

Gendered Aahar-Vihar Practices and Women's Health: A Narrative Review

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Abstract

Aahar (diet) and Vihar (lifestyle or daily activities) are central to the Ayurvedic understanding of health and disease prevention. Yet, dietary and lifestyle practices cannot be understood independent of the social contexts in which women live. This narrative review examines how gender relations, household responsibilities, cultural and religious practices, work, and social location shape women's Aahar-Vihar practices and their implications for health and health-related behaviour. Drawing on literature on Ayurveda, nutrition, sociology, gender studies, and related fields, the review focuses particularly on household dietary inequality, food provisioning, fasting, menstrual dietary practices, and everyday lifestyle. The reviewed literature demonstrates that women's Aahar-Vihar practices are social, rather than individual phenomena. Evidence of intra-household dietary inequalities establishes unequal access to food, whereas qualitative research documents how gender roles, kinship systems, labour, and customary practices shape food provisioning. Studies of fasting further indicate that socially embedded practices simultaneously embody identity and recognition. Menstrual dietary practices similarly demonstrate how culturally salient notions of the female body become part of everyday behavioural patterns. Aahar-related literature remains fragmented, however, with Ayurvedic studies primarily focusing on health-promoting principles of Aahar and Vihar, while sociological and related studies centre on gender relations, cultural meaning, and social inequality. Thus, the review identifies a need to bring these perspectives together. A sociological understanding of Aahar-Vihar can contribute to a more context sensitive approach to women's health by examining how structural conditions and individual choice interact in everyday health practices.

Keywords: Aahar-Vihar, women's health, gender, food practices, medical sociology

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Introduction

Health is often framed as an individual choice. what people eat, how much they exercise, when they sleep, and whether they consult a doctor when they feel unwell. Everyday life, however, rarely lends itself to such free choices. For women in India, the question of what to eat, when to sleep, whether to fast, how to balance work and rest, and when to take care of oneself is embedded in family relations and cultural expectations as well as gendered divisions of labour. A woman may cook meals for an entire household(family) but have limited say over her own nutrition. she may combine paid work and domestic responsibilities in a way that leaves little time for sleep and exercise and in some settings, she may observe religious fasts more frequently and strictly than male members of the same household. Such practices make women's health not simply a biomedical concern but a sociological question, one that requires attention to the social institution of everyday life. Within Ayurveda, Aahar and Vihar occupy a central position in the maintenance of health and prevention of disease. Ayurvedic literature continues to describe Aahar and Vihar as interrelated aspects of a preventive and health-oriented lifestyle. Aahar-Vihar emphasized diet,

routine, physical activity and regulation of everyday behaviour (Singh & Zambare, 2024; Zafar & Thakur, 2024)^{1,2}. Yet, the interpretation of these principles in everyday life is not simply a question of individual discipline. The social conditions within which people eat, work, rest and care for themselves determine what forms of lifestyle are possible. This is particularly significant for women since their everyday practices are often structured around obligations to others. Thus, the question is not only about whether women follow an Ayurvedic lifestyle, but how gendered social relations structure the possibility of following, modifying, negotiating or preceding such practices. The issue becomes particularly salient in relation to food. An ideal model of health would imply that women have adequate access to nutritious food, sufficient autonomy over dietary choices, opportunities for rest and physical activity, and the freedom to make health-related decisions according to their needs. Evidence from India suggests that this ideal is unevenly realised. (Gupta et al. 2020)³ using comparable measures of dietary diversity across women and their households in 3,600 households, examined the "dietary gap" between women and

