Female Sexual Health Issues: Causes, Symptoms, Diagnosis, Modern Treatment and the Role of Unani Medicine

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Medical literature reviewed and updated: September 2026

Introduction

As a physician working with patients affected by sexual disorders and infertility, I have noticed that women's sexual-health problems are often discussed much less openly than men's.

A man may comfortably say:

“Doctor, my erection is weak.”

But a woman may remain silent for months or years before finally saying:

“Doctor, I do not feel sexual desire anymore.”

Another may say:

“I have desire, but I cannot become properly aroused.”

Another may tell me:

“Intercourse has become painful.”

A newly married woman may say:

“Whenever penetration is attempted, my body becomes tight and intercourse cannot happen.”

Another may explain:

“I enjoy sexual activity but cannot reach orgasm.”

These are not necessarily the same disorder.

The term **female sexual dysfunction (FSD)** is an umbrella term covering several different difficulties involving sexual desire, arousal, orgasm, pain and medication-related sexual problems.

The American College of Obstetricians and Gynecologists (ACOG) currently describes female sexual dysfunction as problems involving one or more areas of **desire, arousal, orgasm or pain**, usually when the problem causes personal distress. Its Practice Bulletin on female sexual dysfunction was reaffirmed in 2025.

A major 2026 medical review similarly describes four broad diagnostic areas in current DSM-based practice:

- sexual interest/arousal disorder,
- orgasmic disorder,
- sexual pain or penetration disorder,
- and medication/substance-induced sexual dysfunction.

This distinction is extremely important because a woman with vaginal dryness should not automatically receive the same treatment as a woman with depression-related loss of desire.

A woman with vaginismus needs a different approach from a woman with difficulty reaching orgasm.

And a woman who is perfectly comfortable having relatively little sexual desire does not necessarily have a disease simply because somebody else thinks she should want sex more frequently.

Sexual-health treatment should be based on the woman's own symptoms, health, circumstances and distress—not on social pressure or unrealistic expectations.

At **Saira Health Care**, my approach is therefore to understand the woman as a whole before deciding what, if anything, requires treatment.

What Is Female Sexual Health?

Sexual health is much broader than the ability to have intercourse.

Healthy sexuality can involve:

- sexual desire,
- physical and emotional arousal,

- genital comfort,
- adequate lubrication,
- pleasure,
- orgasm,
- freedom from unnecessary pain,
- emotional intimacy,
- body confidence,
- communication,
- consent,
- reproductive well-being,
- and the ability to participate in sexual activity voluntarily and comfortably.

A problem in one area may affect several others.

For example:

Pain → fear → reduced arousal → reduced lubrication → more pain → reduced desire.

Or:

Stress → reduced desire → less sexual activity → relationship tension → more stress.

This is why modern medicine increasingly uses a **biopsychosocial approach**.

It considers:

Biological factors – hormones, nerves, blood flow, disease, medicines and anatomy.

Psychological factors – anxiety, depression, stress, trauma, beliefs and body image.

Social and relationship factors – communication, emotional intimacy, partner problems, cultural beliefs, privacy and life circumstances.

The 2026 medical literature continues to emphasize this individualized, multidisciplinary approach to female sexual dysfunction.

Female Sexual Response Is Not the Same in Every Woman

One of the first things I explain to my patients is:

There is no single "correct" sexual response pattern for every woman.

Traditional models sometimes described sexuality as a straight sequence:

desire → arousal → orgasm → resolution.

In reality, many women's experiences are more complex.

A woman may not initially feel spontaneous sexual desire but may develop desire after:

- affectionate touch,
- emotional closeness,
- kissing,
- appropriate stimulation,
- or beginning sexual activity in a comfortable situation.

ACOG specifically recognizes that sexual desire does not always have to be present at the beginning of sexual activity and may emerge as arousal develops.

This concept helps prevent unnecessary diagnosis.

A woman should not be labelled “low libido” simply because she does not experience spontaneous desire as frequently as somebody else.

The key questions are:

Has her sexual response changed?

Is she personally distressed?

Is there an identifiable medical, psychological or relationship factor?

Main Types of Female Sexual Health Problems

For patients, I find it useful to divide these concerns into several broad groups.

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1. Low Sexual Desire

A woman may report:

- reduced interest in sexual activity,
- fewer sexual thoughts or fantasies,
- rarely initiating intimacy,
- reduced responsiveness to sexual cues,
- or a general feeling that sexual desire has disappeared.

When a persistent reduction in sexual interest and arousal causes clinically significant distress, it may fall within **female sexual interest/arousal disorder** or, in appropriate clinical contexts, **hypoactive sexual desire disorder (HSDD)**.

But low desire is not automatically a disease.

Sexual desire naturally varies according to:

- age,
- relationship circumstances,
- pregnancy,
- breastfeeding,
- menopause,
- stress,
- sleep,
- illness,
- medication,
- and many other factors.

A disorder is diagnosed when the clinical criteria are met and the woman herself experiences meaningful distress or difficulty.

ACOG emphasizes this distinction between normal variation and sexual dysfunction.

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2. Sexual Arousal Problems

A woman may mentally want sexual activity but feel that her body is not responding.

She may experience:

- reduced genital sensation,
- difficulty becoming physically excited,
- inadequate lubrication,
- reduced genital swelling or sensitivity,
- or inability to maintain arousal.

Another woman may experience physical genital response but say:

“My mind still does not feel sexually excited.”

Sexual arousal has both psychological and physiological components.

Arousal difficulties can therefore involve:

- hormonal changes,
- inadequate stimulation,
- medication,
- poor sleep,
- anxiety,
- relationship problems,
- diabetes,
- neurological illness,
- menopause,
- genital pain,
- or other factors.

ACOG recognizes pregnancy, breastfeeding, insufficient sleep, inadequate physical activity, antidepressants, alcohol or drug use, body-image concerns and relationship difficulties among possible contributors.

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3. Orgasmic Difficulties

Orgasmic problems may include:

- never having experienced orgasm,
- orgasm taking much longer than previously,
- orgasm occurring infrequently,
- substantially reduced orgasm intensity,
- or inability to reach orgasm despite adequate arousal and stimulation.

A woman may also tell me:

“I can reach orgasm when I stimulate myself, but not during intercourse.”

This is very different from generalized inability to orgasm.

The type of sexual stimulation matters.

Many women require direct or indirect **clitoral stimulation**, and vaginal penetration alone does not guarantee orgasm.

Orgasmic problems may be associated with:

- inadequate stimulation,
- insufficient sexual education,
- anxiety,
- depression,
- relationship changes,
- certain medicines,
- pelvic surgery or radiation,
- neurological disease,
- menopause,
- or previous trauma.

ACOG recognizes that orgasmic difficulties may involve delayed, less frequent or less intense orgasms or complete absence of orgasm.

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4. Pain During Sexual Activity

Painful intercourse is medically known as **dyspareunia**.

Pain can occur:

- at the vaginal entrance,
- within the vagina,
- around the vulva,
- or deeper in the pelvis.

It may feel like:

- burning,
- tearing,
- sharp pain,
- pressure,
- irritation,

- or deep pelvic aching.

ACOG notes that painful intercourse is common and may result from both gynecological conditions and problems with sexual arousal or response.

Possible causes include:

- vaginal dryness,
- infection,
- vulvodynia,
- vaginismus,
- pelvic-floor muscle dysfunction,
- endometriosis,
- ovarian or pelvic disease,
- childbirth injury,
- scars,
- menopause-related changes,
- and inadequate arousal.

Frequent or severe sexual pain deserves proper medical assessment.

