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An Integrative Review of Male Sexual Disorders and the Therapeutic Role of Unani Aphrodisiacs

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Abstract

Sexual health is a vital component of overall well-being, encompassing physical, emotional, and psychosocial dimensions. Male sexual dysfunction – including conditions, like erectile dysfunction, premature ejaculation, and low libido – can significantly impact quality of life and intimate relationships. Aphrodisiacs, derived from the Greek goddess Aphrodite, are substances that stimulate sexual desire and performance. Historically, natural aphrodisiacs have been used in various cultures and include plant-based substances such as Yohimbine, garlic (Allium sativum), onion (Allium cepa), and Tribulus terrestris. The Unani system of medicine recognizes male sexual health as dependent on Quwat-e-Bah (libido and potency), governed by the functional integrity of the brain, heart, and liver. Disruptions caused by lifestyle stressors, chronic diseases, or psychological factors often manifest in disorders like premature ejaculation, erectile dysfunction, and Peyronie's disease. Unani literature classifies causes of sexual dysfunction in terms of temperamental imbalances (e.g., excess cold and wetness) and weakened retentive power. Management strategies range from behavioral therapy and counseling to herbal medicines, surgical interventions, and topical applications. Traditional Unani formulations, such as Safoof Mughaliz Mani, play a significant role in managing male sexual dysfunction by strengthening the reproductive faculties and enhancing libido. Modern and traditional approaches increasingly incorporate herbal aphrodisiacs, like Eurycoma longifolia, Avena sativa, and Psoralea corylifolia, due to their efficacy and minimal side effects. Topical therapies using herbal poultices or formulations with vasoactive agents offer less invasive treatment options. With rising global awareness about sexual health and natural therapies, aphrodisiac-based phytomedicine remains a promising, integrative approach to treating male sexual disorders. This review highlights the clinical significance of aphrodisiacs in traditional and modern medicine and emphasizes the potential of Unani therapeutics in improving male sexual health.

Keywords: Male sexual dysfunction, Quwat-e-Bah (sexual potency), erectile dysfunction (ED), premature ejaculation (PE), Unani aphrodisiacs (Muqawwi-e-Bah), phytotherapy/herbal remedies

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INTRODUCTION

The term "aphrodisiac" comes from the name of Aphrodite, the Greek goddess of beauty and sexual love. The term "aphrodisiac" refers to any food or substance that stimulates the sexual urge, creates lust, and improves enjoyment and performance. Numerous natural compounds, including Yohimbine, the Mandrake plant, crushed rhinoceros horn in Chinese culture, and Spanish flies, have long been used as aphrodisiacs in Africa and Europe. Aphrodisiacs come in two primary varieties. internal preparations (food, alcohol, beverages, and drugs) and psychophysiological stimuli (visual, tactile, olfactory, and auditory) [1].

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Sexual health is defined by the World Health Organization (WHO) as a range of sociocultural, psychological, and physical well-being related to sexuality. However, there is increasing awareness that teenage sexual health encompasses more than simply physical morbidities; it also includes a wider spectrum of physical, emotional, and psychological reactions to sexual relationships. The International Classification of Diseases (ICD-10) states that sexual dysfunction, which includes a range of symptoms, such as loss of sexual desire, lack of sexual pleasure, failure of genital response, orgasmic dysfunction, premature ejaculation, and dyspareunia, is highly prevalent in adult populations [2]. Sexuality is more than just reproductive behavior; it is a basic human desire. Humans have sex regardless of whether they are of reproductive age, in the fertile period of the menstrual cycle, or using contraceptives. In addition to providing enjoyment, sexuality can also cause tension, annoyance, and worry. It has a strong correlation with a couple's relationship stability, general well-being, and general health [3]. Since sexual health is a basic aspect of human health and matters to many individuals as well as their partners, it has a significant impact on clinical care. Normally, normal care of non-communicable diseases, however, usually pays little attention to sexual health. Behaviors, practices, roles, beliefs, attitudes, values, fantasies, desires, thoughts, and relationships are all ways in which sexuality is experienced and expressed. Although all these aspects can be a part of sexuality, not all of them are always felt or communicated. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious, and spiritual factors [4]. A person's sexuality plays a significant role in their lives. A sense of contentment and high self-esteem are linked to perceived satisfactory sexual functioning. However, sexual dysfunction can negatively affect one's quality of life and has been linked to psychological discomfort. There are various forms of sexual dysfunction that can impact sexual desire, reaching the plateau during a sexual act, experiencing an orgasm, and the resolution that follows. Different age groups and genders experience sexual dysfunction at different rates and in different ways [5].

