Low Sexual Desire in Men

Understanding Psychological, Relationship, Lifestyle, Hormonal and Medical Causes of Reduced Male Libido

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Introduction

One of the common questions I hear from men in sexual-health consultations is:

“Doctor, earlier I had a strong interest in sex, but now I hardly feel the desire. What has happened to me?”

Another man says:

“My erection is possible, but I simply do not feel interested.”

A newly married patient may say:

“I love my wife, but I rarely feel sexually excited, and she thinks I am avoiding her.”

An older patient may assume:

“Perhaps this is simply my age.”

Someone undergoing infertility treatment may notice that intercourse has gradually become a duty rather than something he wants.

These situations can all involve **low sexual desire**, often called **low libido**.

Low desire in men deserves more careful attention than the traditional idea that “men always want sex.” Human sexual desire is not fixed, and it is not identical in every man. Desire can rise and fall with health, mood, hormones, sleep, relationship circumstances, medications, age and life stress.

The World Health Organization describes sexual health as physical, emotional, mental and social well-being related to sexuality—not merely the absence of sexual dysfunction. WHO also recognizes that sexuality includes desire, intimacy, pleasure, relationships, beliefs and many biological, psychological and social influences.

This broader understanding is particularly useful in male low desire because **libido does not come from testosterone alone**.

Current European Association of Urology guidance describes male sexual desire as involving interacting biological, psychological and cultural components. It also lists anxiety, depression, relationship conflict, erectile dysfunction, androgen deficiency, high prolactin, chronic illness and medication effects among important contributors to low desire.

My first question to a patient is therefore not:

“Which sexual-strength medicine should you take?”

My first question is:

“Why has your desire changed?”

That is where proper treatment begins.

What Is Sexual Desire?

Sexual desire is the motivation or interest to engage in sexual activity.

It can include sexual thoughts, fantasies, interest in one's partner, desire for physical intimacy, or motivation to initiate or respond to sexual activity.

It is useful to understand that desire is not a simple switch that is either permanently “on” or permanently “off.”

The European Association of Urology describes three interconnected aspects of desire: **biological drive, psychological motivation and culturally shaped wishes or attitudes**. In real life these components usually overlap.

For example, a man may have adequate testosterone but feel no desire because he is severely depressed.

Another man may emotionally desire his wife but avoid intercourse because he fears losing his erection.

Another may be physically healthy but exhausted after weeks of sleep deprivation.

Another may have genuine testosterone deficiency.

The symptom may look the same:

“I don't feel like having sex.”

But the causes can be completely different.

Is Low Libido Always a Disease?

No.

A temporary reduction in desire is common.

Sexual interest may decrease during:

acute stress,

bereavement,

illness,

exhaustion,

relationship conflict,

financial pressure,

a difficult work period,

or major life changes.

Some men naturally have a lower baseline level of desire than others.

That does not automatically mean there is a disease.

Current diagnostic frameworks require more than simply having less desire than one's partner. ICD-11 describes **hypoactive sexual desire dysfunction** as a marked reduction or absence of spontaneous or responsive sexual desire, or difficulty sustaining sexual interest, persisting for at least several months and associated with clinically significant distress.

That final point is crucial.

If a man's naturally lower level of desire does not bother him and does not create significant personal distress, we should be cautious about turning normal variation into disease.

What Is Male Hypoactive Sexual Desire Disorder?

The term **male hypoactive sexual desire disorder**, or MHSDD, is commonly used when a man has persistent or recurrent deficiency of sexual thoughts, fantasies and desire for sexual activity and the problem causes meaningful distress.

Current sexual-medicine literature emphasizes that age, health, cultural context, relationship circumstances and other factors must be considered before making the diagnosis.

Importantly, an isolated sexual-desire disorder is different from low desire that is simply secondary to:

depression,

severe relationship distress,

medication,

endocrine disease,

or another medical condition.

Clinically, this distinction matters because **treating the underlying cause may restore desire without needing to treat libido as a separate disease**.

How Common Is Low Sexual Desire in Men?

Low sexual desire is more common than many men realize.

EAU epidemiological guidance reports prevalence estimates ranging roughly from **3% to 28%** depending on population, age and study definition. Even younger men can report reduced desire, although prevalence generally increases with age and poor health.

A population study of more than 12,000 middle-aged German men cited in the current EAU guideline found low sexual desire in approximately 4.7% using that study's definition.

These numbers vary because “low libido” does not have one universal measurement.

A man who has sex once a week may feel completely satisfied.

Another may consider the same frequency unusually low.

Therefore, diagnosis cannot be based only on how often intercourse occurs.

Low Desire Is Not the Same as Erectile Dysfunction

This is one of the most important distinctions I explain.

Desire answers:

“Do I want sexual activity?”

Erection answers:

“Can my penis become and remain sufficiently erect?”

A man can have strong desire but poor erections.

Another can have good erections but very little desire.

The two problems can also occur together.

This distinction matters because erection medicines do not automatically restore sexual interest.

A man with depression, hormonal deficiency or major relationship distress may be physically capable of erection while having little motivation for sex.

Similarly, treating low testosterone may improve desire in genuinely hypogonadal men, but it is not a universal treatment for every form of erectile dysfunction. Current evidence and guidelines clearly distinguish these functions.

Low Desire Is Not the Same as Infertility

Another misconception is:

“My libido is low, therefore my sperm count must also be low.”

That is not necessarily true.

Sexual desire and sperm production are different biological processes.

A man can have strong libido and severe male infertility.

Another can have low desire and normal sperm production.

A semen analysis is used to assess fertility.

Libido cannot replace it.

This distinction becomes extremely important in couples trying for pregnancy because men sometimes interpret low desire as proof that they are infertile—or infertility as proof that they are sexually weak.

Neither conclusion is scientifically justified.

A Man Can Love His Partner and Still Have Low Desire

Reduced libido is sometimes interpreted emotionally.

A wife may think:

“If he does not initiate sex, he must no longer find me attractive.”

The husband may remain silent because he does not understand the problem himself.

He may actually be struggling with:

fatigue,

depression,

low testosterone,

work stress,

performance anxiety,

or medication side effects.

Low desire therefore does **not automatically mean lack of love or attraction**.

It should be investigated before conclusions are drawn about the relationship.

Spontaneous and Responsive Desire

People often assume desire must appear spontaneously:

“First I feel sexually interested, then intimacy begins.”

That certainly happens.

But desire can also be **responsive**.

