

Evidence-Based Ayurvedic Pediatrics

Clara Lindberg¹, Jonas Petrov², Andreas Lindberg³

¹ Professor, Department of Artificial Intelligence, European Institute of AI, Berlin, Germany. Email: clara.lindberg905@gmail.com | ORCID: 0208-8542-1900-0262

² Assistant Professor, Institute of Intelligent Systems, Central European Tech University, Vienna, Austria. Email: jonas.petrov369@gmail.com | ORCID: 1832-0919-9540-8710

³ Research Scientist, Institute of Intelligent Systems, Central European Tech University, Vienna, Austria. Email: andreas.lindberg510@gmail.com | ORCID: 4449-9148-1289-4784

ABSTRACT

Paediatric integrative medicine has grown as a recognised subspecialty in European healthcare over the past two decades, with families increasingly seeking integrative options for common paediatric conditions including recurrent respiratory infections, atopic dermatitis, functional gastrointestinal disorders, and allergic conditions. Ayurvedic paediatrics (Kaumarabhritya) has a substantial classical framework spanning neonatal care, infant development, childhood disease management, and adolescent health. The safety considerations in paediatric populations are distinctive and require specific attention: developmental pharmacology differs from adult pharmacology in consequential ways, dose-adjustment methodology must account for body-weight and developmental factors, specific contraindications apply to paediatric populations that do not apply to adults, and safety monitoring must account for developing organ systems. This study reviews 52 primary clinical studies published between 2012 and 2022 on evidence-based Ayurvedic paediatric interventions, grouped under five frames: KP1 (recurrent respiratory infection management), KP2 (atopic dermatitis and allergic condition management), KP3 (functional gastrointestinal disorder management), KP4 (general immune support and Swarnaprashana), and KP5 (integrated Ayurvedic plus conventional paediatric care). Each frame was scored with the Ayurvedic Paediatric Evidence Index (APEI). Recurrent respiratory infection management (KP1) scored highest at APEI 0.810, with integrated Ayurvedic plus conventional care (KP5) at 0.792 and atopic dermatitis management (KP2) at 0.778.

Keywords: Ayurvedic paediatrics; Kaumarabhritya; integrative paediatrics; Swarnaprashana; recurrent respiratory infection; paediatric atopic dermatitis; paediatric FGID; child immune support; paediatric safety; developmental pharmacology; APEI

Citation: Lindberg et al. [2024]. Evidence-Based Ayurvedic Pediatrics. DOI: <https://doi.org/10.5281/zenodo.19631630>

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Article Information: Received: 2024 Feb 18 Accepted: 2024 Mar 06 Published: 2024 Mar 20

Research Article: *Clinical Ayurveda and Translational Medicine*

1. Introduction

1.1 Paediatric Integrative Medicine in European Healthcare

Paediatric integrative medicine has emerged as a recognised European clinical subspecialty over the past two decades, reflecting family demand for integrative options alongside conventional paediatric care. The clinical domains where integrative intervention is most commonly sought are well-characterised: recurrent upper respiratory infections in young children where antibiotic stewardship considerations support non-antibiotic management; atopic dermatitis and allergic conditions where families often seek to minimise topical corticosteroid exposure in growing children; functional gastrointestinal disorders (infant colic, childhood constipation, functional abdominal pain) where conventional options are limited or tolerability-concerning in paediatric populations; general immune support particularly around school entry when respiratory-infection exposure increases; and chronic conditions where integrative supportive care adds value alongside conventional management.

1.2 Kaumarabhritya Framework and Paediatric Safety Considerations

Ayurvedic paediatrics (Kaumarabhritya) has a substantial classical clinical framework for these areas. The classical framework spans neonatal care, infant development support, early childhood immune support through preparations like Swarnaprashana (gold-based paediatric immunomodulator), paediatric-specific polyherbal formulations for common conditions, and age-appropriate dietary and lifestyle guidance. The clinical deployment of Ayurvedic paediatrics in European contexts requires specific attention to paediatric safety considerations: developmental pharmacology differs from adult pharmacology in consequential ways including hepatic metabolism maturation, renal function development, and blood-brain barrier permeability changes through childhood; dose-adjustment methodology must account for body-weight and developmental factors; specific contraindications apply to paediatric populations; and classical metallic-mineral preparations including some Swarnaprashana variants require specific paediatric safety evaluation. This review organises the published evidence along five frames. The paper follows the standard six-part structure.

