



Natural by Constitution: Essentialist Cognition and the Gendering of Women's Health in Ayurvedic Marketing

Meher Gupta

Step By Step School, Noida, India

Corresponding author: mehergupta2810@gmail.com

DOI: 10.47814/ijssrr.v9i9.3617

Abstract

Medicine emerged as a modern institution in the 20th century which treats male and female bodies at par with each other. Critical scholarship has pointed out how modern allopathic western medicine excludes women both in the conceptualisation and implementation of medicinal knowledge. While exclusion of women has been a debated concern in the context of western medicine, Ayurveda on the other hand constitutes a culturally specific ideal of women in the Indian context. This paper argues that Ayurveda does not neglect women; it produces a normative figure of the ideal Indian woman, defined through reproduction in its classical formulations and through beauty, purity and “naturalness” in its commercial ones. Existing scholarly accounts document this content but leave a question unanswered: why are such representations persuasive and resistant to revision? The paper brings cognitive science to bear on the sociological material, proposing that Ayurvedic discourse recruits three general features of human cognition — psychological essentialism about natural kinds, an ideational preference for the natural, and schema-consistent processing of gendered information — so that culturally contingent norms arrive as facts about bodies. The concept of prakriti, an innate and unalterable constitution, is examined as an essential placeholder of unusual cultural potency. Survey data from 94 urban Indian women support three predictions. Belief that natural remedies are safer is statistically independent of willingness to rely on Ayurveda in serious illness ($r = .09$), indicating a judgement about provenance rather than efficacy. Self-rated knowledge correlates with endorsement of Ayurveda's claims suggesting confidence indexes affiliation rather than calibrated understanding. Respondents report using Ayurveda overwhelmingly for prevention and functional complaints rather than appearance, which sits at odds with the beauty-centred address documented in the marketing literature.

Keywords: *Ayurveda; Gender; Psychological Essentialism; Naturalness Bias; Medical Pluralism; Marketing Strategies*

Introduction:

The question of whether medicine is neutral has been answered decisively in the negative by decades of feminist scholarship. The body biomedicine takes as default is a male body (Martin, 1987); the female body appears as a deviation, legible chiefly through reproductive difference. This critique has been applied far less systematically to India's traditional systems, which are frequently positioned by practitioners, marketers and popular discourse as holistic, culturally rooted alternatives to a mechanistic biomedicine. While this is true for mainstream medicine, Ayurvedic brands use the gender scripts as a strategic site for marketing. Ayurveda is a rapidly expanding commercial sector, valued at roughly USD 9.1 billion and projected to reach USD 25.2 billion by 2035. It reaches consumers not primarily through the clinic but through the advertisement, the packaging and the influencer video. Whatever ideas about women's bodies Ayurveda carries, it now carries them at considerable scale.

In light of this context, this paper asks two questions. How are Indian women represented within the cultural field of Ayurvedic medicine? A purely sociological account can establish that Ayurvedic discourse aligns women with nature, beauty and reproduction, and can trace the conditions under which that alignment was produced. It cannot easily explain why such claims feel self-evident, why they survive contact with disconfirming information,

or why the rhetoric of “naturalness” is so much more effective than the equivalent claim stated in other terms. The argument which this paper develops is that Ayurveda’s gender politics operate through *presence* rather than absence, and are stabilised by ordinary gendered cognition rather than ideology alone. Women are abundantly present in Ayurvedic discourse, but within a narrow range of roles; they get featured as reproductive bodies, beauty-seeking consumers, guardians of familial health, embodiments of a “natural” order standing in for tradition.

Medicine Cultures in India

Medical pluralism is when multiple different types or categories of healthcare practices coexist alongside each other. Instead of competing or trying to eliminate one another, they serve different purposes and needs. One specific medicinal practice doesn't dominate the market or culture, and people are able to choose among different healthcare systems depending on accessibility, affordability, cultural beliefs, and personal preference. India is a good example of this because here various medical practices thrive alongside modern-day allopathy (the most common in the western world). Indian systems of medicine can include medicinal practices that either originated in India or came as foreign knowledge yet were integrated into Indian culture eventually. Broadly speaking, India has 7 systems of medicine: Ayurveda, Siddha, Unani, Sowa-Rigpa, Yoga, Naturopathy and Homoeopathy. Even though Homoeopathy (introduced in the 18th century) and Unani did not originate in India, they assimilated into the culture and got changed and refined, similar to the other traditional systems, hence it is considered a part of the recognised systems. India also has many local and folk healing traditions, and although these are not formally recognised under the Indian systems of medicine, they continue to survive and serve communities.

