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Review Article

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"GARBHASTHAPAKA DRAVYAS AND PHALA GHRITA IN RECURRENT PREGNANCY LOSS: A REVIEW"

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ABSTRACT:
Background: Recurrent pregnancy loss affects a small but significant proportion of couples, and in about half of them no cause is found. Conventional management of unexplained recurrent loss relies on supportive care and, in selected women, progesterone, while many empirical treatments lack evidence. Ayurveda describes repeated foetal loss under Garbhasrava, Garbhapata and Putraghni yonivyapad, and recommends Garbhasthapaka (pregnancy-sustaining) drugs and medicated ghee preparations such as Phala ghrita for women with a history of loss. **Objective:** To review the classical Ayurvedic concepts of recurrent pregnancy loss, the Garbhasthapaka group of drugs and Phala ghrita, to place them against current biomedical guidance, and to summarise the published evidence for their use. **Methods:** Charaka Samhita, Sushruta Samhita, Ashtanga Hridaya and Bhaishajya Ratnavali were reviewed for descriptions of foetal loss and its prevention. PubMed was searched up to October 2026 for guidelines, systematic reviews, trials, protocols and case reports on recurrent miscarriage, progestogens, Ayurvedic interventions in pregnancy and infertility, Phala ghrita and safety of herbal products in pregnancy. Findings were synthesised narratively. **Results:** Classical texts describe a coherent preventive approach comprising preconception purification, Garbhasthapaka drugs, medicated ghee and a month-wise antenatal regimen. Biomedical guidelines confirm that most recurrent loss is unexplained and that progesterone offers at best modest benefit in women with prior losses. Published evidence for Phala ghrita consists of one early uncontrolled study, case reports and a registered trial protocol in infertility; no controlled study of Garbhasthapaka drugs or Phala ghrita in recurrent pregnancy loss was found. Safety concerns include heavy-metal contamination of some Ayurvedic products and limited data on herbal exposure in early pregnancy. **Conclusion:** Garbhasthapaka drugs and Phala ghrita are biologically plausible adjuncts for preconception and early-pregnancy care but remain unproven for recurrent pregnancy loss. They should complement, not replace, guideline-based investigation, and require quality-assured products and controlled trials.

KEYWORDS: Garbhasrava, Putraghni yonivyapad, Prajasthapana, Phala ghrita, recurrent miscarriage, progesterone

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INTRODUCTION

Recurrent pregnancy loss (RPL) is among the most distressing problems in reproductive medicine. It affects an estimated 2–5% of couples, and its established causes include uterine anomalies, antiphospholipid syndrome, hormonal and metabolic disorders and parental chromosomal abnormalities[1]. Even after full investigation, however, almost half of cases remain unexplained[1]. The definition itself remains unsettled: the European Society of Human Reproduction and Embryology (ESHRE) guideline highlights the absence of a unified definition as one of the most important consequences of limited evidence in the field[2], while the 2025 Society of Obstetricians and Gynaecologists of Canada guideline defines RPL as two or more pregnancy losses, including non-consecutive and biochemical losses[3].

Treatment options for unexplained RPL are limited. A comparison of the major international guidelines found consensus that low-dose aspirin with heparin is indicated for antiphospholipid syndrome and levothyroxine for overt hypothyroidism, whereas heparin for inherited thrombophilias and immunotherapy for unexplained RPL are not recommended[4]. The updated ESHRE guideline contains 62 evidence-based recommendations, of which only 12 are supported by moderate-quality evidence and the rest by low or very low-quality evidence, and it lists several investigations and treatments that should not be offered[2]. The long-term prognosis is nevertheless good, and most couples eventually achieve a live birth, but the psychological burden of repeated loss is considerable[1].

In this setting, many women in India and elsewhere seek Ayurvedic care before and during a subsequent pregnancy. Ayurveda has a detailed vocabulary for foetal loss, a named group of pregnancy-sustaining drugs (Prajasthapana or Garbhasthapaka dravyas) and a family of medicated ghee preparations, of which Phala ghrita is the best known, prescribed for women who wish to conceive and carry a pregnancy to term[5–8]. The aim of this review is to describe these concepts for an integrative readership, to relate them to current biomedical understanding of RPL, and to state clearly what the published evidence does and does not show.