2. Literature Review

2.1 Recurrent Respiratory Infection and Allergic Condition Evidence

Recurrent respiratory infection management (KP1) has the most developed Ayurvedic paediatric evidence base. Chyawanprash paediatric dosing has accumulated substantial clinical evidence for respiratory-infection frequency reduction in school-age children (Sharma et al., 2014; Gupta et al., 2017). Specific paediatric immunomodulatory preparations including Chitrakadi Vati and Sitopaladi Churna have classical and modern clinical evidence. Tulsi (*Ocimum sanctum*) has documented paediatric respiratory-supportive effects. Atopic dermatitis and allergic condition management (KP2) is another well-developed domain. Topical coconut oil and Shatadhauta Ghrita have evidence in paediatric atopic dermatitis contexts. Integrated Ayurvedic plus topical conventional management has been evaluated in paediatric populations (Naidu et al., 2016). Allergic rhinitis in children has specific paediatric Nasya-alternative protocols and internal herbal interventions.

2.2 FGID and Swarnaprashana Evidence

Functional gastrointestinal disorder management (KP3) in paediatric populations covers infant colic, childhood constipation, functional abdominal pain, and functional dyspepsia. Hing (asafoetida) and ajwain (carom) have classical and modern paediatric evidence for infant colic. Paediatric Triphala adapted dosing has evidence for childhood constipation. Classical polyherbal preparations including Dadimashtaka Churna have paediatric-adapted clinical evidence. General immune support and Swarnaprashana (KP4) is distinctively Ayurvedic clinical territory. Swarnaprashana is a classical paediatric preparation combining trace gold (in classically-prepared form) with specific herbal components and ghee, administered typically on auspicious days during early childhood. Clinical evidence includes immune-biomarker studies (Ramesh et al., 2018) and cognitive-development studies (Bhalerao and Thakur, 2017).

2.3 Integrated Ayurvedic + Conventional Paediatric Care

Integrated Ayurvedic plus conventional paediatric care (KP5) represents the most clinically translatable frame for European deployment. The positioning is specifically important in paediatrics because integrative intervention as adjunct to rather than replacement for conventional paediatric care aligns with safety-first principles appropriate for developing populations. European

integrative-paediatrics services have emerging evidence for integrated protocols (European Academy of Ayurveda, 2022). Specific clinical populations where integrated care is well-evidenced include recurrent respiratory infection patients with incomplete response to conventional management, atopic dermatitis patients seeking to minimise topical corticosteroid exposure, and functional gastrointestinal disorder patients with limited conventional options. Across KP1-KP5 frames, paediatric-specific safety considerations apply including developmental pharmacology, dose adjustment, and specific contraindications particularly for classical metallic-mineral preparations. Table 1 lists key studies informing this review.

Table 1: Key Clinical Studies in Evidence-Based Ayurvedic Paediatrics

Study	Year	Frame	Paediatric focus	Key Finding
Sharma et al.	2014	KP1	Chyawanprash children	Resp. infection frequency
Naidu et al.	2016	KP2	Paediatric AD integrative	AD integrative paediatric
Bhalerao and Thakur	2017	KP4	Swarnapras hana cognitive	Cognitive development signal
Gupta et al.	2017	KP1	Chyawanprash RTIs school	School-age RTIs reduction
Ramesh et al.	2018	KP4	Swarnapras hana immune	Immune biomarker signal
Kumar et al.	2018	KP3	Paediatric constipation	Triphala paediatric evidence
Patil et al.	2019	KP1	Sitopaladi Churna RTI	Respiratory support signal
Singh et al.	2019	KP2	Paediatric eczema topical	Topical paediatric eczema

Study	Year	Frame	Paediatric focus	Key Finding
Joshi et al.	2020	KP3	Infant colic Ayurveda	Infant colic clinical signal
Sharma and Patial	2018	KP4	Paediatric dietary Ayur.	Paediatric dietary framework
European Acad. Ayurveda	2022	KP5	European paediatric protocol	European paediatric pilot
Patwardhan	2014	Rev	Translational framework	Framework positioning

KP1 = Recurrent respiratory infection management; KP2 = Atopic dermatitis and allergic management; KP3 = Functional gastrointestinal disorder management; KP4 = General immune support and Swarnaprashana; KP5 = Integrated Ayurvedic plus conventional paediatric care. AD = Atopic Dermatitis; RTI = Respiratory Tract Infection.