their respective households. Similarly, (Ellena and Nongkynrih 2018)⁴ comparative work among Khasi and Chakhesang communities in Northeast India demonstrates that food supplying cannot be separated from gender relations, customary laws and the division of labour. Their findings illustrate that women's involvement in food production and supplying does not automatically translate into greater social status. the meaning of women's food-related labour varies according to the wider social organisation of the community. Fasting offers an especially rich example of the way Aahar can become a gendered social practice. In a study of rural Maharashtra, women were found to fast more frequently and more strictly than men within the same households. Many women reported beginning the practice after marriage, whereas reasons included local gender expectations, family tradition and religious beliefs. In fact, research on women's food and religious practices in South Asia has emphasised the ways in which women negotiate identity, family relationships, religious commitment and agency through practices such as fasting (Kumar & Sanyal, 2020)⁵. Menstruation provides another example of the interaction between gender, culture and Aahar. A qualitative study among rural households in Haryana found that dietary restrictions during menstruation were associated with beliefs about pain, cramps and bodily well-being for example, many households reported avoiding curd, buttermilk and pickles during menstruation, while certain hot beverages were believed to provide relief or strength (Goel et al., 2023)⁶. Such practices demonstrate why dietary behaviour cannot always be reduced to nutritional knowledge or individual choice. Food carries symbolic meanings, reproduces cultural norms and can become a medium through which ideas about the female body are communicated and regulated. At the same time, women are not passive recipients of such norms. they interpret, negotiate and sometimes modify them according to particular family and community contexts. A sociological review therefore needs to contain both dimensions. the structural constraints surrounding women's practices and their capacity for decision within those structures. The same tension extends from Aahar to Vihar. Women's everyday routines are shaped by the distribution of paid and unpaid work, caregiving responsibilities, mobility, sleep and opportunities for leisure or physical activity. These dimensions are significant since an Ayurvedic conception of a balanced lifestyle presupposes some degree of regulation of everyday routines, whereas many women's routines are structured around the needs of other household members. The problem then, is not so much that women may lack awareness of healthy lifestyle practices, but that the conditions under which women perform domestic, reproductive and

productive roles may constrain the time, autonomy and resources available for self-care.

More specifically, research on Ayurveda and women has increasingly addressed conditions such as polycystic ovary syndrome and reproductive health, while recent evidence also examines women's use of traditional and complementary medicine. These studies are valuable, but much of this literature remains oriented towards clinical outcomes, specific reproductive conditions or descriptions of individual dietary and lifestyle practices. The social production of Aahar-Vihar among women-how gender relations, household responsibilities, cultural expectations and social location shape these practices-has received considerably less integrated attention. This gap is important since the consequences operate at more than one level. At the individual level, constrained dietary choices, lack of rest, irregular routines or restrictive practices may interact with nutritional and reproductive health. At the household level, the unequal distribution of food, labour and health-related decision-making may reproduce gendered patterns of well-being. At the larger level, treating women's lifestyle as an individual responsibility can make unclear the social conditions that make particular health behaviours easier for some women and more difficult for others. The challenge, then, is not to decide whether Ayurveda is "good" or "bad" for women's health, or to evaluate individual religious practices from outside their cultural context. The more sociologically productive question is how Ayurvedic and culturally embedded understandings of Aahar-Vihar intersect with the social organisation of women's everyday lives.

Aim and objective of the study

The present narrative review responds to this gap by bringing together literature that is often examined in isolation. Ayurvedic understandings of Aahar-Vihar, research on women's dietary and lifestyle practices, learning on gender and household food relations, and studies of cultural practices such as fasting and menstrual dietary restrictions. The review is informed primarily by a social determinants and gender-relations perspective, while drawing on the broader sociological understanding that health practices are produced through the interaction of individual choice and social structure. In this framework, Aahar-Vihar is conceptualised not simply as a set of health prescriptions but as a set of everyday practices situated within family, work, cultural and socioeconomic relation.

Gendered Aahar-Vihar Practices and Women's Health

Aahar and Vihar hold a central place in the Ayurvedic understanding of health and disease prevention. Contemporary Ayurvedic literature presents Aahar and Vihar as interrelated components of healthy living, emphasising appropriate food, daily routine, physical activity, environmental

adaptation, and balance as foundations of wellbeing (Singh & Zambare, 2024; Zafar & Thakur, 2024)^{1,2}. (Singh and Zambare 2024)¹, through a review of Ayurvedic texts and related literature, discuss Aahar and Vihar primarily as preventive and health-promoting practices, while (Zafar and Thakur 2024)² similarly conceptualise them as approaches for the prevention of lifestyle disorders. (Allen and Sachs 2007)⁷ conceptualise women's relationship with food in terms of material, socio-cultural and corporeal domains. The idea highlights the contradiction that women often remain responsible for nourishing others while having limited control over food resources and their own nutritional needs. In the Indian context, (Joseph 2019)⁸ similarly shows that women's responsibility for family food can co-exist with their own vulnerability to food insecurity, particularly when cultural and religious expectations normalise women eating after men or leftovers. (Chandra 2019)⁹ further demonstrates this in the household, highlighting that male dominance, women's service roles and traditional behavioural norms structure food production, serving and consumption in rural North Indian homes.