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5. Vaginismus or Genito-Pelvic Pain/Penetration Disorder

Some women experience involuntary tightening of the pelvic-floor muscles when vaginal penetration is attempted or anticipated.

Penetration may become:

- difficult,
- extremely painful,
- or completely impossible.

This is commonly called **vaginismus** and is now often considered within the broader clinical category of **genito-pelvic pain/penetration disorder**.

The woman usually does not consciously decide to tighten her muscles.

She may genuinely want intercourse while her pelvic floor contracts involuntarily.

Treatment may include:

- pelvic-floor physiotherapy,
- gradual desensitization,
- appropriately supervised vaginal dilators,
- psychosexual therapy,
- CBT,
- treatment of underlying pain,
- and partner education.

Forced penetration is not treatment.

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6. Medication- or Substance-Related Sexual Dysfunction

Medicines are often forgotten when assessing sexual problems.

A woman may have completely normal sexual function until she starts a new medicine.

ACOG lists several categories that can affect sexual function, including:

- SSRIs and other mental-health medicines,
- some blood-pressure medicines,
- hormone-containing medicines,
- anticholinergic medicines,
- pain medicines,
- alcohol,
- opioids,
- and recreational substances.

A 2026 systematic review and meta-analysis found that SSRIs were particularly associated with increased orgasmic dysfunction and reduced sexual satisfaction.

However:

Never suddenly stop an antidepressant or another important medicine because of sexual side effects.

The correct approach is to discuss the problem with the prescribing clinician.

Causes of Female Sexual Dysfunction

There is rarely one universal cause.

The following factors may operate alone or together.

Hormonal Changes

Hormones influence female sexual function, but patients should avoid the oversimplified idea:

“Every sexual problem means hormonal imbalance.”

That is not medically correct.

Estrogen plays an important role in maintaining:

- vaginal tissue thickness,
- elasticity,
- genital blood flow,
- and lubrication.

Around and after menopause, declining estrogen can contribute to **genitourinary syndrome of menopause (GSM)**.

Symptoms may include:

- vaginal dryness,
- burning,
- irritation,
- reduced lubrication,
- painful intercourse,
- and urinary symptoms.

ACOG confirms that estrogen decline can make vaginal tissue thinner, dryer and less elastic, contributing to painful intercourse and reduced sexual comfort.

Hormonal changes during breastfeeding may also produce vaginal dryness.

Testosterone may influence sexual desire in some women, particularly after menopause, but a single testosterone blood result should **not** be used by itself to diagnose HSDD.

ISSWSH recommends a full biopsychosocial assessment before considering testosterone treatment.

Menopause

Menopause deserves special attention because several factors may appear simultaneously:

- estrogen decline,
- vaginal dryness,
- painful intercourse,
- sleep problems,
- hot flashes,
- changing body image,
- relationship changes,
- and age-related medical conditions.

A 2026 review on sexual dysfunction during menopause emphasizes that effective treatment should remain individualized and integrate biological, psychological and relational factors.

For many women, treating vaginal discomfort itself can substantially improve sexual experience.

Pregnancy and Breastfeeding

Sexual desire commonly changes during pregnancy and after delivery.

Possible contributors include:

- hormonal changes,
- physical discomfort,
- fatigue,
- fear about pregnancy,
- body-image changes,
- childbirth recovery,
- breastfeeding,
- sleep deprivation,
- and the demands of caring for a newborn.

Breastfeeding-related low estrogen can also contribute to dryness and painful intercourse.

These changes do not automatically mean permanent sexual dysfunction.

Diabetes

Diabetes can influence sexual function through several pathways:

- vascular changes,
- nerve dysfunction,
- hormonal and metabolic factors,
- recurrent genital infections,
- depression or anxiety,
- and general health burden.

A 2026 systematic review and meta-analysis confirms that female sexual dysfunction is an important but frequently neglected complication among women living with diabetes.

Good diabetic control is therefore relevant not only for heart, kidney and eye health but also for sexual and reproductive well-being.

Cardiovascular and Metabolic Health

Healthy sexual response depends partly on normal circulation and general physical health.

Conditions such as:

- obesity,
- hypertension,
- metabolic syndrome,
- cardiovascular disease,
- and physical inactivity

can affect energy, self-image, genital vascular response and overall sexual function.

This does not mean that every sexual problem is vascular.

It means general health should not be ignored.

Neurological Disorders

Sexual sensation and orgasm depend on communication between:

- the genital organs,
- peripheral nerves,
- spinal cord,
- and brain.

Neurological disorders such as:

- multiple sclerosis,
- spinal-cord injury,
- peripheral neuropathy,
- or nerve injury following pelvic surgery

can affect arousal, sensation and orgasm.

The exact effect depends on the location and severity of the neurological problem.

Thyroid and Other Endocrine Disorders

Thyroid disorders can influence:

- mood,
- energy,
- menstruation,
- body weight,
- and sexual interest.

However, thyroid testing should be ordered because the clinical history suggests thyroid disease—not simply because libido is low.

The same principle applies to prolactin and other hormone testing.

Good medicine investigates according to clinical clues rather than ordering every hormone test for every woman.

Depression

Depression can reduce:

- interest,
- pleasure,

- motivation,
- energy,
- confidence,
- and emotional connection.

A woman may lose sexual desire because depression itself has reduced her ability to experience pleasure.

At the same time, some antidepressant medicines may affect sexual response.

Therefore, the physician must distinguish:

sexual symptoms caused by depression

from

sexual symptoms caused or worsened by treatment.

Sometimes both are present.

Anxiety and Chronic Stress

The brain is central to sexual response.

A woman who is constantly thinking about:

- family problems,
- money,
- children,
- work,
- illness,
- fertility,
- relationship conflict,
- or sexual performance

may find it difficult to remain mentally engaged with sexual sensations.

Anxiety may cause:

- self-monitoring,
- distraction,

- pelvic muscle tension,
- fear of failure,
- and avoidance.

Reducing anxiety can therefore improve physical sexual response even without changing hormone levels.

Sexual Trauma and Negative Experiences

A history of sexual coercion or trauma can have long-term effects on:

- trust,
- physical relaxation,
- sexual arousal,
- pelvic-floor tension,
- and emotional safety.

But I want to emphasize:

Not every woman with sexual dysfunction has experienced trauma.

Healthcare professionals should never assume this.

When trauma is present, care should be trauma-informed, confidential and patient-controlled.

Body Image

A woman may avoid intimacy because she feels unhappy about:

- weight,
- breasts,
- scars,
- stretch marks,
- genital appearance,
- aging,
- surgery,
- or other physical changes.

These concerns may reduce confidence even when sexual anatomy and hormones are normal.

Body-image support can therefore be part of sexual-health treatment.

Relationship Problems

Relationship factors can strongly influence female sexual response.

Common issues include:

- unresolved arguments,
- poor communication,
- lack of emotional connection,
- lack of privacy,
- distrust,
- differences in sexual desire,
- sexual pressure,
- fear of pregnancy,
- or lack of consideration for the woman's pleasure.

However, relationship problems should not automatically be blamed either.

Women in healthy, loving relationships can still develop medical sexual disorders.

Partner Sexual Dysfunction

Sometimes the woman's complaint cannot be understood without considering the partner.

For example, a male partner with:

- erectile dysfunction,
- very rapid ejaculation,
- delayed ejaculation,
- performance anxiety,
- or infertility-related stress

may unintentionally influence the couple's sexual pattern.

ACOG also notes that a partner's sexual-health difficulty may contribute to anxiety and uncomfortable sexual experiences.