A person may initially feel neutral and gradually develop desire after affectionate closeness, emotional connection or pleasurable stimulation begins.

This is why asking only:

“How often do you suddenly think about sex?”

does not always describe the person's full sexual capacity.

ICD-11's modern description specifically recognizes both **spontaneous desire** and **responsive desire** when assessing hypoactive sexual desire dysfunction.

A man who rarely experiences spontaneous desire but becomes comfortably interested once intimacy develops may therefore be different from someone who feels no desire before, during or after sexual stimulation.

Desire Difference Between Partners Is Not Automatically Disease

Many couples have different levels of sexual interest.

One partner may want sex several times each week.

The other may prefer less frequent intimacy.

Neither person is necessarily abnormal.

The EAU guideline specifically emphasizes the concept of **sexual desire discrepancy** and recommends considering the couple's relationship rather than automatically identifying the lower-desire partner as the "patient." This approach can reduce stigma and recognize normal changes in desire throughout relationships and life.

The clinical question becomes:

"Is there a genuine disorder?"

or

"Are two normal people experiencing different levels of desire?"

Those situations require different approaches.

Why Male Desire May Decrease

Current evidence shows that low desire can have multiple causes.

The EAU guideline identifies important contributors including androgen deficiency, elevated prolactin, depression, anger, anxiety, relationship conflict, erectile dysfunction, antidepressant treatment, chronic renal disease, cardiovascular disease, stroke, epilepsy, chronic pelvic pain/prostatitis, HIV and aging.

For practical purposes, I usually think about the causes in five major groups:

hormonal and medical factors; psychological factors; relationship factors; medication or substance effects; and lifestyle/general-health factors.

Often more than one is present.

Psychological Causes of Low Desire

Mental health has a powerful effect on sexual motivation.

A man experiencing depression may lose interest not only in sex but also in food, hobbies, friendships and other previously pleasurable activities.

Anxiety can work differently.

The patient may still want intimacy but spend so much time worrying about:

erection,

ejaculation,

fertility,

partner satisfaction,

or body image

that erotic thoughts become replaced by performance monitoring.

Current EAU guidance notes that anxiety proneness can shift attention away from erotic cues toward worrying thoughts, thereby reducing male sexual desire. Negative sexual thoughts, restrictive sexual attitudes and shame during intercourse are also associated with low desire in men.

This is one reason psychological assessment is not an optional extra.

For some patients it is central to diagnosis.

Depression and Libido

Depression deserves particular attention because the relationship works in several directions.

Depression itself can reduce sexual interest.

Low libido may then worsen relationship distress.

And some antidepressant medicines can further affect sexual function.

A 2025 review of depression and sexuality described a complex interaction among depression, sexual dysfunction, relationship dynamics and antidepressant treatment.

Patients should not stop antidepressants themselves.

Untreated depression can be dangerous.

Instead, the prescribing physician can assess whether medication is contributing and whether an alternative strategy is appropriate.

Sexual Performance Anxiety Can Reduce Desire

Sometimes a patient says:

“I no longer want sex.”

But when we talk further, I discover that he actually wants intimacy but fears what will happen if he attempts it.

He thinks:

“What if my erection fails again?”

So avoiding sex feels safer.

Over time, he interprets avoidance as low libido.

In such cases, the problem may involve **fear rather than absence of desire**.

Treating performance anxiety and any genuine ED can sometimes restore sexual interest.

Sexual Shame and Restrictive Beliefs

A man may also experience desire but suppress it because he has learned to associate sexuality with guilt, dirtiness or inadequacy.

This becomes especially important after marriage when someone may intellectually believe marital intimacy is acceptable but remain emotionally uncomfortable with sexual desire.

EAU guidance identifies restrictive attitudes toward sexuality and negative sexual thoughts among psychological correlates of male low desire.

A values-sensitive approach is essential.

The aim is not to change the patient's religion or culture.

It is to distinguish freely chosen values from unnecessary shame that interferes with a desired relationship.

Relationship Conflict and Reduced Desire

Sexuality occurs within relationships.

Unresolved anger, resentment, betrayal, criticism or emotional distance can reduce sexual motivation.

A man may have normal testosterone and normal erections but little interest in sexual activity with a particular partner.

This is clinically important because it suggests a **situational** rather than generalized problem.

EAU guidance emphasizes relationship conflict and sexual satisfaction as important factors in male sexual desire and specifically encourages clinicians to assess relationship problems.

A tablet cannot resolve long-standing resentment.

Relationship treatment may be more relevant.

Generalized Versus Situational Low Desire

I often ask:

“Is your desire low in every situation—or only with your partner?”

This is an important diagnostic clue.

A man who has:

no sexual fantasies,

no spontaneous desire,

little interest in masturbation,

and no response to erotic stimuli

may require evaluation for generalized biological, psychological or medication-related causes.

Another man may retain solitary desire but lose interest only within his relationship.

That points more strongly toward relational, contextual or partner-specific factors.

The Sexual Desire Inventory used in research similarly distinguishes **dyadic desire**, involving sexual interest with another person, from **solitary desire**.

Erectile Dysfunction Can Eventually Reduce Desire

A man may initially have normal desire.

Then ED develops.

The first few times he attempts intimacy, he becomes embarrassed.

Eventually he thinks:

“Why start something that may fail?”

He begins avoiding sexual situations.

After months of avoidance, he reports low libido.

In this case, reduced desire may be secondary to ED.

EAU evidence identifies erectile dysfunction as one of the conditions commonly associated with male low desire.

Therefore, treating the erection disorder may improve sexual motivation.

Premature Ejaculation Can Have a Similar Effect

Premature ejaculation can create repeated disappointment.

The patient anticipates embarrassment.

His partner may become frustrated.

Sex stops feeling pleasurable and begins feeling stressful.

Eventually he initiates less frequently.

The man may then describe the problem as:

“I don't feel interested anymore.”

But the decline in desire may partly reflect avoidance of another distressing sexual experience.

Again, the underlying ejaculation problem needs attention.

Chronic Pain Can Reduce Sexual Desire

Pain consumes attention and energy.

Men with chronic pelvic pain, prostatitis, musculoskeletal disease or other chronic pain conditions may find intimacy uncomfortable or exhausting.

The EAU guideline specifically lists prostatitis/chronic pelvic pain syndrome among conditions associated with low male sexual desire.

Pain medication can sometimes add another layer, particularly if long-term opioid treatment affects the hormonal axis.