Ayurveda in literal terms means the science of life. It is distinct from other medical systems because it has its own theoretical and philosophical framework upon which it is built, one that has remained constant throughout the decades. Instead of evolving the system through trial and error, it stays rooted in the principles it was initially built upon, focusing on diagnosis and treatment. It was one of the first systems to view health in a holistic manner. Rather than isolating disease, it considered health, illness, and overall well-being as part of an integrated system. Ayurveda first established its ideas, solidifying the theory before creating remedies derived from and based on that knowledge. Furthermore, Ayurveda was not fully built upon religious beliefs; its foundations also relied on certain classical Indian schools of thought, particularly, Samkhya and Nyaya-Vaisheshika. These aided Ayurveda to be developed as a rational system, relying on observation, sensory evidence and human reasoning as well.

Siddha system of medicine is mainly practised in parts of South India, specially Tamil Nadu. It originated and developed alongside the Tamil civilisation, influencing and being influenced over the course of time by other streams of medicine as well. Despite its close affinity to Ayurveda, it has a distinct identity formed through its reliance on drugs of metal or mineral origin. This is unlike Ayurvedic medicine, which depends mainly on plant-based medicines. Unani medicine originated in ancient Greece. It is believed to have been established and developed by some of the most influential scholars in philosophy, physics, anatomy, and physiology of their times. These included but were not limited to Hippocrates, Aristotle, and Dioscorides. It was later further developed by scholars in Egypt, Persia, and the Arab world. Unani was introduced to India around 1350 AD by the Arabs. After arriving in India, it was firmly established, and hospitals, colleges, and important physicians helped extend it further. After independence, the Indian government also officially supported Unani through research institutions and healthcare organisations, aiding in the preservation and expansion of the practice.

Despite the long history of these traditional medicine systems in India, all of them continue to play a vital role in the makeup of the country's healthcare system. According to the First All India Survey on AYUSH (2022-23), awareness of AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homoeopathy) systems is extremely high, with around 95% of people in rural areas and 96% in urban areas reporting that they are familiar with them. Furthermore, Among all the recognised systems, Ayurveda was the most commonly practised, accounting for approximately 40.5% of AYUSH users in rural areas and 45.5% in urban areas. These findings highlight the fact that traditional systems of medicine still remain widely accepted and continue to coexist alongside modern allopathic healthcare.

History and Development of Ayurvedic Medicine

Ayurveda does not have a single founder; instead, its knowledge base developed over centuries through systematic observations of nature, human health, and medicinal plants. It is generally believed to have originated in the 2nd century BC, making it one of the oldest medical systems globally. Ayurveda was primarily influenced

by three schools of thought: Vaisheshika, Nyaya, and Samkhya. The foundational concepts of Ayurveda were mainly derived from these ancient Indian philosophies, which emphasized on observation, logical reasoning, and understanding the patient prior to treatment. Traditional beliefs however, suggest an alternative origin for Ayurveda. According to Ayurvedic traditions, the knowledge was given by Lord Brahma and subsequently transmitted to the sages, who then imparted it to their disciples. This knowledge was distributed to society orally and, later, documented in writing. In this context, Ayurveda is viewed not only as a medical system but also as sacred knowledge of divine origin. Many of the earliest medicinal practices and descriptions of healing plants were later recorded in the Rig Veda and Atharva Veda.