(Silva and Recine 2023)¹⁰ extend this understanding by showing that women's food-related responsibilities within the home are shaped by race and socioeconomic inequality, unpaid domestic work and double workloads can affect women's capacity to maintain healthy food environments. Thus, women's health-related Aahar practices can be seen as socially embedded practices shaped by gender, household responsibilities and wider inequalities.

Gender, Household Food Relations and Aahar

A substantial body of Indian research show that women's dietary practices are shaped within household relations rather than dictated solely by individual nutritional preferences. (Gupta et al. 2020)³ provide particularly important quantitative evidence through an analysis of 3,600 households across four Indian districts. By constructing a comparable "dietary gap" between women's dietary diversity and that of other household members, the study found that women consumed fewer food groups, particularly nutrient-rich non-staple foods such as fruits and vegetables, meat/fish/poultry, and dairy. The strength of the study lies in its large-scale household-level data and methodological attempt to overcome challenges of comparing different dietary diversity measures. Thus, it contributes empirical evidence to the sociological problem of intra-household inequality in Aahar. Nevertheless, its quantitative design is less suited to explaining why these dietary gaps occur-whether through resource allocation, women's own preferences, household bargaining, norms of sacrifice, or culturally-defined gender roles. Thus, while establishing inequality, the study leaves the social processes that generate it

relatively unexplored. (Chandra 2019)⁹ found that men were privileged within the household food cycle, while women undertook substantial labour in preparing and serving food. This corresponds with (Joseph's 2019)⁸ observation that women are culturally positioned as the primary providers of family food even when their own nutritional needs are secondary.

(Mohan and Gill 2023)¹¹ add an intersectional dimension in examining gendered food practices in rural Rajasthan: gendered food practices are shaped not only by gender but also by caste, poverty, social status and access to resources. Women from marginalised communities face additional constraints in their decision and access to nutritious food. (Regmi's 2025)¹² study of Brahman women in Kathmandu shows that cooking can simultaneously express gender expectations and provide women with identity, pleasure and a degree of decision-making power within the household. (Ellena and Nongkynrih 2018)⁴ address this limitation by conducting a qualitative and comparative examination of food provisioning among Khasi and Chakhesang Indigenous communities in North-East India. Drawing on 200 informants, 20 focus-group discussions, 28 key-informant interviews, ethnographic and ethnobotanical methods, and a feminist political ecology framework, the authors demonstrate that gender relations and divisions of labour shape women's roles in food production and provisioning. Importantly, the comparison between matrilineal Khasi and patrilineal Chakhesang societies shows that "women's food practices" cannot be treated as culturally uniform. Gender roles were more fluid among the Khasi whereas they were more clearly defined and hierarchical among the Chakhesang. The study thus complicates a universal explanation of women's dietary disadvantage by demonstrating that kinship systems, customary laws, resource access and changing economic conditions mediate gendered food practices. This suggests that household Aahar should not be viewed as merely the result of deprivation. Women's food work may involve care, obligation, identity and agency at the same time, making gendered food relations inherently contradictory.

Fasting, Religious Practice and the Gendered Body

Fasting represents a particularly interesting intersection between Aahar, Vihar, gender, culture and embodied health. Evidence from rural Maharashtra illustrates that fasting can itself become gendered. (Barker et al. 2006)¹³, examining gender differences in lifestyle and body mass index in rural India, reported that women fasted more frequently and strictly than men in the studied population. The study linked women's lifestyle to household and agricultural responsibilities, sleep patterns, food practices and socioeconomic circumstances. Its quantitative orientation is valuable since it situates