For this reason, sexual medicine sometimes treats **the couple**, not one isolated individual.

Lack of Sexual Education

Many women enter marriage without accurate knowledge of:

- female genital anatomy,
- the clitoris,
- arousal,
- lubrication,
- orgasm,
- foreplay,
- or the normal variability of sexual response.

Some have been taught only that sex is a marital duty.

Then they are expected suddenly to understand how their body should respond.

This gap in education can contribute to:

- fear,
- painful first intercourse,
- difficulty communicating,
- unrealistic expectations,
- and orgasmic problems.

Sexual education is therefore a legitimate therapeutic intervention.

Sleep Deprivation and Fatigue

A woman who is chronically exhausted may have little interest in sexual activity.

This can occur with:

- caring for young children,
- night-shift work,

- chronic illness,
- insomnia,
- menopause,
- or high stress.

ACOG specifically includes insufficient sleep among factors influencing arousal.

No aphrodisiac can completely compensate for severe chronic exhaustion.

Alcohol, Smoking and Recreational Drugs

Substances can influence:

- brain function,
- vascular health,
- mood,
- lubrication,
- sexual judgement,
- and medication interactions.

Alcohol may initially reduce inhibition but can impair sexual response at higher amounts.

Certain prescription sexual medicines also have important alcohol-related safety warnings, which I discuss later in this article.

Gynecological Causes of Sexual Pain

Pain during sex should never be dismissed as:

“Just psychological.”

Possible physical causes include:

- vaginitis,
- vulvodynia,
- pelvic-floor dysfunction,
- endometriosis,
- ovarian cysts,

- scarring,
- vulvar skin disorders,
- menopausal tissue changes,
- and other pelvic conditions.

ACOG specifically recommends clinical evaluation when sexual pain is frequent or severe.

Common Symptoms of Female Sexual Dysfunction

Women may experience one or several of the following:

Desire-related symptoms

- reduced sexual interest,
- fewer sexual thoughts,
- rarely initiating intimacy,
- little motivation for sexual activity,
- reduced responsiveness to partner initiation.

Arousal-related symptoms

- difficulty becoming mentally excited,
- poor genital response,
- reduced lubrication,
- reduced genital sensation,
- inability to maintain arousal.

Orgasm-related symptoms

- delayed orgasm,
- infrequent orgasm,
- inability to reach orgasm,
- weaker orgasm than previously,
- orgasm only under certain circumstances.

Pain-related symptoms

- burning during penetration,

- pain at the vaginal opening,
- deep pelvic pain,
- vaginal dryness,
- involuntary muscle tightening,
- avoidance of penetration,
- fear of pain.

Emotional effects

- frustration,
- guilt,
- embarrassment,
- reduced confidence,
- relationship stress,
- avoidance of intimacy,
- and anxiety about sexual activity.

Not Every Sexual Difficulty Is a Disease

This is one of the most important parts of responsible sexual medicine.

A woman does not have to:

- want sex every day,
- reach orgasm every time,
- experience spontaneous desire,
- or enjoy every type of sexual activity

to be medically normal.

People differ greatly in sexual interest and response.

ACOG defines clinically important female sexual dysfunction partly by the presence of **personal distress**.

Therefore, treatment should never be prescribed simply because:

“My husband thinks I should want sex more.”

The woman's own health, wishes and well-being matter.

Female Sexual Dysfunction and Infertility

Because my clinical work focuses strongly on sexual disorders and infertility, this relationship deserves careful explanation.

Female sexual dysfunction does **not automatically mean infertility**.

A woman may have:

- low libido,
- absent orgasm,
- or difficulty with arousal

while having completely normal:

- ovaries,
- ovulation,
- fallopian tubes,
- uterus,
- and fertility.

Likewise, orgasm is **not required** for conception.

However, sexual dysfunction can indirectly interfere with pregnancy.

For example:

- vaginismus may prevent vaginal intercourse,
- severe dyspareunia may reduce intercourse frequency,
- low desire may make intercourse around ovulation difficult,
- infertility treatment itself can create sexual pressure,
- relationship stress can reduce intimacy.

A 2026 systematic review examining interventions among women experiencing infertility found that sexual-health interventions—including sex-therapy, counselling and some pharmacological or complementary approaches—can improve sexual-function outcomes, although study designs and interventions varied.

This is why fertility care should not look only at:

AMH, follicles, semen analysis and tubes.

The couple's sexual relationship can also matter.

Diagnosis: How I Evaluate Female Sexual Health Problems

There is no single test called a:

“female sexual dysfunction test.”

Diagnosis begins with a detailed and respectful conversation.

Step 1: Identify the Main Problem

I first ask:

Is the main difficulty desire, arousal, orgasm, pain or penetration?

This sounds simple but is clinically very important.

A patient may initially say:

“My sexual life is not good.”

After discussion, we may discover that her actual problem is:

- severe vaginal dryness,
- antidepressant-related delayed orgasm,
- vaginismus,
- low sexual desire,
- or her partner's erectile dysfunction.

Correctly defining the problem can change the entire treatment plan.

Step 2: Determine When the Problem Started

I ask whether the condition is:

lifelong – present since sexual activity began,

or

acquired – sexual function was previously satisfactory and later changed.

An acquired problem makes me ask:

“What happened around the time symptoms started?”

Possible clues include:

- childbirth,
- menopause,
- new medication,
- depression,
- relationship change,
- surgery,
- illness,
- painful intercourse,
- infection,
- or infertility treatment.

Step 3: Is It Generalized or Situational?

A woman may experience difficulty:

- with every partner and every situation,

or only:

- during penetration,
- with one type of stimulation,
- with a particular partner,
- or during certain circumstances.

For example:

Orgasm during self-stimulation but not intercourse

suggests a different problem from:

No orgasm under any circumstances.

Step 4: Menstrual and Reproductive History

Depending on the patient's age and symptoms, I may ask about:

- menstrual regularity,
- pregnancy,
- childbirth,
- breastfeeding,
- contraception,
- menopause,
- infertility,
- pelvic pain,
- previous gynecological surgery,
- PCOS,
- and reproductive treatment.

Step 5: Medical History

Relevant conditions may include:

- diabetes,
- thyroid disease,
- neurological disorders,
- cardiovascular disease,
- depression,
- anxiety,
- chronic pain,
- cancer,
- and pelvic disorders.

Step 6: Medication History

I ask specifically about:

- antidepressants,
- antipsychotics,

- blood-pressure medicines,
- hormones,
- contraception,
- sedatives,
- pain medicines,
- and herbal or dietary supplements.

This is particularly important when the problem began after medication was changed.

Step 7: Psychological and Relationship Assessment

When appropriate, I sensitively ask about:

- stress,
- anxiety,
- depression,
- body image,
- relationship satisfaction,
- communication,
- fear of pregnancy,
- sexual guilt,
- previous trauma,
- and sexual expectations.

These are medical questions, not moral judgements.

Step 8: Physical Examination When Necessary

Not every low-desire or orgasm problem requires an extensive pelvic examination.

A physical examination becomes more important when there is:

- genital pain,
- vaginal dryness,
- abnormal discharge,

- bleeding,
- pelvic-floor dysfunction,
- menopausal symptoms,
- vulvar disease,
- altered sensation,
- or suspected anatomical pathology.

The examination should always be respectful and consent-based.

Step 9: Laboratory Tests Only When Indicated

Depending on symptoms, investigations may include:

- thyroid tests,
- diabetes screening,
- selected reproductive hormones,
- blood count,
- nutritional investigations,
- or other tests.