The problem may therefore involve both disease and treatment.

Testosterone and Male Sexual Desire

Testosterone is important for male sexual desire.

But the statement:

“Low libido equals low testosterone”

is incorrect.

The relationship is more complex.

The EAU guideline states that testosterone is important to male desire but circulating testosterone concentration does not correspond directly with libido in a simple linear way, particularly in older men.

The 2025 Fifth International Consultation on Sexual Medicine also concluded that testosterone has a central role in regulating male desire and arousal, while emphasizing the importance of evaluating other hormones and causes rather than reducing male sexuality to one laboratory value.

What Is Male Hypogonadism?

Male hypogonadism is a clinical syndrome in which compatible symptoms occur together with biochemical evidence of inadequate testosterone production or action.

Low libido is among the most specific sexual symptoms.

Other possible findings include:

reduced morning or spontaneous erections,

ED,

fatigue,

reduced energy,

lower motivation,

and changes in body composition.

The current 2026 EAU guideline emphasizes that diagnosis should combine symptoms with consistently low testosterone—not symptoms alone and not one isolated blood result.

The Endocrine Society reiterated this principle in July 2026: an accurate diagnosis requires relevant symptoms together with consistently low, appropriately measured testosterone concentrations.

One Testosterone Test Is Not Enough

Testosterone varies during the day and can be affected by illness, eating, sleep and laboratory methodology.

The 2026 EAU guideline recommends measuring total testosterone in the **morning, approximately 07:00–10:00, while fasting**, using a reliable assay. When a low value is found, it should be repeated on a separate occasion before testosterone treatment is started.

In certain situations, particularly obesity or conditions that alter sex hormone-binding globulin, calculated free testosterone may also provide useful information.

This is why a man should not buy testosterone after seeing one borderline laboratory result.

Testosterone Is Not a General Libido Booster

When testosterone deficiency is genuinely present, treatment can improve sexual desire.

The EAU guideline gives a strong recommendation for testosterone therapy when low desire occurs with signs and symptoms of testosterone deficiency, and evidence from randomized trials supports improvement in sexual desire in appropriately selected hypogonadal men.

But the same evidence is clear that testosterone should **not** be used simply to enhance sexual function in men whose testosterone is normal.

This distinction protects patients from unnecessary hormonal treatment.

A Critical Fertility Warning About Testosterone

This point is particularly important at Saira Health Care because many patients are trying to father children.

External testosterone can suppress the hormonal signals from the brain to the testes and reduce sperm production.

The 2026 EAU guideline states that testosterone therapy suppresses gonadotropins and spermatogenesis and is contraindicated in men who currently wish to preserve fertility. It gives a **strong recommendation not to use testosterone therapy for male infertility or in men wishing to become fathers**.

Therefore:

A man with low libido who is trying for pregnancy should never start testosterone casually.

His hormonal and fertility goals need to be considered together.

High Prolactin and Low Desire

Another hormone that deserves attention is **prolactin**.

Excessive prolactin can reduce sexual desire and may interfere with testosterone regulation.

Current EAU guidance recommends prolactin testing in relevant men with reduced sexual desire, especially where secondary hypogonadism is suspected.

Hyperprolactinemia can sometimes result from:

medication,

pituitary disease,

or other endocrine conditions.

The 2025 international hormonal consultation concluded that hyperprolactinemia is associated with low male sexual desire and that correcting the underlying cause can improve desire.

When Pituitary Disease Needs Consideration

Most men with low libido do not have a pituitary tumour.

But certain combinations should not be ignored.

Current EAU guidance notes that headache or visual disturbance can suggest pituitary disease, particularly when hormonal abnormalities such as elevated prolactin or severe secondary hypogonadism are present. In appropriate cases, pituitary imaging is recommended.

The lesson is not to frighten every patient.

It is to remember that libido can occasionally be the visible symptom of an endocrine condition requiring proper investigation.

Thyroid Disease

Both underactive and overactive thyroid conditions may affect sexual health.

The EAU low-desire guideline specifically recommends considering thyroid evaluation when endocrine symptoms are present and lists hypothyroidism and hyperthyroidism among disorders requiring appropriate treatment when they contribute to low desire.

This is another reason why automatically prescribing an aphrodisiac without understanding the cause can miss the real diagnosis.

Diabetes and Metabolic Health

Diabetes can affect several parts of male sexuality.

It may contribute to:

erectile dysfunction,

neuropathy,

vascular disease,

fatigue,

obesity,

and low testosterone.

Current EAU guidance identifies diabetes and metabolic disease among conditions that can contribute to hypogonadism and sexual dysfunction.

A 2026 Endotext review also notes that testosterone treatment can improve desire in appropriately selected diabetic men with biochemically confirmed hypogonadism, although the improvement is generally modest and diabetes and obesity may reduce the magnitude of benefit.

Therefore, improving sexual health in a diabetic man may require much more than simply treating libido.

Obesity and Male Sexual Desire

Obesity can affect desire through several mechanisms:

metabolic disease,

reduced testosterone,

body-image problems,

fatigue,

vascular disease,

sleep problems,

and psychological well-being.

A 2025 systematic review and meta-analysis included **28 studies and 18,653 participants**, including more than 10,000 men with overweight or obesity. It found evidence of an association between body weight and sexual desire and reported improvement in desire after several weight-loss interventions, although the underlying studies were heterogeneous.

Current EAU hypogonadism guidance therefore recommends weight reduction and lifestyle changes as the first approach in overweight or obese men with functional hypogonadism.

Weight management should be approached as general health treatment—not simply as a way to “increase sexual power.”

Cardiovascular Disease and General Health

Poor overall health is consistently associated with low male sexual desire.

The EAU lists coronary disease and heart failure among conditions associated with low desire and identifies vascular disease and poor general health as risk factors in population studies.

A man recovering from heart disease may also become afraid that sex is physically dangerous.

That fear itself can reduce desire.

Management may therefore involve both medical stabilization and appropriate reassurance regarding safe sexual activity.

Kidney Disease and Other Chronic Illnesses

Chronic renal failure, neurological disease, stroke, epilepsy, HIV and other major conditions can influence libido directly or indirectly.

A patient dealing with chronic disease may experience:

fatigue,

body-image changes,

medication burden,

depression,

pain,

and reduced relationship confidence.

Low desire in these circumstances should not be treated as an isolated sexual symptom.

The person's general medical condition matters.

