# Female Sexual Fitness: Understanding Desire, Arousal, Lubrication, Orgasm, Pelvic Health and Sexual Well-Being

**A Comprehensive Guide to Female Sexual Health, Common Difficulties, Physical Fitness, Pelvic-Floor Health and the Integrative Unani Approach**

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**Introduction**

When we talk about **fitness**, most people immediately think about body weight, exercise, muscle strength or cardiovascular health. But a woman's health is much broader than this. Sexual health is also an important part of physical, emotional and relationship well-being.

I sometimes use the patient-friendly expression **"sexual fitness"** to describe how comfortably and positively a woman experiences her sexual health. However, it is important to clarify that **"female sexual fitness" is not a formal medical diagnosis**. In clinical medicine, we separately assess sexual desire, arousal, lubrication, orgasm, pain, pelvic-floor function, body image, emotional health and relationship factors.

The World Health Organization describes sexual health as a state of **physical, emotional, mental and social well-being related to sexuality**, not merely the absence of disease or dysfunction. It also emphasizes pleasurable and safe sexual experiences, respect and freedom from coercion.

This is very close to how I explain the concept to my patients:

**Good female sexual health does not simply mean having intercourse frequently. It means that a woman understands her body, feels safe, can communicate her needs, experiences intimacy without unwanted pain or pressure and receives appropriate medical care when sexual function changes.**

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**What Does “Female Sexual Fitness” Mean?**

For general public education, female sexual fitness can be understood as the combined health of several interconnected areas:

- sexual desire and interest;
- ability to become mentally and physically aroused;
- adequate genital comfort and lubrication;
- ability to experience pleasure and, where desired, orgasm;
- pelvic-floor health;
- absence or appropriate treatment of sexual pain;
- positive or acceptable body image;
- emotional security;
- healthy communication and consent within relationships;
- general physical health, sleep and energy;
- and freedom from untreated medical problems that interfere with sexuality.

These areas overlap.

A woman may have good physical fitness yet experience low desire because of severe stress.

Another may feel emotionally close to her partner but avoid intercourse because of vaginal dryness.

Another may have normal desire but difficulty reaching orgasm.

Another may have pelvic-floor muscles that are too tight rather than too weak.

Therefore, I do not believe that female sexuality should be reduced to one hormone, one muscle or one medicine.

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**Female Sexual Function Is Not a Simple Linear Process**

One common misconception is that every healthy sexual response must follow exactly the same sequence:

**desire → arousal → lubrication → orgasm.**

In real life, women's sexual response is often more variable.

ACOG notes that desire may or may not be present at the beginning of an intimate encounter and may develop after the brain begins processing pleasurable sexual stimulation.

This is sometimes described as **responsive desire**.

For example, a woman may not suddenly feel sexual desire while doing household work or finishing a stressful workday. But after emotional connection, privacy, affectionate touch and adequate stimulation, desire may emerge.

That can be completely normal.

A lack of spontaneous desire therefore does not automatically mean that something is medically wrong.

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**What Are Female Sexual Difficulties?**

ACOG groups common female sexual difficulties broadly into:

**desire problems, arousal problems, orgasmic problems, sexual pain and medication- or substance-related sexual problems.**

These problems frequently overlap.

A woman experiencing pain may naturally develop lower desire.

Reduced arousal may lead to less lubrication.

Reduced lubrication can make penetration painful.

Fear of pain may then make arousal even more difficult.

Sexual problems should therefore be understood as **interconnected rather than isolated**.

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**When Is Low Desire Actually a Disorder?**

Low sexual desire is not automatically a disease.

Sexual interest naturally changes:

- during stress;
- pregnancy;
- breastfeeding;
- menopause;
- illness;

- relationship changes;
- periods of poor sleep;
- after childbirth;
- during grief;
- and with many medications.

A sexual difficulty becomes clinically important particularly when it is **persistent and causes personal distress**.

ACOG emphasizes this distinction and notes that problems of sexual interest or arousal are considered disorders when symptoms persist and cause meaningful anxiety or distress rather than simply reflecting normal variation.

I consider that distinction very important.

A woman should not be labelled “sexually weak” simply because her partner wants sex more frequently than she does.

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**Symptoms That May Suggest Reduced Sexual Well-Being**

A woman may consider seeking professional advice when she experiences a persistent and unwanted change in one or more of the following areas.

**Reduced Desire**

She may notice:

- little interest in sexual activity;
- fewer sexual thoughts or fantasies;
- rarely wanting to initiate intimacy;
- loss of interest that is different from her previous pattern;
- or distress about reduced sexual motivation.

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**Difficulty Becoming Aroused**

A woman may feel mentally interested but notice that her body does not respond as expected.

Or the reverse may occur: physical responses may happen without a strong subjective feeling of excitement.

