Namardi (Male Sexual Weakness / Zoafe Bah) in Unani Medicine: Causes, Symptoms, Diagnosis, Modern Treatment and an Integrative Unani Approach

Introduction

Namardi is a commonly used South Asian term for difficulties related to male sexual function. In traditional Unani medicine, many of the complaints that people describe as Namardi are discussed under the broader concept of **Zu'f-i-Bah or Zoafe Bah**, meaning sexual debility or reduced sexual capacity.

The word "Namardi," however, should be used carefully. It literally carries the idea of "lack of manhood" and may cause unnecessary shame or embarrassment. A sexual disorder does **not** make a man less masculine. From a medical perspective, it is much more useful to identify the actual problem—such as **erectile dysfunction, reduced sexual desire, premature ejaculation, hormonal deficiency, psychological sexual dysfunction or another reproductive-health disorder**—and treat its underlying cause.

The Central Council for Research in Unani Medicine (CCRUM), Ministry of AYUSH, describes **Zu'f-i-Bah** as a condition in which sexual desire and the capability to perform sexual activity are reduced. Its traditional description recognizes several possible contributing factors, including penile flaccidity, general or vital-organ weakness and psychological factors. CCRUM's treatment principles also demonstrate that Unani physicians have historically considered both physical and psychological aspects of sexual debility.

Contemporary sexual medicine takes a similarly broad view, although it uses different scientific terminology. Erectile function depends on healthy blood vessels, nerves, hormones, psychological arousal and relationship factors. Sexual desire can be influenced by testosterone, prolactin, thyroid disease, depression, stress and medicines. Premature ejaculation has its own biological and psychological mechanisms and should not simply be called "weakness."

The **2026 European Association of Urology (EAU) Sexual and Reproductive Health Guidelines** continue to treat erectile dysfunction, disorders of ejaculation, low sexual desire and male hypogonadism as distinct conditions requiring individual assessment. The 2026 edition substantially updated the evidence relating to ejaculation disorders and hypogonadism and reorganized recommendations for erectile-dysfunction management.

For patients seeking Unani treatment, the most scientifically responsible approach is therefore an **integrative model**: identify the exact modern diagnosis, investigate important medical causes, understand the patient's Mizaj and overall condition, correct lifestyle and psychological factors, and then select individualized Unani treatment where appropriate.

What Does Namardi Mean?

Namardi is **not a single internationally recognized medical diagnosis**.

Different patients may use the same word for completely different problems.

One man may mean:

“I do not get a sufficiently hard erection.”

Another may mean:

“My erection disappears during intercourse.”

Another may be concerned that:

“I ejaculate too quickly.”

Another may have:

“No desire for sex.”

A fifth patient may have completely normal sexual function but severe anxiety about his ability to satisfy his partner.

These conditions require different investigations and different treatments.

Calling all of them “Namardi” can therefore hide the actual diagnosis.

A more useful clinical concept is:

Male sexual dysfunction is a group of conditions affecting sexual desire, erection, ejaculation, orgasm or sexual satisfaction.

Within traditional Unani terminology, **Zoafe Bah** can function as a broad concept of sexual debility, but contemporary clinical assessment should identify the specific disorder present.

Understanding Zoafe Bah in Unani Medicine

CCRUM's Standard Unani Treatment Guidelines describe **Zu‘f-i-Bah (sexual debility)** as decreased sexual desire and decreased capability to perform sexual activities.

The traditional guideline associates it with factors including **Qillat-i-Mani**, weakness of major or vital organs, **Istirkha-i-Qazib** or penile flaccidity, and **Umur Wahmiyya**, referring to psychological influences.

This is historically important because it demonstrates that classical Unani medicine did not view sexual health exclusively as a problem of the penis.

Physical strength, reproductive function and psychological state were considered together.

Another CCRUM publication discussing traditional male sexual weakness notes that classical scholars such as Ibn Sina, Zakaria Razi, Ismail Jurjani and others described several male sexual and reproductive disorders within the broad framework of Zoafe Bah, including penile flaccidity and premature ejaculation.

Modern medicine separates these into specific diseases, which helps make diagnosis more precise.

Three Major Problems Commonly Described as Namardi

The patient's description of Namardi most commonly falls into one or more of three categories.

Problem	Main Complaint	Modern Medical Term
Difficulty becoming or staying erect	"My erection is weak"	Erectile dysfunction
Reduced interest in sexual activity	"I have no desire"	Low sexual desire / male hypoactive sexual desire disorder when clinically applicable
Ejaculation earlier than desired with poor control and distress	"I discharge too quickly"	Premature or early ejaculation

These disorders may exist independently or together.

For example, a man may develop erectile dysfunction and then begin rushing intercourse because he is frightened that his erection will disappear. This anxiety may subsequently contribute to early ejaculation.

Similarly, low testosterone may reduce libido and contribute to erectile problems without necessarily causing premature ejaculation.

This is why diagnosis should come **before** choosing a medicine.

A. Erectile Dysfunction

What Is Erectile Dysfunction?

Erectile dysfunction, or ED, is the **persistent inability to achieve or maintain an erection sufficiently firm for satisfactory sexual activity**.

