

**INSTITUTIONALIZED ALTERNATIVE MEDICINE IN NORTH INDIA:
PLURALITY, LEGITIMACY, AND NATIONALIST DISCOURSES**

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This dissertation examines state-sanctioned medical pluralism in contemporary India by focusing on seven codified non-biomedical traditions: Ayurveda, Yoga, Naturopathy, Unani, Siddha, Sowa-Rigpa, and Homeopathy, officially known under the acronym AYUSH. Informed by ethnographic work in Uttarakhand, North India, I explore therapeutic practices and narratives of AYUSH practitioners in relation to government policy and public discourses on alternative medicine. This work puts forward four major arguments. First, although the Indian government delineates different AYUSH modalities from one another as well as from biomedicine and uncodified local health traditions, in reality AYUSH practitioners frequently engage in treatments that fall outside their state-sanctioned area of expertise. For example, a doctor of Homeopathy can integrate elements of Ayurveda, biomedicine, numerology, and religious healing.

Second, despite state legitimation and a purportedly equal governmental support, AYUSH traditions occupy unequal positions, among which Ayurveda has emerged as the most socially, ideologically, and financially privileged. Based on the analysis of statistics, doctors' narratives, policy documents, and the rhetoric and activities of an extraordinarily popular guru Ramdev, I argue that medical plurality in India is increasingly "ayurvedicalized."

Third, the hierarchy of medical traditions in India is reinforced through the debates about what and who constitute the nation. Within these discourses, Ayurveda has been promoted as the only homegrown and authentically Indian tradition. Hence, I argue that the paradox between the

state legitimation of medical plurality and a hegemonic position of Ayurveda is embedded in the tension between two opposing nationalist ideologies: the ideology of inclusive nationalism anchored in the Nehruvian principle of unity in diversity and the ideology of Hindu nationalism. Finally, by scrutinizing how exactly Ayurveda is promoted by guru Ramdev, I reveal moralizing discourses that invoke citizens' duty (*seva*) to the nation which encourage them to consume Ayurvedic products in order to improve their personal health, contribute to national economy, and honor the ancient Vedic sages. Building on theorizations of biopower and biomorality, this dissertation evinces that the promotion of Ayurveda has become a bio-moral project which weds consumerist desires with Hindu nationalist sentiment.

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NOTE ON TRANSLATION AND TRANSLITERATION

All non-English words throughout this dissertation are written in italics and when they appear for the first time, their translations are given in parenthesis. Hindi, Urdu, and Sanskrit words are transliterated according to the romanization guidelines provided by the Library of Congress (1997) but I have made exceptions for commonly accepted spellings, such as *swadeshi* rather than *svadeśī*, *gurdwara* than *gurudvārā*, and *Ghar Wapsi* than *ghar wāpasī*. Furthermore, following Alter (1992), Attewell (2007), and other scholars, I have used diacritics only in the first appearance in the text and in Glossary. Otherwise, for simplicity and readability by non-specialists, diacritics have been omitted.

Words that have been incorporated into English, such as guru or chai, are not italicized. Neither are the names of people, places, organizations, and brands. Instead, they are simply capitalized and spelled according to common convention (e.g. Patanjali, the Rashtriya Swayamsevak Sangh). Moreover, although contemporary anthropological literature on South Asian medicine is inconsistent in the use of capitalized and lower-case spellings for medical traditions (e.g. ayurveda and Ayurveda, Yoga or Yoga, homeopathy), I have decided to capitalize all of them to signal their institutionalized status.

A description of most commonly used non-English words and other terms are provided in Glossary (Appendix).

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1.0 INTRODUCTION

Alternative medical traditions occupy a noticeable place in contemporary societies and many governments work to integrate them into mainstream healthcare systems. The institutionalization of medical plurality often leads to the creation of novel medical practices and categories, such as the category of CAM (“Complementary and Alternative Medicine”) in the United States or the category of AYUSH (“Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy”) in India. However, the government regulation also results in the marginalization of certain forms of medical knowledge that are deemed irrational, ineffective, esoteric, or foreign. In response to the government’s involvement, doctors of alternative medicine develop various strategies, from aligning themselves with the government to contesting new therapies and categories, defending the legitimacy of their practice, and finding ways of circumventing the government control.