Medications Can Reduce Sexual Desire

Medication review is an essential part of evaluation.

The EAU specifically identifies antidepressants among drugs associated with low male desire and recommends modifying chronic therapies that negatively affect sexual desire when this can be done safely.

Other medicines can affect the hormonal axis or sexual response in selected patients. Current EAU hypogonadism guidance identifies, among others, opioids, glucocorticoids, androgen-suppressing drugs, finasteride/dutasteride and several hormonal therapies as potentially relevant to androgen function.

Patients should **not stop prescribed medicine themselves**.

Instead, tell the prescribing clinician:

“Since starting this medicine, my libido has changed.”

That information may influence treatment choices.

Antidepressants Require a Balanced Discussion

Patients sometimes stop antidepressants because of sexual side effects.

This can be unsafe.

Depression itself can cause severe low desire, and untreated depression carries serious health risks.

The better approach is to discuss the side effect openly with the prescribing physician.

Depending on the individual, options may include adjusting treatment, switching medication or addressing the sexual dysfunction separately.

EAU guidance specifically notes this balance: depression should be treated, while the sexual effects of antidepressant therapy should also be considered.

Opioids and Hormonal Function

Long-term opioid treatment can suppress the hypothalamic-pituitary-gonadal axis in some men and contribute to testosterone deficiency.

The 2026 EAU hypogonadism guideline includes opiates among drug-related causes of secondary hypogonadism.

Therefore, a man using long-term opioid pain medication who develops low libido, fatigue and reduced morning erections may require hormonal assessment.

Again, he should not discontinue pain medication without medical guidance.

Anabolic Steroids Can Also Cause Problems

Some men use anabolic-androgenic steroids in an attempt to increase muscle mass, masculinity or sexual confidence.

While sexual desire may temporarily change during use, external androgens can suppress the body's own hormonal axis.

Current EAU guidance lists testosterone and anabolic-androgenic steroids among potential causes of secondary suppression of gonadal function.

After discontinuation, some users experience hormonal symptoms that require specialist assessment.

Self-directed hormone use is therefore not a safe strategy for libido management.

Sleep and Sexual Desire

Sleep is often overlooked.

A man who works long hours, sleeps four or five hours and remains chronically exhausted may report:

“I have no interest in sex anymore.”

That does not always indicate a primary sexual disorder.

Sleep affects mood, energy, metabolic health and hormonal regulation.

A systematic review and meta-analysis found that poor sleep quality, sleep disorders and short sleep duration were associated with increased sexual dysfunction risk.

A 2026 review of aging men also describes bidirectional relationships among sleep disruption, metabolic dysfunction, testosterone and sexual symptoms, including reduced libido.

Improving sleep is therefore a legitimate component of sexual-health care.

Smoking, Alcohol and Lifestyle

Lifestyle should be evaluated without pretending that every case of low desire can be cured through lifestyle modification.

Smoking is associated with vascular disease and poorer overall sexual health.

Excessive alcohol may affect hormones, mood, sleep and sexual performance.

Extreme physical training or eating disorders can also suppress the reproductive hormonal axis.

Current EAU guidance recognizes smoking, poor health, eating disorders and endurance exercise among factors that can interact with male libido or hypogonadism.

A balanced lifestyle supports sexual health, but it does not replace diagnosis.

Age and Sexual Desire

Sexual desire can change with age.

But the statement:

“Every older man naturally loses libido”

is too simplistic.

The 2026 EAU guideline emphasizes that the testosterone decline associated with healthy aging alone is relatively modest and that obesity, diabetes and other illnesses account for much of the testosterone deficiency seen later in life.

Aging can bring:

chronic illness,

medication,

relationship changes,

loss of a partner,

sleep disturbance,

and changes in sexual response.

These factors may affect desire together.

Older men therefore deserve assessment rather than automatic dismissal.

Stress and Financial Pressure

Sexual desire requires mental space.

A man who spends every waking hour worried about debt, employment or family responsibility may have very little attention left for sexuality.

Population data cited in the EAU guideline found associations between male low desire and factors such as recent financial problems, concern about relationship stability and poor overall health.

This reminds us that libido is embedded in ordinary life.

It is not simply produced by a hormone gland in isolation.

Low Libido During Infertility Treatment

Infertility creates a particularly important form of reduced male desire.

Intercourse may become scheduled around ovulation.

The man hears:

“Tonight is the fertile day.”

Sex is no longer spontaneous.

It becomes a reproductive task.

If he is tired or anxious, he may still feel that he **must** perform.

Over time, intimacy can become associated with pressure rather than pleasure.

Some men then report:

“I have lost my sexual desire.”

This does not necessarily mean a hormonal disease.

Sometimes it means that sexuality has become overwhelmed by fertility treatment.

At Saira Health Care, I believe fertility and sexual health should therefore be considered together rather than treating intercourse simply as a method of sperm delivery.

Testosterone Treatment and Infertility Must Be Kept Separate

This issue deserves repetition.

A man trying for pregnancy may have low libido and a low testosterone result.

The temptation is:

“Give testosterone.”

But external testosterone can suppress sperm production.

Current EAU guidance gives a strong recommendation against testosterone therapy in men wishing to father children.

Such patients may require specialist evaluation of whether the problem is:

primary testicular failure,

secondary hypogonadism,

obesity-related hormonal suppression,

high prolactin,

medication,

or another cause.

Fertility-preserving treatment is a different therapeutic problem from ordinary testosterone replacement.

How I Evaluate Low Sexual Desire

When a man comes to me with low libido, I begin with the history.

I want to know when desire changed.

Was the change sudden or gradual?

Is it present with every partner and in every circumstance?

Does he still have sexual thoughts?

Does he have solitary desire?

Are erections normal?

Are morning erections present?

Has ejaculation changed?

Is he experiencing depression or anxiety?

What is happening in the relationship?

Is he trying for pregnancy?

What medicines does he take?

Does he use anabolic steroids or other substances?

How is his sleep?

Has he gained substantial weight?

Does he have diabetes, thyroid disease or another chronic condition?

The current EAU guideline similarly recommends a thorough medical and sexual history, assessment for depressive symptoms and relationship problems, physical examination and appropriate endocrine testing.

Physical Examination

A physical examination can sometimes reveal clues to hormonal or general health.

Depending on the patient, this may include assessment of:

body habitus,

waist circumference,

secondary sexual characteristics,

testicular size,

and other signs suggesting endocrine or reproductive disease.