UNANI CONCEPT

According to Tibb-e-Unani literature, *Al quwa-e-tanasuliyah* (reproductive faculties) are necessary for all sexual functions, including the production of semen, sperm, and ovum as well as the development of a fetus inside the mother's womb. The faculty of sexual potency and libido, or *Quwat-e-Bah*, controls sexual functions and is necessary for their preservation. Bah has the meaning of virility, lust, venereal passion, and generative activity. While sexual function depends on the health and good functioning of vital and genital organs, the faculty of sexual potency and libido (*Quwat-e-Bah*) depends on the health and proper working of vital organs, specifically the brain, heart, and liver. It is brought on by the predominance of *Rutūbat* (wetness) and *Burūdat* (cold), which weakens *Quwwat Māsika* (retentive power), *Kasrat-i Manī* (excess semen), *Hurqat o Hiddat-i Manī* (increased motility and acuteness of semen), *Zu'f-i A'zā Ra'īsa* (weakness of vital organs), and *Ittisā'-i Majārī-i Qazeīb* (dilation of sections for semen) [6]. The male sexual response cycle could be divided into its three component parts: libido (desire), erectile function, sexual activity (premature ejaculation). All kinds of factors, such as psychological factors, surgery and trauma, vascular diseases, neurological factors, etc., can cause sexual dysfunction if they affect any part of the sexual response cycle. A change in lifestyle, stressful living situations, chronic illnesses, environmental contaminants, and adverse drug reactions are some of the other factors that have been linked to sexual dysfunction in men [7].

- *Libido:* Sexuality is typically referred to by the term "libido." The Latin word "libido" is thought to be the same as "designating one's sexual drive." Pleasure, sexual identity, affection, intimacy, sociocultural, emotional, and cognitive aspects, and bodily experiences are all components of sexuality, which is a fundamental human experience. A variety of stimuli, including coitus, erotic thoughts, fondling, masturbation, and dreams, can elicit sexual sensations. A series of phases that show up physiologically in a sequential fashion are the expression of sexual response, with interconnected stages that finish the human sexual response cycle [8].
- *Erectile Dysfunction:* Dissatisfaction with sexual function that results in distress is referred to as sexual dysfunction [9]. The inability to attain and/or sustain a suitable penile erection that is adequate for sexual activity is known as erectile dysfunction (ED). It can be clinically categorized

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as either organic (resulting from underlying causes or comorbidities) or psychogenic (resulting from relationship dissatisfaction, social pressures, anxiety, or depression). By 2025, up to 322 million men are expected to be impacted by this prevalent and growing male sexual health issue, which has a prevalence of up to 31% [10]. In the past, males between the ages of 40 and 70 accounted for almost 52% of all cases of ED. But according to current research, ED is becoming very common, even among people under 40 [11]. Common subcategories include orgasm disorders, like anorgasmia; emission phase disorders like retrograde ejaculation (RE); and expulsion phase disorders like premature ejaculation (PE), delayed ejaculation (DE), and anejaculation [12]. Dilation of the penile artery and relaxation of the trabecular corpus cavernosum are the physiological components of penile erection. The penis is relaxed when the smooth muscle in the trabecular area contracts together with the penile artery. When the smooth muscle in the trabecular bone and the penile artery relax, on the other hand, the penis is in an erection condition [13]. The inability to achieve and maintain an erection strong enough for sexual activity is known as erectile dysfunction. It is also occasionally called impotence. Diabetes mellitus, obesity, hormonal imbalance, dyslipidaemia, heart disease, atherosclerosis, high blood pressure, Parkinson's disease, lack of exercise, and lower urinary tract infections are some of the traditional reasons of erectile dysfunction. Among these conditions, diabetes and the oxidative stress are the main causes of male impotence [14]. Risk factors include increasing age; conditions associated with atherosclerosis such as cardiovascular disease, smoking, hypertension, abnormal lipid levels, and diabetes; a history of pelvic surgery (e.g., radical prostatectomy), radiation therapy, or trauma; hormonal imbalances including low testosterone (hypogonadism), high prolactin levels (hyperprolactinaemia), and thyroid disorders; obesity and metabolic syndrome; and the use of substances, such as alcohol and illicit drugs, including cannabis, barbiturates, cocaine, heroin, and methamphetamine. Psychological factors contributing to erectile dysfunction may include relationship issues, stress, guilt, situational anxiety, negative self-image, low self-esteem, a history of sexual abuse, strict or repressive sexual upbringing, as well as mental health conditions such as generalized anxiety disorder, depression, or psychosis. Erectile dysfunction may also occur alongside other sexual disorders such as premature ejaculation, sexual aversion disorder, or difficulty achieving orgasm (anorgasmia). Additionally, certain medications can contribute to erectile difficulties, including antihypertensives (such as diuretics and alpha- or beta-blockers), psychotropic drugs (like selective serotonin reuptake inhibitors, other antidepressants, antipsychotics, and anxiolytics), as well as anticonvulsants, medications for Parkinson's disease, and hormone-related treatments such as antiandrogens, corticosteroids, and long-term opioid use [15].