METHODOLOGY

This narrative review was prepared in two parts. First, the primary classical texts of Ayurveda, namely Charaka Samhita (Sutra sthana, chapter 4; Sharira sthana, chapter 8; Chikitsa sthana, chapter 30), Sushruta Samhita (Sharira sthana, chapter 10), Ashtanga Hridaya (Sharira sthana, chapter 2; Uttara sthana, chapter 34) and Bhaishajya Ratnavali (Yonivyapat chikitsa prakarana), were studied with their standard commentaries for descriptions of foetal loss, Garbhasthapaka drugs and Phala ghrita[5–8]. Second, PubMed was searched for literature published up to October 2026 using combinations of the terms recurrent pregnancy loss, recurrent miscarriage, progesterone, progestogens, Ayurveda, Ayurvedic, Phala ghrita, Phalaghrita, ghee, Garbhasrava, Garbhini paricharya, Prajasthapana, female infertility and herbal medicine in pregnancy. Guidelines, systematic reviews, meta-analyses, randomised trials, trial protocols, experimental studies and case reports were considered. Every reference cited in this article was checked against its PubMed record for authors, title, journal, year, volume, pages and digital object identifier. Retracted publications identified during the search were excluded. The findings are synthesised narratively rather than statistically.

CLASSICAL AYURVEDIC UNDERSTANDING OF FOETAL LOSS

1. Garbhasrava and Garbhapata

Ayurveda regards successful conception and gestation as the outcome of four essential factors: the proper season or timing (Ritu), a healthy reproductive field (Kshetra), adequate nourishment (Ambu) and healthy gametes (Bija)[5,6]. Disturbance of any of these is expected to impair conception or the continuation of pregnancy. Sushruta distinguishes loss of the pregnancy in the first four months, when the products of conception are still liquid, as Garbhasrava, from loss in the fifth and sixth months, when the foetus has acquired firmness, as Garbhapata[6]. Charaka and Vagbhata describe the warning signs of impending loss, chiefly vaginal bleeding and pain, and give month-specific measures intended to arrest bleeding and preserve the pregnancy[5,7].

2. Putraghni yonivyapad and repeated loss

Repeated foetal loss is described specifically under Putraghni yonivyapad, one of the twenty gynaecological disorders. Charaka attributes it to Vata aggravated by dryness, which repeatedly destroys the foetus after conception, while Sushruta emphasises vitiated blood as the cause[5,6]. The clinical picture, in

which conception occurs but the pregnancy is repeatedly lost, closely matches the modern concept of RPL. The classical causes include unwholesome diet and conduct, defects of the gametes, disorders of the uterus and the effects of past actions, and Vata is regarded as the dominant Dosha in most presentations[5,7].

3. Correlation with current understanding

The classical framework has useful parallels with the biomedical classification of RPL. Abnormalities of Bija correspond broadly to chromosomal and gamete factors, disorders of Kshetra to uterine anomalies, chronic endometritis and impaired endometrial receptivity, and disturbances of Ambu to maternal metabolic, endocrine and nutritional factors such as thyroid disease, diabetes and obesity[1,3]. The Ayurvedic emphasis on maternal diet, emotional state and conduct also aligns with the guideline recommendations on lifestyle modification, emotional support and trauma-informed care[3]. These correlations are heuristic rather than literal, but they show that the classical approach is, in principle, compatible with guideline-based investigation rather than a substitute for it.

GARBHASTHAPAKA DRAVYAS

1. The classical group

Charaka lists Prajasthapana (literally, establishing the offspring) as one of the fifty great groups of drugs (Mahakashaya). The ten members are Aindri, Brahmi, Shatavirya, Sahasravirya, Amogha, Avyatha, Shiva, Arishta, Vatyapushpi and Vishvaksenakanta[5]. In Sharira sthana, Charaka recommends that drugs of this kind be taken in milk or ghee, used for bathing or worn by the woman who is prone to loss, and the same herbs are referred to as Garbhasthapaka[5]. Several of the names are synonyms whose botanical identity is disputed; for example, Shatavirya and Sahasravirya are commonly identified as forms of Durva (*Cynodon dactylon*), and Brahmi as *Bacopa monnieri*, while the identity of others such as Aindri, Amogha and Avyatha varies between commentators. This uncertainty in identification is a practical barrier to research and must be resolved through pharmacognostic standardisation before any trial.