The EAU notes that ED can have organic, psychological or mixed causes, with mixed causes being extremely common.

Having one unsuccessful erection after fatigue, stress, excessive alcohol intake or an argument with a partner does not automatically mean that a man has ED.

The problem becomes clinically significant when it is recurrent or persistent and causes difficulty or distress.

How a Normal Erection Occurs

An erection is a complex neurovascular event.

Sexual stimulation begins in the brain and nervous system. Signals reach the penis, causing release of substances including nitric oxide. Smooth muscle inside the penile erectile tissue relaxes, arterial blood flow increases and the erectile chambers fill.

At the same time, veins responsible for draining blood are compressed, helping the penis remain firm.

A problem anywhere in this chain can impair erection.

This includes:

brain and psychological factors, peripheral nerves, spinal pathways, testosterone and other hormones, penile blood vessels, erectile tissue and medications that interfere with sexual function.

Therefore, ED should never automatically be attributed to “weak semen” or general weakness.

Causes of Erectile Dysfunction

Some of the most important causes include diabetes, hypertension, cardiovascular disease, high cholesterol, obesity, metabolic syndrome, smoking, physical inactivity, neurological disease, hormonal abnormalities, pelvic surgery or injury, medications and psychological stress.

Current EAU guidance identifies vascular, hormonal, neurological and psychological disorders among major causes and recognizes diabetes, hypertension, cardiovascular disease, obesity, smoking and physical inactivity among established risk factors.

Age increases the likelihood of ED, but erectile dysfunction should not simply be dismissed as an unavoidable part of becoming older.

Many treatable factors remain important even in older men.

Erectile Dysfunction Can Be an Early Health Warning

A healthy erection depends substantially on healthy blood vessels.

The penile arteries are relatively small, so vascular dysfunction may sometimes become clinically noticeable as ED before more obvious cardiovascular symptoms develop.

Current EAU guidance therefore emphasizes cardiovascular risk assessment in men presenting with predominantly vascular erectile dysfunction.

A man repeatedly taking sexual-performance medicine without checking diabetes, blood pressure, lipids or cardiovascular health may therefore be treating the symptom while ignoring an important underlying disease.

Psychological Erectile Dysfunction

Not all ED is caused by physical disease.

Performance anxiety is extremely common.

A man may experience one unsuccessful sexual encounter and then begin thinking:

“What if it happens again?”

During the next encounter, instead of experiencing sexual stimulation naturally, he monitors his erection continuously.

That anxiety activates the body's stress response and may make erection more difficult.

One unsuccessful experience then becomes a cycle:

fear → reduced erection → greater fear → further difficulty.

Relationship conflict, depression, traumatic sexual experiences, restrictive beliefs about sexuality and excessive pressure to “perform” can also contribute.

The EAU therefore recommends considering life stress, psychosexual factors and cognitive concerns during evaluation and recommends cognitive-behavioural therapy when appropriate, often together with medical treatment.

B. Loss of Libido

What Does Low Libido Mean?

Libido means sexual desire.

Low libido refers to a meaningful reduction in interest in sexual thoughts, intimacy or sexual activity.

A naturally lower sexual frequency is not automatically abnormal.

The condition becomes clinically important when there is a persistent or recurrent reduction in desire that is unusual for the individual and causes personal or relationship distress.

The EAU describes male hypoactive sexual desire disorder as persistent or recurrent deficiency or absence of sexual or erotic thoughts and desire for sexual activity, interpreted in the context of the person's age and circumstances.

Causes of Reduced Sexual Desire

Sexual desire is not controlled by testosterone alone.

Potential causes include:

androgen deficiency, elevated prolactin, thyroid abnormalities, depression, anxiety, relationship conflict, erectile dysfunction, chronic medical disease, certain antidepressants, ageing and other psychological or physical factors.

The EAU specifically emphasizes that sexual desire reflects interacting biological, psychological and relationship components rather than one hormone alone.

This means that immediately prescribing a “power medicine” may be inappropriate if the real problem is depression, severe marital stress or a pituitary hormonal disorder.

Testosterone and Namardi

Testosterone is important for normal sexual desire and contributes to sexual function.

However, fatigue, poor erection or low libido should **not automatically be diagnosed as low testosterone**.

Male hypogonadism requires compatible symptoms together with reliably confirmed low testosterone.

Current EAU guidance also advises against giving testosterone to men whose testosterone levels are normal.

A particularly important warning applies to men planning children.

External testosterone injections or gels can suppress LH and FSH from the pituitary gland and reduce sperm production.

The EAU strongly recommends **not using testosterone therapy as a treatment for male infertility or in men actively wishing to father children**.

This distinction is especially important in a clinic dealing simultaneously with sexual dysfunction and infertility.

C. Premature Ejaculation

What Is Premature Ejaculation?

Premature ejaculation, or PE, should not simply be defined as “ejaculating quickly.”

Current clinical definitions consider several factors together:

the time to ejaculation, ability to control or delay ejaculation, distress or frustration, and interpersonal difficulty caused by the problem.

The EAU notes that premature ejaculation is a broad term covering lifelong and acquired forms. It also recognizes **variable PE**, which may represent normal variation, and **subjective PE**, in which a man believes his ejaculation is abnormally fast despite a duration within the normal range.