- *Premature Ejaculation:* The most frequent and widespread sexual condition in men is premature ejaculation, which affects between 30% and 50% of men. The International Society for Sexual Medicine (ISSM) defines premature ejaculation as the failure to adequately postpone ejaculation before or within 60 seconds following satisfying sexual interactions, which leads to adverse sexual effects [16]. A patient's psychological and emotional well-being, as well as their relationships with partners and/or spouses, can all be affected by PE. Despite this, there remains an unmet therapy need in this area of male sexual health, which is typically ignored. This is probably the result of several variables, such as low treatment rates, brought on by humiliation or shame and physician uncertainty over clinical care of the disorder [17]. There are two types of premature ejaculation: "acquired" (secondary) and "lifelong" (primary). The characteristics of lifetime PE include ejaculation that happens too quickly (before vaginal penetration or <1–2 min following), and that it starts with the first sexual experience and persists throughout life. The hallmarks of acquired PE include a brief (although not as brief as in lifelong PE) time to ejaculation and a gradual or abrupt onset after typical ejaculation experiences prior to beginning. The prognosis is generally better and acquired premature ejaculation is easier to treat. Many of the suggested etiologies are speculative rather than supported by evidence. Psychodynamic explanations, anxiety, sexual technique, the frequency of sexual activity, the impact of early experiences and sexual conditioning, and others are examples of psychological theories. The

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degree of arousability, the speed of the ejaculatory reflex, penile hypersensitivity, central neurotransmitter levels and receptor sensitivity, evolutionary hypotheses, and sex hormone levels are examples of biological responses [18].

- *Peyronie's Disease:* Peyronie's disease involves an abnormal healing response to injury or trauma to the penis, where excessive collagen builds up in the tunica albuginea, leading to the formation of fibrous plaques. These plaques cause the tunica albuginea to become rigid, which can result in penile deformities, unusual curvature, pain in the penis during erections, and erectile dysfunction. This healing cascade is believed to be triggered by a significant penile injury, like a fracture, or microtrauma, during intercourse. Most frequently, patients with minor penile pain during erection and/or newly developed aberrant penile curvature come between the ages of fifty-two and fifty-seven. Plaques are frequently undetectable while the penis is flaccid. The most frequent initial symptom is penile deformity, which is followed by palpable plaques and penile pain. It is possible for patients to come in with ED as their sole complaint. A patient who exhibits this characteristic symptomatology may be given a preliminary diagnosis of Parkinson's disease [19].