Ayurvedic practices were initially transmitted orally. Over time, scholars began compiling this knowledge into written texts, amalgamating the fragmented knowledge into a structured medical system. The knowledge preserved by the vedas was compiled by Agnivesha and later revised and expanded by Charaka into the Charaka Samhita, one of the most influential texts of Ayurveda. Along with this, the Sushruta Samhita also became another foundational text, one specifically for Ayurvedic surgery and serves as an important referential text for healers. Both the texts standardized medical knowledge. As these texts were copied and translated, Ayurvedic knowledge disseminated to regions such as Tibet, China, Persia, and the Arab world, achieving international recognition. Following the compilation of these major texts, Ayurveda entered what is often regarded as its golden period. It became the dominant healthcare system across most of the Indian subcontinent and received widespread support from both the public and rulers. During this period, many of its core principles, formulations, and methods of treatment were further developed and refined.

Before colonial rule, Ayurveda was one of India's most dominant medical systems. However, after the British colonised India, the colonial administration promoted a healthcare system based on Western scientific medicine. This led to a gradual shift in funding, medical education, institutional support, accessibility, and prestige towards allopathic medicine. As a result, Ayurveda gradually lost its position within the formal healthcare system. Despite these circumstances, Ayurvedic practices continued to survive within local Indian communities as a deeply rooted cultural tradition. Families continued to use Ayurvedic remedies at home, and knowledge was passed down through generations. Therefore, despite losing official and institutional support during the colonial period, Ayurvedic traditions did not disappear and continued to be practised throughout India. Interest in Ayurveda began to revive during India's national freedom movement, when efforts were made to restore it as an important part of the country's healthcare system and cultural heritage. Following India's independence in 1947, Ayurveda received official recognition from the government and was gradually reintegrated into the national healthcare system. To support this revival, the Government of India established Ayurvedic hospitals, colleges, universities, research institutes, and regulatory councils to promote education, research, and standardisation. These initiatives strengthened the institutional foundation of Ayurveda and helped preserve the system for future generations.

As modern medicine advanced, its side effects also started gaining attention amongst its users. Bacterial resistance increased and chronic diseases became more common. Despite the obvious advantages of modern medicine for many conditions, its limitations in promoting long-term wellness and disease prevention encouraged people to explore alternative approaches to healthcare. As people began exploring these possibilities, scientists carried out more rigorous research on Ayurveda, leading to greater scientific recognition of the system. Ayurveda also gained increasing global interest, while governments began promoting the development, regulation, and awareness of traditional systems of medicine. Together, these factors contributed to the rapid expansion of the Ayurvedic industry and its widespread revival in modern times.

Market Size of Ayurvedic Medicines in India

The Ayurvedic industry is an advanced commercial ecosystem that includes much more than simply selling traditional medicines. Currently, the industry consists of healthcare products, wellness items, personal care products, dietary supplements, and preventive healthcare products, demonstrating the gradual process of commoditisation of the medical knowledge. Unlike focusing solely on promoting individual products, many Ayurvedic companies have developed their brands based on principles such as holistic health, balance in life, and general wellbeing. Owing to the rising consumer interest in preventative healthcare and natural products, the Ayurvedic industry can be classified as one of India's fastest-growing sectors of healthcare and wellness.

Rapid development in terms of revenue generation is reflective of the growing economic importance of Ayurveda in India's healthcare and wellness industry. Recent estimations suggest that the industry is valued at

roughly USD 9.1 billion. With an expected growth forecast up to USD 25.2 billion by 2035 at a CAGR of 12%, the consistent growth demonstrates that there is an ever-increasing need for Ayurvedic products. Therefore, it becomes evident that Ayurveda is transitioning from being an exclusively traditional healthcare industry into becoming a highly commercially oriented industry. Since this sector will continue expanding further, the communication strategy used in marketing by Ayurvedic brands could possibly affect more consumers.

To address changing consumer demands, many Ayurvedic firms have developed diverse ranges of products going far beyond traditional medicines. The current range of products includes tablets, syrups, tonics, herbal supplements, oils, lotions, creams, cosmetic products, dental care products, and specialised healthcare formulations. They can be sold as healthcare products, haircare products, skincare products, oral care products, wellness products, and women's health products. Hence, there is greater scope for catering to a wider customer demographic base.

Big brands such as Patanjali, Dabur, Himalaya, and Baidyanath hold significant market shares due to their longstanding reputation. Because of having established reputations among consumers, extensive product portfolios, vast distribution channels, financial resources to engage in advertisement activities, conducting research, and setting retail outlets nation-wide. Thus, larger companies remain relatively more accessible to customers in comparison with new entrants into this industry.