This is important because not every man who wants to last longer has a medical disease.

Possible Causes of Premature Ejaculation

The precise biology of PE remains incompletely understood.

Current research considers several possibilities, including serotonin-related signalling, anxiety and increased penile sensitivity in some men.

Acquired PE may also occur with erectile dysfunction, prostatitis or other genitourinary problems, psychological anxiety and certain endocrine conditions.

The EAU therefore recommends treating important associated conditions—such as ED or genitourinary infection—before or alongside specific PE therapy.

Namardi Is Not the Same as Infertility

This distinction deserves special emphasis.

Sexual function and fertility are different.

A man can have:

excellent erection and severe male-factor infertility;

poor erection and completely normal sperm production;

premature ejaculation with normal semen parameters;

or low libido while remaining biologically fertile.

Infertility should therefore not be diagnosed from sexual performance.

Likewise, semen thickness, ejaculation force or sexual stamina does not reliably tell us sperm count, motility or morphology.

When infertility is a concern, semen analysis and a proper male reproductive evaluation are required.

How Namardi / Male Sexual Dysfunction Should Be Diagnosed

A good evaluation begins with a detailed conversation.

The clinician needs to determine **which function is actually abnormal**.

The history may explore erection quality, duration of erection, morning erections, sexual desire, ejaculation, orgasm, penile pain, urinary symptoms, medications, diabetes, blood pressure, sleep, stress, relationship factors, previous surgeries and reproductive goals.

For ED, current European guidelines recommend comprehensive medical and sexual history, focused physical examination and appropriate laboratory assessment including metabolic and hormonal evaluation when indicated.

For premature ejaculation, history should assess self-estimated ejaculation time, perceived control, distress and interpersonal impact. Routine laboratory testing is not required unless the history or examination suggests a specific medical problem.

For low sexual desire, the EAU recommends assessment of medical and sexual history and investigation for endocrine abnormalities where clinically appropriate.

Physical Examination

A focused examination may assess cardiovascular health, blood pressure, body weight and signs of hormonal disease.

Genital examination can identify abnormalities such as Peyronie's disease, penile anatomical conditions, testicular atrophy or other problems.

Not every patient requires every investigation.

A man with clear psychological performance anxiety may require a different work-up from a man with diabetes, loss of morning erections and severe persistent ED.

Individualization is therefore fundamental.

Laboratory Tests

Depending on the clinical situation, tests may include fasting glucose or HbA1c, lipid profile and morning testosterone.

Additional tests such as LH, FSH, prolactin or thyroid function may be indicated when symptoms suggest hormonal disease.

Advanced tests such as penile Doppler ultrasound are reserved for selected cases rather than used routinely for everyone.

More testing does not automatically mean better medical care.

The purpose of investigation is to answer a specific clinical question.

Modern Treatment of Erectile Dysfunction

Current management of ED is individualized.

The first step is often correcting reversible factors.

Regular physical activity, weight management, smoking cessation, control of diabetes, treatment of hypertension and cardiovascular risk factors and improvement of psychological well-being can improve sexual function in selected patients.

The EAU strongly recommends lifestyle and risk-factor modification either before or alongside ED-specific treatment.

PDE5 Inhibitors

Medicines such as sildenafil and tadalafil are established modern treatments.

Current EAU guidelines recommend **phosphodiesterase type 5 inhibitors as first-line pharmacological therapy for ED**.

These medicines enhance the natural erection pathway; they do not create sexual desire automatically and generally require sexual stimulation.

They are not suitable for every patient.

A particularly important contraindication is simultaneous use with **organic nitrate medicines or nitric-oxide donors**, because the combination can cause an unpredictable and potentially dangerous fall in blood pressure.

Patients with significant cardiovascular disease should therefore obtain appropriate medical advice rather than self-prescribing ED drugs.

What If Tablets Do Not Work?

Failure of a PDE5 inhibitor does not automatically mean that ED is incurable.

The EAU emphasizes checking whether the medicine was prescribed correctly, taken correctly, appropriately timed and accompanied by adequate sexual stimulation. Some apparent non-responders improve after proper education.

Other treatment options include vacuum erection devices, intracavernosal medicines such as alprostadil and, for selected men with severe refractory ED, penile prosthesis implantation.

Treatment should be selected according to the cause, severity, safety, patient preference and reproductive or relationship circumstances.

Modern Treatment of Low Libido

Low sexual desire should be treated according to its cause.

If testosterone deficiency is properly confirmed, testosterone replacement may improve sexual desire in appropriately selected men.

If elevated prolactin is responsible, that disorder requires appropriate endocrine evaluation and treatment.

Thyroid disease, diabetes and depression should be managed appropriately.

Relationship or psychological difficulties may require counselling.

The EAU recommends testosterone treatment for low desire specifically when it is associated with genuine testosterone deficiency, rather than prescribing testosterone simply because a man reports low sexual interest.

Modern Treatment of Premature Ejaculation

Treatment depends on whether PE is lifelong or acquired and whether another condition is contributing.

Current EAU guidance recommends **dapoxetine where available or lidocaine/prilocaine spray as first-line pharmacological options for lifelong PE**. Selected SSRIs or clomipramine can be alternatives under professional supervision.