fasting within a larger pattern of gendered lifestyle rather than as an isolated religious behaviour. However, its primary focus was on BMI and socioeconomic lifestyle determinants, rather than the meanings women attach to fasting. Consequently, it cannot fully explain how women negotiate religious obligation, family expectations and identity through fasting. This interpretive dimension is elaborated more explicitly in (Kumar and Sanyal's 2020)⁵ edited volume *Food, Faith and Gender in South Asia*. Bringing together studies of Hindu and Muslim women across South Asia, the volume examines food, fasting, religious practice, family relations, identity and women's agency. Rather than assuming that fasting necessarily represents female subordination, the collection demonstrates that apparently prescribed food practices can also provide women with forms of social recognition, religious identity, negotiation and agency. This perspective is especially relevant to the present review since it avoids a simplistic binary between "tradition" and "health" or between "constraint" and "choice." At the same time, the volume's ethnographic and interpretive diversity makes direct comparison of health outcomes difficult. Its contribution is therefore primarily conceptual. It encourages analysis of fasting as an embodied and socially meaningful practice in which structure and agency coexist. (Mitra's 2019)¹⁴ analysis of 48 women in Kolkata further strengthens this argument through a Bourdieusian interpretation of dieting and religious fasting. The study demonstrates that women's eating and fasting practices are shaped by structurally-rooted dispositions and social hierarchies, while the meanings attached to these practices vary according to women's social positions and everyday circumstances. This is particularly relevant to a sociological narrative review since it connects the micro-level body with broader structures of class, gender, family and social recognition. However, the relatively small and urban Kolkata-based sample limits generalisability. (Joseph 2019)⁸ notes that regular fasting undertaken by women for family wellbeing can become internalised as a marker of virtue and moral responsibility despite its potential implications for women's physical and psychological wellbeing. (Srishti 2025)¹⁵ based on qualitative interviews in Patna, similarly finds that women's vrat practices are frequently oriented towards husbands, children and family wellbeing, while men's fasting is more often associated with personal devotion, health or spiritual fulfilment. (Srishti 2025)¹⁵ does not present women only as passive recipients of religious norms. Some women find spiritual satisfaction, personal meaning and agency through fasting, while some describe social or familial expectations, including pressure from mothers-in-law. The practice reveals an important contradiction, fasting may simultaneously provide

religious agency and reproduce gender responsibility. This connects with (Suchithra 2023)¹⁶ who argues that food practices are sites where gender identities, cultural expectations and power relations are negotiated.

Taken together, the fasting literature suggests an interesting pattern women's fasting may simultaneously involve social expectation, embodied discipline, religious meaning, family tradition and individual agency. The literature warns against evaluating fasting exclusively as either a harmful restriction or an autonomous personal choice.

Menstruation, Dietary Taboos and Everyday Vihar

Gendered Aahar is also visible in menstrual food practices. (Goel et al. 2023)⁶ examined traditional dietary practices and food-related taboos during menstruation among women from 90 rural households in Haryana. Using a community-based study and an open-ended questionnaire, the researchers found that many households practised dietary restrictions concerning particular foods; for example, 66.7% reported avoiding buttermilk/curd and pickles due to their perceived effect on menstrual pain and cramps. The study is valuable since it demonstrates how cultural beliefs become incorporated into everyday dietary behaviour. However, its cross-sectional design, household-level reporting and geographically specific sample restrict the extent to which the findings can explain variation across social groups. More importantly, it documents practices more effectively than it explains the gender relations through which these practices are reproduced or contested. The literature on Vihar presents a similar issue. Ayurvedic recommendations frequently emphasise routine, physical activity, rest, sleep and behavioural regulation (Singh & Zambare, 2024; Zafar & Thakur, 2024)^{1,2} whereas sociological research demonstrates that women's everyday time is structured by domestic work, agricultural labour, caregiving and culturally-assigned responsibilities (Ellena & Nongkynrih, 2018)⁴.

Patterns, Contradictions and the Knowledge Gap

Three broad patterns can be seen in the literature: first, that women's Aahar-Vihar practices are always related to social relations rather than individual behaviour. Quantitative evidence finds dietary inequality (Gupta et al., 2020)³, while qualitative research gives an explanation of gender roles, institutions and customary systems producing such differences (Ellena & Nongkynrih, 2018)⁴. Second, cultural and religious practices such as fasting and menstrual food restrictions show that women's food practices have meanings going beyond nutrition, and may involve discipline, identity, family expectations, spirituality, social recognition and agency (Kumar & Sanyal, 2020; Mitra, 2019)^{5,14}. Third, the literature reveals the substantial

contextual variation, challenging the idea that "Indian women" are a homogeneous category.

The literature is fragmented across disciplines. Ayurvedic studies address mainly what are appropriate Aahar and Vihar and their potential preventative value, while nutrition studies measure dietary adequacy or inequality, and gender-oriented sociological and anthropological studies look at food, fasting, labour and cultural meaning. They rarely come together in a single framework to explain how gender relations, household structure, cultural practices, work and time, socioeconomic position and social location together shape Aahar-Vihar, and then influence women's health and health behaviour. Much of the empirical literature focuses on Aahar or a specific practice such as fasting or menstruation, rather than Aahar and Vihar as dimensions of everyday life.