Theoretical Framework: Cultural Schemas and the Cognitive Grip of Prakriti

Cognitive anthropology has long occupied the space between sociology and cognitive science, on the premise that culture is carried in shared mental models organising perception and inference. Strauss and Quinn's account states that cultural schemas are learned, internalised networks of association that render some interpretations effortless and others effortful. A schema is powerful not because it is argued for but because it does not need to be. This paper asks what schemas Ayurvedic discourse activates, and why they are so readily activated.

Psychological essentialism. Essentialism is the disposition to treat categories as having an underlying, non-obvious, causally powerful essence that makes members what they are. Gelman's work established that this disposition emerges early, requires no instruction, and applies most readily to biological kinds and to social categories construed as biological. Essentialised categories are experienced as natural rather than conventional, sharply bounded and immutable; prescriptive norms attached to them acquire the appearance of descriptions.

Ayurveda supplies an unusually well-formed vehicle for this disposition. *Prakriti* designates an individual's innate constitution, fixed at conception through the proportion of *vata*, *pitta* and *kapha*, understood to persist unchanged while determining physiology, susceptibility, temperament and appropriate regimen. Formally, it is what Medin and Ortony termed an essence placeholder: an assumed inner nature explaining surface properties without itself being observable. It is causally deep, individually invariant and diagnostically generative, an ideal object for essentialist reasoning.

The claim is not that this framework was designed to naturalise gender, but that its structure makes it an efficient carrier for gender claims once they are attached to it. When a message locates a woman's health needs in her constitution focusing on what she innately *is*, it converts a contingent norm into a fact about kinds. Research on essentialist beliefs about social categories indicates that such conversions predict stronger stereotype endorsement and reduced perceived malleability of group differences.

The naturalness preference. A preference for natural over synthetic products is well documented, and the important finding is that it is largely *ideational* rather than instrumental: it persists even when consumers are told the natural and synthetic versions are chemically identical and equally effective, and is more pronounced for medicines than foods. It is not a mistaken belief about efficacy that better information would correct, but an evaluative stance concerning provenance. This has two implications. First, it explains why "natural" functions in Ayurvedic communication as a claim requiring no support: it does work that evidence would not strengthen. Second, the persistent alignment of the female body with nature is not a neutral aesthetic choice. It attaches to women an evaluative frame operating below deliberate assessment, and exempts the associated prescriptions from scrutiny.

Gender schemas. Gender schema theory holds that individuals develop organised knowledge structures about gender guiding attention, encoding and retrieval. Schema-consistent information is attended to more readily and recalled more reliably than inconsistent information, which is more likely to be discounted or forgotten. Advertising exploits this asymmetry structurally, since it operates under severe constraints of attention and is rewarded for trafficking in what is already expected. Together these describe a self-reinforcing system. Gender

schemas make the representations easy to process; the naturalness preference makes them agreeable; essentialism makes them feel true.

Propositions

- **P1 (ideational naturalness).** If the naturalness preference is ideational rather than instrumental, endorsement of “natural is safer” should be independent of willingness to rely on Ayurveda when stakes are high, the first being a judgement about provenance, the second about outcome.
- **P2 (confidence as affiliation).** If self-rated knowledge indexes cultural attachment rather than calibrated understanding, it should correlate with endorsement of Ayurveda’s claims but not with recognition of its limits.
- **P3 (transmission without authority).** Women should be recognised as principal carriers of Ayurvedic knowledge within families while that knowledge is accorded lower epistemic standing than professional advice.
- **P4 (low salience).** If essentialised, schema-congruent content is received as description rather than proposition, items asking respondents to evaluate Ayurveda’s treatment of women should show markedly higher non-committal response than items on efficacy or heritage.

The framework also predicts an asymmetry in commercial address that female-targeted advertising will favour naturalness and constitution framing while male-targeted advertising favours strength and performance. Testing this requires a systematic advertising corpus, which this study does not have; the prediction is noted for completeness and returned to in the limitations.