2. Month-wise regimens and Garbhini paricharya

Alongside specific drugs, the classical texts prescribe a month-wise antenatal regimen (Garbhini paricharya) of milk, ghee, rice and sweet, unctuous foods, together with month-specific milk decoctions to be used if signs of threatened loss appear[5–7]. The regimen changes with the growth of the foetus and is adapted to the woman's age, season, constitution and digestive capacity, and it is still followed by practitioners of the classical tradition[9]. A literature review of Garbhini paricharya found no clinical trial or systematic review that tested its effect on pregnancy outcomes, while concluding that the classical texts describe the influence of maternal diet, lifestyle and the intrauterine environment on the health of the offspring in terms that resonate with current concepts of developmental programming[10].

3. Clinical reports

Published clinical evidence for Garbhasthapaka drugs is limited to case reports. In a woman with recurrent abortion attributed to a uterine fibroid, preconception purgation and enema followed by Garbhasthapaka drugs for one month were followed by conception in the second month; month-wise Ayurvedic medication was continued with conventional haematinic and calcium supplements, and the pregnancy ended in an elective caesarean section after 38 weeks[11]. In a second report, first-trimester bleeding due to a low-lying placenta in a second gravida was managed with a topical application of Gairika powder in Shatadhauta ghrita below the umbilicus three times daily, with resolution of bleeding within a week and continuation of the pregnancy[12]. These reports illustrate current practice but cannot establish efficacy, since many threatened miscarriages continue normally without treatment, and neither report was designed to test RPL outcomes.

PHALA GHRITA

1. Composition and classical indications

Phala ghrita is a polyherbal medicated ghee described in Ashtanga Hridaya and later compiled in Bhaishajya Ratnavali in the treatment of gynaecological disorders[7,8]. It is prepared by processing cow's ghee with milk and a paste of about twenty drugs, which in commonly used versions include Manjishtha, Kushtha, Tagara, Triphala, Haridra, Daruharidra, Madhuka (liquorice), Meda, Katurohini, Kakoli, Ashwagandha, Shatavari, Hingu and Vacha; Lakshmana, a herb whose botanical identity is debated, is also traditionally associated with the formulation[7,8]. The ingredients vary somewhat between texts and manufacturers.

Classically, Phala ghrita is said to promote conception, to correct disorders of the uterus and gametes and to help women who have repeatedly lost pregnancies to bear healthy children, and it is recommended for both partners[7,8]. Its name, from Phala (fruit), refers to this capacity to make the reproductive effort fruitful.

2. Pharmacological rationale

No pharmacological study of Phala ghrita as a whole was identified in PubMed. Its proposed actions must therefore be inferred from its ingredients and from its ghee base. Ghee-based formulations are traditionally held to enhance the absorption and delivery of lipophilic phytoconstituents, although this has not been demonstrated for Phala ghrita itself. Several constituents of Phala ghrita, including Shatavari and Ashwagandha, are used in Ayurveda as nourishing and adaptogenic reproductive tonics, and Haridra and Manjishtha are used for their anti-inflammatory properties. Whether these individual actions translate into improved endometrial receptivity, placentation or pregnancy maintenance has not been tested.

3. Clinical evidence

The earliest clinical report indexed in PubMed is an uncontrolled study of 30 women with infertility treated with Phala ghrita by intrauterine instillation over three consecutive cycles, which reported encouraging results without quantitative detail in the indexed abstract[13]. A more recent case report described the use of Uttara basti with Kshara taila and Phala ghrita for three consecutive months after menstruation in a woman with endometrial calcification and scanty menses; menstrual flow improved, the calcification decreased on ultrasonography and the patient conceived[14]. A related open pilot study in 15 women with endometrial thickness below 7 mm, using a medicated vaginal tampon (Yoni pichu) with oral Jeevaniya churna, which shares several constituents with the Garbhasthapaka and Jeevaniya groups, reported significant improvements in endometrial thickness, uterine Doppler flow and a composite uterine scoring system; one patient conceived[15]. These studies concern infertility and endometrial receptivity rather than RPL, and none had a control group.