Arousal can be influenced by body image, pregnancy, breastfeeding, exercise, sleep, antidepressants, alcohol, drugs and relationship problems.

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**Vaginal Dryness or Reduced Lubrication**

Dryness can make sexual activity uncomfortable.

Possible contributors include:

- inadequate arousal time;
- menopause;
- breastfeeding;
- certain medications;
- hormonal changes;
- some medical conditions.

Dryness should not automatically be interpreted as:

**“My body no longer wants sex.”**

The physical tissues and the psychological experience of desire are related but not identical.

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**Difficulty Reaching Orgasm**

Some women may:

- take much longer to reach orgasm;
- experience orgasms less frequently;
- notice reduced intensity;
- have never experienced orgasm;
- or be unsure whether they have experienced one.

ACOG notes that orgasm difficulties are common and can be associated with medical problems, psychological conditions, relationship change or prior pelvic treatment.

Not every woman considers orgasm necessary for satisfying intimacy.

Treatment is appropriate when the woman herself is distressed or wishes to improve this aspect of her sexual experience.

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**Pain During Sexual Activity**

Pain should **never simply be accepted as normal**.

ACOG reports that pain with intercourse is common and estimates that nearly three out of four women experience it at some point in their lives, although it may be temporary in many.

Possible causes include:

- inadequate lubrication;
- genitourinary syndrome of menopause;
- vaginismus or pelvic-floor spasm;
- vulvodynia;
- endometriosis;
- ovarian or pelvic disorders;
- infection;
- childbirth-related injury;
- scars;
- pelvic-floor dysfunction;
- inadequate arousal;
- or psychological fear after previous painful experiences.

Frequent or severe pain deserves professional assessment.

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**“Low Sexual Fitness” Does Not Automatically Cause Infertility**

This is an important correction to a common assumption.

Low desire, difficulty with orgasm or sexual dissatisfaction does **not automatically damage fertility**.

Fertility depends on factors such as:

- ovulation;
- ovarian reserve where clinically relevant;
- fallopian-tube function;
- uterine conditions;

- reproductive age;
- sperm factors;
- timing and frequency of intercourse;
- and many other variables.

Sexual difficulties can indirectly make conception more difficult if intercourse becomes painful, infrequent or impossible, but low libido itself is not equivalent to infertility.

At Saira Health Care, because my focused practice includes both **sexual disorders and infertility**, I consider these two areas separately while also examining where they may overlap.

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**Low Sexual Function Does Not Automatically Cause Hormonal Imbalance**

The relationship often works in the opposite direction.

Hormonal and medical conditions may affect sexual function.

Examples can include:

- menopause;
- thyroid disorders;
- hyperprolactinaemia;
- diabetes;
- some endocrine disorders;
- certain medications.

A woman should not be told that a reduced sex drive itself has “damaged her hormones.”

Instead, where symptoms suggest a medical cause, appropriate assessment should be performed.

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**What Can Affect Female Sexual Health?**

Female sexual function is best understood using a **biopsychosocial model**.

That means we consider the **body, mind, relationship and social environment together**.

ISSWSH specifically rejects a “one size fits all” approach to female sexual dysfunction because multiple biopsychosocial factors can contribute.

**Physical Health**

Sexual function may be affected by:

- diabetes;
- cardiovascular disease;
- neurological disease;
- chronic pain;
- cancer;
- arthritis;
- thyroid disease;
- pelvic-floor disorders;
- endometriosis;
- urinary problems;
- menopause;
- fatigue;
- chronic illness.

ACOG specifically identifies several medical and surgical conditions as contributors to sexual difficulties.

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**Mental and Emotional Health**

Anxiety, depression, stress, shame and low self-esteem can affect:

- desire;
- arousal;
- orgasm;
- comfort;
- communication.

Sexuality is especially sensitive to psychological safety.

A woman who constantly feels exhausted, anxious or judged may find it difficult to become sexually engaged even when there is no genital disease.

**Relationship Factors**

Relationship tension may affect sexual health through:

- unresolved conflict;
- poor communication;
- resentment;
- fear;
- pressure;
- lack of privacy;
- mismatched desire;
- loss of emotional intimacy.

A woman's sexual function should therefore not be treated as if it exists independently of her relationship circumstances.

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**Body Image**

Body image can change after:

- pregnancy;
- childbirth;
- weight change;
- surgery;
- ageing;
- menopause;
- breast treatment;
- illness.

Feeling uncomfortable with one's body may make it harder to relax during intimacy.

Sexual treatment should therefore never focus only on anatomy.

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**Medicines Can Affect Sexual Function**

Certain medications can reduce desire, arousal or orgasmic response.

ACOG lists several categories, including:

- some antidepressants, especially SSRIs;
- certain heart or blood-pressure medicines;
- some hormonal medicines;
- anticholinergic medicines;
- opioids and other pain medicines.