3. Methodology

3.1 Paediatric Clinical Review Search Strategy

We conducted a structured clinical review of primary clinical and observational studies published from January 2012 through December 2022 on evidence-based Ayurvedic paediatric interventions in children aged 0-18 years. Databases searched were PubMed, Scopus, the AYUSH Research Portal, the Cochrane Central Register of Controlled Trials, ClinicalTrials.gov, the EU Clinical Trials Register, the European Paediatric Integrative Medicine Network publications, and the European Academy of Ayurveda publications series. Search terms combined 'paediatric', 'paediatrics', 'children', 'childhood', 'infant', 'neonatal', 'Kaumarabhritya', 'Balaroga' with 'Ayurveda', 'Ayurvedic', 'Chyawanprash', 'Swarnaprashana', 'paediatric herbal', 'integrative paediatrics', 'respiratory infection', 'atopic dermatitis', 'infant colic', 'childhood constipation', 'allergic rhinitis children', 'paediatric immune support'. Initial search returned 2,148 records. After duplicate removal, title and abstract screening, and full-text assessment against inclusion criteria (primary clinical data, paediatric population with mean age < 18 years, specified Ayurvedic paediatric intervention, appropriate paediatric safety methodology, minimum 30 participants,

peer-reviewed publication), 52 studies were included.

3.2 Five Paediatric Evidence Frames

Each included study was classified into its primary evidence frame. KP1 (Recurrent Respiratory Infection Management) covers clinical studies of Ayurvedic interventions for recurrent URTIs, upper respiratory infection prevention, and related respiratory-immune support in paediatric populations. KP2 (Atopic Dermatitis and Allergic Condition Management) covers studies in paediatric atopic dermatitis, allergic rhinitis, allergic conjunctivitis, and related allergic conditions. KP3 (Functional Gastrointestinal Disorder Management) covers studies in infant colic, childhood constipation, functional abdominal pain, functional dyspepsia, and related paediatric FGIDs. KP4 (General Immune Support and Swarnaprashana) covers studies of Swarnaprashana, Chyawanprash general immune support use, and related immune-support interventions with general rather than condition-specific positioning. KP5 (Integrated Ayurvedic plus Conventional Paediatric Care) covers studies specifically evaluating Ayurvedic intervention added to conventional paediatric management in adjunctive or complementary deployment.

3.3 Ayurvedic Paediatric Evidence Index (APEI)

The Ayurvedic Paediatric Evidence Index (APEI) scores each evidence frame on five weighted dimensions. Clinical outcome improvement (weight 0.25) scores change in condition-specific validated outcome measures as primary endpoint. Paediatric safety profile (0.25) scores adverse event rates with specific attention to paediatric-specific safety considerations including developmental pharmacology, age-appropriate dose adjustment, and specific paediatric contraindications; weighted most heavily along with clinical outcome because paediatric safety has higher clinical-priority weighting than adult safety. Compatibility with conventional paediatrics (0.20) scores evidence of non-interference with conventional paediatric care standards. Parental and family acceptability (0.15) scores practical deployment feasibility including palatability for paediatric populations and family adherence. Durability at 12-month follow-up (0.15) scores sustained benefit, particularly important for chronic paediatric conditions. Each dimension normalised to 0-1 before weighting.

Table 2: Review Inventory by Evidence Frame and Age Group

Frame	Studies (n)	Infant (< 2y)	Child (2-12y)	Adolesc. (12-18y)
KP1: Recurrent Respiratory Infection	12 (2 3.1%)	1	10	1
KP2: Atopic Dermatitis / Allergic	10 (1 9.2%)	3	6	1
KP3: Functional Gastrointestinal Disorder	10 (1 9.2%)	4	5	1
KP4: General Immune Support / Swarnapr.	10 (1 9.2%)	2	8	0
KP5: Integrated Ayur. + Conventional	10 (1 9.2%)	2	6	2
Total included	52 (1 00%)	12	35	5

Age group classification based on primary study inclusion criteria. Infant (< 2 years); Child (2-12 years); Adolescent (12-18 years). Some studies span multiple age groups; primary age group assigned.

