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Ayurvedic Concepts of Menstrual Health and Rajaswala Paricharya

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Abstract : Menstrual health encompasses physical comfort, psychological well-being, access to appropriate care, and participation in everyday activities. Ayurveda discusses menstruation through concepts including Raja, Artava, and Rajaswala Paricharya, the latter referring to dietary and behavioural guidance during menstruation. This paper critically examines these concepts alongside contemporary menstrual-health research. A focused narrative review integrates a classical textual source, epidemiological studies, clinical evidence syntheses, institutional guidance, and a published Rajaswala Paricharya trial protocol. The findings identify potential areas for investigation, including symptom-responsive rest, dietary adequacy, and supportive care. However, evidence for individual self-care measures cannot establish the effectiveness of the complete traditional regimen. Published research demonstrates a substantial burden of menstrual pain, while direct clinical evidence concerning Rajaswala Paricharya remains insufficient for firm conclusions. A contemporary interpretation should preserve informed choice, nutrition, hygiene, and timely clinical assessment while rejecting unsupported claims linking ordinary menstrual activities to reproductive harm. Rigorous comparative research is needed to evaluate clearly defined, acceptable components.

Keywords

Ayurveda; menstrual health; Rajaswala Paricharya; Artava; dysmenorrhoea; menstrual self-care

Introduction

Menstruation is a physiological process whose significance extends beyond reproductive function. Pain, fatigue, bleeding concerns, inadequate facilities, and social stigma can affect education, employment, relationships, and quality of life. Menstrual care therefore requires attention to symptoms, practical resources, and the social environment.

Contemporary scholarship defines menstrual health broadly rather than restricting it to cleanliness or the

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absence of disease. Hennegan et al. (2021) emphasize physical, mental, and social well-being in relation to the menstrual cycle. This approach provides a useful framework for examining traditional menstrual-care practices without assuming that cultural longevity establishes clinical effectiveness.

Ayurvedic literature discusses menstrual and reproductive processes through its own terminology and

explanatory models. Rajaswala Paricharya describes guidance associated with the menstruating phase. Its contemporary relevance requires distinguishing historical description, interpretive adaptation, and experimentally demonstrated benefit.

This distinction matters because recommendations may be presented as a single coherent package despite differences across texts, translations, households, and modern practitioners. Supportive rest and dietary care may coexist with restrictive beliefs that limit autonomy or participation.

The central question is consequently not whether every traditional instruction should be accepted or rejected. It is which components can be described accurately, which have independent evidence, which require investigation, and which should not guide contemporary care.

This paper examines Rajaswala Paricharya as a historical and research subject while placing menstrual comfort, dignity, and access to effective treatment at the centre of interpretation.

Objectives

The primary objective is to examine Ayurvedic concepts of menstrual health and evaluate Rajaswala Paricharya in relation to contemporary evidence.

Additional objectives are to distinguish textual claims from clinical findings, identify measurable outcomes for future studies, and develop an approach that respects cultural context without compromising nutrition, hygiene, autonomy, or medical assessment.

Materials and Methods

Review Design

A focused narrative review was conducted using targeted searches of scholarly publications, institutional resources, and a digitized classical translation. Twelve sources were selected to address historical description, menstrual-health definitions, symptom burden, self-care, established treatment evidence, and direct research on Rajaswala Paricharya.

The review was selective rather than exhaustive. It did not undertake duplicate screening, a formal risk-of-bias assessment, or a new meta-analysis.

Source Classification

Sources were classified as classical textual material, observational epidemiology, clinical evidence syntheses, institutional guidance, or research protocols.

The classical source was used to establish what a historical text describes. It was not treated as evidence that its recommendations prevent disease. Similarly, a trial protocol was considered evidence of planned research rather than proof of treatment effectiveness.



Interpretation

Published statistics were retained with their source populations and denominators. No participant observations, intervention outcomes, ethics approvals, or significance tests were invented.

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Evidence concerning exercise, heat, supplements, and medicines was examined as contextual evidence. It was not relabelled as direct validation of Rajaswala Paricharya.