A woman should **not stop prescribed medicine herself**.

Instead, the medication list should be reviewed with the prescribing healthcare professional.

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**Pregnancy and the Postpartum Period**

Pregnancy and childbirth can substantially change:

- libido;
- body image;
- energy;
- lubrication;
- pelvic-floor function;
- sleep;
- relationship dynamics.

Breastfeeding can be associated with lower estrogen levels and increased vaginal dryness in some women.

After delivery, scar discomfort, pelvic-floor injury, fear of pain and exhaustion can also influence sexual activity.

Recovery should not be rushed.

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**Menopause and Sexual Health**

Menopause is one of the most important stages in female sexual health.

Declining estrogen and androgen concentrations can produce **genitourinary syndrome of menopause (GSM)**.

Symptoms may include:

- vulvar or vaginal dryness;
- burning;
- irritation;
- painful intercourse;
- urinary symptoms;
- reduced genital comfort.

The 2025 AUA/SUFU/AUGS guideline—endorsed by ISSWSH and The Menopause Society—states that GSM is diagnosed based on symptoms with or without examination findings after other causes are considered. The guideline identifies **low-dose local vaginal estrogen as the treatment with the strongest evidence base** among available options.

ACOG also notes that topical estrogen can improve vulvovaginal dryness and pain with intercourse in appropriate women.

This is an example of why a woman with “low sexual fitness” may actually need treatment of a specific medical condition rather than a general tonic.

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**Sexual Pain After Menopause Should Not Be Ignored**

Dryness and tissue changes can make penetration increasingly uncomfortable.

If pain becomes expected, a woman may develop:

**pain → fear of pain → pelvic-floor tightening → reduced arousal → more pain → avoidance.**

Treatment may involve:

- lubricants;
- moisturizers;
- local hormonal treatment where appropriate;
- selected non-estrogen medicines;
- pelvic-floor physiotherapy;
- sex therapy;
- treatment of another identified vulvovaginal condition.

A recent 2026 clinical review recommends pelvic-floor physiotherapy when examination identifies pelvic-floor tenderness, guarding or penetration-limiting hypertonicity.

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**Physical Fitness and Female Sexual Function**

Regular physical activity can support sexual wellbeing through several mechanisms.

Exercise can improve:

- cardiovascular fitness;
- blood circulation;
- mood;
- body confidence;
- sleep;
- stress management;
- metabolic health;
- physical stamina.

A major **2026 systematic review and meta-analysis** evaluated exercise interventions for women's sexual dysfunction. Twenty-three studies were included, and the meta-analysis found improvements across domains including desire, arousal, lubrication, orgasm, satisfaction and sexual pain. However, the evidence certainty remained low because the studies and exercise programmes differed considerably.

The takeaway is encouraging but realistic:

**Exercise is good for general health and may improve sexual function, but it should not be advertised as a guaranteed cure for every female sexual problem.**

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**Pelvic-Floor Health and Sexual Function**

The pelvic floor is a group of muscles supporting structures including the bladder, uterus and rectum.

These muscles also participate in:

- continence;
- genital sensation;
- pelvic stability;

- aspects of orgasm;
- sexual comfort.

Pelvic-floor training can be helpful for selected women.

A 2024 systematic review and meta-analysis of **21 randomized trials** found improvements in overall sexual-function scores as well as arousal, orgasm, satisfaction and pain following pelvic-floor muscle training, although the certainty of evidence was considered very low because study protocols varied substantially.

A 2025 meta-analysis in postmenopausal women also reported improvements in sexual-function measures following pelvic-floor muscle training.

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**Kegel Exercises: Helpful, But Not for Every Woman**

Kegel exercises involve voluntarily contracting and relaxing pelvic-floor muscles.

They may be useful when pelvic-floor weakness is present.

But there is an important misunderstanding:

**a painful or dysfunctional pelvic floor is not always weak.**

Some women have an **overactive or hypertonic pelvic floor**.

Their muscles are already excessively tight.

Repeatedly telling such a woman to “do more Kegels” can be inappropriate.

Women with:

- pain during penetration;
- pelvic-floor spasm;
- difficulty relaxing the vagina;
- pelvic pain;
- vaginismus-type symptoms

may need assessment by a pelvic-floor physiotherapist and may benefit from **relaxation, coordination and down-training**, not simply strengthening.

I therefore recommend individual assessment rather than prescribing one universal Kegel routine.

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**A Simple Kegel Approach for Appropriate Women**

When pelvic-floor strengthening is suitable and there is no pain or excessive muscle tension, a basic approach may involve:

identifying the muscles used to prevent passing gas or interrupt urine flow, then practising gentle contractions while breathing normally.