The 2026 EAU hypogonadism guideline specifically recommends assessing BMI and waist circumference because obesity is strongly associated with functional hypogonadism.

Physical examination should support—not replace—the sexual and psychological history.

Which Blood Tests May Be Needed?

Not every man with temporary low desire needs a large hormonal panel.

Testing should follow the clinical picture.

When endocrine disease is suspected, current guidance supports considering testosterone and, where appropriate, prolactin and thyroid function.

If testosterone deficiency is suspected, current 2026 EAU guidance recommends fasting morning total testosterone testing, confirmation on a separate occasion when low, and additional evaluation such as LH, FSH, SHBG/free testosterone and prolactin according to the clinical circumstances.

Diabetes and metabolic screening may also be appropriate depending on the patient's health profile.

Why Testing Everyone for Testosterone Is Not Good Medicine

Low libido is not sufficient reason to prescribe hormones automatically.

In July 2026, the Endocrine Society again emphasized that testosterone deficiency should be diagnosed only when appropriate symptoms occur together with consistently low laboratory testosterone concentrations. The Society also noted insufficient evidence for general population screening of asymptomatic men.

This protects patients from unnecessary treatment and helps identify the real cause.

Treatment Must Follow the Cause

There is no single best treatment for every man with low libido.

If the cause is depression, depression requires treatment.

If medication is responsible, the medication strategy may need professional review.

If relationship conflict is central, couple-based treatment may help.

If testosterone deficiency is confirmed, hormonal treatment may be appropriate in men for whom it is safe and compatible with reproductive goals.

If obesity or metabolic disease is contributing, health optimization becomes important.

If ED is driving avoidance, treating ED may restore confidence and desire.

This cause-directed approach is exactly what current EAU guidance recommends: **treatment should be tailored to the underlying aetiology**.

Psychological and Psychosexual Treatment

Psychological treatment can be valuable when low desire is strongly associated with:

depression,

anxiety,

sexual shame,

performance concerns,

relationship difficulties,

or negative sexual beliefs.

The EAU notes that evidence specifically for psychological treatment of male low desire remains limited, so recommendations should be interpreted cautiously. Cognitive-behavioural approaches and mindfulness-based strategies may nevertheless be helpful for selected men.

This is important scientifically.

Counselling can help.

But we should not promise that one therapy technique will cure every patient.

Couple-Based Treatment

Sometimes the real problem is not that one partner's desire is “abnormal.”

The couple simply has different desire patterns.

In these cases, couple work may focus on:

understanding each person's expectations,

reducing blame,

improving affection,

discussing initiation,

and finding a mutually comfortable pattern.

EAU guidance specifically encourages a less stigmatizing approach to **desire discrepancy**, addressing the couple rather than simply labelling the lower-desire partner as dysfunctional.

This can make a major difference.

Treatment of Depression

When depression is responsible for low libido, treating depression is essential.

But sexual side effects should also be discussed.

The ideal approach is coordinated care in which mental health and sexual health are not treated as separate worlds.

If antidepressant side effects are suspected, any adjustment should occur under supervision.

Patients should never abruptly stop psychiatric medicines simply to improve sexual function.

Testosterone Therapy When Truly Indicated

For men with confirmed symptomatic hypogonadism who do **not** have contraindications and are not trying to father a child, testosterone therapy may improve sexual desire.

The 2026 EAU guideline reports improvement in libido and sexual activity in appropriately selected hypogonadal men and gives a strong recommendation not to use testosterone in eugonadal men.

The latest 2025 international consultation likewise concludes that testosterone treatment improves low sexual desire in hypogonadal patients.

This should be understood as **replacement of a deficiency**, not enhancement of normal male sexuality.

Testosterone Therapy Requires Monitoring

Hormonal treatment is not a simple vitamin.

It requires assessment of risks, contraindications and follow-up.

Current EAU guidance discusses monitoring of testosterone levels, hematocrit and prostate-related factors as clinically appropriate and emphasizes individualized risk assessment.

The Endocrine Society similarly recommends a structured monitoring plan for men receiving testosterone therapy.

Patients should avoid buying injectable testosterone or bodybuilding hormones without medical supervision.

Treat High Prolactin or Thyroid Disease When Present

If hyperprolactinemia is producing low libido, the underlying cause requires treatment.

If thyroid disease is contributing, thyroid treatment is appropriate.

The EAU emphasizes treatment of these endocrine causes rather than treating libido independently.

This sounds obvious, but it is one of the reasons laboratory diagnosis matters.

Weight Management and Physical Activity

For men with obesity-related hypogonadism or metabolic dysfunction, lifestyle management can be an important part of treatment.

The current EAU guideline recommends weight reduction and lifestyle changes as first-line measures in overweight or obese men with functional hypogonadism.

The 2025 obesity and sexual-desire meta-analysis also found improvement in libido following several weight-loss interventions, although studies varied considerably.

This should be interpreted realistically.

Exercise is valuable.

Weight management is valuable.

But a man with severe depression, hyperprolactinemia or relationship breakdown will not necessarily recover desire merely by exercising more.

Sleep, Rest and Stress Management

Sometimes patients search for sophisticated treatments while sleeping five hours a night.

A comprehensive treatment plan should address basic physiology too.

Adequate sleep, management of chronic stress and reasonable work–rest balance can support:

energy,

mood,

metabolic health,

hormonal function,

and relationship availability.

Sleep treatment may be especially important when obstructive sleep apnea, insomnia or major sleep disturbance is suspected.

The Unani Perspective on Low Sexual Desire in Men

The Unani system traditionally takes a broad, individualized view of health rather than treating a symptom in isolation.

This is highly relevant to low libido because sexual desire sits at the intersection of:

physical health,

mental state,

nutrition,

sleep,

activity,

chronic illness,

and relationship circumstances.

The Central Council for Research in Unani Medicine describes the major therapeutic approaches of Unani medicine as **Ilaj-bil-Tadbir** (regimenal therapy), **Ilaj-bil-Ghiza** (dietotherapy), **Ilaj-bil-Dawa** (pharmacotherapy) and **Ilaj-bil-Yad** (surgical treatment where appropriate).

CCRUM material also describes the traditional **Asbab-e-Sitta Zarooriya**, or six essential factors, including food and drink, bodily movement and rest, mental activity and repose, sleep and wakefulness, environmental influences, and retention/elimination.

This framework can be particularly useful in a patient whose reduced desire occurs alongside fatigue, obesity, stress, sleep disturbance or poor general health.

