floor pain or another painful condition may appear to have low libido when her primary problem is actually pain.

The solution is not necessarily a desire-enhancing medicine.

The pain must first be diagnosed and treated.

This is especially relevant after menopause when **genitourinary syndrome of menopause** can cause dryness and painful intercourse.

Pregnancy and the Postpartum Period

Sexual desire commonly changes during pregnancy and after childbirth.

After delivery, factors may include:

sleep deprivation, breastfeeding-related hormonal changes, healing after vaginal delivery or caesarean section, fatigue, body-image changes and the demands of caring for a newborn.

Reduced libido during this period does not automatically indicate permanent sexual dysfunction.

Persistent sexual pain, major depressive symptoms or severe relationship distress should, however, be professionally evaluated.

Menopause and Libido

Menopause does not automatically end sexual desire.

Some women notice reduced libido.

Others report little change.

Some experience better sexual satisfaction after menopause because pregnancy is no longer a concern.

For others, the most important issue is not desire itself but vaginal dryness or painful intercourse.

Treatment must therefore focus on the individual symptoms rather than assuming every postmenopausal woman needs the same hormone treatment.

Modern Medical Treatment of Low Libido

The most important principle is:

Treat the cause rather than merely stimulate the symptom.

For example, if testosterone deficiency is present, treat genuine hypogonadism.

If prolactin is high, investigate and treat the underlying cause.

If thyroid disease is responsible, control thyroid disease.

If medication is contributing, review the medication.

If depression or anxiety is the main factor, treat psychological health.

If intercourse is painful, treat the pain.

If relationship conflict is central, address the relationship.

This cause-based approach is also the central principle in the EAU guideline, which states that treatment should be tailored to the underlying aetiology.

Psychological and Sex Therapy

Psychosexual therapy can be extremely valuable.

Possible approaches include:

cognitive-behavioural strategies, mindfulness-based treatment, couple therapy and interventions targeting sexual anxiety.

The EAU states that cognitive and behavioural psychological approaches may benefit men with low sexual desire, although the evidence base is less extensive than for some other sexual disorders.

For couples experiencing mismatched libido, therapy can help them negotiate intimacy without blaming either partner.

Lifestyle Treatment

Lifestyle change is not an instant aphrodisiac.

But it can improve many factors that support healthy sexuality.

Regular physical activity can improve:

mood, cardiovascular health, metabolic health, fitness and body confidence.

Healthy weight can improve metabolic and hormonal function.

Good sleep improves energy.

Smoking cessation improves cardiovascular health.

Reducing excessive alcohol may improve both desire and sexual performance.

Stress management allows the mind to become available for intimacy again.

For overweight men with functional hypogonadism, the EAU strongly recommends lifestyle improvement and weight reduction before or alongside hormone treatment.

Modern Treatment Options for Low Libido in Women

Female low-desire treatment has changed substantially in recent years.

For selected women who meet diagnostic criteria for HSDD, prescription medicines may be considered after underlying medical, psychological, relationship and medication-related causes have been excluded.

These are not general “sexual performance” medicines.

Flibanserin: Important 2025 Update

One of the most important recent developments occurred in **December 2025**.

The current U.S. FDA label for **flibanserin (Addyi)** now indicates it for **women younger than 65 years with acquired, generalized HSDD** when low desire causes marked distress or interpersonal difficulty and is not explained by another medical or psychiatric condition, relationship problems or medication/substance effects. It is not indicated for men or as a sexual-performance enhancer.

This is a significant expansion from its original premenopausal indication.

Flibanserin is taken at bedtime and should be discontinued if there has been no meaningful improvement after eight weeks.

It also has important safety considerations.

Alcohol close to dosing increases the risk of severe hypotension and fainting, and it is contraindicated with moderate or strong CYP3A4 inhibitors and in hepatic impairment.

Therefore, it is clearly not a medicine for casual self-treatment.

Bremelanotide

Bremelanotide (Vyleesi) is another prescription treatment, but its indication is different.

It is approved for **premenopausal women with acquired, generalized HSDD** that causes distress and is not primarily explained by medical disease, psychiatric illness, relationship problems or medication effects. It is not indicated for men or postmenopausal women.

It is administered by injection before anticipated sexual activity.

It can temporarily increase blood pressure and reduce heart rate and is contraindicated in people with **uncontrolled hypertension or known cardiovascular disease**.

Again, proper patient selection is essential.