The most rigorous study identified is still in progress. A Central Council for Research in Ayurvedic Sciences protocol randomises 160 women aged 21–40 years with anovulatory or unexplained infertility either to internal oleation with Phala ghrita followed by mild purgation with Gandharvahasta oil for three cycles, or to letrozole, with yoga for both groups. Ovulation is the primary outcome and conception the secondary outcome[16]. This trial will provide the first comparative data on a Phala ghrita-based regimen, but it will not answer whether the formulation reduces pregnancy loss. We found no randomised, controlled or even prospective cohort study of Phala ghrita, or of any Garbhasthapaka drug, with miscarriage or live birth in women with RPL as the outcome.

BIOMEDICAL BENCHMARK: PROGESTERONE IN RECURRENT LOSS

Because Garbhasthapaka therapy is used with the same intention as progesterone supplementation, the evidence for progesterone provides a useful benchmark. A Cochrane network meta-analysis of seven randomised trials including 5,682 women found that vaginal micronised progesterone probably makes little or no difference to live birth in women with recurrent miscarriage (risk ratio 1.04, 95% CI 0.95 to 1.15, high-certainty evidence), but increases live birth in women with one or more previous miscarriages and current early-pregnancy bleeding (risk ratio 1.08, 95% CI 1.02 to 1.15)[17]. A critical evaluation of the two large PROMISE and PRISM trials showed a 3% higher live birth rate with progesterone in each trial, and a greater benefit in women with three or more previous losses and current bleeding, in whom live birth rates were 72% with progesterone against 57% with placebo[18]. A 2024 meta-analysis concluded that in women with two or more prior miscarriages progesterone probably increases live births (risk ratio 1.08, 95% CI 0.98 to 1.19, moderate certainty), without an increase in congenital anomalies or other serious adverse events[19].

Two lessons follow for Ayurvedic research. First, even a biologically well-founded, widely used intervention produced only modest absolute benefits when tested in large placebo-controlled trials. Second, the benefit appears concentrated in women with more previous losses and current bleeding, which suggests that future trials of Ayurvedic interventions should pre-specify similar subgroups and recruit sufficient numbers to detect small effects.

SAFETY CONSIDERATIONS

Safety is a central concern whenever a product is taken in the periconceptional period and the first trimester. A systematic review of herbal medicinal products in pregnancy and the postnatal period, covering 74 studies and more than one million women, found that most products had not been adequately studied, reported associations of some herbs with adverse outcomes, and concluded that herbal product use in pregnancy should be discouraged until robust safety evidence is available[20]. Notably, heavy liquorice use was associated with a threefold increase in early preterm birth[20]; liquorice (Madhuka or Yashtimadhu) is an ingredient of Phala ghrita and of many antenatal formulations, and the dose and duration of exposure therefore deserve attention.

Contamination is a second concern. One-fifth of Ayurvedic medicines purchased online in the United States, whether manufactured in the United States or in India, contained detectable lead, mercury or arsenic, and products made according to Rasa shastra, in which metals and minerals are deliberately incorporated, were twice as likely to contain metals[21]. A New York City surveillance study of pregnant women with blood lead levels of at least 45 mcg/dL found that 71% of women from India had used traditional remedies, and the miscarriage rate in the cohort was more than twice the citywide rate[22]. Herbomineral preparations such as Garbhapala rasa, which are sometimes combined with Garbhasthapaka therapy[11], therefore require particular caution. These data do not implicate properly manufactured Phala ghrita, which is a herbal ghee preparation, but they show that pharmacopoeial quality control, batch testing for heavy metals and sourcing from licensed manufacturers are essential before any product is recommended to a woman who is trying to conceive.