The study address the gap by bringing these strands into a common sociological framework and see gendered Aahar-Vihar practices as not isolated individual choices but as social practices produced by the interaction of gender norms, household responsibilities, cultural and religious expectations, work and time, and socioeconomic and demographic location. The study consider how these practices may reshape women's health, self-care, health-related behaviour and capacity to negotiate their own well-being. So the study bridge Ayurvedic perspectives with medical sociology and gender studies.

Its main contribution is therefore not to judge particular practices as inherently healthy or unhealthy, but to explain how social structures and women's agency produce different possibilities for practising Aahar and Vihar and pursuing health in everyday life.

Discussion

The literature reviewed suggests that women's Aahar-Vihar practices cannot be adequately understood when health behaviour is seen as an individual matter. While Ayurvedic literature presents generally Aahar and Vihar as important elements of maintaining health and preventing disease, the practical possibility of following such recommendations is shaped by the social conditions of everyday life (Singh & Zambare, 2024; Zafar & Thakur, 2024)^{1,2}. The central issue is not simply whether women follow healthy dietary or lifestyle practices, but how gender relations, household responsibilities, the cultural expectations and access to resources influence what women are able to eat, how they can organize their daily routines and how much space they have to their own health.

One of the clearest patterns emerging is the household as an important site for producing gendered health practices. (Gupta et al. 2020)³ present quantitative evidence of a dietary gap between women and other household members, in the consumption of several nutrient-rich non-staple

food groups. However, the significance of this finding can be seen, when read alongside the work of (Ellena and Nongkynrih 2018)⁴, who see the dietary inequality as a wider organization of food, labour, resources, and decision-making. Their comparison of Khasi and Chakhesang communities shows that gendered food relations are varied according to kinship systems and customary law. Thus, women's dietary position should not be read as the outcome of a single, uniform cultural rule, but as produced through particular household and community arrangements.

This distinction is important for understanding the relationship between gender and Aahar. Women may be key to food production, procurement, preparation and distribution without necessarily having an equally powerful position in determining what they consume. The literature therefore points towards a distinction between responsibility for food and control over food. A woman may carry great responsibility in maintaining the household's food system while having little autonomy over the allocation of food, time or resources. Such a possibility complicates an individualistic understanding of dietary behaviour, as the ability to maintain a nutritionally adequate diet depends partly on household relations rather than knowledge or preference.

The same structural dimension can be seen in Vihar. Ayurvedic approaches look at daily routine, physical activity, rest, sleep, behavioural regulation as components of healthy living (Singh & Zambare, 2024; Zafar & Thakur, 2024)^{1,2}. Yet the evidence reviewed shows that women's time is often organized around domestic work, agricultural labour, caregiving and household responsibilities. (Barker et al. 2006)¹³, for instance, found substantial gender differences in work, household chores, sleep, eating patterns, and fasting, in rural Maharashtra. However, their study did not establish a direct relationship between the observed behaviours and BMI. Such a limitation prevents a simplistic causal interpretation, but shows that women's everyday routines were differently structured than men, in the same social setting. Vihar therefore can be seen sociologically as involving not just behaviour, but access to time, rest, mobility, and opportunities to take care of oneself.

Fasting is a useful example of the tension between social structure and individual agency. (Barker et al. 2006)¹³ found women (in the studied rural Maharashtra population) fasted more frequently and strictly than men. However, this finding is not evidence that fasting is inherently harmful or imposed. (Kumar and Sanyal 2020)⁵ show that women's food and fasting practices may also be connected with religious identity, family relationships, recognition, and the forms of agency. (Mitra's 2019)¹⁴ analysis similarly shows that dieting and religious fasting can take on different meanings

according to women's social position and everyday circumstances. Read together, these works suggest that the same practice can serve as social expectation and as meaningful participation, identity or negotiation.

This intersection of constraint and agency is relevant to a sociological understanding of women's health. According to (Srishti 2025)¹⁵ Women's choices are not made outside social structures, but women are not passive recipients of these structures. A woman may follow a fasting practice because of family expectations, religious commitment, personal belief, social recognition or a combination of these factors. The analytical task is therefore not to decide whether the practice represents "choice" or "constraint" in absolute terms, but to look at the circumstances under which choice is exercised. This perspective prevents the reduction of culturally embedded practices to simple categories of healthy and unhealthy behaviour.