However, routinely stopping the urine stream should be used only to identify the muscles—not as a regular exercise habit.

Correct technique matters more than force.

If there is uncertainty, leakage, prolapse or pain, professional pelvic-floor assessment is preferable.

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**Yoga and Female Sexual Function**

Yoga may help through a combination of:

- physical movement;
- flexibility;
- body awareness;
- breathing;
- stress reduction;
- relaxation.

A 2024 systematic review and meta-analysis of randomized trials included 730 adults, more than 93% of whom were women. Yoga was associated with a **small improvement in sexual function**, but the certainty of evidence was low and larger high-quality studies are still needed.

A separate randomized clinical trial in reproductive-age women also compared yoga and pelvic-floor exercise for sexual-function outcomes.

So yoga may be a useful supportive practice.

It should not be described as a proven replacement for medical treatment of conditions such as severe dyspareunia, infection or hormonal GSM.

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**Sleep Is Part of Sexual Health**

A woman who sleeps four or five hours every night because of childcare, work or insomnia may understandably have reduced:

- energy;
- mood;
- concentration;
- interest in intimacy.

Before concluding that her hormones are abnormal, we should ask about her daily reality.

Good sleep cannot solve every sexual problem, but it is one of the foundations of overall health.

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**Nutrition and Sexual Well-Being**

A balanced diet supports:

- cardiovascular health;
- metabolic health;
- energy;
- body composition;
- reproductive health;
- micronutrient adequacy.

I do not recommend telling women that one food will automatically “increase female sexual power.”

Nutrition should address the person as a whole.

A woman with anaemia requires appropriate assessment and treatment.

A woman with diabetes needs a diabetes-appropriate diet.

A woman who is undernourished needs a different approach.

There is no single sexual-fitness diet suitable for everyone.

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**Emotional Intimacy and Communication**

For many women, the sexual environment matters as much as physiology.

A woman may have no medical disorder but experience reduced desire because intimacy has become associated with:

- pressure;

- arguments;
- criticism;
- rushed intercourse;
- lack of affectionate touch;
- unresolved resentment.

Good sexual health requires communication about:

- desire;
- preferences;
- boundaries;
- comfort;
- pain;
- contraception;
- stimulation;
- expectations.

Sexual intimacy should not become an examination of performance.

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**Consent Is Part of Sexual Fitness**

A woman's sexual health cannot be separated from her autonomy.

WHO's sexual-health framework emphasizes pleasurable and safe sexual experiences **free from coercion and violence**.

Sexual activity should therefore never be used as:

- an obligation;
- proof of love;
- punishment;
- a test of marital loyalty.

Feeling safe to say both **yes and no** is part of healthy sexual functioning.

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**Orgasm: Quality, Not Competition**

Women sometimes become anxious because they hear:

**“Every healthy woman must orgasm every time.”**

That is not a useful medical standard.

Some women experience orgasm easily.

Others require specific stimulation.

Some may enjoy sexual intimacy without orgasm on every occasion.

Treatment becomes relevant particularly when a woman personally wants orgasm but consistently experiences difficulty and is distressed by it.

ACOG suggests that additional stimulation, different forms of stimulation and exploration of sexual preferences may help some women.

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**Improving Sexual Fitness: A Practical Evidence-Based Approach**

For most women, improvement should begin with understanding the specific problem rather than searching for a universal libido booster.

A useful clinical plan may address several areas together.

**Physical Activity**

Aim for regular appropriate aerobic and strength exercise according to general health and fitness level.

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**Pelvic-Floor Assessment**

Strengthen when weakness is present.

Relax and rehabilitate when hypertonicity or pain is present.

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**Adequate Arousal**

Allow sufficient time for:

- emotional connection;
- affectionate touch;
- sexual stimulation;
- lubrication.

Rushing penetration can create discomfort even in healthy tissues.

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**Lubricants and Moisturizers**

Lubricants can reduce friction during sexual activity.

ACOG recommends water- or silicone-based lubricants when condoms are used.

Vaginal moisturizers can help some women with ongoing dryness.

Persistent menopausal dryness may require clinical treatment.

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**Improve Sleep and Stress Management**

Stress reduction can involve:

- exercise;
- relaxation;
- meditation;
- yoga;
- counselling;
- workload changes where possible.

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**Communication**

Explain what feels comfortable, pleasurable or painful.

A partner cannot reliably guess another person's sexual experience.

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**Treat Underlying Conditions**

Treatment may be necessary for:

- GSM;
- pelvic-floor dysfunction;
- depression;
- anxiety;
- diabetes;

- thyroid disease;
- pain disorders;
- medication-associated dysfunction;
- endometriosis;
- vulvovaginal disorders.

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**Female Sexual Dysfunction Requires Individualized Treatment**

Female sexual difficulties are not treated with one universal medicine.