I do not support ordering a huge hormone panel for every sexual-health complaint.

Testing should answer a clinical question.

Validated Questionnaires

Clinicians and researchers sometimes use tools such as the **Female Sexual Function Index (FSFI)** and measures of sexual distress.

These instruments can help:

- identify affected domains,
- establish a baseline,
- and assess response to treatment.

However, a questionnaire should complement—not replace—a clinical conversation.

Modern Treatment of Female Sexual Dysfunction

There is no single treatment appropriate for every woman.

The most important principle is:

Treat the cause and the affected sexual domain.

A major 2026 review concluded that different types of female sexual dysfunction have different evidence-based treatments and that team-based care may involve therapists, pelvic-floor physical therapists, psychiatric support, partners and medication when appropriate.

Sexual Education

Many women improve simply by understanding their bodies more accurately.

Education may include:

- understanding the clitoris,
- understanding arousal and lubrication,
- normal variation in sexual desire,
- responsive versus spontaneous desire,
- adequate stimulation,
- communication,
- and recognizing that penetration alone does not guarantee orgasm.

Education removes fear and unrealistic expectations.

Communication With the Partner

A woman should be able to communicate:

- what feels comfortable,
- what feels pleasurable,
- when she needs more time,
- when penetration hurts,
- what type of stimulation she prefers,
- and when she does not want sexual activity.

A partner should not interpret this information as criticism.

Communication can be part of treatment.

Cognitive Behavioral Therapy

CBT can help identify beliefs and thought patterns that interfere with sexual response.

Examples include:

“I must orgasm.”

“If I do not want sex frequently, something is wrong with me.”

“My husband will reject me.”

“Sex is always going to hurt.”

“I must perform perfectly.”

A 2025 systematic review and meta-analysis found that CBT can improve female sexual-function outcomes, although certainty varied between outcomes and further large studies remain desirable.

Mindfulness-Based Treatment

Mindfulness encourages attention to:

- physical sensations,
- breathing,
- touch,
- pleasure,
- and present-moment experience

rather than constant self-evaluation.

A large 2026 network meta-analysis of 45 studies involving 4,726 women found benefits from several psychological approaches, including:

- sex education,
- CBT,
- mindfulness-based interventions,
- PLISSIT-based sexual counselling,

- and general sexual counselling.

Mindfulness-based approaches ranked particularly well for reducing sexual distress, while PLISSIT-based interventions performed strongly for overall sexual-function scores.

This reinforces something I frequently tell patients:

Sexual counselling is not a "weak" treatment. It can be a genuine evidence-based treatment.

Sex Therapy

Sex therapy may address:

- desire discrepancy,
- performance pressure,
- orgasmic difficulties,
- fear of penetration,
- sexual communication,
- avoidance,
- and relationship dynamics.

Depending on the condition, treatment may include:

- sensate-focus exercises,
- directed self-stimulation,
- graded exposure,
- communication exercises,
- and couple-based interventions.

Pelvic-Floor Physiotherapy

Pelvic-floor treatment can be particularly valuable for women experiencing:

- vaginismus,
- pelvic-floor overactivity,
- sexual pain,
- childbirth-related dysfunction,

- or certain arousal problems.

A systematic review and meta-analysis has found evidence that pelvic-floor muscle interventions can improve aspects of female sexual function, although the correct programme depends on whether muscles are weak, excessively tense or poorly coordinated.

This is important because blindly prescribing Kegel exercises to every woman is not appropriate.

A woman with an excessively tight pelvic floor often needs to learn **relaxation and coordination**, not simply more strengthening.

Vaginal Dilators

For appropriately diagnosed vaginismus or penetration difficulty, graded vaginal dilators may form part of therapy.

The principle is gradual desensitization—not forced penetration.

Treatment generally progresses from:

- understanding and relaxing the pelvic floor,
- becoming comfortable with touch,
- tolerating smaller insertion,
- and gradually progressing when comfortable.

Pain should not be treated as something the patient must simply endure.

Lubricants

Lubricants can reduce friction and may improve comfort when penetration is painful because of insufficient lubrication.

ACOG recommends water- or silicone-based lubricants when appropriate, particularly when condoms are being used.

However, lubricant cannot treat:

- endometriosis,
- infection,
- severe vulvodynia,
- or a major pelvic-floor disorder.

Again, cause matters.

Vaginal Moisturizers

Vaginal moisturizers can be useful for persistent vaginal dryness, particularly around menopause.

They are used regularly rather than only during intercourse.

ACOG recommends moisturizers and lubricants among first-line options for menopausal dryness and painful intercourse.

Local Vaginal Estrogen

When genitourinary syndrome of menopause is causing:

- dryness,
- burning,
- tissue thinning,
- or painful intercourse,

local vaginal estrogen may be appropriate after medical assessment.

ACOG notes that topical vaginal estrogen can improve vaginal and vulvar dryness and painful intercourse, often within several weeks.

This treatment is aimed at **estrogen-deficient genital tissue**.

It is not a universal treatment for low libido or absent orgasm.

Systemic Menopausal Hormone Therapy

Some women with broader menopausal symptoms may be candidates for systemic menopausal hormone therapy.

The decision depends on:

- age,
- symptoms,
- medical history,
- cardiovascular risk,

- cancer history,
- uterus status,
- and individual preferences.

Hormone therapy should therefore never be started simply because a woman says:

“My sexual desire is low.”

The complete menopausal picture needs assessment.

Testosterone Treatment in Selected Women

Testosterone is widely marketed online as a simple cure for female low libido.

The evidence is more nuanced.

ISSWSH guidance supports consideration of **systemic transdermal testosterone** particularly for appropriately diagnosed postmenopausal women with HSDD when the disorder is not primarily caused by modifiable relationship, psychological or medical factors.

The guideline describes a **moderate therapeutic benefit**, while emphasizing that long-term safety data remain incomplete and that testosterone levels should not be used alone to diagnose HSDD.

A July 2026 systematic review found the strongest evidence for testosterone treatment in postmenopausal women, while evidence in premenopausal women remains more limited.

Therefore:

Testosterone is not a general female sexual tonic.

It requires careful diagnosis, dosing and monitoring under an appropriately experienced clinician and consideration of local regulatory status.

Flibanserin for HSDD

Flibanserin is a centrally acting prescription medicine used for a very specific diagnosis:

acquired, generalized hypoactive sexual desire disorder.

This means low desire:

- developed after previously normal desire,
- occurs across situations or partners,
- causes significant distress,

- and is not primarily explained by a medical or psychiatric disorder, relationship problem or medication.

An important current update is that the U.S. FDA-approved indication was expanded in **December 2025** to include **women younger than 65 years** meeting these criteria.

Flibanserin is **not** approved simply to enhance sexual performance.

It also has important safety considerations.

The current U.S. prescribing information contains warnings concerning:

- hypotension,
- fainting,
- alcohol taken too close to the dose,
- interacting CYP3A4 medicines,
- sedation,
- and liver impairment.

Treatment should be stopped if there is no improvement after eight weeks.

Therefore, this medicine must never be treated like an over-the-counter aphrodisiac.

Bremelanotide

Bremelanotide is another centrally acting treatment for **acquired, generalized HSDD**, but its current U.S. indication remains for **premenopausal women**.

It is administered by subcutaneous injection before anticipated sexual activity.

It is not a general sexual-performance drug.

Important safety considerations include:

- temporary increases in blood pressure,
- nausea,
- possible hyperpigmentation,
- and contraindication in women with uncontrolled hypertension or known cardiovascular disease.