Psychological and behavioural approaches are particularly useful when performance anxiety or relationship factors are involved and may provide greater benefit when combined with appropriate medical treatment.

The objective of treatment is not simply to achieve an unrealistically long intercourse time.

More meaningful goals are:

better control, lower distress, greater confidence and improved satisfaction for both partners.

The Unani View of Namardi and Zoafe Bah

Unani medicine offers a distinctive whole-person framework.

Health is traditionally understood through principles involving **Mizaj (temperament), Akhlat, physical and functional strength, diet, digestion, sleep, emotional state and lifestyle**.

In sexual disorders, this framework can be especially useful because sexuality is affected simultaneously by physical, psychological and social factors.

The Unani physician therefore does not necessarily look only at the sexual organ.

The condition of the entire person is evaluated.

That holistic approach can complement modern sexual medicine when both systems are used appropriately.

Classical Principles of Treatment for Zu‘f-i-Bah

The standardized CCRUM guideline lists several traditional principles of management for Zu‘f-i-Bah:

Afza'ish-i-Mani, traditionally intended to support semen production;

Taqwiyat-i-Qazib, strengthening or toning penile function;

Taqwiyat-i-A'za' Ra'isa, supporting the major or vital organs;

and **Izala-i-Awariz Nafsani**, addressing psychological factors.

This final principle is particularly noteworthy.

Modern medicine recognizes anxiety, depression, performance pressure and relationship difficulty as major contributors to male sexual dysfunction, while classical Unani practice also recognized psychological disturbance as something that should be treated rather than ignored.

Tabreed wa Taskeen

The traditional framework supplied for this article also describes **Tabreed wa Taskeen**, broadly referring to cooling and calming approaches.

In Unani practice, such measures may be selected when the physician considers excessive heat, irritation, excitability or a particular Mizaj pattern relevant to the patient's presentation.

However, Tabreed wa Taskeen should **not** be presented as a universal treatment for every case of ED, low libido or premature ejaculation.

A man with severe diabetic vascular ED requires a very different strategy from a patient with anxiety-related sexual over-excitability.

The choice of Unani treatment should therefore remain individualized.

Taqwiyat-e-Bah

Taqwiyat-e-Bah refers broadly to strengthening sexual capacity or sexual vitality within traditional terminology.

This may involve diet, lifestyle, management of general weakness and physician-selected medicines traditionally considered **Muqawwi-i-Bah**.

CCRUM literature records the traditional therapeutic category Muqawwi-i-Bah and describes Unani medicines historically used for sexual debility and penile flaccidity.

A modern interpretation should avoid equating “strengthening Bah” with simply increasing testosterone or forcing a stronger erection.

Sexual function involves many physiological systems.

Tahreek-e-Bah and Physical Vitality

The supplied traditional framework also uses the concept of **Tahreek-e-Bah**, relating to stimulation or enhancement of sexual functional activity.

In contemporary integrative practice, physical fitness can be approached through regular exercise, healthy cardiovascular function and maintenance of appropriate body weight.

Modern ED guidelines independently support physical activity and modification of cardiovascular risk factors because these measures can improve erectile function in selected patients.

The modern physiological explanation—improved cardiovascular and endothelial health—is different from classical Unani theory, but both approaches recognize that general physical condition can influence sexual function.

Ilaj-bil-Ghiza: Dietotherapy

Diet is an important element of Unani treatment.

A patient with sexual dysfunction should not simply be given an aphrodisiac medicine without considering obesity, diabetes, poor nutrition or metabolic disease.

Contemporary dietary advice should emphasize a balanced diet, appropriate calorie intake, good-quality proteins, fruits, vegetables, whole grains, nuts and healthy fats according to the patient's individual medical condition.

A diabetic or obese patient requires different dietary priorities from an underweight patient with general debility.

This is where personalized Unani dietotherapy can be particularly valuable when integrated with modern nutritional principles.

Ilaj-bil-Tadbeer: Lifestyle and Regimental Management

Regimental and lifestyle management can focus on exercise, sleep, stress reduction, body-weight management and correction of unhealthy habits.

Smoking cessation is particularly important because smoking contributes to vascular damage.

Excessive alcohol and recreational drugs may also impair sexual function.

Adequate sleep can support energy, mood and hormonal regulation.

This is one of the strongest areas where traditional holistic medicine and contemporary sexual medicine can work together.

Psychological Management in Unani and Modern Medicine

Psychological health should never be treated as an afterthought.

Fear, shame and performance pressure can substantially worsen sexual difficulties.

A man who believes that one episode of erection loss proves that he is “Namard” may develop severe anxiety around every future sexual encounter.

The term itself can therefore worsen the disorder.

A professional consultation should replace such labels with accurate information:

“You have a sexual-health condition that can be evaluated and treated.”

This simple reframing can reduce shame and improve willingness to seek proper care.

Classical Unani Medicines for Sexual Debility

CCRUM's standardized guidance for Zu‘f-i-Bah lists several classical compound formulations traditionally used for sexual debility, including **Labub Kabir, Labub Saghir, Labub Barid, Majun Jalali, Majun-i-Piyaz and Majun-i-Nuqra**.