Data Collection and Methodology

Primary data for this paper was collected using an online questionnaire administered through Google Forms using convenience and snowball sampling. A total of 103 responses were received of which 94 were from women. Male respondents ($n = 9$) were excluded from the study as the focus is women’s own accounts rather than gender comparison. The sample is demographically narrow in ways that qualify every finding. Respondents were overwhelmingly urban (97 per cent metro or large city), highly educated (97 per cent graduate or postgraduate), predominantly married (89 per cent) and concentrated in middle age, with 71 per cent aged 45–59 and only four under 30. Eighty-three of 94 respondents identified as Hindus. As a result, this is not a sample supporting population-level inference. It is, however, a reasonable approximation of the segment Ayurvedic wellness marketing most actively addresses which includes urban, educated, middle-aged women with household health decision-making authority. The findings should be read as characterising that segment.

The instrument comprised demographic items, behavioural items on frequency and mode of use, and fifteen five-point Likert items covering efficacy beliefs, cultural and religious affiliation, intergenerational transmission, and perceptions of Ayurveda’s treatment of women. Three open-ended items invited accounts of family remedies, personal definitions of Ayurveda, and experiences relating to women’s health. Participation was voluntary and anonymous, with consent obtained at entry. The instrument contains a self-rated knowledge item but no measure of demonstrated knowledge. As a result, what the data permits is a weaker but informative test: whether self-rated knowledge behaves like calibrated understanding or like affiliation.

Advertising pilot. Five advertisements were retrieved from the Meta Ad Library, filtered to India, using the keyword “Ayurvedic Medicine”. This corpus is used illustratively only. Five cases cannot support comparison across target gender, and the single keyword is in any case a poor frame, since it selects toward therapeutic products and away from the cosmetic and wellness segments where the patterning described is expected to concentrate.

Findings

Self-rated knowledge and the structure of confidence

Table. 1: Self-rated knowledge of Ayurveda ($N = 94$, five-point scale)

Rating	1	2	3	4	5
n	15	27	32	15	4
%	16.0	28.7	34.0	16.0	4.3

Thirty-two women, the modal group, rated their knowledge at 3 of 5, and the distribution is modest overall ($M = 2.63$, $SD = 1.10$), with 44.7 per cent at 1 or 2. These women do not present themselves as experts of Ayurvedic

medicine. Self-rated knowledge is strongly predicted by frequency of use ($r = .51$, $p < .001$), indicating that respondents index their ratings to habitual exposure rather than instruction: 67 per cent identified family and elders as a main source of learning, against 22.3 per cent citing a qualified Ayurvedic doctor.

An insightful revealing pattern is the ways in which beliefs of self-rated knowledge relate with other factors. It correlates positively and significantly with every endorsement item viz. Ayurveda maintains long-term health ($r = .27$, $p = .009$), is safer because natural ($r = .28$, $p = .006$), treats root causes ($r = .29$, $p = .005$), and addresses women's health well ($r = .28$, $p = .007$). It correlates with neither qualifying item: trusting modern medicine for serious illness ($r = .01$, $p = .91$) and judging Ayurvedic treatment too slow ($r = .01$, $p = .90$).

This asymmetry is insightful: if self-rating indexed calibrated understanding, higher ratings should track more differentiated judgement, greater endorsement where claims are well supported *and* sharper recognition of limits. Instead it tracks endorsement alone and is uninformative about limiting cases which shows that P2 is supported in its revised form. A confidence that grows with attachment while remaining flat with respect to counter-indications is the epistemic profile on which schema-consistent messaging operates most freely.

Patterns of use

Engagement is domestic, routine and additive rather than substitutive. Kitchen remedies dominate (90.4 per cent), followed by over-the-counter products (44.7 per cent), Panchakarma or wellness treatments (23.4 per cent) and consultation with a qualified practitioner (13.8 per cent). Sixty-eight per cent use Ayurveda alongside allopathic medicine; only 9 women treat it as first choice and 8 as last resort. It is not a rival system but a supplementary layer of everyday health management.