This again illustrates why correct diagnosis matters.

Medication-Induced Sexual Dysfunction

If a medicine is contributing to sexual dysfunction, options may sometimes include:

- adjusting the dose,
- changing treatment,
- changing medication timing,
- treating the sexual side effect,
- or using an alternative medicine.

However, these decisions should be made with the prescribing clinician.

A 2025 systematic review evaluated several pharmacological strategies for antidepressant-induced sexual dysfunction in women, but treatment choice remains individualized because evidence differs between interventions and psychiatric stability remains essential.

Treatment of Diabetes and Other Medical Conditions

If sexual dysfunction is occurring alongside poorly controlled diabetes, thyroid disease, depression or another medical disorder, treatment of that underlying condition becomes part of sexual-health care.

There is little value in repeatedly prescribing a libido medicine while ignoring uncontrolled disease.

Treatment of Pain

When pain is present, I consider pain treatment a priority.

Depending on the cause, treatment may involve:

- treatment of infection,
- lubrication,
- vaginal moisturizers,
- pelvic-floor physiotherapy,
- management of vulvodynia,
- menopausal therapy,
- treatment of endometriosis,

- gynecological treatment,
- or other appropriate specialist care.

Painful sex should not be accepted as normal merely because a woman is married.

Exercise

Regular exercise can support:

- cardiovascular health,
- mood,
- metabolic health,
- body confidence,
- sleep,
- and general well-being.

Exercise may therefore indirectly support sexual health.

But exercise should not be advertised as a guaranteed cure for every sexual disorder.

Sleep and Stress Management

For some patients, improving sleep and reducing stress can make a significant difference.

Treatment may involve:

- regular sleep timing,
- reducing excessive workload where possible,
- relaxation techniques,
- mindfulness,
- appropriate exercise,
- counselling,
- and addressing underlying anxiety or depression.

This is an area where modern biopsychosocial care and classical Unani lifestyle principles overlap meaningfully.

Yoga and Mind-Body Approaches

Yoga, relaxation and meditation may support:

- stress management,
- body awareness,
- pelvic awareness,
- and general psychological well-being.

However, I prefer to describe these as **supportive strategies**, not as universal cures for female sexual dysfunction.

Mindfulness-based psychological interventions have stronger current evidence than vague claims about “energy balancing,” with a 2026 network meta-analysis showing improvement in sexual function and distress.

What About Acupuncture?

Acupuncture and other complementary approaches have been investigated for some aspects of female sexual health, but evidence is less consistent than for established psychosexual, medical and pelvic-floor interventions.

I do not advise patients to delay diagnosis of:

- painful intercourse,
- hormonal disease,
- depression,
- diabetes,
- vaginal disease,
- or neurological problems

while relying solely on alternative therapy.

Understanding Female Sexual Health in the Unani System of Medicine

As a physician trained in Unani medicine, I value one principle especially:

The patient should be understood as a complete human being, not merely as one symptom.

Classical Unani medicine traditionally evaluates health through concepts including:

- **Mizaj** – temperament,
- **Akhlat** – humoral theory,
- diet,
- physical activity,
- mental and emotional condition,
- sleep,
- environment,
- and individual constitution.

The Ministry of AYUSH describes traditional Unani medicine as historically based on humoral theory involving **Dam, Balgham, Safra and Sauda**, while emphasizing maintenance of health through lifestyle and individualized treatment.

I believe it is important to explain this accurately.

The Unani humoral system is a **traditional conceptual framework**.

It should not be presented as though modern laboratory science has proven that a woman's libido can be measured by the quantity of “blood” or “phlegm” in her body.

Modern sexual medicine describes sexual function through:

- hormones,
- neurotransmitters,
- nerves,
- blood flow,
- pelvic-floor function,
- psychological processes,
- relationships,
- and social context.

A responsible integrative practitioner can respect classical Unani principles while also using modern diagnostic knowledge.

Asbab-e-Sitta Zarooriya and Female Sexual Health

One of the most practically useful Unani concepts is **Asbab-e-Sitta Zarooriya**, the six essential factors traditionally considered important for maintaining health.

The Ministry of AYUSH describes these as broadly involving:

1. air and environment,
2. food and drink,
3. physical activity and rest,
4. psychological activity and rest,
5. sleep and wakefulness,
6. retention and elimination.

When I look at female sexual health, several of these principles remain clinically meaningful.

For example:

Poor sleep can reduce desire and increase fatigue.

Chronic psychological stress can interfere with arousal.

Poor physical health can reduce energy and sexual confidence.

Inactivity and metabolic illness can affect overall vascular and hormonal health.

Nutrition influences general well-being.

Therefore, these Unani lifestyle principles can contribute meaningfully to an individualized management plan.

Four Major Modes of Unani Treatment

The Central Council for Research in Unani Medicine describes four traditional modes of Unani therapy:

Ilaj-bil-Tadbir

Regimenal therapy

Ilaj-bil-Ghiza

Dietotherapy

Ilaj-bil-Dawa

Pharmacotherapy

Ilaj-bil-Yad

Surgery

For female sexual-health problems, the first three may have supportive or therapeutic roles depending on the individual diagnosis.

Surgery has no general role in “female sexual weakness” but may obviously be relevant when a separate structural or gynecological condition requires surgical management.

Ilaj-bil-Ghiza: Dietotherapy

In Unani medicine, diet is not treated merely as a source of calories.

Food is traditionally selected according to:

- individual constitution,
- health status,
- digestion,
- body weight,
- and disease pattern.

In contemporary practice, I combine this individualized philosophy with sound nutritional principles.

Depending on the patient, dietary goals may include:

- correcting undernutrition,
- achieving healthy body weight,
- improving protein intake,
- increasing vegetables and fruits,
- supporting metabolic health,
- controlling diabetes,
- ensuring adequate micronutrients,
- and maintaining hydration.

I do **not** tell patients that one particular food is a guaranteed:

“natural female Viagra.”

That would not accurately reflect the complexity of female sexual response.

Ilaj-bil-Tadbir: Regimenal Therapy

Regimenal therapy in Unani medicine involves non-drug approaches aimed at restoring balance and supporting health.

CCRUM describes it as a systematic therapeutic approach and includes lifestyle modification, exercise and various traditional regimens within this category.

In female sexual-health care, the most relevant supportive principles may include:

- regular physical activity,
- relaxation,
- appropriate rest,
- improved sleep,
- stress reduction,
- and individualized lifestyle correction.

However, a traditional regimen should not be confused with specialized treatments.

For example:

Pelvic-floor physiotherapy for vaginismus is a specialist rehabilitation technique.

General Unani regimenal care may complement it but should not falsely claim to replace it.

Ilaj-bil-Dawa: Unani Pharmacotherapy

Unani medicine contains numerous single drugs and compound preparations traditionally used for different health concerns.

However, I believe female sexual dysfunction is an area where indiscriminate prescribing should be avoided.

There should not be one bottle labelled:

“Female sexual weakness medicine for everybody.”

A woman with:

- menopausal dryness,
- vaginismus,
- absent orgasm,

- medication-induced sexual dysfunction,
- or depression-related low desire

does not have the same condition.

Therefore, if I consider Unani pharmacotherapy, I first assess:

- the woman's main sexual complaint,
- Mizaj and general health,
- age,
- menstrual and menopausal status,
- medical conditions,
- medications,
- sleep,
- psychological health,
- nutritional status,
- and reproductive goals.

The treatment should then be individualized.

Herbal Medicines: What Does Modern Research Show?

Several medicinal plants have been studied for female sexual function.