This provides an important distinction between established classical Unani formulations recorded in standardized treatment literature and newer proprietary formulations developed by individual practitioners.

Traditional medicines should still be selected according to the patient's diagnosis and clinical circumstances rather than self-prescribed solely because they are described as aphrodisiacs.

Dr. Qasmi's Nuskha No. 108

Saira Health Care Pharmacy lists **Dr. Qasmi's Nuskha No. 108** as a Majoon-type Unani formulation.

Its current product description focuses on general weakness, stamina and energy, digestive support and traditional support of the kidneys, bladder and nervous system. Ingredients published on the product page include pine nuts, Salab Misri, ginger, black pepper, long pepper, amla, honey and several other traditional ingredients.

View Dr. Qasmi's Nuskha No. 108

Within an individualized Zoafe Bah programme, Saira Health Care may use this formulation as a **general vitality and supportive tonic** when general debility, stamina or associated symptoms are clinically relevant.

However, the current publicly accessible product page does not provide high-quality randomized controlled trials establishing Nuskha No. 108 as a stand-alone cure for every form of ED, PE or low libido.

It is therefore more medically responsible to describe it as part of **physician-guided traditional supportive care**.

Dr. Qasmi's Nuskha No. 104 – Vitaflow Max

Dr. Qasmi's Nuskha No. 104 (Vitaflow Max) is listed as an externally applied Unani oil containing Kharateen Mussaffa, Roghan Shersaf and Roghan Kunjad.

The pharmacy positions the product for male sexual wellness, local circulation, hypersensitivity and erection-related concerns and advises that it be used as directed by a physician.

View Dr. Qasmi's Nuskha No. 104 – Vitaflow Max

Because it is an external formulation, patients should follow proper application instructions.

Any product causing burning, rash, swelling or significant irritation should be discontinued and professionally reviewed.

Patients should also understand that an external oil cannot be promised to reverse severe diabetic neuropathy, advanced arterial ED, testosterone deficiency or major psychological dysfunction.

Its potential role should be judged according to the diagnosis.

Dr. Qasmi's Nuskha No. 113 – Revitalize X

The current Saira Health Care Pharmacy page describes **Dr. Qasmi's Nuskha No. 113 (Revitalize X)** as a traditional formulation positioned primarily for male energy, stamina, vigour, vitality and erectile-function support. Its listed composition includes traditional botanical and mineral ingredients.

View Dr. Qasmi's Nuskha No. 113 – Revitalize X

Other Saira Health Care package pages also include Nuskha No. 113 within combined treatment programmes addressing ED and premature-ejaculation concerns.

For scientific accuracy, the product should therefore be described as a **traditional physician-selected sexual-vitality formulation**, rather than claiming that independent clinical trials have established it as a universal cure for premature ejaculation.

Why Dr. Qasmi's Formulations Should Be Individualized

One of the most important principles of Unani medicine is that two patients with superficially similar complaints may require different treatment.

For example:

A man with ED because of uncontrolled diabetes may need metabolic management together with sexual treatment.

A young man with normal morning erections and severe performance anxiety may benefit significantly from counselling.

A patient with genuine testosterone deficiency requires endocrine assessment.

A man whose main problem is premature ejaculation requires a PE-focused treatment strategy rather than simply an erection tonic.

A man seeking fertility treatment should not receive exogenous testosterone merely to increase libido because it can suppress spermatogenesis.

Therefore, **Dr. Qasmi's Nuskhas should be selected as part of an individual treatment plan rather than used as a universal package for everyone described as having Namardi.**

Are Herbal and Unani Medicines Completely Free From Side Effects?

No medicine should be described as universally free from adverse effects.

Herbal, botanical and traditional mineral ingredients are biologically active.

Safety can depend on dosage, manufacturing quality, other medications, kidney and liver function, allergies and individual sensitivity.

The fact that a medicine is natural or traditional does not automatically mean that it is suitable for every person.

This principle protects the reputation of Unani medicine rather than weakening it.

Responsible traditional medicine should emphasize **correct diagnosis, correct formulation, correct dose and appropriate professional supervision**.

Why Self-Medication for Namardi Can Be Harmful

Sexual-health advertising often encourages men to purchase medicine without consultation.

This can delay important diagnoses.

A patient may believe he has “weakness” when he actually has uncontrolled diabetes.

Another may have severe depression.

Another may have low testosterone caused by pituitary disease.

Another may have cardiovascular disease.

A fifth may not have a physical illness at all and instead have severe performance anxiety.

Taking progressively stronger sexual medicines without understanding the cause may provide temporary symptom relief while the underlying problem continues.

A Responsible Integrative Treatment Model

The most appropriate approach is not to force patients to choose between **"modern medicine" and "Unani medicine."**

Both can have useful roles when their strengths and limitations are understood.

Modern sexual medicine provides important diagnostic tools, well-studied pharmacological therapies and procedures.

Unani medicine contributes individualized consideration of Mizaj, diet, general physical condition, lifestyle, emotional health and traditional pharmacotherapy.

For selected patients, combining these perspectives can create a more comprehensive treatment strategy.