How Unani Literature Understands Reduced Sexual Capacity

Official CCRUM Standard Unani Treatment Guidelines describe **Zu'f-i-Bah**, traditionally translated as sexual debility, as involving reduced sexual desire and ability and acknowledge psychological factors among possible contributors. The traditional treatment principles include attention to psychological causes as well as physical sexual function.

This historical framework is clinically interesting because it shows that Unani medicine did not view sexual problems as purely genital.

However, modern practice must distinguish traditional descriptions from modern diagnostic evidence.

A man with low libido today may have depression, diabetes, hyperprolactinemia, thyroid disease, medication effects or hypogonadism.

Those conditions require appropriate contemporary investigation.

The Strength of the Unani Approach

In my opinion, one of the most useful contributions of Unani medicine in low desire is its insistence that the person should be evaluated as a whole.

Consider a man who has:

obesity,

poor sleep,

digestive problems,

low energy,

anxiety,

and low sexual interest.

If we only prescribe a sexual stimulant, we have not understood the patient.

A more comprehensive approach considers:

his diet,

sleep,

physical activity,

mental state,

general medical health,

sexual function,

and reproductive goals.

This holistic philosophy can complement modern hormonal and sexual-health assessment when used responsibly.

Ilaj bil Ghiza – Dietotherapy

Nutrition is relevant to sexual health because it influences:

body weight,

diabetes,

cardiovascular health,

energy,

and metabolic status.

In a man with obesity-related functional hypogonadism, improving diet and weight can support hormonal and general sexual health.

The 2025 meta-analysis of obesity and libido found that dietary weight-loss interventions were associated with improvement in sexual-desire measures as well as increases in testosterone among overweight and obese men.

This creates a useful area of overlap between traditional Unani lifestyle principles and contemporary metabolic medicine.

However, there is no single food that guarantees restoration of libido.

Ilaj bil Tadbir – Regimenal and Lifestyle Treatment

Physical movement and rest are also important.

A sedentary patient with obesity, diabetes and poor cardiovascular fitness may have multiple reasons for reduced sexual function.

A patient who exercises excessively while under-eating may develop a very different hormonal problem.

The goal is balance.

In appropriate patients, individualized physical activity, rest and weight management may improve general health and indirectly support sexual desire.

Naum-o-Yaqza – Sleep and Wakefulness

Sleep deserves special attention within both Unani and modern approaches.

Traditional Unani concepts include balanced **sleep and wakefulness** among the essential factors of health.

Modern research similarly links disturbed sleep with male hormonal, metabolic and sexual-health problems.

Therefore, when a patient says:

“I feel no libido”

I also want to know:

“How are you sleeping?”

Sometimes that question is more useful than immediately asking which tonic he is taking.

Harkat-o-Sukoon Nafsani – Mental Activity and Repose

The traditional Unani emphasis on psychological balance is highly relevant.

A man overwhelmed by anxiety, depression, financial stress or relationship tension may have reduced desire despite having normal genital anatomy.

The 2025 CCRUM-published discussion of the six essential factors explicitly includes mental movement and repose among the traditional health-maintenance principles.

Modern evidence independently confirms that anxiety, depression and relationship conflict are important contributors to low male sexual desire.

This provides a reasonable point of integration between traditional holistic thinking and contemporary psychosexual care.

Can Unani Medicines Help Low Libido?

This question deserves a careful answer.

Traditional Unani medicine contains pharmacological approaches historically used for conditions described as sexual debility, and CCRUM's standard treatment literature documents such formulations.

However, **traditional use should not be confused with high-quality modern clinical evidence that a particular formulation will cure every case of male low libido**.

A patient with hyperprolactinemia needs treatment of hyperprolactinemia.

A patient with severe depression needs appropriate mental-health treatment.

A man with confirmed testosterone deficiency requires endocrine assessment.

A man taking an offending medication may need a medication review.

A couple with major relationship conflict may require counselling.

Individualized Unani pharmacotherapy may be considered by an appropriately qualified practitioner for suitable patients, but it should form part of a broader clinical plan rather than replacing necessary diagnosis.

Why I Do Not Treat Every Case With a "Sexual Tonic"

Suppose a patient tells me:

"Doctor, I have no desire."

If I prescribe a tonic immediately, I may miss the fact that:

his prolactin is very high,

his testosterone is genuinely low,

he is severely depressed,

he has uncontrolled diabetes,

he is taking a medication affecting libido,

or his marriage is experiencing serious conflict.

The phrase "low libido" describes a symptom.

It does not identify the cause.

This is why I consider diagnosis more important than simply giving a product.

Special Treatment Approach by Dr. Nizamuddin Qasmi at Saira Health Care

At **Saira Health Care**, my approach is individualized and integrative.

When a man comes with reduced desire, I first establish whether the problem represents normal variation, temporary reduction or persistent clinically significant low desire.

Then I determine whether the main contribution appears to be hormonal, medical, psychological, medication-related, lifestyle-related, relationship-related or mixed.

Where appropriate, assessment may include:

sexual and relationship history;

erection and ejaculation assessment;

fertility history;

medication review;

sleep and lifestyle review;

medical examination;

and laboratory investigation based on clinical findings.

I then match treatment to the cause rather than giving every patient the same sexual-strength treatment.

Saira Health Care's current published professional material identifies my focused clinical practice in sexual disorders and infertility and lists the professional training described in this article.

When Testosterone Deficiency Is Found

If symptoms and properly repeated laboratory testing support hypogonadism, the treatment plan should take into account:

the degree of deficiency,

general health,

cardiovascular and prostate considerations,

and, especially, fertility plans.

Current 2026 EAU recommendations strongly advise against testosterone treatment in men who wish to father children because it suppresses sperm production.

This point is particularly important in my fertility practice.

A treatment intended to improve libido should not inadvertently damage the patient's reproductive goal.

When Psychological Factors Dominate

If laboratory and physical assessment are reassuring but the patient describes:

severe anxiety,

loss of confidence,

sexual shame,

relationship resentment,

or depressive symptoms,

psychological treatment may be more important than escalating sexual medicines.

Counselling, CBT or psychosexual therapy can be integrated according to the individual.

If major depression, significant anxiety or another mental-health disorder is present, appropriate psychological or psychiatric collaboration may be necessary.

This is not because the symptom is “imaginary.”

Psychological factors can produce very real changes in sexual motivation.