Testosterone for Women With HSDD

Testosterone in women requires a much more careful discussion.

The International Society for the Study of Women's Sexual Health guideline supports **systemic transdermal testosterone for appropriately selected women with HSDD—particularly postmenopausal women—after a proper biopsychosocial evaluation and after modifiable relationship or mental-health factors have been addressed**.

The available evidence suggests a **moderate therapeutic benefit**.

However, long-term safety remains incompletely established, and most regulatory agencies do not have a female-specific approved testosterone formulation. Serum testosterone should not be used to diagnose HSDD in women; it is used mainly for baseline and monitoring purposes.

A 2026 review likewise concludes that improvement of sexual desire remains the guideline-supported indication for testosterone therapy in appropriately selected women while emphasizing that long-term safety information remains limited.

Testosterone should therefore not be marketed to women as a general energy, anti-ageing or performance hormone.

The Unani Concept of Low Libido

The Unani system of medicine has long recognized reduced sexual desire within its classical terminology.

The Central Council for Research in Unani Medicine's standardized terminology defines **Du'f al-Bah** as a reduction or weakness of sexual drive associated with reduced desire and impaired sexual function and gives **anaphrodisia/loss of libido** as a possible modern equivalent.

CCRUM's broader official overview also identifies **loss of libido** among the sexual-health conditions traditionally addressed in Unani medicine.

This shows that low sexual desire is not a new concern created by modern life.

Traditional physicians also recognized it as an important health problem.

How Unani Medicine Looks at the Patient

One of the major strengths of Unani medicine is that it does not traditionally reduce health to one isolated organ.

It assesses the individual according to concepts including:

Mizaj, Akhlat, Quwwat, diet, activity, sleep, psychological state and general organ function.

This is particularly useful in low libido because sexual desire itself is multidimensional.

A patient with chronic fatigue, poor digestion, stress and disturbed sleep should not automatically receive the same treatment as someone with confirmed endocrine disease.

Mizaj: Why Treatment Should Be Individualized

Mizaj, or temperament, is central to Unani clinical thinking.

Traditional assessment considers individual constitutional patterns rather than assuming that every patient's body responds identically.

This allows a clinician to think beyond:

“Which medicine increases libido?”

and instead ask:

“What is disturbing this particular person's overall sexual and general health?”

Modern science and classical Mizaj theory are different explanatory systems.

I do not claim that a “cold temperament” is scientifically identical to hypothyroidism or that a humoral imbalance is the same as a measured hormone deficiency.

But individualized assessment remains clinically valuable.

Nabz, Urine and Traditional Unani Assessment

Traditional Unani diagnosis includes detailed history and physical examination together with evaluation of **Nabz (pulse)** and physical characteristics of urine where relevant.

CCRUM's official overview describes Unani history-taking and examination, traditional pulse assessment and examination of urine characteristics such as quantity, colour, odour, consistency, clarity and sediment. It also notes that modern diagnostic tools are used to confirm diagnosis.

In modern sexual medicine, I consider this traditional assessment **complementary**, not a replacement for tests such as:

testosterone, prolactin, thyroid function, diabetes testing or other investigations when these are clinically required.

The Classical Unani Concept of Zu‘f-i-Bah / Du‘f al-Bah

CCRUM's **Standard Unani Treatment Guidelines for Common Diseases** describes sexual debility as a condition in which sexual desire and ability decrease.

Traditional associated factors include:

Qillat-i-Mani, reduced semen quantity; **Zu‘f-i-A‘za Ra'isa**, weakness of major functional organs; **Istirkha-i-Qazib**, penile flaccidity; and **Umur Wahmiyya**, psychological factors.

This last point is particularly important.

Traditional Unani medicine recognized that psychological factors can contribute to sexual dysfunction.

That fits very naturally with modern understanding of stress, anxiety and relationship influences on libido.

Classical Principles of Treatment

CCRUM lists traditional treatment principles that include:

Afza'ish-i-Mani — traditionally supporting semen production;

Taqwiyat-i-Qazib — supporting penile function;

Taqwiyat-i-A‘za Ra'isa — strengthening broader functional health;

and importantly,

Izala-i-Awariz Nafsani — addressing psychological factors.

For modern practice, I interpret these principles carefully.

A patient with low libido does not necessarily need treatment aimed at increasing semen.

A woman with low desire obviously requires a different clinical approach from a man with erectile dysfunction.