ACOG's guidance—reaffirmed in 2025—emphasizes that treatment depends on whether the main issue concerns desire, arousal, orgasm or pain.

This is why I avoid phrases such as:

**“This medicine is best for every woman's sexual weakness.”**

That is not how responsible sexual medicine works.

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**Treatment of Low Sexual Desire**

When a woman experiences persistent, unwanted low desire and significant personal distress, clinicians may evaluate for **hypoactive sexual desire disorder (HSDD)** or related sexual interest/arousal problems.

Treatment begins by considering:

- relationship circumstances;
- psychological health;
- medications;
- pain;
- menopause;
- physical illness;
- sleep;
- stress.

Psychosexual counselling or cognitive-behavioural approaches may be appropriate for some patients.

In certain countries, prescription treatments such as **flibanserin** or **bremelanotide** may be available for selected premenopausal women with HSDD. Clinical trials of bremelanotide demonstrated improvements in desire and distress but also adverse effects including nausea, flushing and headache.

These medicines are not general aphrodisiacs and are not appropriate for every woman.

Availability and regulatory approval differ between countries.

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**Testosterone in Women**

Testosterone should **not** be casually used as a female sexual-fitness supplement.

ISSWSH has published a clinical guideline for systemic testosterone in carefully selected women with HSDD following proper biopsychosocial assessment.

The evidence base is strongest in appropriately selected **postmenopausal women with HSDD**, with specialist assessment and monitoring.

A woman should not begin testosterone simply because:

- libido is lower than her partner's;
- she feels tired;
- she wants stronger orgasms;
- or an internet test says her level is “low.”

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**Vaginal Dryness and GSM Treatment**

For menopausal women with genital dryness or painful intercourse, evidence-based options can include:

- vaginal moisturizers;
- lubricants;
- low-dose local vaginal estrogen where appropriate;
- and selected alternatives such as other prescription therapies depending on individual circumstances.

The 2025 GSM guideline identifies low-dose local estrogen as having the most robust evidence among hormonal treatments.

Medical history—including a history of hormone-sensitive cancer—may alter management and should be discussed with the treating clinician.

**Be Cautious With "Vaginal Rejuvenation"**

Women may encounter advertisements promising that laser or energy-based procedures will:

- tighten the vagina;
- restore sexual function;
- cure dryness;
- improve orgasm.

ACOG states that the FDA has **not approved vaginal laser or other energy-based devices for cosmetic vaginal surgery or treatment of menopausal symptoms, urinary incontinence or sexual problems**, and these procedures can cause burns, scarring and persistent pain.

A woman should not undergo an invasive procedure simply because she has been told her vagina needs "rejuvenation."

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**The Unani Perspective on Female Sexual Health**

As a physician trained in Unani medicine, I consider one of its strengths to be its **holistic view of health**.

Classical Unani medicine considers factors such as:

- **Mizaj** – individual temperament;
- **Akhlat** – classical humoral concepts;
- food and nutrition;
- physical activity;
- sleep;
- mental and emotional state;
- general body function.

These traditional concepts are not identical to modern physiological measurements, but they can provide a useful framework for discussing the whole patient's lifestyle.

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**Asbab-e-Sitta Zarooriya: Six Essential Factors**

Unani medicine gives particular importance to **Asbab-e-Sitta Zarooriya**, the Six Essential Factors of life.

Official CCRUM terminology describes these as:

- air;
- foods and drinks;
- physical movement and rest;
- mental activity and peace;
- retention and evacuation;
- sleep and wakefulness.

The Ministry of Ayush similarly identifies these factors as central to health promotion in Unani medicine and describes four broad therapeutic modes: **Ilaj bit Tadbir, Ilaj bil Ghiza, Ilaj bid Dawa and Ilaj bil Yad**.

For female sexual health, these concepts can help us discuss:

sleep, fatigue, physical fitness, nutrition, emotional stress and healthy daily routines.

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**Ilaj bil Ghiza – Dietotherapy**

A woman's sexual wellbeing can be influenced by her general nutritional status.

Unani dietotherapy can contribute by individualizing dietary advice according to:

- constitution;
- age;
- activity;
- weight;
- metabolic health;
- existing illness.

But I do not believe that every woman with low desire should be told to consume calorie-dense “sexual strength foods.”

If obesity, diabetes or metabolic syndrome is present, such advice may be inappropriate.

Nutrition should support the patient's overall health.

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**Ilaj bit Tadbir – Regimenal and Lifestyle Care**

This part of Unani practice can complement contemporary health recommendations by emphasizing:

- regular appropriate physical movement;
- adequate rest;
- sleep;
- mental relaxation;
- healthy routine.

For a woman whose sexual health is being affected by chronic exhaustion and stress, improving these foundations may be genuinely helpful.