The purposes reported are the most consequential result:

Table 2: Self-rated knowledge of Ayurveda (N = 94, five-point scale)

Purpose	n	% of women
Prevention / immunity / wellbeing	66	70.2
Cold, cough, seasonal ailments	55	58.5
Digestion	50	53.2
Skin and hair	28	29.8
Stress, sleep, mental wellbeing	17	18.1
Women's health (menstrual, pregnancy, post-natal, menopause)	16	17.0
Chronic / long-term conditions	4	4.3

Women here use Ayurveda overwhelmingly for prevention, immunity and common functional complaints. Appearance-related use ranks fourth, reported by fewer than a third and significantly below preventive use. Because respondents could select multiple purposes, the two proportions are paired and compared with an exact McNemar test: 43 women reported preventive but not appearance-related use, against 5 reporting the reverse ($p < .001$). Reproductive and menstrual health the domain around which the classical corpus organises the female body accounts for 17 per cent.

This diverges from the patterns catalogued in above. The commercial construction of the female Ayurvedic consumer as principally a seeker of beauty does not correspond to what these women report seeking. The gap discriminates between two explanations of gendered marketing: if advertising simply reflected demand, the beauty skew in creative should mirror a beauty skew in use. The current sample shows that it does not.

7.3 Belief structure

Table 3: Self-rated knowledge of Ayurveda (N = 94, five-point scale)

Item	n	M	SD	% agree	% neutral	% disagree
Important part of Indian cultural heritage	94	4.17	1.02	78.7	16.0	5.3
Home-remedy knowledge passed down mainly by women	94	3.82	1.10	67.0	22.3	10.6
For serious illness would trust modern medicine more	91	3.75	1.19	60.4	23.1	16.5
Effective for maintaining long-term health	91	3.73	0.94	52.7	41.8	5.5
Safer than modern medicines because natural	93	3.61	1.11	52.7	33.3	14.0
Treats root cause rather than symptoms	92	3.61	1.09	55.4	30.4	14.1
Addresses women's health needs well	93	3.48	0.95	49.5	35.5	15.1
Advice about women's bodies feels respectful	92	3.46	1.13	46.7	37.0	16.3
Treatments are too slow to show results	93	3.44	1.06	53.8	24.7	21.5
Gives women a valued role as keepers of knowledge	91	3.44	1.05	44.0	45.1	11.0

Item	n	M	SD	% agree	% neutral	% disagree
Trust family knowledge as much as a doctor's advice	93	3.35	1.25	46.2	30.1	23.7
Connects me to family or community traditions	94	3.29	1.18	47.9	30.9	21.3
Some beliefs about women feel outdated or restrictive	92	3.07	1.10	34.8	39.1	26.1
Have followed rules for menstruation/pregnancy/post-partum	93	2.99	1.19	33.3	33.3	33.3
Connected to my religious or spiritual beliefs	91	2.85	1.35	30.8	33.0	36.3

Heritage without religion. The strongest endorsement in the instrument is Ayurveda as cultural heritage ($M = 4.17$), the weakest as religiously connected ($M = 2.85$, with more disagreeing than agreeing). Ayurveda is held as national-cultural inheritance rather than devotional practice consistent with the historical account, and indicating that “tradition” appeals address a cultural rather than religious identification.

The naturalness belief is ideational. Fifty-three per cent agreed Ayurvedic remedies are safer because they are natural; 60 per cent agreed that for serious illnesses they would trust modern medicine more. These are not opposing camps: the items are statistically independent ($r = .09$, $p = .40$), and 32 women agreed with both. Holding both is incoherent if the naturalness belief concerns efficacy, since a remedy genuinely believed safer and more fundamental should not be set aside precisely when stakes are highest. It is entirely coherent if naturalness functions, as Rozin and colleagues found, as an evaluative stance about provenance. P1 is supported, and the survey provides direct evidence for the mechanism independently of any advertising data.

Transmission is female; authority is not. Sixty-seven per cent agreed home-remedy knowledge was passed down mainly by women, and 67 per cent named family and elders as their main source. Yet only 44 per cent agreed Ayurveda gives women a *valued role* as keepers of that knowledge — the item with the highest neutrality in the instrument (45.1 per cent) — and only 46 per cent trust family knowledge as much as a doctor's advice. P3 is supported. These women recognise their custodial role while ranking it below professional authority: cultural centrality and epistemic standing come apart.