Some reviews have reported promising findings for certain plant products.

For example, a systematic review of **Tribulus terrestris** found improvement in some sexual-function scores across several small randomized trials.

However, the authors rated the **certainty of evidence as very low** and emphasized that additional trials were needed.

A separate meta-analysis of natural products reported preliminary beneficial findings for some products such as Tribulus and ginseng, but also emphasized the preliminary nature of the evidence.

This is how I believe herbal evidence should be communicated:

Promising does not mean proven.

Traditional use does not mean guaranteed effectiveness.

Natural does not mean risk-free.

Herbal Safety Matters

The Ministry of AYUSH's pharmacovigilance programme specifically warns against the widespread assumption that:

“Natural is always safe.”

AYUSH Suraksha emphasizes monitoring adverse reactions and promoting safer use of Ayurveda, Siddha and Unani medicines.

This is particularly important in sexual medicine because patients may simultaneously be taking:

- antidepressants,
- blood-pressure medicines,
- diabetes medicines,
- contraceptives,
- fertility treatment,
- anticoagulants,
- or hormones.

Herbal products can interact with conventional medicines.

Therefore, the physician should know everything the patient is taking.

Hijama, Massage and Other Regimenal Procedures

Traditional Unani regimenal medicine includes interventions such as massage and Hijama in selected disorders.

However, the current evidence does **not** justify claiming that Hijama or massage is a proven stand-alone cure for:

- HSDD,
- female orgasmic disorder,
- vaginismus,
- or other female sexual dysfunctions.

Massage may help some patients with:

- relaxation,
- stress,
- general well-being,
- and body awareness.

But I would not replace:

- pelvic-floor physiotherapy,
- treatment of vaginal atrophy,
- psychological therapy,
- or medical diagnosis

with massage alone.

Responsible Unani care means knowing both the strengths and limitations of each treatment.

Psychological Health in the Unani Approach

Classical Unani health principles give importance to **psychic movement and rest** as part of the six essential factors.

This is particularly relevant in female sexual-health disorders.

A woman may have completely normal anatomy while sexual function is affected by:

- chronic stress,
- anxiety,
- guilt,
- grief,
- fear,
- relationship conflict,
- or previous trauma.

In such patients, counselling and modern psychological treatment are not in conflict with Unani medicine.

They can be integrated.

The latest 2026 research strongly supports psychological interventions such as CBT, mindfulness and structured sexual counselling for many female sexual-function problems.

Dr. Nizamuddin Qasmi's Individualized Treatment Approach

At **Saira Health Care**, I do not begin treatment by asking:

"Which sexual tonic should I give?"

I begin by asking:

"What is actually wrong?"

My individualized approach can be understood in the following steps.

Step 1: Identify the Exact Sexual-Health Problem

Is this primarily:

- reduced desire,
- arousal difficulty,
- absent or delayed orgasm,
- vaginal dryness,
- painful intercourse,
- vaginismus,
- medication-induced dysfunction,
- menopausal sexual dysfunction,
- or several problems together?

Without this distinction, treatment becomes guesswork.

Step 2: Establish Whether the Problem Is New or Lifelong

A lifelong condition suggests one group of possibilities.

A newly acquired condition makes me investigate what changed.

For example:

Normal desire for years → antidepressant started → desire and orgasm deteriorated

is a very different clinical story from:

Never experienced sexual desire or orgasm.

Step 3: Review Medical and Reproductive Health

Depending on the patient, I consider:

- menstrual health,
- menopause,
- pregnancy,
- breastfeeding,
- infertility,
- PCOS,
- diabetes,
- thyroid disease,
- neurological disorders,
- pelvic disease,
- and medication history.

Step 4: Understand Pain Before Treating Desire

If intercourse hurts, reduced desire may simply be a protective response.

Why would the brain desire an activity it expects to hurt?

Therefore:

Treat the pain first.

The patient may not need a libido medicine at all.

Step 5: Assess Psychological and Relationship Factors

I consider:

- stress,
- anxiety,

- depression,
- body image,
- relationship conflict,
- trauma,
- performance pressure,
- and sexual misconceptions.

This assessment must be confidential and non-judgmental.

Step 6: Correct Sexual Misinformation

I regularly correct beliefs such as:

“Every woman must orgasm from penetration.”

“Low libido always means low hormones.”

“Pain during sex is normal for women.”

“A woman who cannot reach orgasm is infertile.”

“Natural medicine cannot cause side effects.”

“If a woman loves her husband she can never have vaginismus.”

These statements are medically inaccurate.

Patient education itself can improve outcomes.

Step 7: Correct Lifestyle Factors

When relevant, I address:

- poor sleep,
- physical inactivity,
- chronic stress,
- unhealthy weight,
- poorly controlled diabetes,
- nutritional deficiency,
- excessive alcohol,

- smoking,
- and general health.

This is where **Ilaj-bil-Ghiza**, **Ilaj-bil-Tadbir** and modern lifestyle medicine can work together particularly well.

Step 8: Introduce Evidence-Based Sexual Therapy

Depending on the diagnosis, this may include:

- sexual education,
- CBT,
- mindfulness,
- sex therapy,
- couple counselling,
- directed self-stimulation,
- sensate focus,
- appropriate clitoral stimulation,
- graded desensitization,
- or pelvic-floor rehabilitation.

A 2026 meta-analysis provides strong support for psychological and sexual-counselling approaches across female sexual-function outcomes.

Step 9: Individualized Unani Treatment

When appropriate, I may incorporate selected Unani approaches for:

- nutritional support,
- general vitality,
- stress and sleep management,
- metabolic health,
- digestive health,
- menstrual and reproductive wellness,
- and other identified aspects of the patient's constitution and health.

Any pharmacotherapy should be selected individually rather than through a one-formula-fits-all approach.

Step 10: Use Modern Medical Treatment When Indicated

A responsible integrative approach also means recognizing when the patient may need:

- vaginal estrogen,
- treatment of infection,
- menopausal care,
- antidepressant review,
- HSDD medication,
- pelvic-floor physiotherapy,
- endocrine treatment,
- or another evidence-based intervention.

Traditional medicine should not delay necessary treatment.

Step 11: Refer When Another Specialist Is Needed

Depending on the underlying cause, I may advise evaluation by a:

- gynecologist,
- endocrinologist,
- psychiatrist,
- psychologist,
- psychosexual therapist,
- pelvic-floor physiotherapist,
- neurologist,
- oncologist,
- or other appropriate specialist.

Referral is not treatment failure.

It is part of responsible patient care.

Female Sexual Dysfunction and the Saira Health Care Approach to Infertility

Female sexual health is particularly important in infertility practice.

A couple may come saying:

“We have been unable to conceive.”

But the underlying difficulty may actually be:

- vaginismus,
- painful intercourse,
- very infrequent intercourse,
- severe stress around ovulation,
- male erectile dysfunction,
- or sexual difficulties caused by fertility treatment itself.

The physician should therefore understand both:

reproductive function

and

sexual function.

At Saira Health Care, our public material identifies sexual disorders and infertility as central areas of clinical focus.

I believe this overlap is important because a semen report, AMH result or ultrasound gives only part of the couple's reproductive picture.

What Successful Treatment Really Means

The word **success** should not be limited to one laboratory number or one sexual-performance target.

For one woman, successful treatment may mean:

Her painful intercourse becomes comfortable.

For another:

She learns that clitoral stimulation is necessary for her orgasm and stops believing her body is abnormal.

For another:

Her menopausal vaginal dryness is treated and intimacy becomes enjoyable again.