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**Psychological Well-Being in the Unani Framework**

The concept of **Harkat-o-Sukoon Nafsani—psychological activity and repose—** is particularly relevant.

Women experiencing:

- chronic stress;
- relationship anxiety;
- body-image distress;
- sexual fear;
- performance pressure

may have difficulty with desire and arousal.

A responsible integrative programme should therefore make space for counselling and psychological care rather than treating every concern pharmacologically.

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**Unani Pharmacotherapy and Female Sexual Well-Being**

Unani pharmacotherapy may be used by appropriately qualified practitioners when there is a clear individual indication.

However, I consider it essential to differentiate between:

**traditional use**

and

**benefit established through modern clinical trials.**

Traditional knowledge deserves respect.

But a plant should not be advertised as a scientifically proven cure simply because it has historically been used for reproductive health.

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**Ashwagandha and Female Sexual Function**

**Withania somnifera**, commonly known as Ashwagandha or Asgandh, is used in several South Asian traditional medical contexts.

A randomized placebo-controlled study published in 2022 included **80 women aged 18–50** with low sexual-function scores. Eight weeks of a standardized ashwagandha root extract was associated with greater improvements than placebo in Female Sexual Function Index scores, including desire, arousal, lubrication, orgasm, satisfaction and pain.

An earlier pilot trial of 50 women reported improvements in several sexual-function measures as well.

These findings are encouraging.

But they are still based on relatively small studies.

They do **not** prove that every ashwagandha product improves every female sexual problem.

Different preparations can have different composition and quality.

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**Shatavari – Asparagus racemosus**

**Asparagus racemosus**, commonly called Shatavari, has a long tradition of use in South Asian medicine, particularly in women's reproductive-health traditions.

A notable **2026 randomized, double-blind, placebo-controlled trial involving 135 women** evaluated standardized Shatavari alone, Shatavari combined with Ashwagandha and placebo over eight weeks.

The combined Shatavari–Ashwagandha group showed improvements in overall sexual-function scores and several domains including arousal, lubrication and orgasm compared with placebo. Shatavari alone improved total sexual-function and satisfaction measures in that trial.

This is useful new evidence.

But it is **one recent short-term trial**.

We should therefore describe the findings as promising rather than declaring Shatavari a proven cure for female sexual dysfunction.

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**Is Shatavari Specifically a Unani Medicine?**

This point deserves clarity.

Shatavari is particularly well known within **Ayurvedic** literature, and the recent 2026 trial itself describes its Ayurvedic traditional use.

Plants can be used across more than one traditional pharmacopoeia, but historical use in one system should not automatically be presented as evidence that it is uniquely or exclusively a Unani medicine.

For Saira Health Care, I believe accurate terminology strengthens the credibility of traditional medicine.

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**What About Ashwagandha Around Menopause?**

Randomized trials have also investigated standardized ashwagandha preparations for perimenopausal and menopausal symptoms.

An earlier trial in 100 perimenopausal women reported improvement in menopause symptom and quality-of-life scores.

A more recent randomized trial in 60 women aged 45–55 similarly reported improvement in menopause symptom scores after eight weeks compared with placebo.

These studies are interesting but should not be used to replace established treatment for severe GSM, osteoporosis risk or other menopause-related medical conditions.

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**Herbal Does Not Automatically Mean Safe**

Even a natural product can:

- cause adverse effects;
- interact with medicines;
- be inappropriate during pregnancy;
- affect thyroid function;
- affect liver function;
- vary in quality or potency.

Therefore, traditional medicines should ideally be:

- properly identified;
- standardized;
- appropriately dosed;
- selected according to the patient's medical history.

A woman should not combine several “female power” herbs simply because each is advertised as natural.

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**My Approach at Saira Health Care**

When a woman consults me with what she describes as **low sexual fitness**, I do not immediately prescribe a libido-enhancing medicine.

I first want to understand what she actually means.

I ask:

**Is desire reduced?**

**Is the problem new or lifelong?**

**Is arousal difficult?**

**Is lubrication reduced?**

**Is intercourse painful?**

**Can she reach orgasm?**

**Is she satisfied with her sexual relationship?**

**Has menopause begun?**

**Has she recently delivered a baby or is she breastfeeding?**

**Is pelvic-floor dysfunction present?**

**Is she using medications that may affect sexual function?**

**Is there diabetes, thyroid disease or another chronic condition?**

**Is she depressed or severely stressed?**

**Does she feel safe and comfortable in her relationship?**

**Is infertility also a concern?**

The answers determine the treatment.

**Clinical Examination and Investigations**

Not every woman needs a large laboratory panel.