7.4 Ambivalence and low salience

The five items concerning women are distinguished less by their means than by their neutrality, running from 33.3 to 45.1 per cent the highest in the instrument. Agreement that Ayurvedic advice about women's bodies is respectful (46.7 per cent) and agreement that some beliefs about women are outdated (34.8 per cent) are statistically independent ($r = .05$, $p = .66$), with sixteen women endorsing both.

Two readings are available and the data do not decisively separate them. The first is genuine ambivalence: respondents distinguish an Ayurvedic tradition they value from specific prescriptions menstrual seclusion, dietary restriction, post-partum confinement. They experience as constraining, seeing no contradiction because the two attach to different objects. The second is low salience: the gender dimension has not been thematised, and midpoint responses register the absence of a formed opinion rather than a balanced one.

The second is somewhat better supported, since neutrality is elevated on precisely these items and not on efficacy or heritage items, where respondents answered decisively. P4 is supported with that qualification. If so, the finding is substantive rather than a nuisance. A representational regime is most secure when not perceived as a regime at all, and the framework predicts exactly this: essentialised, schema-congruent content does not present itself as a proposition inviting assent or dissent.

7.5 The advertising pilot

The five logged advertisements were for a blood-sugar juice (Kapiva), an ophthalmic preparation (Sreedhareeyam), a slimming oil (Rare Slimming Oil), acidity tablets (VedistryIndia) and a dandruff shampoo (Indulekha). One compact instance of the mechanisms described above is the slimming oil copy pairs antiquity with contemporary efficacy and stacks purity, naturalness and effectiveness as coordinate virtues, for a product whose function is body modification. Tradition supplies authority, naturalness supplies safety, and an aesthetic outcome is presented as wellness. Against expectation, however, three of the five are gender-neutral therapeutic products addressing specific pathologies, and nothing in this corpus corroborates a pervasive beauty skew. Whether that reflects the keyword or the segment cannot be determined here. The pilot supplies one illustrative case and no evidence bearing on the representational prediction in either direction.

8. Conclusion

From the discussion above, we can draw three conclusions. First, the critique feminist scholarship has directed at Western biomedicine cannot simply be transposed onto Ayurveda, because the mechanism of gendering is different. Biomedicine has been faulted for treating the male body as default and rendering women invisible. Ayurveda's construction is not one of invisibility but of confinement: women are extensively present within the

tradition and its marketplace, but within roles organised around reproduction, appearance, caregiving and cultural authenticity. Visibility is not equity, and a system may attend closely to women's bodies while granting women little authority over the knowledge describing them. The survey shows this from the inside: two-thirds of respondents identify women as the carriers of family health knowledge, while fewer than half accord that knowledge the standing of professional advice.

Second, commercialisation has not dissolved older gender scripts but has proved an efficient vehicle for them. The classical association of the female body with generativity and nature has been retained and repurposed to underwrite cosmetic consumption. Because these appeals are voiced in the register of an ancient indigenous science, they are harder to contest.

Third, their persistence is not explained by economic interest alone. Ayurvedic communication is effective because it recruits general-purpose cognitive dispositions: essentialist reasoning converts contingent norms into constitutional facts, the ideational preference for the natural insulates those claims from evidential challenge, and schema-consistent processing ensures they are encoded easily and revised reluctantly. The survey evidence for the second of these is direct — the independence of the naturalness belief from willingness to rely on Ayurveda in serious illness ($r = .09$) is difficult to reconcile with naturalness as a claim about efficacy. *Prakriti* is significant here not as a doctrinal curiosity but as a culturally elaborated essence placeholder: an unusually well-formed vehicle for claims about what women innately are. This is where sociological and cognitive analysis become interdependent rather than adjacent. Cognition specifies the mechanism, but only a sociological view can explain what these contain.

The implications are practical as well as analytical: we need closer regulatory attention to health claims in wellness advertising. We also need greater representation of women among the authoritative voices of Ayurvedic institutions, and a broadening of the “women's health” category beyond its reproductive and cosmetic boundaries. The representational prediction model laid out above will require a stratified advertising corpus of 150–200 items sampled across therapeutic, cosmetic and wellness category terms and by major brand. A demonstrated-knowledge instrument would permit a direct test of explanatory-depth effects in a traditional medical system. Comparative work across AYUSH systems would establish whether the essentialist affordances identified here are specific to *prakriti* or general to constitutional medicine.