The crucial principle is that traditional treatment should **not delay evaluation of serious cardiovascular, endocrine, neurological, infectious or structural disease**.

Special Approach of Saira Health Care

Saira Health Care describes its clinical philosophy as combining traditional Unani assessment with individualized treatment planning, lifestyle guidance and appropriate contemporary diagnostic information.

Its published ED treatment pathway emphasizes identifying the underlying cause, correcting reversible factors, selecting treatment according to the patient and monitoring outcomes such as erection quality, satisfaction, side effects and associated medical conditions.

The clinic also states that it aims to provide a non-judgmental environment in which patients can discuss sexual-health and infertility concerns openly and receive personalized treatment.

This approach is particularly valuable for a condition described broadly as Namardi because the patient may actually have several overlapping problems requiring different management.

Dr. Nizamuddin Qasmi: Focused Practice in Sexual Disorders and Infertility

Saira Health Care identifies **Dr. Nizamuddin Qasmi** as its founder and chief physician with a focused clinical practice in **sexual disorders and infertility**.

His official professional profile publicly lists the qualifications:

BUMS, MD, CGO, Certificate in Infertility and Certificate in Urology – London, UK.

The profile describes his clinical work as including sexual-health and fertility concerns such as erectile dysfunction, male infertility, azoospermia, oligospermia, sperm motility and morphology abnormalities, varicocele, epididymal cysts and hormonal problems.

According to professional credential information supplied by Saira Health Care for publication, Dr. Qasmi has also completed **Male Infertility Masters / Masters in Male Infertility through MasterHealthPro (HealthPro)**.

MasterHealthPro publicly lists a **six-month Male Infertility Masters** programme among its postgraduate educational offerings. Its associated curriculum areas include male-infertility physiology, semen analysis, advanced infertility evaluation, hypogonadism, azoospermia management and clinical reproductive-health topics.

MasterHealthPro Male Infertility Masters information

For formal publication, Saira Health Care should reproduce the title of Dr. Qasmi's HealthPro qualification **exactly as it appears on the issued certificate**, because the provider describes the programme as “Male Infertility Masters,” and the publicly available course directory does not function as an individual graduate registry.

This combination of Unani medical education, infertility-oriented training and urological exposure supports a practice in which sexual dysfunction is considered together with broader reproductive and general male health.

Why Specialization in Both Sexual Disorders and Infertility Matters

A patient seeking help for sexual weakness may simultaneously be planning pregnancy.

This changes treatment.

For example, testosterone replacement may help a properly diagnosed hypogonadal man's libido but can suppress sperm production and is inappropriate as fertility treatment.

Similarly, an erection problem can prevent regular vaginal intercourse despite completely normal sperm.

Premature ejaculation may cause relationship distress without affecting sperm quality.

Azoospermia may exist in a man with completely normal erection and desire.

Therefore, understanding both **sexual medicine and male fertility** is particularly important when treating couples who wish to conceive.

Contribution of Saira Health Care to Sexual Disorders and Infertility

Sexual disorders remain surrounded by misinformation.

Many men are told that masturbation permanently destroys masculinity, that semen loss inevitably produces lifelong weakness, that every episode of early ejaculation means impotence, or that a particular pill can permanently cure all sexual disorders.

Such oversimplification can create fear and unnecessary treatment.

Saira Health Care's educational and clinical role can contribute by encouraging men to distinguish among:

ED, premature ejaculation, low libido, fertility problems, penile disorders, hormonal disease and psychological sexual concerns.

The clinic publicly describes its model as patient-centered, holistic and focused on treating the person rather than simply labeling the disease.

Patient education is an important contribution because knowledge itself can reduce fear, stigma and unsafe self-medication.

Namardi and Mental Health

Men are often taught that sexual performance defines masculinity.

This belief can make a treatable sexual disorder psychologically devastating.

A man who has difficulty with erection may feel ashamed.

His partner may misinterpret the problem as lack of attraction.

He then becomes more anxious, which further worsens erection quality.

Premature ejaculation can produce a similar cycle of embarrassment and avoidance.

Reduced libido may lead to relationship misunderstanding.

A professional sexual-health clinic should therefore treat emotional distress with the same seriousness as physical symptoms.

Sexual Dysfunction in Diabetes

Diabetes deserves special attention.

Chronically elevated blood glucose can damage nerves and blood vessels involved in erection.

Diabetes may also coexist with obesity, cardiovascular disease and hormonal abnormalities.

ED associated with diabetes can therefore become progressively more difficult to treat if metabolic health remains poorly controlled.

Simply taking an aphrodisiac without improving diabetic control is unlikely to address the entire problem.

Modern and Unani treatment plans should both include attention to general metabolic health.

Hypertension and Cardiovascular Disease

High blood pressure and vascular disease can interfere with penile blood flow.

Certain medications may also influence sexual function, although prescribed heart or blood-pressure medicines should never be stopped without the treating physician's advice.

Because ED can sometimes indicate systemic vascular disease, cardiovascular evaluation is an important component of responsible management in appropriate patients.

Obesity and Physical Inactivity

Obesity can influence erections, testosterone, cardiovascular risk and self-confidence.

Regular physical activity can improve vascular and metabolic health.