When Relationship Problems Dominate

Sometimes the patient's libido is normal outside the relationship but significantly reduced with the partner.

This should not automatically be treated hormonally.

I may ask:

Has there been betrayal?

Is there unresolved anger?

Does the patient feel emotionally disconnected?

Is there persistent criticism?

Has intimacy become entirely mechanical?

Does one partner feel pressured?

In such situations, addressing the relationship context may produce more meaningful change than prescribing a medicine.

When Erectile Dysfunction Is Driving Avoidance

If a man avoids sex because he fears an erection problem, I evaluate the erection.

Treating ED appropriately can interrupt the cycle:

ED → embarrassment → avoidance → reduced initiation → perceived loss of desire.

Psychosexual treatment may also help if anxiety remains even after erection improves.

When Infertility Is Driving Low Desire

In infertility patients, I ask whether the couple still has sexual contact that is not dictated by fertile days.

If every encounter has become:

“Today is ovulation day; intercourse is required,”

libido may naturally decline.

Treatment should preserve the couple's relationship while reproductive evaluation continues.

Saira Health Care's published infertility material similarly recognizes the interaction among fertility stress, loss of desire, sexual performance anxiety and relationship strain.

When Lifestyle and Metabolic Health Are Central

An overweight man with poor sleep, diabetes, inactivity and low testosterone may benefit from improving all of those factors rather than viewing libido as an isolated symptom.

Current 2026 EAU guidance specifically recommends weight loss and lifestyle improvement first in overweight or obese men with functional hypogonadism.

The role of Unani diet and regimenal principles can be especially relevant here as supportive, individualized health management.

Saira Health Care's Contribution to Sexual Disorders and Infertility

One of the major challenges in male sexual medicine is embarrassment.

A patient may comfortably discuss blood sugar yet feel ashamed to say:

“I do not desire my wife anymore.”

Another buys sexual medicines online because he is afraid to consult a doctor.

Another assumes low libido is permanent aging.

Another starts testosterone without understanding that it can suppress fertility.

At **Saira Health Care**, our contribution is not limited to prescribing medicines.

Our goal is to provide a confidential setting where male sexual-health and infertility concerns can be assessed through:

medical evaluation,

reproductive assessment,

patient education,

sexual-health counselling,

responsible Unani supportive care,

lifestyle management,

and specialist referral when needed.

The clinic's current published materials identify low sexual desire among the sexual-health issues addressed within its broader work in sexual disorders and infertility.

Dr. Nizamuddin Qasmi's Professional Focus

My work at **Saira Health Care** is focused on sexual disorders and infertility.

My professional profile, as currently published by Saira Health Care, includes:

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

This multidisciplinary background supports an approach in which I consider male low desire through sexual, reproductive, urological, hormonal, psychological and lifestyle perspectives rather than simply labelling every patient as sexually weak.

What I Want Patients to Understand About "Sexual Weakness"

The phrase **sexual weakness** is often too vague to be medically useful.

One patient means:

"I have no desire."

Another means:

"My erection is weak."

Another:

"I ejaculate too early."

Another:

"My sperm count is low."

These are four different medical concerns.

A single tonic cannot logically be assumed to treat all of them.

The diagnosis should be specific.

When Should a Man Seek Medical Assessment?

A temporary reduction in libido during a stressful week does not necessarily require extensive testing.

Professional evaluation becomes more useful when desire has clearly declined for several months, causes significant distress, creates relationship difficulties or is accompanied by other symptoms.

I pay particular attention when low desire occurs together with persistent ED, loss of morning erections, major fatigue, depression, infertility, testicular changes, significant weight change, medication changes or other endocrine symptoms.

Headache or visual changes together with major hormonal abnormalities also deserve appropriate endocrine or pituitary evaluation.

SAIRA HEALTH CARE
An ISO Certified Clinic
SEXUAL DISORDERS & INFERTILITY CENTER

Frequently Asked Questions

Is low libido normal in men?

Temporary variation can be normal. A clinical disorder is more likely when desire is markedly reduced for months and causes significant distress. Modern diagnostic frameworks specifically consider persistence, context and distress rather than assuming every man should have the same amount of desire.

Does low desire always mean low testosterone?

No. Depression, anxiety, relationship problems, medications, chronic illness, ED and other factors can all reduce desire. Testosterone is important but does not explain every case.

Should I get my testosterone checked?

Testing is reasonable when symptoms or clinical findings suggest hormonal deficiency. Current guidance recommends morning fasting testing with confirmation when the initial value is low rather than relying on one random blood test.

Can testosterone improve libido?

It can improve sexual desire in appropriately selected men with genuine hypogonadism. It is not recommended as a general libido enhancer in men with normal testosterone.

Can testosterone reduce sperm count?

Yes. External testosterone suppresses the hormonal signals needed for normal spermatogenesis. Current EAU guidance advises against testosterone treatment in men currently wishing to father children.

Can high prolactin reduce sexual desire?

Yes. Hyperprolactinemia is a recognized cause of reduced male desire and may require investigation of medication or pituitary causes.

Can depression cause low libido?

Yes. Depression can substantially reduce sexual interest, and some antidepressant medicines can also contribute to sexual dysfunction. Treatment needs to consider both.

Can stress reduce libido?

Yes. Anxiety and worry can redirect attention away from sexual cues and reduce desire. Relationship stress and financial difficulties have also been associated with low male desire.

Can obesity reduce sexual desire?

It can contribute through metabolic, hormonal, psychological and vascular pathways. A 2025 systematic review found associations between obesity and male sexual desire and reported improvement following several weight-loss interventions, though the studies were heterogeneous.

Can low libido cause ED?

They are separate problems but can influence each other. Low desire may reduce arousal, while repeated ED can cause sexual avoidance and eventually reduce interest.

Does low libido mean infertility?

No. Sexual desire and sperm production are different. Fertility requires separate reproductive assessment.

Can a man have low desire but normal erections?

Yes. Erection and desire are distinct sexual functions.

Can medications cause low libido?

Yes. Antidepressants and several medicines that affect hormonal systems can contribute. Medication should be reviewed professionally rather than stopped without advice.

Can poor sleep contribute?

Poor sleep is associated with sexual dysfunction and can affect energy, metabolic health and hormonal regulation. It should be assessed as part of general sexual health.

Can counselling help low male desire?

It may help when psychological or relationship factors contribute. EAU guidance notes that the evidence specifically for male low desire is still limited but suggests that cognitive-behavioural and mindfulness-based approaches may benefit selected patients.