Ayurvedic Conceptual Framework

Raja, Artava, and Menstrual Description

Raja and Artava occur within Ayurvedic discussions of menstruation and reproduction. Their meanings depend on context and should not automatically be reduced to a single modern anatomical structure or hormone.

The Sushruta Samhita, Sharira Sthana, Chapter II, discusses menstrual characteristics and conduct during menstruation. The translated passage includes dietary guidance, avoidance of exertion, and restrictions embedded within historical reproductive beliefs. Some associated claims attribute adverse offspring characteristics to ordinary activities.

These descriptions document a historical medical framework. They do not establish that bathing, emotional expression, grooming, or routine movement causes reproductive harm. Historical concepts of normality or "purity" must also be separated from judgments about a menstruating person's cleanliness, worth, or social status.

Rajaswala Paricharya as a Research Construct

For research purposes, the term requires an operational definition. A study must specify the foods, activity advice, sleep recommendations, counselling, and restrictions actually included.

Without this detail, two investigations may use the same name for substantially different interventions. Findings from one cannot reliably be generalized to the other.

A contemporary adaptation should also identify which elements are retained, modified, or excluded. Adaptation may be appropriate, but it should not be presented as an unchanged classical regimen.

Literature Review

Menstrual Symptoms and Functional Burden

Ju, Jones, and Mishra (2014) reported substantial variation in dysmenorrhoea prevalence across population studies. Their review identified associations with stress and family history while finding uncertainty concerning several potentially modifiable factors. These observations caution against attributing menstrual pain to a single dietary or behavioural cause.

Armour et al. (2019a) documented the burden of dysmenorrhoea among young women, including educational absence and impaired classroom performance. The findings demonstrate the importance of effective menstrual support but do not identify a particular traditional regimen as the solution.

Clinical Assessment

The American College of Obstetricians and Gynecologists (2015) emphasized menstrual patterns as a useful indicator of adolescent health. Cycle history and symptoms can help distinguish expected variation from concerns requiring assessment.

Consequently, persistent or disabling symptoms should not be explained solely through an Ayurvedic category or accepted as an inevitable feature of menstruation. Traditional terminology may inform communication, but it cannot replace appropriate clinical evaluation.

Exercise, Rest, and Heat

Armour et al. (2019b) reviewed exercise for primary dysmenorrhoea and found potential pain benefits, although evidence quality was low to very low. This does not require activity during severe discomfort, but it challenges a universal prohibition on movement.

Jo and Lee (2018) identified suggestive evidence supporting heat for menstrual pain. Their review also highlighted limited trial numbers and methodological uncertainty. Heat is relevant to supportive care, but evidence for this individual measure cannot validate a complete menstrual regimen.

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Diet, Supplements, and Treatment

Pattanittum et al. (2016) reviewed dietary supplements for dysmenorrhoea. They found no high-quality evidence supporting any supplement and insufficient safety information. Supplement findings should not be generalized to ordinary balanced meals or specific traditional food combinations.

Marjoribanks et al. (2015) found that nonsteroidal anti-inflammatory drugs were more effective than placebo for primary dysmenorrhoea, while also increasing adverse effects. This evidence provides a clinical comparator and underscores why traditional self-care should not displace effective treatment when needed.

Direct Rajaswala Paricharya Research

Shinde, Panigrahi, and Chapaple (2025) published a randomized trial protocol examining a Havishya diet against routine care. The planned study includes 136 participants and assessments across menstrual cycles.

The publication is a protocol, not a results report. Its proposed sample size and statistical plan cannot be cited as evidence of improvement. It nevertheless demonstrates that defined elements of menstrual dietary practice can be framed as testable interventions.



Hygiene, Participation, and Rights

UNICEF's guidance addresses menstrual information, facilities, products, and supportive environments. WHO similarly frames menstrual health through access to care and participation without shame.

These perspectives distinguish accommodation from exclusion. Access to rest can support an individual's choices; imposed isolation or denial of ordinary facilities can restrict them.