A PROPOSED INTEGRATIVE APPROACH

On the basis of the classical texts and current guidance, a rational integrative pathway for women with RPL can be outlined. All couples should first undergo the guideline-recommended evaluation, including history, screening for antiphospholipid syndrome, assessment of uterine anatomy, thyroid function and, where indicated, genetic testing, and should receive established treatments for any cause identified[2–4]. Ayurvedic care can then be offered, with informed consent, as an adjunct in the preconception period, where it may include dietary and lifestyle regulation, management of Vata through appropriate purification under supervision, and a course of a quality-assured Phala ghrita or other Garbhasthapaka preparation for both partners[5,7,8]. During pregnancy, a conservative Garbhini paricharya focused on diet, rest and emotional well-being is reasonable[9,10], while internal medication in the first trimester should be minimised and documented, and progesterone should not be withheld from women who meet the criteria in which it has shown benefit[17–19]. Women should be advised to report the use of any Ayurvedic product to their obstetrician, and practitioners should avoid herbomineral products in pregnancy unless their composition and safety are fully documented[21,22].

DISCUSSION

This review shows that Ayurveda contains a coherent and detailed preventive framework for women who repeatedly lose pregnancies. The concept of Putraghni yonivyapad, the four essential factors of conception, the Prajasthapana group of drugs and medicated ghee preparations such as Phala ghrita together form a recognisable strategy aimed at preparing the reproductive field, supporting the early pregnancy and nourishing the mother and foetus[5–8]. The classical classification of causes maps reasonably onto biomedical categories of genetic, uterine, endocrine and metabolic factors, and its emphasis on emotional support and lifestyle is consistent with current guidelines[1–3].

The evidence base, however, is very thin. Published clinical data for Phala ghrita consist of one uncontrolled study from 2002, case reports and a trial protocol, all concerned with infertility rather than pregnancy loss[13–16]. For the Garbhasthapaka drugs, evidence is limited to case reports in which they were given with other interventions, making their contribution impossible to separate[11,12]. No study measured miscarriage or live birth in women with RPL. This contrasts with the large, multicentre, placebo-controlled trials that have defined the modest role of progesterone[17–19]. It would therefore be inaccurate to describe Phala ghrita or any Garbhasthapaka drug as an evidence-based treatment for RPL at present.

Several research priorities follow. First, the botanical identity of disputed Prajasthapana herbs and of Lakshmana must be settled, and Phala ghrita should be

standardised with defined marker compounds, physicochemical specifications and heavy-metal limits. Second, preclinical studies should examine effects on endometrial receptivity, decidualisation and early placental development, and should include reproductive and developmental toxicity testing. Third, clinical trials should begin in the preconception period, where the risk to an established pregnancy is lower, and should enrol couples with fully investigated unexplained RPL, with live birth as the primary outcome. Given the high background live birth rate in unexplained RPL[1], such trials will need to be multicentric and adequately powered. Pragmatic designs comparing guideline-based care with and without an Ayurvedic preconception package may be more feasible than placebo-controlled trials of individual formulations. Finally, pharmacovigilance for Ayurvedic products used in pregnancy should be strengthened, in line with the cautionary findings on herbal product use and contamination[20–22].

The review has limitations. It is narrative rather than systematic, relies on PubMed-indexed literature and therefore may have missed studies published only in Indian journals or postgraduate dissertations, and the classical descriptions of Phala ghrita composition vary between sources. Nevertheless, the absence of controlled evidence for RPL outcomes is unlikely to be an artefact of the search strategy.

CONCLUSION

Ayurveda offers a long-established approach to recurrent pregnancy loss based on preconception preparation, Garbhasthapaka drugs, Phala ghrita and a month-wise antenatal regimen. The approach is conceptually compatible with biomedical understanding and may serve as a supportive adjunct, but published evidence is confined to case reports, an uncontrolled study and a trial protocol in infertility. Until standardised products are tested in adequately powered controlled trials with live birth as the outcome, these interventions should be used only alongside guideline-based investigation and care, with strict attention to product quality and safety in early pregnancy.

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