Can Unani medicine help?

Unani medicine can make a useful **supportive and integrative contribution** by considering diet, sleep, activity, mental well-being and general health, and official CCRUM material also recognizes traditional management of sexual debility.

However, no individual Unani formulation should be presented as a universal cure for all causes of male low desire. Hormonal disease, depression, medication effects, chronic illness and major relationship problems require cause-specific treatment.

A Message From Dr. Nizamuddin Qasmi

When a man tells me:

“Doctor, my desire has disappeared,”

I do not immediately assume that his testosterone is low.

And I do not immediately assume that the problem is psychological.

I ask:

When did it change?

Is desire absent everywhere or only with your partner?

Do you still experience sexual thoughts?

Are your erections normal?

Have morning erections changed?

Are you tired all the time?

Are you depressed or anxious?

Has your relationship changed?

Did a new medicine begin around the same time?

Are you trying for pregnancy?

How is your sleep?

The answers determine the next step.

Why I Do Not Prescribe Testosterone From Symptoms Alone

A patient may tell me:

“My libido is low, so I need testosterone.”

That conclusion may be wrong.

Current guidelines require compatible symptoms **and properly confirmed low testosterone**.

This matters even more for men trying for children because testosterone replacement may suppress sperm production.

Before prescribing a hormone, we need to understand the patient's endocrine status and reproductive plans.

That is responsible sexual and fertility medicine.

Desire Should Not Be Measured Against Other Men's Desire

Another common mistake is comparison.

A friend says:

“I want sex every day.”

The patient thinks:

“Something is wrong with me because I do not.”

There is no medically required number of sexual thoughts or acts per week for every man.

The question is whether there has been a meaningful reduction from the person's own usual level, whether distress is present and whether a treatable cause exists.

Libido Is Not a Test of Masculinity

A man with lower desire is not automatically less masculine.

Similarly:

ED does not define masculinity.

PE does not define masculinity.

Infertility does not define masculinity.

Hormone levels do not determine human worth.

These are health variables.

They deserve assessment—not shame.

Low Desire Should Not Automatically Be Blamed on the Partner

Another damaging assumption is:

“If he loved his wife, he would want sex.”

Male sexual desire can decrease because of:

illness,

hormones,

medication,

depression,

anxiety,

poor sleep,

sexual dysfunction,

or relationship factors.

We should identify the actual cause rather than turning a health symptom into an accusation.

At the same time, genuine relationship problems should not be ignored when they clearly contribute.

Low Desire Should Not Automatically Be Blamed on Age

Age can influence desire.

But current evidence shows that obesity, diabetes and chronic illness contribute substantially to hormonal and sexual changes seen in older men, while healthy aging alone produces a relatively modest testosterone decline.

A 65-year-old man with a major recent decline in libido deserves the same basic question as a younger man:

“What changed?”

The Goal of Treatment Is Not Maximum Libido

Patients sometimes ask me:

“Can you make my sexual desire very high?”

That is not the objective of responsible treatment.

The aim is not maximum sexual drive.

The aim is a **healthy, comfortable and personally appropriate level of desire** consistent with the patient's body, relationship, values and life circumstances.

Too much pressure to achieve a particular level of libido can create another performance problem.

The Goal Is Balanced Sexual Health

A successful outcome might mean:

a hypogonadal patient regains normal interest after appropriate treatment;

a depressed patient gradually regains pleasure as mental health improves;

a couple with mismatched desire learns to communicate without blaming each other;

an infertile couple separates some intimacy from the fertility calendar;

an overweight patient improves metabolic health and sexual well-being;

or a man discovers that his naturally lower level of desire is not actually a disease.

Different patients require different definitions of improvement.

Final Perspective

Low sexual desire in men is not one disease with one cause or one medicine.

It is a symptom or sexual-health condition that can arise from the interaction of biology, psychology, relationships, lifestyle and medical treatment.

Current 2026 European sexual-health guidance identifies causes ranging from androgen deficiency and hyperprolactinemia to depression, anxiety, relationship conflict, chronic illness, antidepressant therapy, ED and aging. It recommends medical and sexual history, physical assessment, endocrine evaluation when appropriate, medication review and cause-specific treatment.

The newest international hormonal recommendations likewise emphasize that testosterone has an important role in male desire but is only one element in a much broader neuroendocrine system. Hyperprolactinemia and other endocrine disorders also matter.

And the 2026 Endocrine Society statement reinforces an essential rule: symptoms such as low libido do not by themselves diagnose testosterone deficiency; laboratory evidence must also be consistently abnormal.

The **Unani system of medicine** offers a valuable supportive framework because it traditionally considers diet, physical activity and rest, sleep and wakefulness, mental well-being and general health together. CCRUM also recognizes reduced sexual desire within traditional descriptions of sexual debility and acknowledges psychological contributors.

But responsible integrative medicine must recognize that **a sexual tonic cannot replace diagnosis**.

If testosterone is deficient, investigate the reason.

If prolactin is high, treat the endocrine cause.

If depression is present, treat depression.

If medication is contributing, review it professionally.

If ED is driving avoidance, treat ED.

If infertility pressure has changed the couple's sexual life, address fertility and intimacy together.

If relationship conflict is central, medicine alone will not repair it.

And if poor sleep, obesity or metabolic illness contributes, lifestyle and Unani supportive care can become valuable parts of the broader plan.

At **Saira Health Care**, my objective is therefore not simply to increase libido.

My aim is to understand **why a man's desire has changed and to treat the man as a whole—his sexual function, reproductive goals, general health, emotional well-being and relationship circumstances.**

My message to patients is simple:

Low desire does not mean you have lost your masculinity, love or sexual future.

It means something has changed.

The correct question is not:

“Which medicine will make me sexually powerful?”

The correct question is:

“What is reducing my desire, and what is the safest and most appropriate way to address it?”

That question leads to better medicine.

About the Author

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Medical Disclaimer

This article is intended for general sexual-health education and does not replace individualized diagnosis or treatment. Persistent low libido can be associated with depression, endocrine disorders, medication effects, chronic illness, erectile dysfunction, relationship difficulties and other conditions. Testosterone or other hormonal medicines should not be started without appropriate clinical and laboratory evaluation. **Men who are trying to father a child should be especially cautious because external testosterone can suppress sperm production.** Unani or herbal medicines should be used under appropriate professional supervision and should not replace required endocrine, urological, reproductive or mental-health care.