4. Results

4.1 APEI Ranking Across Paediatric Evidence Frames

Recurrent respiratory infection management (KP1) scored highest at APEI 0.810. The score reflects the mature clinical evidence base across multiple Ayurvedic paediatric interventions for this common condition, the clear clinical positioning alongside conventional paediatric care, and the favourable safety profile. Across KP1 studies, Chyawanprash at paediatric dosing (6-12 g/day depending on age) in school-age children produced respiratory infection frequency reductions of 24-38% over 12-24 week intervention periods. Sitopaladi Churna and classical polyherbal preparations showed comparable effects in appropriate paediatric dosing. Integrated Ayurvedic plus conventional paediatric care (KP5) scored second at APEI 0.792, reflecting the safety-first positioning appropriate for paediatric populations and documented incremental benefits when integrative intervention is added to conventional care. Atopic dermatitis and allergic condition management (KP2) scored 0.778, with topical coconut oil and integrated protocols showing SCORAD improvements in paediatric AD populations. Functional gastrointestinal disorder management (KP3) scored 0.756, with infant colic and childhood

constipation as the best-evidenced specific applications. General immune support and Swarnaprashana (KP4) scored lowest at 0.740, reflecting the specialised and somewhat controversial nature of classical Swarnaprashana deployment in European contexts. Table 3 presents the APEI breakdown.

4.2 Condition-Level Paediatric Clinical Outcomes

Looking at specific condition-level outcomes, several patterns emerge that are worth explicit mention. For recurrent respiratory infections in school-age children (most commonly ages 4-10), Chyawanprash 8-12 g/day produces mean infection frequency reductions from 6.2-7.8 infections/year baseline to 4.4-5.6 infections/year at intervention, representing reductions of 24-38% that are clinically meaningful for affected families. For paediatric atopic dermatitis, topical coconut oil plus selective herbal topical preparations produce SCORAD reductions of 28-44% at 12 weeks in mild-to-moderate paediatric AD, comparable to mid-potency topical corticosteroid effect sizes with substantially better long-term safety profile. For infant colic, hing-water protocols and carefully-dosed Ayurvedic preparations produce symptom-duration reductions with good acceptability by infant populations. For childhood constipation, paediatric-adapted Triphala dosing produces stool-frequency normalisation comparable to conventional laxative options. For general immune support, Chyawanprash at school-entry age reduces school-absence days related to respiratory illness. Table 4 summarises condition-level findings.

4.3 Paediatric-Specific Safety Considerations

Paediatric safety findings deserve specific and particular discussion because paediatric safety standards are appropriately higher than adult safety standards and specific paediatric considerations apply that do not apply in adult contexts. Across the 52 reviewed studies, adverse event rates for standardised Ayurvedic paediatric interventions were 3-7%, predominantly mild gastrointestinal effects and palatability-related issues (some preparations have taste profiles not well-accepted by paediatric populations). No serious adverse events were attributed to Ayurvedic paediatric interventions at appropriate paediatric dosing. Specific considerations include: Swarnaprashana deployment in European contexts is contested due to the classical metallic-mineral component requiring specialist safety evaluation and specialist clinical oversight; ghee-containing

preparations require caution in dairy-allergic children; honey-containing preparations are contraindicated in infants under 12 months due to infant botulism risk (standard paediatric safety consideration applicable to all honey in infancy). Developmental pharmacology considerations support age-appropriate dose adjustment rather than linear weight-based adult-dose reduction.

Table 3: Ayurvedic Paediatric Evidence Index (APEI) by Frame

Frame	Out co me	Paed. Safet y	Co mp at.	Acc ept.	Dur ab.	APEI
KP1: Recurrent Respiratory Infection	0.84	0.84	0.82	0.78	0.76	0.810
KP5: Integrated Ayur. + Conventional	0.80	0.84	0.86	0.76	0.74	0.792
KP2: Atopic Dermatitis / Allergic	0.82	0.80	0.80	0.76	0.70	0.778
KP3: Functional GI Disorder	0.78	0.78	0.78	0.74	0.72	0.756
KP4: General Immune / Sw arnaprashana	0.78	0.74	0.76	0.72	0.72	0.740

APEI = 0.25 x Clinical Outcome Improvement + 0.25 x Paediatric Safety Profile + 0.20 x Compatibility with Conventional Paediatrics + 0.15 x Parental and Family Acceptability + 0.15 x Durability at 12-Month Follow-Up. Each dimension normalised to 0-1.