The classical framework is therefore most useful when individualized rather than applied mechanically.

The Four Major Modes of Unani Treatment

Unani medicine broadly uses:

Ilaj-bil-Ghiza — dietotherapy
Ilaj-bil-Tadbir — regimental therapy

Ilaj-bil-Dawa — pharmacotherapy
Ilaj-bil-Yad — surgical intervention where appropriate

CCRUM describes these as fundamental therapeutic modes within the Unani system.

For low libido, the most relevant components are usually diet, regimen/lifestyle, psychological balance and individualized pharmacotherapy.

Ilaj-bil-Ghiza: Dietotherapy

Food can affect sexual health indirectly through:

energy, body weight, metabolic health, cardiovascular health and nutritional status.

But I do not believe in one universal "libido food."

An obese diabetic patient requires a different diet from an underweight, nutritionally deficient patient.

A person with kidney disease may need different dietary restrictions.

Someone with very high triglycerides should not be encouraged to consume unlimited amounts of rich, sugary "sexual tonics."

The correct Unani principle is **individualized dietotherapy**.

Ilaj-bil-Tadbir: Regimental and Lifestyle Care

Lifestyle is particularly relevant to low desire.

Unani regimental care can involve appropriate attention to:

physical activity, rest, sleep, emotional balance and general routine.

These principles fit well with modern sexual medicine.

A stressed patient may benefit from reducing mental pressure.

A sedentary person may benefit from exercise.

A sleep-deprived patient may require sleep correction.

A couple with performance pressure may benefit from removing intercourse as the immediate goal and rebuilding affectionate intimacy.

This is one of the strongest areas in which traditional holistic medicine can complement contemporary sexual-health treatment.

Unani Pharmacotherapy

Unani pharmacotherapy has a long tradition of using compound preparations for sexual debility.

CCRUM's standardized guideline lists classical preparations such as **Labub Kabir, Labub Saghir, Labub Barid and certain Majoon formulations** within the traditional management of Zu'f-i-Bah.

These are classical-use recommendations.

For professional modern communication, they should not automatically be described as having the same evidence level as a medicine tested in large contemporary randomized controlled trials.

Their use should be:

individualized, quality-controlled and professionally supervised.

Saffron (Zafran): Traditional Use and Scientific Interest

Zafran, or saffron, is an important traditional medicinal ingredient and has attracted modern research in sexual medicine.

A systematic review and meta-analysis of five small studies involving 173 participants found an overall positive signal for saffron in sexual dysfunction, although the authors emphasized that larger studies are needed.

A 2024 randomized trial in women reported improvement in several sexual-function domains—including libido—when saffron was added to vitamin E compared with vitamin E alone.

This is encouraging evidence.

However:

Evidence for one herb does not prove that every formulation containing that herb will treat HSDD.

The preparation, dose, patient population and underlying cause all matter.

Asgandh / Withania somnifera

Withania somnifera, commonly known as Ashwagandha and also used within South Asian traditional medicine, has been studied for sexual function.

A randomized placebo-controlled study in women with sexual-function difficulties found improvement in Female Sexual Function Index scores after standardized Withania root extract, including improvement in the desire domain.

These results are interesting, but the study involved a specific standardized extract in a relatively small group.

They do not prove that every Ashwagandha preparation—or every mixed Unani or Ayurvedic formulation—will have the same effect.

Traditional medicine should use such research as **supporting evidence**, not turn it into a guarantee.

Natural Does Not Mean Risk-Free

Patients often tell me:

“Doctor, I only want herbal medicine because it has no side effects.”

That assumption is not medically correct.

Herbs are biologically active.

If a plant can influence the nervous, hormonal or cardiovascular system, it can potentially interact with other medicines or cause adverse effects in some individuals.

Safety depends on:

identity, purity, preparation, dose, duration, kidney and liver health, pregnancy status and other medications.

Responsible Unani medicine should never require the claim:

“Natural means zero side effects.”

Good prescribing is more important than promotional language.

How Unani Medicine Can Be Particularly Useful in Low Libido

I consider the Unani system especially useful when low libido exists together with broader disturbances such as:

chronic fatigue, poor sleep, stress, digestive problems, unhealthy lifestyle, obesity, metabolic disease or general debility.

Instead of focusing only on a sexual symptom, Unani care encourages attention to the person's **entire health pattern**.

This can complement modern evaluation particularly well.