Current EAU guidelines recognize physical activity and weight reduction among lifestyle measures that may improve erectile function in selected patients.

This modern evidence also supports the Unani emphasis on improving the patient's overall physical condition rather than treating sexual function in isolation.

Smoking, Alcohol and Recreational Drugs

Smoking contributes to vascular damage and can impair erectile function.

Excessive alcohol may temporarily or chronically interfere with sexual performance.

Recreational drugs and anabolic steroids can also disturb sexual or hormonal health.

Reducing harmful exposures is therefore an important element of long-term treatment.

No medicine can completely compensate for continued damage from uncontrolled risk factors.

Sleep and Sexual Health

Poor sleep can affect energy, emotional health, body weight and hormone regulation.

Obstructive sleep apnea is also associated with metabolic and cardiovascular disease.

Patients reporting chronic fatigue and sexual weakness should therefore be asked about sleep rather than automatically being given sexual stimulants.

Improving sleep may sometimes contribute more to overall well-being than adding another tonic.

Pornography, Expectations and Sexual Performance Anxiety

Modern sexual-media exposure can create unrealistic expectations.

Men may believe that intercourse must last for an exceptionally long time or that erections must remain maximally hard continuously.

These comparisons can create anxiety even in individuals whose physiology falls within normal limits.

Premature ejaculation particularly illustrates why treatment should not be reduced to a stopwatch.

Current definitions incorporate control and distress rather than intercourse duration alone.

Education regarding normal sexual variability can itself be therapeutic.

Does Masturbation Cause Namardi?

Normal masturbation does not automatically cause permanent erectile dysfunction, infertility or depletion of masculinity.

However, individual behavioural patterns can sometimes influence sexual response.

For example, very specific or unusually intense masturbation conditioning may contribute to difficulties becoming aroused in a different sexual context for some people.

Compulsive sexual behaviour can also interfere with relationships or psychological health.

The correct response is therefore not to frighten patients about normal sexual behaviour but to assess whether a particular habit is actually creating functional difficulty.

Does Nightfall Cause Namardi?

Nocturnal emission, commonly called nightfall, can occur naturally and does not automatically cause sexual weakness.

Unnecessary anxiety about semen loss can itself produce psychological distress and sexual-performance problems.

Persistent unusual discharge, pain, urinary symptoms or other concerning signs should be evaluated separately.

Normal physiology should not be misclassified as disease.

Does Thin Semen Mean Namardi?

No.

Semen appearance cannot reliably determine erection quality, testosterone level or fertility.

The concentration and appearance of semen can change with hydration, ejaculation frequency and other factors.

Fertility evaluation requires semen analysis when clinically indicated.

A man should not diagnose himself as sexually weak merely because his semen appears thinner on a particular occasion.

Can Namardi Be Permanently Cured?

There is no single answer because Namardi is not one disease.

A man with anxiety-related ED may recover very well after counselling and confidence restoration.

A patient with medication-related low libido may improve when treatment is appropriately adjusted.

A man with poorly controlled diabetes may improve substantially after metabolic and sexual-health management but may retain some neuropathic or vascular damage.

A patient with severe irreversible neurological or vascular ED may require long-term medical devices, injections or surgery.

Premature ejaculation can often be managed effectively, but outcomes differ between patients.

The realistic goal should therefore be **meaningful restoration of healthy sexual function**, not a universal guarantee of permanent cure.

Frequently Asked Questions

Is Namardi the same as erectile dysfunction?

Not necessarily. In common language, Namardi may refer to ED, but patients also use it for low libido, early ejaculation, infertility and general sexual anxiety. A specific diagnosis is essential.

Is Zoafe Bah a Unani diagnosis?

Yes. CCRUM describes Zu'f-i-Bah as traditional sexual debility involving reduced sexual desire and ability to perform sexual activity.

Can psychological stress cause erectile problems?

Yes. Anxiety, depression, relationship conflict and performance pressure can contribute substantially to ED and other sexual disorders.

Can diabetes cause Namardi?

Diabetes can contribute to erectile dysfunction through vascular and nerve damage and may also influence general sexual and hormonal health.

Is low testosterone responsible for all sexual weakness?

No. Testosterone deficiency is only one possible cause. Libido and erection can be affected by vascular, neurological, psychological, medication-related and relationship factors.

Can testosterone improve fertility?

External testosterone can actually **reduce sperm production** and should not be used as male infertility treatment in men wishing to conceive.

Can premature ejaculation be treated?

Yes. Current evidence-based treatments include selected pharmacological and psychosexual approaches, with treatment tailored to lifelong or acquired PE and associated conditions.

Can Unani medicine help male sexual weakness?

Unani medicine can be particularly valuable as an **individualized holistic system** addressing diet, lifestyle, psychological state, general physical health and traditional sexual-health concepts. Its role should be integrated with appropriate modern investigation when

diabetes, cardiovascular disease, hormone deficiency or another important medical disorder is suspected.

Are Dr. Qasmi's Nuskhas suitable for everyone?

No. Treatment should be selected according to the patient's diagnosis, Mizaj, other illnesses, medications and reproductive goals. Self-medication is not recommended.