For another:

Her antidepressant-related sexual dysfunction is recognized and safely managed.

For another:

Her vaginismus improves through pelvic-floor rehabilitation and psychosexual therapy.

For another:

Her sexual desire returns after depression, sleep and relationship stress are addressed.

And for another woman:

The consultation confirms that her naturally lower level of sexual desire is normal for her and does not require treatment.

All of these can represent good medical outcomes.

Why I Do Not Believe in Manufactured "Success Stories"

Healthcare websites sometimes publish dramatic statements such as:

"Patient completely cured in seven days."

"One herb restored her sexual power permanently."

Unless these are genuine, documented cases published with appropriate consent, such stories should not be presented as medical evidence.

Individual outcomes vary.

A trustworthy healthcare clinic should distinguish between:

- real patient experiences,
- clinical observations,
- traditional medical knowledge,
- and evidence from controlled scientific research.

I believe this distinction strengthens the credibility of Unani medicine rather than weakening it.

Common Myths About Female Sexual Health

Myth: A woman who does not want sex frequently has a disease.

Fact: Desire varies greatly. It becomes a medical concern when there is a meaningful change or persistent difficulty that causes personal distress.

Myth: Every woman should experience spontaneous desire.

Fact: Some women experience responsive desire that appears after affectionate or sexual stimulation begins.

Myth: Penetration alone should always produce orgasm.

Fact: Many women require direct or indirect clitoral stimulation.

Myth: No orgasm means infertility.

Fact: Female orgasm is not required for conception.

Myth: Pain during intercourse is something a woman must tolerate.

Fact: Frequent or severe sexual pain requires proper evaluation.

Myth: Low libido always means estrogen or testosterone deficiency.

Fact: Desire can be affected by psychological, relationship, medical, medication, sleep and lifestyle factors as well as hormones.

Myth: One hormone test can diagnose low libido.

Fact: HSDD is diagnosed clinically. Even testosterone guidelines state that a testosterone concentration should not be used alone to diagnose the condition.

Myth: Herbal medicines have no side effects.

Fact: The Ministry of AYUSH specifically emphasizes pharmacovigilance and warns against assuming that natural products are always safe.

Myth: One herbal aphrodisiac works for all women.

Fact: Female sexual dysfunction consists of several different conditions requiring different treatments.

Myth: Sexual problems are always psychological.

Fact: Diabetes, menopause, medications, pelvic disease, neurological problems and other physical conditions can contribute.

Myth: Sexual problems are always physical.

Fact: Psychological and relationship factors can be equally important.

Frequently Asked Questions

Is female sexual dysfunction common?

Yes.

Sexual-health difficulties are common, although exact prevalence varies depending on age, population, diagnostic criteria and whether personal distress is required.

ACOG notes that female sexual dysfunction is relatively prevalent but frequently under-discussed in healthcare.

Is low libido always abnormal?

No.

There is no universal number of times per week or month that a healthy woman must desire sex.

The woman's own experience and distress matter.

Can diabetes cause female sexual problems?

Yes.

Diabetes can affect sexual health through vascular, neurological, metabolic and psychological pathways.

Can antidepressants affect orgasm?

Yes.

SSRIs are particularly associated with orgasmic dysfunction and reduced sexual satisfaction in current research.

Do not stop antidepressants independently.

Can menopause affect sexual health?

Yes.

Menopause can contribute to vaginal dryness, painful intercourse and changes in sexual desire and response.

Many of these problems are treatable.

Is vaginal estrogen useful?

For women with appropriate menopause-related vaginal dryness or painful intercourse, local vaginal estrogen can be very effective.

It is not a general libido medicine.

Is testosterone useful for women?

In appropriately selected women with HSDD—particularly postmenopausal women—transdermal testosterone may have a role under specialist supervision.

It is not suitable as a general sexual-enhancement supplement, and long-term safety information remains incomplete.

Is there an FDA-approved medicine for low female sexual desire?

In the United States, yes, for carefully defined HSDD.

Flibanserin is currently indicated for women younger than 65 with acquired, generalized HSDD. Its indication was updated in December 2025.

Bremelanotide remains indicated for premenopausal women with acquired, generalized HSDD.

These medicines are not appropriate for every woman with a sexual complaint and should not be used simply for sexual performance enhancement.

Can Unani medicine help female sexual-health problems?

Unani medicine can contribute meaningfully to an individualized treatment programme through:

- dietotherapy,
- regimenal and lifestyle management,
- attention to sleep and psychological health,
- general metabolic and nutritional care,
- reproductive-health assessment,
- and carefully selected traditional pharmacotherapy when appropriate.

However, a woman with a specific medical condition such as:

- vaginismus,
- severe vaginal atrophy,
- endometriosis,
- infection,
- depression,
- medication-induced dysfunction,
- or neurological disease

also needs treatment directed at that underlying cause.

Are herbal aphrodisiacs scientifically proven?

Some natural products have shown promising results in small trials and reviews.

However, for several commonly marketed herbs the certainty of evidence remains low or very low.

For example, the systematic review of Tribulus terrestris specifically concluded that confidence in the estimated benefits was **very low**.

Therefore, no herbal product should be advertised as a guaranteed cure for all female sexual dysfunction.

Does a woman need orgasm to become pregnant?

No.

Female orgasm is not required for fertilization.

However, conditions such as vaginismus or painful intercourse may indirectly make conception difficult by preventing or reducing vaginal intercourse.

When Should a Woman Seek Professional Help?

I recommend consultation when:

- sexual desire has significantly reduced and the change is distressing,
- arousal is persistently difficult,
- orgasm was previously possible but has become difficult or absent,
- orgasm has never occurred and this causes concern,
- sex is painful,
- vaginal dryness is severe,
- penetration repeatedly remains impossible,
- sexual problems began after a new medicine,
- symptoms developed after pelvic surgery or childbirth,
- menopause-related changes are interfering with intimacy,
- diabetes or neurological disease is present,
- depression or anxiety is significant,
- previous sexual trauma is affecting intimacy,
- sexual difficulty is creating serious relationship distress,
- or a sexual problem is interfering with attempts to conceive.

Women should seek prompt medical evaluation when sexual symptoms occur with:

- unusual vaginal bleeding,
- bleeding after sex,

- genital sores,
- unexplained lumps,
- fever,
- foul-smelling discharge,
- severe pelvic pain,
- new neurological symptoms,
- or another concerning physical change.

These symptoms require proper diagnosis rather than self-treatment with sexual tonics.

Dr. Nizamuddin Qasmi and Saira Health Care

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

My professional education and training listed for this clinical work 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 current public physician profile lists BUMS, MD, CGO, Certificate in Infertility and Certificate in Urology – London, UK, and describes my focused work in sexual disorders and infertility.

Saira Health Care's currently published clinical material also lists the **Masters in Male Infertility – MasterHealthPro (HealthPro)** and **Integrated Sexual and Reproductive Health – ISRH, UNFPA** within my professional profile used in its sexual- and reproductive-health content.

This combination of training is particularly relevant in sexual-health practice because many patients do not arrive with one isolated disorder.

A woman may simultaneously experience:

- low desire,
- painful intercourse,
- menstrual problems,
- infertility stress,
- relationship anxiety,
- and a partner with male sexual dysfunction.

Good sexual medicine therefore requires a broad clinical perspective.

Saira Health Care's Contribution to Female Sexual Health, Sexual Disorders and Infertility

One of the greatest barriers in female sexual health is **silence**.

Women may tolerate problems for years because they fear:

- embarrassment,
- judgement,
- family involvement,
- loss of privacy,
- or being told that sexual pleasure does not matter.