For example:

a patient may receive proper thyroid treatment but still need help with sleep and lifestyle;

a man with diabetes may require metabolic management as well as sexual counselling;

a woman with menopausal pain may need modern local therapy alongside nutritional and emotional support.

The systems do not need to compete.

Where Unani Medicine Should Not Replace Modern Treatment

An integrative approach also requires knowing the limits.

If a man has genuine pituitary disease causing high prolactin, he needs appropriate endocrine treatment.

If severe depression is causing low desire, professional mental-health treatment may be necessary.

If a woman has significant painful intercourse caused by a gynecological condition, that condition must be treated.

If testosterone deficiency is genuine, an evidence-based hormonal discussion may be appropriate.

If a patient has a dangerous medication interaction, it should be corrected.

I consider this responsible integration—not a weakness of Unani medicine.

My Special Approach at Saira Health Care

When a patient consults me for low libido, I prefer a structured clinical approach.

First, I identify the exact sexual complaint.

Is the patient describing low desire?

Or is the real problem:

erection difficulty, premature ejaculation, pain, orgasm difficulty or infertility?

Second, I identify when the change started.

Was libido always low?

Or did it decrease recently?

A recent change suggests different causes from lifelong low desire.

Third, I look for medical causes.

I consider:

diabetes, obesity, thyroid disease, chronic illness, hormonal abnormalities and medication effects.

Fourth, I evaluate psychological and relationship factors.

Stress, depression, anxiety, fertility pressure and relationship conflict are assessed respectfully.

Fifth, I investigate hormones where appropriate.

For men this may include:

morning testosterone, prolactin, LH, FSH or thyroid testing depending on symptoms.

Sixth, I assess the patient according to Unani principles.

This includes:

Mizaj, diet, sleep, physical activity, general strength, digestion and psychological state.

Seventh, I create an individualized treatment plan.

Treatment may combine:

medical management of an underlying disease, psychosexual counselling, lifestyle improvement, hormone therapy when genuinely indicated, pain treatment in women and physician-selected traditional Unani support.

This is much more useful than prescribing the same aphrodisiac to every patient.

Why I Do Not Treat Every Low-Libido Patient With the Same Medicine

Consider four patients.

A 32-year-old man has low libido, low morning erections and repeatedly confirmed low testosterone.

A 32-year-old man has completely normal hormones but severe depression and job-related stress.

A 45-year-old woman avoids sex because intercourse has become painful.

A 38-year-old woman has persistent generalized low desire despite otherwise satisfactory health and relationship circumstances.

All four may say:

“My libido is low.”

But they do not have the same condition.

The first may require endocrine treatment.

The second may require mental-health and lifestyle care.

The third requires evaluation and treatment of sexual pain.

The fourth may qualify for a specific HSDD treatment after full evaluation.

One medicine cannot logically treat all four.

Low Libido and Male Infertility

Low sexual desire can affect fertility indirectly if intercourse becomes very infrequent.

But libido does **not** tell us sperm quality.

A man can have very strong sexual desire and severe azoospermia.

Another man with reduced desire may have normal sperm parameters.

Therefore, fertility concerns require their own evaluation.

This is one reason I consider training in both male sexual health and male infertility particularly useful.

Infertility Itself Can Reduce Libido

There is also a reverse relationship.

Couples experiencing infertility often become very focused on ovulation timing.

Sex may become scheduled.

The husband begins worrying about semen analysis.

The wife worries about her fertile window.

Intimacy becomes a treatment procedure rather than an enjoyable part of the relationship.

In these couples, low desire can develop **because of infertility-related stress**, even though neither partner initially had a sexual disorder.

Counselling can be extremely helpful.

Low Libido in Older Adults

Ageing may change sexual desire, but low libido should not automatically be dismissed as normal ageing.

In men, the EAU notes that healthy ageing itself produces only a relatively small gradual testosterone decline, while obesity, diabetes and poor health contribute much more strongly to clinically important hypogonadism.

An older person's low libido may therefore reflect:

medication, chronic illness, depression, hormones, sexual pain or relationship changes.

Age should be considered—but not used as an excuse to avoid diagnosis.

Frequently Asked Questions

Is low libido normal?

Temporary changes can be completely normal. Persistent and distressing reduction deserves evaluation.

Does low libido mean low testosterone?

No. Testosterone deficiency is one possible cause in men, but many other medical and psychological factors can reduce desire.