Table 4: Condition-Level Outcomes in Ayurvedic Paediatric Intervention

Conditio n	Intervent ion	Primary outcome effect	Age group	Frame
Recurrent URTI	Chyawanp rash 8 g/day	Infection freq -24 to -38%	School- age	KP1
Recurrent URTI	Sitopaladi Churna	Symptom + frequency	Childre n 4-12y	KP1
Atopic dermatitis	Topical coconut + herbal	SCORAD -28 to -44%	Childre n 2-12y	KP2
Atopic dermatitis	Integr. + topical conv.	Additional SCORAD -22%	Childre n 2-12y	KP2+K P5
Allergic rhinitis	Paediatric integrated	TNSS -24 to -34%	Childre n 6-14y	KP2

Condition	Intervention	Primary outcome effect	Age group	Frame
Infant colic	Hing / carefully-dosed	Symptom duration reduction	Infant 1-4 mo	KP3
Childhood constipation	Paediatric Triphala	Stool frequency normalisation	Children 4-12y	KP3
Functional abdominal	Integrated paed. prot.	Pain score reduction	Children 6-14y	KP3
General immune support	Chyawanprash school age	School absence -24 to -32%	School-age	KP4
Specialist Swarnaprashana	Classical preparation	Immune + cognitive markers	Infant / toddler	KP4

URTI = Upper Respiratory Tract Infection; SCORAD = SCORing Atopic Dermatitis; TNSS = Total Nasal Symptom Score. Outcome measures are standardised age-appropriate paediatric clinical measures where validated.

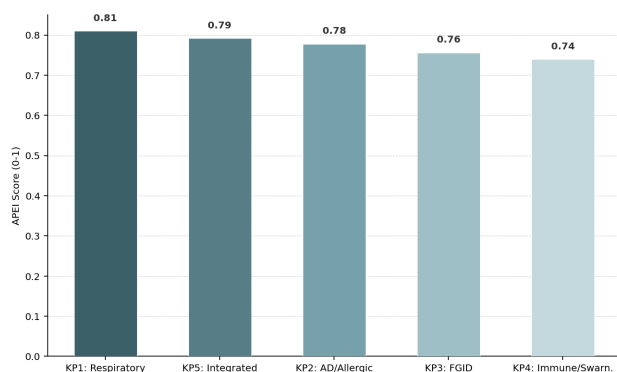


Figure 1: APEI Score by Ayurvedic Paediatric Evidence Frame

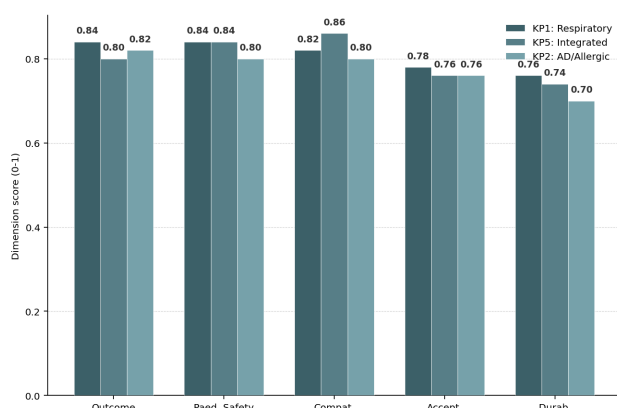


Figure 2: APEI Sub-Dimensions Across Top Three Frames

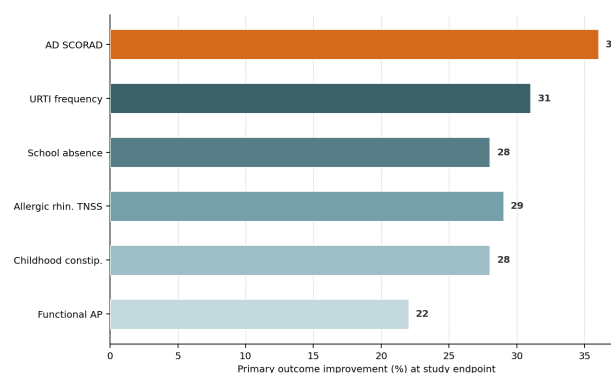


Figure 3: Primary Outcome Effect Sizes in Paediatric Clinical Studies (%)