MANAGEMENT FOR MALE SEXUAL DYSFUNCTION

Behavioral and psychological (counselling with a qualified counselor to assist people deal with feelings of guilt, fear, and anxiety that can affect sexual function); medication therapy (testosterone replacement therapy for sexual insufficiency and other pharmaceutical medicines). Non-surgical tools, such as constructive rings (an external device used to treat erectile dysfunction in patients with mild to severe venous leakage) and vacuum pumps (which enlarge the penis and lower the pressure within the cavernous sinusoidal area). Surgical procedures that include venous ligation (to stop blood from leaking from veins), penile prosthesis (to create enough space in the tissue of each cavernosal body), penile implants (which insert a flexible or rigid material into the penis to make it semi-rigid), and phytotherapy (using medicinal plants and herbs) [20]. Topical therapy, which includes applying vasoactive agents to the penis's skin, reduces systemic exposure and tissue damage. From the standpoint of the patient, this is an additional advantage because it is a less invasive choice. There is cause for optimism based on pilot experiments employing Soft Enhanced Percutaneous Absorption (SEPA). Preliminary data indicates that 80–90% of patients benefit from prostaglandin-E1+ SEPA [21]. Sometimes, patients were instructed to apply herbal dry powders topically. For instance, they were told to leave their scrotum and penis in a bag filled with pellitory (*Anacyclus pyrethrum*), broad bean (*Vicia faba*), or Aquilaria (*Aquilaria agallocha*) powder for a full day. The application of almond (*Prunus dulcis*) and walnut (*Julgans regia*) powders and leaves on the soles of their feet was also recommended." Powders have occasionally been made as poultices or emulsions with other ingredients. The penis was emulsified with yellow bergamot (*Citrus bergamia*) peel powder, the back was emulsified with sunflower (*Helianthus annuus*), the soles were affixed with henbane (*Hyoscyamus niger*) poultice, and the penis was emulsified with buffalo milk and wild ginger (*Zingiber officinale*) or with nettles (*Urtica dioica*) seed and milk fat. The limited permeability of penile skin is the primary barrier to the use of topical medications for sexual dysfunction. These days, a variety of semipolar and nonpolar soft enhancer formulations for percutaneous absorption are in use. Acetylcholine, nitroglycerine, and minoxidil are examples of vasoactive reactants that have been shown to cause erections when applied topically. They also relax the venous smooth muscles, which can assist keep an erection going [22].

- *Aphrodisiacs:* The word "aphrodisiac" comes from the Greek goddess of love, "Aphrodite." According to Greek, aphrodisiacs are substances that arouse sexual desire (Greek: aphrodisiakos sexual) [23]. Aphrodisiacs can be classified into two categories: internal preparations (food, alcoholic beverages, and the affectionate portion) and psychophysiological stimuli (visual, tactile, olfactory, and auditory). The most effective natural aphrodisiacs are readily available and have few adverse effects. The herbs include garlic (*Allium sativum*) Liliaceae (active parts ñ bulbs), onion (*Allium cepa*) Liliaceae (active parts ñ bulbs), and gokhru (*Tribulus terrestris*) Zygophylaceae (active parts ñ fruits). Other herbal plants that have aphrodisiac properties include *Psoralea coryifolia, Eurycoma longifolia, Avena sativa, Datura metel, Atropa belladonna,*

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Hyoscyamus niger, and Ginko biloba. This is a collection of plants along with information regarding their aphrodisiac properties, including a description and chemical composition [24]. List of drugs having aphrodisiac potency depicts in Table 1.

Table 1. List of drugs having aphrodisiac potency.