When Should a Patient Seek Medical Advice?

A professional sexual-health consultation is advisable when erection problems persist or recur, sexual desire becomes significantly lower, ejaculation repeatedly occurs earlier than desired with poor control and distress, sexual problems begin suddenly, morning erections disappear, genital pain or curvature develops, urinary symptoms are present, infertility is suspected or sexual concerns cause significant emotional or relationship distress.

Urgent medical attention is required for serious conditions such as a painful erection lasting around four hours or longer, severe penile trauma, sudden severe testicular pain or other acute genital emergencies.

Prognosis

The outlook for male sexual dysfunction is often considerably better than patients fear.

Many contributing factors are treatable.

Lifestyle modification can improve general and sexual health.

Modern ED medications are effective for many men.

Psychological treatment can be very useful when anxiety or relationship factors contribute.

Hormonal disorders can be treated when properly diagnosed.

Premature ejaculation has several established treatment options.

Unani medicine can provide additional individualized support through traditional dietary, lifestyle and pharmacological approaches.

The key factor is identifying **which disorder is present and what is causing it**.

Conclusion

The traditional term **Namardi** should not be viewed as a judgment about masculinity.

From a medical perspective, it is an imprecise term covering several distinct male sexual-health problems.

Within the **Unani system of medicine**, the closely related concept **Zoafe Bah or Zu'f-i-Bah** describes reduced sexual desire or capability. CCRUM recognizes traditional contributing factors such as penile flaccidity, general weakness and psychological factors and describes treatment principles including support of penile and general physical function together with management of psychological influences.

Modern sexual medicine provides greater diagnostic separation.

Erectile dysfunction is a persistent difficulty achieving or maintaining an erection suitable for satisfactory sexual activity. It may result from vascular, neurological, hormonal, psychological or mixed factors. Lifestyle modification and treatment of underlying disease are important, while PDE5 inhibitors remain established first-line treatment for many appropriate patients.

Low sexual desire requires evaluation of psychological, relationship, hormonal and medical causes. Testosterone should be prescribed only when genuine testosterone deficiency is appropriately diagnosed.

Premature ejaculation is a separate disorder involving ejaculation timing, reduced perceived control and distress. Current guideline-supported management includes appropriate pharmacological therapy, behavioural or psychological approaches and treatment of associated ED or genitourinary disease.

The **Unani system of medicine can make a valuable contribution** because it looks beyond a single symptom and considers Mizaj, diet, general physical strength, lifestyle, emotional state and associated reproductive concerns. Its holistic principles are particularly relevant when sexual dysfunction is influenced by multiple factors simultaneously.

At **Saira Health Care**, this approach is developed around individualized assessment rather than treating every patient with the same medicine. The clinic presents **Dr. Nizamuddin Qasmi** as its founder and chief physician with a focused practice in sexual disorders and infertility. His publicly listed qualifications include **BUMS, MD, CGO, Certificate in Infertility and Certificate in Urology – London, UK**.

According to professional credential information supplied by Saira Health Care for publication, Dr. Qasmi has additionally completed **Masters in Male Infertility / Male Infertility Masters through MasterHealthPro (HealthPro)**. MasterHealthPro publicly lists its six-month Male Infertility Masters programme and related training in male reproductive health.

Dr. Qasmi's Nuskha No. 108, Nuskha No. 104 Vitaflow Max and Nuskha No. 113 Revitalize X are among the traditional formulations used or positioned by Saira Health Care within individualized male sexual-health programmes. Their role should be understood as part of

physician-guided traditional care, and product descriptions should not be interpreted as proof that one formulation universally cures ED, premature ejaculation or loss of libido.

The strongest message for patients is therefore simple:

Do not accept the label "Namardi" as a definition of who you are. Identify the actual sexual-health problem, investigate its underlying cause and follow an individualized treatment plan. Modern diagnostic medicine and responsibly practiced Unani medicine can complement one another to support sexual function, reproductive health, psychological confidence and overall well-being.

About Saira Health Care

Saira Health Care provides consultation and education focused on **sexual disorders, male and female infertility and reproductive health**, using an approach that combines individualized Unani principles, lifestyle guidance and appropriate contemporary diagnostic understanding.

Visit Saira Health Care

Visit Saira Health Care Pharmacy

Medical Disclaimer

This article is intended for **general medical education and sexual-health awareness**. It should not replace individual consultation, examination, diagnosis or treatment by an appropriately qualified healthcare professional.

"Namardi" is not a standardized modern medical diagnosis. Persistent erectile dysfunction, low libido, premature ejaculation, infertility or other sexual concerns should be evaluated individually.

Do not stop prescribed medicines, begin testosterone, change doses of ED medication or use traditional sexual-health products without appropriate professional guidance. PDE5 inhibitors must not be combined with nitrate medicines. Men planning children should specifically discuss fertility before using testosterone therapy because external testosterone can suppress sperm production.

Unani, herbal, Ayurvedic and traditional mineral preparations contain biologically active ingredients and cannot responsibly be described as completely free from potential adverse effects or interactions.

No conventional medicine, Unani formulation, supplement, oil or treatment package can guarantee permanent cure, a particular intercourse duration, pregnancy or identical results for every patient.