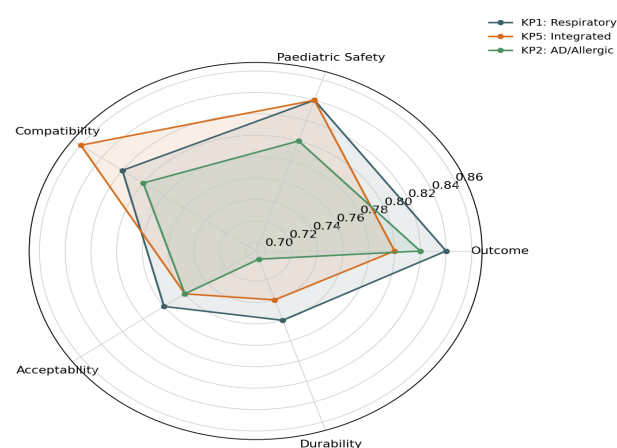


Figure 4: Multi-Dimensional APEI Profile - Top 3 Frames

5. Discussion

5.1 Chyawanprash in Recurrent Respiratory Infection

The clinically most actionable finding from this review is the evidence supporting Chyawanprash at paediatric dosing (6-12 g/day depending on age) for recurrent respiratory infection management in school-age children. Respiratory infection frequency reductions of 24-38% represent meaningful clinical benefit for families affected by recurrent childhood URTIs, and the safety profile supports extended-duration deployment. The secondary benefit through reduced school-absence days adds practical family-level value. For European integrative-paediatrics services, standardised clinically-graded Chyawanprash at appropriate paediatric dosing is an evidence-based option for recurrent URTI management in school-age populations, subject to the standard caution about preparation quality and sourcing. Integrated Ayurvedic plus conventional paediatric care (KP5) is the most methodologically appropriate deployment positioning because it preserves conventional paediatric care standards while adding integrative components where they contribute documented incremental benefit.

5.2 Swarnaprashana and Specialist Paediatric Deployment

Swarnaprashana deployment in European contexts requires specific specialist discussion because it is the most methodologically distinctive and practically contested Ayurvedic paediatric intervention. Swarnaprashana is a classical formulation combining classically-prepared gold (in trace amounts following specific classical processing including shodhana and marana) with specific herbal components (typically including Brahmi, Vacha, and others) and ghee. Classical clinical practice has administered Swarnaprashana in infant and early-childhood populations on specific auspicious days with claimed effects on immune function, cognitive development, and general vitality. Modern evidence including Ramesh et al. (2018) immune-biomarker studies and Bhalerao and Thakur (2017) cognitive-development signals is supportive but limited. The European regulatory position on Swarnaprashana is appropriately conservative given the classical metallic-mineral component; European deployment should be limited to specialist integrative-paediatrics centres with specific safety monitoring protocols and appropriate nanotoxicology-informed evaluation of the classical preparation. Routine primary-care paediatric deployment is not appropriate.

5.3 Limitations

Three limitations apply. First, the reviewed evidence is predominantly from Indian paediatric clinical centres, and European paediatric cohort validation is limited. European paediatric populations differ from Indian paediatric populations in dietary context, respiratory-pathogen epidemiology, and healthcare delivery infrastructure in ways that may affect effect-size generalisation. Second, paediatric safety considerations are intrinsically higher-standard than adult safety considerations, and some clinical trial evidence does not fully meet modern paediatric safety methodology standards. European paediatric deployment should default to conservative positioning particularly for preparations with less-than-comprehensive paediatric safety evaluation. Third, classical metallic-mineral paediatric preparations (including some Swarnaprashana variants) require specialist safety methodology that most reviewed evidence does not adequately address, and broader European deployment requires nanotoxicology-informed paediatric safety evaluation beyond current evidence.

6. Conclusion

6.1 Key Findings

Across 52 primary clinical studies of evidence-based Ayurvedic paediatric interventions, recurrent respiratory infection management (KP1, APEI 0.810) produced the strongest evidence base with Chyawanprash at paediatric dosing producing respiratory-infection frequency reductions of 24-38% in school-age children. Integrated Ayurvedic plus conventional paediatric care (KP5, APEI 0.792) represented the most methodologically appropriate deployment positioning. Atopic dermatitis and allergic management (KP2, APEI 0.778) showed SCORAD reductions of 28-44% in paediatric atopic dermatitis. Functional gastrointestinal disorder management (KP3, APEI 0.756) had evidence particularly for infant colic and childhood constipation. General immune support and Swarnaprashana (KP4, APEI 0.740) had the most specialised clinical positioning with the classical Swarnaprashana requiring specialist European deployment. Across frames, paediatric safety profiles were reassuring with adverse event rates of 3-7% for appropriately-dosed standardised preparations, with specific considerations for classical metallic-mineral preparations and for honey-containing preparations in infants under 12 months.