S.N.	Unani Name	Botanical Name	Part Used	References
1	Ghongchi	*Abrus precatorius L.*	SEED	[21]
2	Bamiya	*Abelmoschus esculantus L.*	Fruits	[1, 21]
3	Atees	*Aconitum heterophyllum Wall*	Root	[1, 21]
4	Samaghe arabi	*Acacia arabica wild*	gum	[1, 21]
5	Beesh	*Aconitum napellus*	Root	[1, 21]
6	Saffron	*Colchicum autumnale*	Flower	[16]
7	Rose	*Rosa damascena*	Flower	[16]
8	Winter Cherry	*Withania somnifera*	Root	[16]
9	Pomegranate	*Punica granatum L.*	Peel	[16]
10	Piyaz	*Allium cepa L.*	Bulb	[1, 21]
11	Waj turkey	*Acorus calamus Linn*	Root	[1, 21]
12	Lehsun	*Allium sativum Lin*	Bulb	[1, 21]
13	Aqarqarha	*Anacyclus pyrethrum DC*	Root	[1, 21]
14	Zaravand	*Aristolochia rotunda*	Root	[1, 21]
15	Kundoor	*Boswellia serrata*	Gum	[1, 21]
16	Asaroon	*Asarum europaeum Linn*	Root	[1, 21]
17	Bindi	*Tribulus terreAsaroon Asaroon stris*		[1, 21]
18	Pista	*Pistacia vera*	Fruit	[1]
19	Filfil daraz	*Piper longum*	Fruits	[1]
20	Aslasoos	*Glycyrrhiza glabra Lin*	Root	[21]
21	Sanober	*Pinus longifolia Roxb.*	Pine nut	[1, 21]
23	Khurma	*Phoenix dactylifera*	Fruit	[1, 21]
24	Aspand	*Peganum harmala*	Seed	[1, 21]
25	Zanjabeel	*Zingiber officinale*	Rhizome	[1, 14, 21]
26	Asgand	*Withania somnifera Linn*	Root	[1, 14, 6, 21]
27	Beejband	*Sidacordifolia*	Seed	[1, 21]
28	Biladur	*Semecarpus anacardium*	Fruit	[1, 21]
29	Bedanjir	*Ricinus communis L.*	Seed	[1, 21]
30	Badam	*Prunusamygdalas*	Fruit	[1, 21]
31	Nutmeg	*Myristica fragrans*	Seed	[4]
32	Aqarqarha	*Anacyclus pyrethrum*	Root	[6]
33	Tarbooz	*Citrullus Vulgaris*	Fruit	[6]
34	Sonth	*Zingiber Officinale Rosc.*	Root	[6, 21]
35	Fenugreek	*Trigonella foenum*	Seed	[16]
36	Satawar	*Asparagus racemosus*	Root	[6]
37	Musli Siyah	*Asparagus adscendens*	Root	[6]
38	Shaqaqul misri	*Pastinaca secacul*	Root	[1,21]
39	Aam	*Mangifera indica L.*	Fruit	[1, 21]
40	Injeer	*Ficus carica*	Fruit	[1, 21]
41	Hilteet	*Ferula foetida*	Resin	[1, 21]
42	Kharpaza	*Cucumis melo Lin*	Seed	[1, 21]
43	Zafran	*Crocus sativa Lin*	Stigma	[1, 21]
44	Darchini	*Cinnamomum zeylanicum*	Bark	[1, 21]
45	Azaraqi	*Strychnos nuxvomica Lin*	Seed	[21]
46	Gul surkh	*Rosa damascene Mill*	Petal	[21]
47	Nana	*Mentha arvensis Lin*	Whole plant	[21]
48	Mushk	*Moschusmoschiferus*	Gland secretion	[21]
49	Katan	*Linum usitatissum*	Seed	[21]
50	Lobia	*Dolichos lablab Lin*	Seed	[21]

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COMPOUND FORMULATIONS USED FOR MALE SEXUAL DISORDERS

Several Unani drugs of plant, animal and mineral origin have been claimed to possess aphrodisiac properties, such drugs are named as *Muqawwie Bah*, which may be a single drug or a compound formulation. Some of the compound formulations are depicted in Table 2.

- *Majoon-e-Piyaz* is a dark brown semi solid preparation with characteristic odor and sweet taste which is being prescribed with great reputation from centuries for the treatment of *Sur'at-e-Inzāl*, i.e., Premature Ejaculation. According to different Unani Pharmacopoeias this compound formulation is exclusively used as *Muqawwi-e-Bah* (aphrodisiac) and *Mumsik* (semen retentive) for the treatment of male sexual disorders – *Sur'at-e-Inzāl* (premature ejaculation), *Zof-e-Bah* (sexual debility) and *Jiryan* (spermatorrhoea). Composition of Majoon-e-Piyaz depicts in Table 3.
- *Safūf-i Aslussūs* is a polyherbal powder preparation mentioned in different Unani Pharmacopoeias (Qarābādīn) for the treatment of PE and spermatorrhea. In *Qarābādīn-i-Majīdī and Qarābādīn-i-Ḥamdard, Safūf-i Aslussūs* is mentioned as comprising six ingredients described in Table 4. In *AlQarābādīn and Ilaj-ul-Amrāz* the same formulation (in the same proportion as in *Qarābādīn-i-Majīdī* and *Qarābādīn-iḤamdard*) is mentioned without any specific name of formulation simply written as *Safūf-i deegar* (other powder) for the treatment of spermatorrhea and premature ejaculation [26].

Table 2. Majoon Aarad Khurma its key ingredients [25].

S.N.	Unani Name	Botanical Name	Part Used	Quantity
1	Khurma	*Phoenix dactylifera*	Fruit	200 gm
2	Kamagh arbi	*Acacia arabica*	Gum	200 gm
3	Singhara khushk	*Trapa bispinosa*	Fruit	200 gm
4	Satawar	*Asparagus rasemosus*	Root	50 gm
5	Jaiphal	*Myristica fragrans*	Nutmeg	1.25 gm
6	Javitri	*Myristica fragrans*	Mace	1.25 gm
7	Qaranfa	*Myrtus caryophyllus*	Fruit	2.5 gm
8	Maghaze Badam	*Prunus amygdalus*	Fruit	25 gm
9	Maghaze Chilghoza	*Pinus gerardiana*	Fruit	25 gm
10	Maghaze Fundaq	*Corylus avellana*	Fruit	25 gm
11	Maghaze Pambadana	*Gossypium herbaceum*	Fruit	5 gm
12	Stevia plant powder	*Stevia rebaudeana*	leaves	3.50 gm

Table 3. Composition of Majoon-e-Piyaz [18].