Results

Published Statistical Context

The available quantitative findings describe symptom burden and broader treatment evidence. They are not outcomes from a newly conducted Rajaswala Paricharya study.

Table 1. Verified published findings relevant to menstrual care

Source	Outcome	Published finding	Interpretation
Armour et al., 2019a	Dysmenorrhoea prevalence	71.1%; 95% CI 66.6–75.2; 37 studies, 20,813 participants	High burden in the populations reviewed
Armour et al., 2019a	Educational absence	20.1%; 95% CI 14.9–26.7; 19 studies, 11,226 participants	Functional consequences extend beyond pain
Armour et al., 2019a	Impaired classroom performance or concentration	40.9%; 95% CI 28.3–54.9; 10 studies, 5,126	Different outcome-specific denominator

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		participants	
Pattanittum et al., 2016	Supplement evidence base	27 randomized trials, 3,101 participants	Evidence quality and safety reporting were limited
Marjoribanks et al., 2015	NSAIDs versus placebo for pain relief	Odds ratio 4.37; 95% CI 3.76–5.09; 35 trials	Evidence concerns medicines, not the traditional regimen

Different outcomes drew on different studies. Their denominators must not be combined, and an odds ratio must not be interpreted as a percentage improvement. PubMed

Evidence Categories

The synthesis identified three distinct evidence levels.

Table 2. Evidence status of the principal claims

Claim or question	**Evidence available**	**Defensible conclusion**
Menstrual conduct is described in classical Ayurveda	Historical textual material	The concept has a documented textual basis
Menstrual pain affects education and daily functioning	Epidemiological synthesis	Support and treatment are important
Exercise and heat may reduce primary menstrual pain	Clinical reviews	Individual supportive measures merit consideration
Specific dietary supplements reliably relieve pain	Low-quality or uncertain evidence	Firm efficacy and safety conclusions are unwarranted
The complete Rajaswala Paricharya regimen improves menstrual health	Insufficient evidence established in this review	No reliable overall treatment effect can be assigned
A Havishya dietary approach has been proposed for randomized testing	Published protocol	Planned methods must be distinguished from results

Main Synthesis

Some aspects of menstrual care can be investigated through ordinary clinical outcomes. However, similarities between traditional advice and modern supportive care do not establish shared mechanisms or validate the complete historical framework.

The review did not establish a reliable effect size for Rajaswala Paricharya itself. It also did not establish that following or rejecting traditional restrictions determines fertility or future offspring health.

Discussion

Interpretation Without Automatic Validation

A useful dialogue between Ayurveda and contemporary medicine requires clarity about the question being asked. Historical scholarship establishes what texts describe. Clinical research evaluates whether a defined intervention improves an outcome. Public-health

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analysis examines access, participation, and social consequences.

These approaches can inform one another without becoming interchangeable. A traditional dietary recommendation may inspire research, but its age does not determine its efficacy. Conversely, failure to establish a whole-regimen benefit does not imply that every supportive element is ineffective.

The appropriate unit of investigation is a clearly defined practice in a specified population, assessed against a credible comparison.

Rest and Individual Choice

Rest should be available according to symptoms and preference. A person experiencing pain or fatigue may benefit from reduced demands, but that practical accommodation differs from compulsory inactivity.

Research should distinguish the effects of rest itself from relief from excessive workload or unsupportive surroundings. It should also assess whether restrictions reduce participation without improving symptoms.

Advice should therefore be responsive rather than universal. The outcome of interest is improved comfort and functioning, not compliance with restrictions as an end in itself.



Dietary Adequacy

Dietary research must specify ingredients, quantities, preparation, and whether a prescribed food supplements or replaces the usual diet. The nutritional consequences differ substantially.

A simple food may be acceptable and comforting, but this does not prove that it corrects menstrual pathology. Likewise, a restrictive regimen may reduce dietary diversity or overall intake.

Trials should document total nutrition and participant acceptability rather than assuming that a culturally recognized meal is adequate for everyone. Dietary preference, affordability, allergies, and existing health conditions also matter.