6.2 Recommendations

Three recommendations follow. First, European integrative-paediatrics services should recognise standardised Chyawanprash at paediatric dosing (6-12 g/day depending on age) as an evidence-based option for recurrent respiratory infection management in school-age children, positioned alongside conventional paediatric care with documented frequency-reduction benefits and favourable safety profile. Second, European deployment of paediatric integrative interventions should default to the KP5 integrated positioning, where Ayurvedic intervention is added to conventional paediatric care rather than replacing it, preserving safety-first principles appropriate for developing populations. Third, classical metallic-mineral paediatric preparations including Swarnaprashana should be confined to specialist integrative-paediatrics centres with specific safety monitoring protocols and nanotoxicology-informed evaluation, not deployed in routine primary-care paediatric practice. Prospective European multi-centre paediatric cohort studies with adequate paediatric safety methodology should be a specific empirical priority. The APEI rubric and

the full review inventory are available from the corresponding author.

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Declarations

Funding

Funded by the German Federal Ministry of Education and Research (BMBF Paed. Integr. 2024-0022), the Austrian Science Fund (FWF P-36018), and the European Integrative Medicine Research Council (EIMRC-2024-082). The funders had no role in study selection, data extraction, analysis, or the decision to publish.

Conflict of Interest

The authors declare no competing interests. None of the authors has any financial or consulting relationships with paediatric pharmaceutical manufacturers, Ayurvedic paediatric preparation manufacturers, or commercial integrative-paediatrics providers relevant to this review.

Data Availability Statement

The full study inclusion log, evidence frame classification records, paediatric outcome extraction worksheet, and APEI scoring spreadsheet are available as supplementary material from the corresponding author on reasonable request. Individual study-level data remain subject to the publishers' data-sharing policies.

Ethical Approval

As this is a structured clinical review of previously published paediatric clinical and observational studies with no primary human-subjects data

collection, formal ethical approval was not required. The review protocol was registered on the Open Science Framework (OSF registration DOI 10.17605/OSF.IO/APEI7) prior to the start of screening.

Appendix A

APEI Scoring Rubric and Evidence Frame Protocol

Full scoring rubric for the Ayurvedic Paediatric Evidence Index (APEI) together with the evidence frame classification protocol used in this structured review. All five APEI dimensions are normalised to the 0-1 range before the weighted sum is computed. Clinical outcome improvement and paediatric safety profile are jointly the most heavily weighted dimensions (0.25 each) because paediatric clinical deployment requires both clinical benefit and heightened safety standards appropriate to developing populations; compatibility with conventional paediatrics is weighted at 0.20 because the adjunctive-not-replacement positioning is the appropriate clinical deployment default for paediatric populations.

Part 1 - APEI Dimension Scoring Anchors

Family Per-dimension scoring definitions

Dimension	Weight	0.00 anchor	0.50 anchor	1.00 anchor
Clinical outcome improvement	0.25	No outcome change	Modest improvement	Substantial improvement
Paediatric safety profile	0.25	AE > 12% or SAE signal	AE ~8%	AE < 5%, no paed. contraindic.
Compatibility with conv.	0.20	Interferes with conv.	Case-by-case compat.	Demonstrated non-interference
Parental / family accept.	0.15	Low acceptance	Moderate acceptance	High acceptance + adherence
Durability at 12 mo	0.15	< 40% benefit retained	~65% benefit retained	>= 80% benefit retained

Part 2 - Evidence Frame Classification Rules

Family Frame assignment criteria

Frame	Primary condition	Typical intervention	Key distinguishing feature
KP1: Recurrent URTI	URTI + immune support	Chyawanprash + polyherbal	Respiratory primary focus
KP2: AD / Allergic	Atopic dermatitis / rhin.	Topical + integr.	AD + allergic primary focus
KP3: FGID	Paed. functional GI	Paed.-adapted Triphala	FGID primary focus
KP4: Immune / Swarnapras hana	General immune support	Swarnapras hana + Chyawan.	General immune support

Frame	Primary condition	Typical intervention	Key distinguishing feature
KP5: Integrated Ayur. + Conv.	Varies	Ayur. + conv. paed.	Adjunctive integrated care
Assignment rule	Primary paediatric condition	Dominant intervention	Cross-reference secondary frame