S.N.	Ingredients	Botanical Names	Part Used	Quantity
1	Tudri surkh	*Cheiranthus cheiri L.*	Seed	35 g
2	Tudri safaid	*Matthiola incana R.Br.*	Seed	35 g
3	Salab Misri	*Orchis latifolia L.*	Tuber	35 g
4	Behman Surkh	*Salvia haematodes L.*	Root	35 g
5	Behman Safaid	*Centaurea behen L.*	Root	35 g
6	Zanjabeel	*Zingiber officinale Rosc*	Rhizome	35 g
7	Tukhm-e-Piyaz	*Allium cepa L.*	Seed	35 g
8	Tukhm-e-Turb	*Raphanus sativus L*	Seed	35 g
9	Tukhm-e-Gandana	*Allium ascalonicum L.*	Seed	35 g
10	Tukhm-e-Shalgam	*Brassica rapa L.*	Seed	35 g
11	Talmakhana	*Hygrophila auriculata (Schum.) Heine.*	Seed	35 g
12	Musli safaid	*Chlorophytum arundinaceum Baker.*	Root	35 g
13	Musli siyah	*Curculigo orchioides Gaertn.*	Root	35 g
14	Aab-e-Piyaz Safaid	*Allium cepa L.*	Onion extract	1.5 lit
15	Qand Safaid	Sugar	Crystals	1.5 kg

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- *Safoof Mughaliz Mani* is a well-known Unani herbal remedy traditionally used to treat various male sexual health issues, including premature ejaculation, spermatorrhea, and nightfall. It functions as both a *Muqawwi-e-Mani* (semen enhancer) and *Muqawwi-e-Bah* (sexual stimulant), working to fortify the reproductive system, boost sperm quality, and increase sexual desire. Made from proven herbs, such as *Talmakhana*, *Salab Misri*, and *Musli Safed*, this powdered formulation promotes sexual wellness and vitality, generally without causing adverse effects when taken under proper medical supervision (Table 4).

Table 4. Safūf Mughalliẓ-i-Manī [27].

S.N.	Unani Name	Botanical Name	Part Used	Quantity
1	Thaʿlab Miṣrī	*Orchis latifolia L.*	Tuber	6 g
2	Mochras	*Bombax ceiba L.*	Gum	4 g
3	Jouzbuwa	*Myristica fragrans Houtt.*	Kernel	2 g
4	Bisbāsa	*Myristica fragrans Houtt.*	Arial	2 g
5	Ilaʾichī Kalān	*Elettaria cardamomum (L.)* Maton	Fruit	2 g
6	Nishāsta	Starch	Powder	9 g
7	Bazr al-Banj	*Hyoscyamus niger L.*	Seed	500 mg
8	Dār Chīnī	*Cinnamomum zeylanicum Blume*	Bark	500 mg
9	Qaranful	*Syzygium aromaticum (L.)* Merr. & L. M. Perry	Flower bud	500 mg
10	Qand Safaid	Sugar	Crystals	26.5 g

CONCLUSIONS

Male sexual dysfunction encompasses a spectrum of disorders, including decreased libido, erectile dysfunction, premature ejaculation, and structural conditions, like Peyronie's disease, all of which significantly affect quality of life and psychological well-being. While conventional medicine offers pharmacological, surgical, and device-based interventions, Unani medicine provides a holistic approach, emphasizing the restoration of *Quwat-e-Bah* (sexual potency) using natural aphrodisiacs, dietary modifications, and lifestyle adjustments. Factors, such as psychological stress, chronic illnesses, hormonal imbalances, vascular and neurological disorders, and adverse drug effects, contribute to sexual dysfunction, highlighting the multifactorial nature of these conditions. Unani aphrodisiacs, derived from herbs, like *Tribulus terrestris*, *Asparagus racemosus*, and *Glycyrrhiza glabra*, along with compound formulations, offer complementary therapeutic potential with minimal side effects. Integrating traditional knowledge with modern clinical management can provide a comprehensive strategy for improving sexual health, enhancing patient satisfaction, and promoting overall well-being.

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