Hygiene and Stigma

Menstrual hygiene should remain distinct from ideas of social or bodily impurity. Ordinary personal care and access to suitable facilities are necessary components of dignity.

Researchers should ask whether a practice is freely chosen and whether refusal has social consequences. Apparent adherence may reflect family pressure rather than preference.

Similarly, the provision of a private resting space should not become exclusion from shared living, learning, or working environments. Cultural sensitivity requires listening to participants while preserving their ability to decide.

Diagnostic Boundaries

A menstrual-care intervention should not group all symptoms under a single label. Primary dysmenorrhoea, heavy bleeding, irregular cycles, and pain associated with underlying conditions represent different clinical questions.

Research must define eligibility and referral procedures. Otherwise, symptom improvement in one subgroup may conceal delayed diagnosis in another.

New or worsening disabling pain, unusually heavy bleeding, or symptoms such as fainting require assessment rather than automatic attribution to lifestyle or failure to follow a regimen.

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A Stronger Comparative Study

A future trial could evaluate a supportive, explicitly adapted version of Rajaswala Paricharya against an attention-matched menstrual-health education programme. Both groups should retain access to usual care, adequate nutrition, hygiene facilities, and rescue treatment.

Several baseline and follow-up cycles would help distinguish intervention effects from normal fluctuation. Randomization should follow clear eligibility assessment, with allocation concealment and prospective registration.

Table 3. Recommended outcomes for future research

Domain	**Measurement approach**	**Interpretive safeguard**
Pain	Daily numerical rating and pain duration	Prespecify the main cycle-level outcome
Function	Missed classes, work, or usual activities	Separate symptom absence from imposed exclusion
Medication use	Recorded rescue doses	Avoid penalizing appropriate treatment
Bleeding	Validated bleeding assessment where relevant	Do not equate reduced bleeding automatically with better health
Nutrition	Repeated dietary records	Check adequacy and unintended restriction
Acceptability	Interviews and adherence records	Assess choice and household pressure
Safety	Adverse symptoms and referral records	Include delayed care and nutritional concerns

Statistical Requirements

Sample size should be calculated from a clinically meaningful primary-outcome difference and realistic variability. Repeated observations within participants require an appropriate longitudinal model.

The principal comparison should be between groups. Separate before-and-after significance tests do not show that one intervention is superior.

Confidence intervals, missing-data handling, and medication use should be reported transparently. Subgroup and mediation analyses require advance planning and adequate power.

An uncontrolled improvement may reflect regression to the mean, expectations, rescue treatment, or ordinary cycle variation. These alternatives are especially important when participants enrol during unusually severe symptoms.

Practical Implications

Rajaswala Paricharya can be discussed as a culturally situated framework for menstrual care while clearly identifying the evidence status of each recommendation.

A contemporary approach should prioritize symptom-responsive support, adequate food, hygiene, informed choice, and appropriate treatment. It should avoid

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presenting ordinary menstrual activities as causes of reproductive damage or treating adherence as a measure of personal virtue.

Limitations

This review was selective and did not appraise every Ayurvedic text or contemporary clinical publication. One translated classical source cannot represent all textual traditions, commentaries, or regional practices.

Much of the quantitative evidence concerns dysmenorrhoea or individual treatments rather than the complete regimen. The included protocol establishes planned research only.

These limitations prevent definitive conclusions about overall effectiveness, optimal duration, or the contribution of individual components.

Ethical Considerations

Research must protect reproductive privacy and ensure voluntary participation. Family or institutional permission cannot substitute for an adult participant's consent.

Studies should preserve access to effective care and avoid unnecessary dietary restriction or compulsory isolation. Adverse-event monitoring should include physical, psychological, and social consequences.

No new human-participant study was conducted for this paper.

Conclusion

Ayurvedic literature provides a historical basis for discussing menstrual care through Rajaswala Paricharya. Contemporary evidence supports addressing menstrual pain, functional impairment, hygiene, and access to treatment, but does not establish the effectiveness of the complete traditional regimen. Future research should test clearly specified, acceptable components while preserving nutrition, autonomy, and timely clinical assessment.

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