Menstrual dietary practices illustrate another dimension of the same process. (Goel et al. 2023)⁶ documented food restrictions and preferences among households in rural Haryana, including avoidance of certain foods due to beliefs concerning menstrual pain and cramps. Such evidence demonstrates how cultural understanding of the body is incorporated into routine dietary behaviour. At the same time, the study's household-level and geographically specific design prevents generalization on all women, or the meanings women may attach to these restrictions. The evidence is therefore more useful for finding the presence of culturally patterned practices, rather than establishing a uniform relationship between menstrual taboos and health outcomes.

Across examples, Aahar and Vihar appear more interrelated than separate categories. Food practices are linked to work schedules, religious observance, household responsibilities, bodily experiences and access to rest. Vihar, lifestyle practices cannot be separated completely from food, because meal timing, fasting, household food preparation and daily labour are embedded within the same social organization of time. This interconnectedness is significant, as approaches looking just at dietary intake may miss the conditions under which food is consumed, and approaches just looking at lifestyle may miss household food relations.

The literature demonstrates considerable social and cultural variation. The contrast between Khasi and Chakhesang communities, the rural Maharashtra evidence on fasting and lifestyle, the Haryana study of menstrual dietary practices, the urban Kolkata-based analysis of fasting and dieting all come from different social settings. Their differences caution against treating "Indian women" as a homogeneous analytical category. Gender intersects with household structure, kinship, socioeconomic position, cultural context, generation, and place.

Consequently, a sociological account of Aahar–Vihar needs to be attentive to the social location of women, rather than assuming that the same practice has the same meaning or consequences across contexts.

A further issue is the disciplinary separation in the existing literature. Ayurvedic study gives a conceptual account of Aahar and Vihar as components of preventive health, but gives little attention to the social organization of these practices. Nutrition-oriented research is strong in measuring dietary inequalities, while sociological and anthropological work gives greater insight into gender relations, cultural meaning, embodiment, and agency. These perspectives address different parts of the same problem but are rarely brought together. The gap is not simply an absence of research on women's diet or lifestyle rather, it is the limited integration of Ayurvedic health concepts with sociological explanations of how everyday health practices are produced.

Together, the literature reviewed supports a shift from asking whether women follow appropriate Aahar-Vihar practices towards asking under what social conditions particular practices become possible, expected, negotiated or difficult to sustain. Such an approach places women's health in the broader organization of household relations, labour, culture and everyday life. It also allows for understanding agency without overlooking structural constraints. For a sociological examination of Aahar–Vihar, this provides a more productive perspective than treating health behaviour as a matter of individual compliance.

Conclusion

This narrative review brings together Ayurvedic, nutritional, sociological and gender-oriented literature to examine Aahar–Vihar as situated dimensions of women's everyday health practices. The reviewed studies indicate that women's dietary and lifestyle practices are shaped not only by health knowledge or individual preference, but also by household food relations, gendered divisions of labour, cultural and religious practices, and the unequal distribution of time and resources.

The evidence also shows that these practices cannot be understood by a simple distinction of tradition and modernity, or of restriction and individual choice. The dietary inequalities within households point to differences in access and allocation studies of fasting show that culturally prescribed practices may involve social expectations and personal meanings. Similarly, menstrual dietary practices show how culturally shared understanding of the female body can become part of everyday health behaviour. The significance of these practices therefore depends on the social context in which they are performed.

A major gap in the existing literature is the lack of dialogue between Ayurvedic understandings of

Aahar-Vihar and sociological explanations of gender, household relations, labour, culture and agency. Ayurvedic literature establishes the importance of diet and lifestyle for health, while sociological and related research demonstrates that the ability to practise particular forms of diet and lifestyle is socially differentiated. Bringing these perspectives together allows women's health behaviour to be understood not simply in terms of individual adherence, but in relation to the conditions that shape everyday possibilities for self-care.

The review argues for a context-sensitive understanding of gendered Aahar-Vihar practices. Future research should pay greater attention to differences in household structure, socioeconomic position, generation, education, rural-urban location, cultural setting and women's control over time and resources. Such research can contribute to a more socially grounded understanding of women's health and can strengthen the dialogue between Ayurveda, medical sociology and gender studies.

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