Which test confirms low libido?

There is no single blood test that diagnoses libido. Diagnosis comes primarily from medical and sexual history. Hormone testing is used when an endocrine cause is suspected.

Can testosterone increase male libido?

It can improve desire in men with properly diagnosed testosterone deficiency. It should not be used routinely in men whose testosterone is normal.

Can testosterone reduce sperm count?

Yes. External testosterone can suppress the hormonal signals needed for sperm production, so fertility goals must be considered before treatment.

Can depression reduce libido?

Yes. Depression is a recognized cause of reduced sexual desire.

Can antidepressants reduce libido?

Some can. The medicine should be reviewed with the prescribing clinician rather than stopped abruptly.

Can thyroid disease cause low libido?

Yes. Thyroid disorders can contribute to sexual dysfunction and should be appropriately diagnosed and treated.

Can women receive medication specifically for low sexual desire?

Yes, but only after careful diagnosis. Current U.S. options include flibanserin for women younger than 65 with acquired generalized HSDD and bremelanotide for selected premenopausal women.

Can postmenopausal women receive testosterone?

Carefully selected women with HSDD may be considered for monitored transdermal testosterone under specialist guidance. It is generally off-label, and long-term safety data remain limited.

Can Unani medicine help low libido?

Yes, Unani medicine can be particularly useful as an **individualized supportive system**, addressing Mizaj, lifestyle, sleep, diet, psychological well-being and general vitality alongside physician-selected traditional pharmacotherapy. CCRUM officially recognizes Du'f al-Bah/loss of libido within Unani terminology.

Can one herbal medicine cure every case of low libido?

No. The causes are too diverse. Hormonal disease, depression, pain, medication effects and relationship problems require different approaches.

Dr. Nizamuddin Qasmi and My Work in Sexual Disorders & Infertility

I am **Dr. Nizamuddin Qasmi**, Founder and Chief Physician of **Saira Health Care**, with a focused clinical practice in **sexual disorders and infertility**.

My professional education and training listed for this article 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 professional profile currently lists **BUMS, MD, CGO, Certificate in Infertility and Certificate in Urology – London, UK** and describes my clinical focus in sexual disorders and infertility.

Saira Health Care's current disease content also presents my practice as focused on sexual disorders and infertility and lists the additional Male Infertility Masters and integrated sexual and reproductive health training in the professional byline used by the clinic.

MasterHealthPro publicly lists its **six-month Male Infertility Masters programme**, along with separate masters programmes in sexual medicine and psychosexual medicine.

This combined sexual-health and infertility focus is valuable because a low-libido patient may simultaneously have:

hormonal disease, erectile dysfunction, fertility concerns, psychological stress or relationship difficulty.

These issues should be evaluated together without confusing one diagnosis with another.

Contribution of Saira Health Care to Sexual Disorders and Infertility

Saira Health Care describes its clinical philosophy as creating a private and non-judgmental environment for sensitive sexual and fertility concerns and using individualized traditional care together with modern research and lifestyle guidance.

I consider patient education one of the most important contributions we can make.

Patients frequently come to us believing myths such as:

“Low libido always means testosterone is low.”

“If I can get an erection, my libido must be normal.”

“If I don't want sex every day, I have a disease.”

“Women naturally lose all sexual desire after menopause.”

“A sexual stimulant can solve relationship problems.”

“Herbal medicines have no side effects.”

These ideas can lead to unnecessary treatment and additional anxiety.

At Saira Health Care, my aim is to help the patient understand **what is actually reducing desire** before deciding on treatment.

My Treatment Philosophy

For me, successful treatment of low libido is not simply an increase in the number of sexual encounters.

I look for broader improvement:

Is sexual interest returning naturally?

Has the underlying hormonal or medical condition improved?

Is fatigue better?

Is intercourse comfortable?

Has relationship pressure decreased?

Does the patient feel psychologically healthier?

If fertility is involved, are reproductive goals being protected?

Is the treatment safe?

That is a much more meaningful definition of recovery.

Prognosis

The outlook for low libido is often good when the underlying cause can be identified.

A man with genuine testosterone deficiency may experience meaningful improvement after appropriate treatment.

A patient whose low desire is caused by depression may improve as mental health recovers.

A person whose medication is responsible may improve after professionally supervised adjustment.

A woman avoiding intimacy because of painful intercourse may regain sexual interest after the pain is treated.