Assessment may include:

- detailed medical and sexual history;
- medication review;
- menstrual and reproductive history;
- pelvic examination where indicated;
- assessment for vulvovaginal disease;
- pelvic-floor evaluation;
- appropriate blood tests when endocrine disease is suspected.

ACOG recommends evaluating both physical and mental-health factors and notes that pelvic examination may be appropriate, particularly when pain is present.

Tests should be selected to answer a clinical question—not simply because a woman mentions low libido.

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**Saira Health Care's Contribution to Female Sexual and Reproductive Health**

Female sexual health is still frequently neglected.

Many women have spent years thinking:

**“Pain during sex is normal.”**

**“A woman should not talk about sexual pleasure.”**

**“If I do not want sex, I am a bad wife.”**

**“If I cannot orgasm, something is wrong with my femininity.”**

These beliefs can prevent women from receiving appropriate care.

At **Saira Health Care**, one of our important roles in sexual and reproductive healthcare is therefore education.

My aim is to create an environment in which women can discuss:

- sexual desire;
- arousal;

- lubrication;
- orgasm;
- pain;
- pelvic-floor concerns;
- vaginal dryness;
- menopause;
- relationship concerns;
- fertility

without shame.

Sexual health deserves the same professional respect as every other area of health.

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**Specialized Approach of Dr. Nizamuddin Qasmi**

My professional focus includes **sexual disorders and infertility**, supported by training in Unani medicine and additional professional education in reproductive and sexual health:

**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**

My clinical philosophy is that sexual-health treatment should be **individualized**.

One woman may primarily need pelvic-floor physiotherapy.

Another may need treatment for menopausal dryness.

Another may need counselling for severe anxiety.

Another may need medication review.

Another may have a relationship issue rather than a medical disorder.

Another may benefit from carefully selected Unani lifestyle and pharmacological support.

And another may require referral to a gynaecologist, endocrinologist, pelvic-floor physiotherapist or qualified sex therapist.

**A Practical Female Sexual-Fitness Plan**

For appropriate patients, I often explain improvement through several connected areas.

**Improve General Physical Health**

Regular exercise, appropriate weight management and treatment of chronic disease support sexual wellbeing.

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**Protect Pelvic-Floor Health**

Do not assume the muscles are weak.

Assess first when pain or dysfunction is present.

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**Give Arousal Enough Time**

Sexual response should not be rushed.

Affection, psychological comfort and adequate stimulation can be important.

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**Reduce Pain and Friction**

Use an appropriate lubricant when needed.

Persistent dryness or pain needs assessment.

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**Improve Sleep**

Chronic exhaustion is not a minor sexual-health issue.

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**Address Psychological Stress**

Meditation, yoga, counselling and psychological therapy can be useful according to the individual.

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**Communicate Openly**

Partners should be able to discuss comfort, pleasure and boundaries without shame.

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**Treat Medical Causes**

Manage hormonal, menopausal, gynaecological, pelvic-floor or medication-related causes when present.

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**Integrate Unani Care Responsibly**

Use **Ilaj bil Ghiza, Ilaj bit Tadbir, attention to Asbab-e-Sitta Zarooriya and individualized pharmacotherapy** where clinically appropriate.

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**Frequently Asked Questions**

**Is “female sexual fitness” a medical disease?**

No.

It is better understood as a general wellness concept.

Specific medical conditions involve difficulties with desire, arousal, orgasm or pain that cause meaningful distress.

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**Does every woman need a high sex drive to be healthy?**

No.

Sexual desire varies greatly between women and throughout life.

A lower level of desire is not automatically a disorder unless it is persistent and personally distressing.

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**Is vaginal dryness always caused by low desire?**

No.

Dryness can be influenced by menopause, breastfeeding, medication and other physical factors.

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**Can exercise improve women's sexual function?**

Research suggests it can.

A 2026 meta-analysis found improvements in desire, arousal, lubrication, orgasm, satisfaction and pain across exercise interventions, although certainty of evidence was limited by substantial differences among the studies.

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**Are Kegel exercises good for sexual health?**

They can be useful for selected women, and systematic reviews report possible improvement in several sexual-function domains.

However, women with an overly tight or painful pelvic floor may need relaxation-focused physiotherapy instead of more strengthening.

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**Can yoga improve sexual fitness?**

Possibly.

A 2024 meta-analysis found a small improvement in sexual-function measures, particularly among women, but the evidence was of low certainty.

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**Does low libido mean my hormones are low?**

Not necessarily.

Desire is influenced by health, sleep, stress, relationships, medications and many other factors.

Hormonal testing should be guided by the overall clinical picture.

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**Does low sexual fitness cause infertility?**

Not directly.

Sexual problems may reduce the frequency or comfort of intercourse, but infertility has its own causes and should be assessed separately.

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**Can menopause cause sexual problems?**

Yes.