At **Saira Health Care**, our aim is to provide a clinical environment where sexual and reproductive concerns can be discussed professionally and confidentially.

The clinic's current public material describes its model as patient-centered and focused on sexual disorders and infertility, combining traditional Unani knowledge with individualized assessment and contemporary medical understanding.

I believe our contribution should not be measured merely by how many medicines we prescribe.

It should also be measured by our ability to:

- correct myths,
- identify the real disorder,
- educate couples,
- recognize when no disease exists,
- identify when another specialist is required,

- support reproductive-health goals,
- and practice Unani medicine responsibly rather than making exaggerated claims.

My Integrative Philosophy

I do not believe good patient care requires choosing:

“Unani medicine OR modern medicine.”

A patient with diabetes needs proper metabolic management.

A woman with menopausal vaginal atrophy may need appropriate local treatment.

A woman with vaginismus may need pelvic-floor and psychosexual therapy.

A woman with depression may need psychiatric care.

A woman with HSDD may, after appropriate assessment, be a candidate for specific pharmacological treatment.

A woman with poor sleep, stress, inadequate nutrition and general health problems may benefit greatly from individualized Unani diet and regimenal principles.

And a patient may need several of these approaches together.

This is how I understand responsible integrative care:

Use traditional knowledge where it is appropriate.

Use current evidence where it is strong.

Be honest where evidence is limited.

Do not delay necessary treatment.

And always place the patient's health above the desire to promote a particular system of medicine.

Latest Research Perspective in 2026

The newest medical research reinforces several important principles.

A 2026 review in *Obstetrics and Gynecology Survey* emphasizes that female sexual dysfunction comprises distinct diagnostic categories and that treatment should be matched to the subtype, often using multidisciplinary care.

A 2026 systematic review and meta-analysis of desire, arousal and orgasmic disorders found that **mindfulness-based CBT improved desire, arousal and orgasm**, while flibanserin

improved desire and bremelanotide improved desire and arousal in the populations studied. The authors also noted significant heterogeneity across the evidence base.

A separate 2026 network meta-analysis involving 45 studies and 4,726 women found significant benefits from **sex education, CBT, mindfulness, PLISSIT-based therapy and sexual counselling**, further strengthening the role of psychological and educational treatment.

In menopause, 2026 evidence continues to support individualized multidimensional management incorporating hormonal, non-hormonal, psychosexual and pelvic-floor approaches according to symptoms.

These developments support the same clinical message:

There is no universal "female sexual power medicine."

The future of female sexual healthcare is personalized and multidisciplinary.

My Final Message to Women

If your sexual life has changed, please do not immediately tell yourself:

"I have become weak."

Instead, ask:

"What has changed in my body, mind, health, medicines, relationship or life?"

If intercourse hurts, investigate the pain.

If your vagina is dry after menopause, treat the dryness.

If antidepressants affected your orgasm, discuss the medication.

If penetration is impossible because your pelvic floor tightens, treat the vaginismus.

If anxiety is overwhelming, address the anxiety.

If stimulation is inadequate, improve sexual understanding and communication.

If a hormonal disorder genuinely exists, treat that disorder.

If your lifestyle and general health need improvement, address them.

And if your sexual desire is naturally lower but you are healthy and personally comfortable with it, you may not need treatment at all.

Female sexuality should never be reduced to a number, a pill or somebody else's expectations.

At Saira Health Care, I believe sexual-health treatment should provide women with:

knowledge instead of fear,

diagnosis instead of guesswork,

dignity instead of embarrassment,

and

individualized treatment instead of one medicine for everybody.

Conclusion

Female sexual dysfunction is not one disease.

It is a broad group of conditions involving:

- sexual desire,
- arousal,
- orgasm,
- pain,
- penetration,
- and medication-related sexual effects.

These problems often overlap.

Possible contributing factors include:

- hormonal changes,
- menopause,
- pregnancy and breastfeeding,
- diabetes,
- thyroid and neurological disease,
- medications,
- depression,
- anxiety,
- chronic stress,
- trauma,
- relationship problems,

- inadequate sexual stimulation,
- lack of sexual education,
- genital and pelvic disorders,
- sleep deprivation,
- and lifestyle factors.

The modern medical approach is based on the **biopsychosocial model**.

Treatment may therefore include:

- accurate sexual education,
- communication,
- CBT,
- mindfulness,
- sex therapy,
- couple counselling,
- pelvic-floor physiotherapy,
- vaginal dilators where appropriate,
- lubricants and moisturizers,
- menopausal treatment,
- treatment of underlying medical conditions,
- medication review,
- and carefully selected prescription treatment for specific diagnoses such as HSDD.

Current 2026 evidence strongly supports the principle that treatment must be matched to the woman's specific disorder rather than using one universal intervention.

The **Unani system of medicine** can make a valuable contribution through its individualized philosophy and its traditional emphasis on:

- **Mizaj**
- **Asbab-e-Sitta Zarooriya**
- **Ilaj-bil-Ghiza**
- **Ilaj-bil-Tadbir**
- **Ilaj-bil-Dawa**

- and whole-person health.

These principles can be particularly useful for improving:

- nutrition,
- sleep,
- stress,
- physical activity,
- general health,
- metabolic health,
- reproductive well-being,
- and appropriate individualized supportive care.

However, responsible Unani medicine should not claim that a single herbal aphrodisiac cures every female sexual disorder.

Current research on many herbal products remains limited, and government AYUSH pharmacovigilance programmes themselves emphasize that natural medicines require appropriate safety monitoring.

My treatment philosophy at **Saira Health Care** is therefore simple:

Listen before prescribing.

Identify the exact sexual disorder.

Understand the woman as a whole.

Correct reversible causes.

Treat pain rather than expecting women to tolerate it.

Use psychological and pelvic-floor treatment whenever indicated.

Use Unani medicine rationally and individually.

Use modern diagnostic and therapeutic knowledge whenever required.

Refer appropriately when specialist care is needed.

And never promise what medical evidence cannot guarantee.

For me, that is the most responsible way to combine the holistic strength of Unani medicine with modern sexual and reproductive healthcare.

About the Author

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Professional Education & Training

- **BUMS – Hamdard University, Delhi**
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Dr. Nizamuddin Qasmi's current public profile at Saira Health Care describes his clinical work as focused on sexual disorders and infertility and lists his BUMS, MD, CGO, Certificate in Infertility and Certificate in Urology – London, UK among his professional qualifications.

Medical Disclaimer

This article is provided for education and general health awareness.

It is not a substitute for an individual medical consultation, pelvic examination, psychological evaluation, diagnosis or personalized treatment plan.

Female sexual-health problems can arise from physical, hormonal, neurological, psychological, medication-related and relationship factors. Therefore, treatment must be individualized.

Do not independently stop antidepressants or other prescription medicines because of sexual side effects.

Do not take estrogen, testosterone, flibanserin, bremelanotide or other prescription sexual-health medicines without appropriate professional assessment.

Unani medicines and herbal supplements should also be used under qualified supervision. Natural origin does not guarantee safety, suitability or freedom from drug interactions.

Women experiencing severe pelvic pain, unexplained genital bleeding, bleeding after intercourse, genital sores, fever, abnormal or foul-smelling discharge, new breast or genital

abnormalities, significant neurological symptoms, severe depression or another concerning health problem should obtain appropriate medical evaluation.

Where gynecology, endocrinology, psychiatry, psychology, pelvic-floor physiotherapy, neurology or another specialist service is required, appropriate referral should form part of responsible care.