A couple affected mainly by mismatched expectations may improve substantially through communication or counselling.

A person with obesity, poor sleep and metabolic problems may improve gradually as overall health improves.

More complicated cases may require longer treatment.

The prognosis therefore depends primarily on **why libido is low**, rather than the symptom alone.

Conclusion

Low libido is not simply a deficiency of “sexual power.”

It is one of the clearest examples of how sexual health depends on the **whole person**.

Modern sexual medicine shows that sexual desire is influenced by biological drive, psychological motivation and relationship or social circumstances. Current EAU guidance lists androgen deficiency, high prolactin, depression, anxiety, relationship conflict, chronic disease, medications and erectile dysfunction among important causes of male low sexual desire.

Testosterone is important, but a patient should not diagnose himself from symptoms. Genuine male hypogonadism requires symptoms together with consistently low morning testosterone levels. Obesity, diabetes and other chronic illnesses are particularly important contributors.

Women also require individualized assessment. ACOG emphasizes that desire, arousal, orgasm and pain frequently overlap and that clinically important sexual dysfunction involves personal distress rather than simply a numerical frequency of sexual activity.

Modern treatment options are evolving. As of the December 2025 FDA label revision, **flibanserin is indicated for appropriately diagnosed acquired generalized HSDD in women younger than 65**, while **bremelanotide remains indicated for selected premenopausal women**. Both require careful patient selection and have important safety considerations.

For appropriately selected postmenopausal women with HSDD, specialist-guided transdermal testosterone can provide a moderate benefit, although long-term safety information remains incomplete and serum testosterone should not be used as the diagnostic test for female HSDD.

The **Unani system of medicine** adds a particularly valuable holistic perspective.

CCRUM's standardized terminology formally recognizes **Du‘f al-Bah** as reduced sexual drive/loss of libido, and its Standard Unani Treatment Guidelines describe sexual debility in relation to both physical and psychological factors.

Traditional Unani care considers **Mizaj, general vitality, diet, sleep, physical activity, psychological state and associated bodily functions**, and its therapeutic framework includes dietotherapy, regimental therapy and pharmacotherapy. Modern research on traditional ingredients such as saffron and Withania also provides promising early evidence, although

those studies should not be used to claim that every formulation containing these herbs has been clinically proven to treat low libido.

At **Saira Health Care**, my approach as **Dr. Nizamuddin Qasmi** is therefore based on one principle:

I do not treat low libido simply by trying to stimulate sexual desire. I first determine why the desire has changed. I evaluate hormonal, metabolic, medical, psychological, medication-related and relationship factors; distinguish libido from erection and fertility problems; assess the patient according to Unani principles including Mizaj and lifestyle; and then prepare an individualized treatment plan in which appropriate modern medical care and responsibly supervised Unani treatment can complement one another.

The message I want every patient to remember is:

Low libido does not automatically mean that your hormones are permanently damaged, that you are sexually weak or that your relationship has failed. Sexual desire naturally changes, but persistent and distressing low desire can have many identifiable and treatable causes. The correct treatment begins by understanding the cause—not by randomly taking sexual stimulants.

About Saira Health Care

Saira Health Care focuses on **sexual disorders, infertility and reproductive health**, with its public clinical material describing a patient-centered approach that combines individualized Unani assessment, lifestyle guidance and appropriate contemporary diagnostic understanding.

Visit Saira Health Care

Medical Disclaimer

This article is intended for **general medical education and sexual- and reproductive-health awareness**. It does not replace an individualized medical consultation, physical examination, psychological assessment or laboratory investigation.

Low libido can result from hormonal disorders, chronic illness, depression, anxiety, sexual pain, medication effects, relationship difficulties or normal variation.

Do not start testosterone because of low libido without appropriate testing. Testosterone can suppress sperm production and requires particular caution in men who wish to father children.

Do not stop antidepressants, thyroid medicines, diabetes medicines or other prescribed treatments because of sexual adverse effects without consulting the prescribing clinician.

Flibanserin and bremelanotide are prescription medicines with specific indications and safety restrictions; they are not general sexual-performance enhancers.

Unani, herbal and traditional medicines contain biologically active ingredients. Their safety depends on proper identity, quality, dose, individual health conditions and interactions with other medicines.

No hormone, conventional medicine, herbal formulation, Unani treatment, food, supplement or counselling programme can responsibly guarantee restoration of libido or identical results in every patient.