Menopause can contribute to dryness, genital discomfort and painful intercourse through genitourinary syndrome of menopause. The 2025 guideline identifies local low-dose vaginal estrogen as having a strong evidence base for appropriate patients with GSM.

**Can Ashwagandha help female sexual function?**

Small randomized trials have reported improvements in several sexual-function measures with standardized ashwagandha extracts.

These findings are promising but do not mean that every product or every patient will benefit.

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**Can Shatavari improve female sexual function?**

A 2026 randomized placebo-controlled study found improvements in some sexual-function outcomes with standardized Shatavari, particularly when combined with Ashwagandha.

This is promising early evidence rather than proof of a universal treatment.

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**Can Unani medicine improve female sexual health?**

Unani medicine can contribute meaningfully through its holistic focus on:

- food and nutrition;
- physical movement;
- rest;
- sleep;
- psychological balance;
- and individualized treatment.

Official Unani health guidance emphasizes these six essential lifestyle factors.

Where traditional medicines are used, they should complement appropriate diagnosis rather than substitute for treatment of significant gynaecological, hormonal or psychological disease.

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**Can a woman improve orgasm through pelvic-floor exercises?**

Some women may experience improvement, and meta-analysis has reported improved orgasm scores following pelvic-floor muscle training.

But orgasm also depends on stimulation, arousal, psychological state, relationship context and individual anatomy.

**Should painful sex be tolerated?**

No.

Frequent or severe sexual pain deserves assessment because many treatable conditions can cause it.

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**When Should a Woman Seek Professional Help?**

A consultation is advisable when there is:

- persistent unwanted loss of sexual desire;
- difficulty becoming aroused;
- recurrent inability to orgasm that causes distress;
- significant vaginal dryness;
- repeated pain with intercourse;
- bleeding associated with sexual activity;
- unusual genital discharge or irritation;
- pelvic pain;
- substantial postpartum sexual difficulty;
- menopausal symptoms interfering with intimacy;
- severe anxiety or depression affecting sexual health;
- or difficulty conceiving.

**Postmenopausal bleeding should always be medically evaluated rather than attributed to sexual activity or dryness without assessment.**

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**A Message From Dr. Nizamuddin Qasmi**

When a woman tells me:

**“Doctor, my sexual fitness is low,”**

I do not begin by deciding that she needs a sexual-strength medicine.

I first want to know what she is actually experiencing.

Is desire reduced?

Is intercourse painful?

Is there dryness?

Has menopause changed her body?

Is she exhausted?

Is the pelvic floor weak—or actually too tight?

Is medication affecting orgasm?

Is there emotional stress?

Is she comfortable in her relationship?

Is fertility also a concern?

That is how meaningful treatment begins.

Female sexual health should not be measured only by how frequently a woman has intercourse or whether she reaches orgasm every time.

It should be understood through **comfort, pleasure, health, confidence, autonomy and emotional well-being**.

As a physician trained in Unani medicine, I believe its holistic principles have a valuable place here.

**Ilaj bil Ghiza** can support appropriate nutrition.

**Ilaj bit Tadbir** can encourage balanced movement, rest and lifestyle.

**Asbab-e-Sitta Zarooriya** reminds us that food, activity, sleep and psychological health are interconnected.

And carefully selected traditional pharmacotherapy may have a supportive role in appropriate individuals.

At the same time, Unani medicine should work alongside good diagnosis.

A woman with menopausal vaginal atrophy may need evidence-based local treatment.

A woman with severe pelvic-floor spasm may need physiotherapy.

A woman with depression may need mental-health care.

A woman with persistent sexual pain may need gynaecological evaluation.

A woman with infertility deserves a proper reproductive assessment.

**The objective is not merely to increase libido. The objective is to help a woman achieve healthier, safer, more comfortable and more satisfying sexual well-being according to her own needs and preferences.**

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**About the Author**

**Dr. Nizamuddin Qasmi**

**Founder & Chief Physician, Saira Health Care**
**Focused Practice in Sexual Disorders & Infertility**

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

At **Saira Health Care**, the focus is on confidential, individualized and integrative assessment of sexual and reproductive-health concerns, including problems of desire, arousal, sexual pain, pelvic health and infertility.

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**Medical Disclaimer**

This article is intended for **public education and general health information**. “Sexual fitness” is used here as an accessible wellness term rather than a formal medical diagnosis.

Persistent sexual difficulty may have physical, psychological, medication-related, hormonal, pelvic-floor or relationship causes. Individual assessment is therefore important before beginning treatment.

Herbal and Unani medicines should be used under appropriately qualified supervision. The evidence for individual traditional formulations remains more limited than that available for several established treatments of specific female sexual disorders.

Pregnant or breastfeeding women and patients with significant medical conditions should not begin herbal supplements or hormone treatment without professional advice.