References:

- Bode, M. (2008). Taking Indian medicine seriously: Ayurveda among other Asian medicines. *Anthropology Today*, 24(5), 6–10.
- Conrad, P., & Leiter, V. (2004). Medicalization, markets and consumers. *Journal of Health and Social Behavior*, 45(S1), 158–176.
- Ehrenreich, B., & English, D. (1978). *For her own good: Two centuries of the experts' advice to women*. Anchor.
- Gelman, S. A. (2003). *The essential child: Origins of essentialism in everyday thought*. Oxford University Press.
- Gal, D., & Wilkie, W. L. (2010). Real to me: Authenticity consumed in the fictional context of a fairy-tale. *Journal of Consumer Research*, 37(3), 533–546.
- IMARC Group. (2025). India ayurvedic products market report by product type (healthcare products, personal care products), organized/unorganized (organized, unorganized), and region 2025–2033. <https://www.imarcgroup.com/india-ayurvedic-products-market>
- Iyer, A., & Sen, G. (2012). Gendered health inequities in India. In S. Anand, F. Peter, & A. Sen (Eds.), *Public health, ethics, and equity* (pp. 117–138). Oxford University Press.
- Jaiswal, Y. S., & Williams, L. L. (2017). A glimpse of Ayurveda – The forgotten history and principles of Indian traditional medicine. *Journal of Traditional and Complementary Medicine*, 7(1), 50–53. <https://doi.org/10.1016/j.jtcme.2016.02.002>
- Langford, J. M. (2002). *Fluent bodies: Ayurvedic remedies for postcolonial imbalance*. Duke University Press.
- Martin, E. (1987). *The woman in the body: A cultural analysis of reproduction*. Beacon Press.
- Medin, D. L., & Ortony, A. (1989). Psychological essentialism. In R. C. Atkinson, R. J. Herrnstein, G. Lindzey, & R. D. Luce (Eds.), *Stevens' handbook of experimental psychology: Learning and motivation* (2nd ed., Vol. 2, pp. 179–212). Wiley.

- Ministry of Statistics and Programme Implementation. (2024). Survey on AYUSH: 2022–23 fact sheet. Government of India. https://www.mospi.gov.in/sites/default/files/publication_reports/Fact_sheet-Survey_on-Ayush.pdf
- Nemeroff, C., & Rozin, P. (2000). The making of the magical mind. In K. S. Rosengren, C. N. Johnson, & P. L. Harris (Eds.), *Imagining the impossible: Magical, scientific, and religious thinking in children* (pp. 1–33). Cambridge University Press.
- Pugh, J. (2013). *Healing rituals, medical contradictions and charisma in South India*. Routledge.
- Ravishankar, B., & Shukla, V. (2008). Indian systems of medicine: A brief profile. *African Journal of Traditional Complementary and Alternative Medicines*, 4(3), 319. <https://doi.org/10.4314/ajtcam.v4i3.31226>
- Rastogi, S. (2020). Medical pluralism in India: Discovering the convergence. *AYUHOME*, 7(1), 3–4. https://doi.org/10.4103/AYUHOME.AYUHOME_20_21
- Rose, N. (2007). *The politics of life itself: Biomedicine, power, and subjectivity in the twenty-first century*. Princeton University Press.
- Rozin, P., Spranca, M., Krieger, Z., Neuhaus, R., Surillo, D., & Swerdloff, A. (2004). Preference for natural: Instrumental and ideational/moral motivations, and the contrast between foods and medicines. *Appetite*, 43(2), 147–154. <https://doi.org/10.1016/j.appetite.2004.04.009>
- Strauss, C., & Quinn, N. (1997). *A cognitive theory of cultural meaning*. Cambridge University Press.
- Wujastyk, D. (2003). *The roots of Ayurveda: Selections from Sanskrit medical writings*. Penguin Books.

Copyrights

Copyright for this article is retained by the author(s), with first publication rights granted to the journal. This is an open-access article distributed under the terms and conditions of the Creative Commons Attribution license (CC BY 4.0).