This dissertation closely looks at different levels of tension that arise when the government sanctions multiple alternative medical traditions, each with distinct therapeutic repertoire, philosophy, history, and cultural affiliation. In particular, this project examines the tension between the promotion of some medical traditions and marginalization of others, between the production of new therapeutic categories and the reinstatement of old ones, between the state vision and the everyday practice, and, importantly, between medical plurality and medical exceptionalism. In contrast to a wealth of studies which analyze the entanglements of alternative medicine with biomedicine, this work focuses on non-biomedical traditions in India.

The legitimization of India’s healing traditions—indigenous and otherwise—has a long history dating back to the pre-independence period (Alter 2004; Arnold and Sarkar 2002; Attewell 2007; Bala 2007; Berger 2013; Hardiman 2009; Khan 2006; Lambert 2012a; Langford 2002; Leslie 1968; Liebeskind 2002; Wujastyk and Smith 2008; Sivaramakrishnan 2006; Weiss 2008). From the early 1900s, the Government of India “was very reliant on indigenous medical practitioners” in order to address the public health needs, given the dearth of biomedical facilities and doctors (Berger 2013, 3). Thus, from the early days of Indian nation-making, alternative medical providers played a significant role in the national healthcare system. Today the alternative medical sector in India is quite substantial: specialized non-biomedical hospitals constitute about 15% of all hospitals and certified alternative practitioners comprise 42% of all registered doctors in the country (National Health Profile 2012, 166, 149). A more recent investigation of Indian healthcare workforce by the WHO shows that 22.8% of all doctors in the country are state-certified doctors of Ayurveda, Unani, and Homeopathy (Anand and Fan 2016).¹ India also has a sizable population of non-registered healers, especially in rural and remote areas where professional medical care is less accessible. According to a survey conducted by the MIT and Princeton researchers in 2004, village residents resort to “private doctors or traditional healers” 79% of the times they need medical care, but only 90% of these healers have formal medical degrees (cited in Hardiman and Mukharji 2012, 9). Hence, institutionalized alternative medicine in India coexists with both biomedicine and unauthorized healers.

Most anthropological studies have looked at medical plurality from the perspective of patients: how they pick and choose from available medical options. In contrast, I explore the doctors’ perspective: What do they think about different medical traditions? Do practitioners of

¹ Unfortunately, the survey did not include the practitioners of other non-biomedical systems such as Yoga, Naturopathy, Siddha, and Sowa-Rigpa.

one tradition incorporate therapies from other medical systems? Do they compete with one another? Do they welcome legitimation of all traditions? What do they think of government medical policies in general? To answer these questions, I analyze doctors' biographies and worldviews, clinical practices, and attitudes to medical plurality, including their understanding of conceptual *boundaries* between diverse medical systems.

Indeed, the concept of boundaries—the ways of classifying and categorizing the world as well as the strategies for dismissal of those categories—lies at the heart of this project. At the level of practice, medical pluralism is far from the co-existence of distinct medical systems separated by boundaries but rather in India and elsewhere, medicine is always inherently eclectic and plural. In 1980, Marc Nichter wrote about how healers in South India provided a unique blend of therapies and medicines tailored to patients' pockets and preferences. Today too, almost four decades later and despite the government's efforts to standardize the non-biomedical sector, blended treatments are in wide use. Not the least important reason for the persistence of medical eclecticism is the fact that from the perspective of many medical practitioners and their patients, medical boundaries simply do not exist.² For example, the therapeutic repertoire of Dr. Dixit,³ a certified doctor of Homeopathy, includes many elements such as numerology, *manasopchar* (a sort of Ayurvedic psychotherapy), and prayers. In other words, although his medical degree authorizes him to practice only one tradition, Dr. Dixit makes use of treatments from different strands of medical knowledge and does not find such therapeutic blending problematic.

² However, some medical practitioners do “see” the boundaries which they try to preserve, striving to mark their practices as “pure” and authentic. Moreover, commodification and branding of medical tradition can also strengthen the perception that these are distinct well-delineated systems with clear boundaries.

³ All personal names and names of small towns are pseudonyms.

At the same time, although medical practice is eclectic and plural, socially constructed boundaries between different traditions can be taken seriously, patrolled, and fortified. In contrast to practitioners who experiment with various therapies outside their authorized fields, there are doctors who firmly refuse the idea of mixed therapies, insisting that a medical tradition must remain “pure,” i.e. the way it presumably originated. For example, a Sowa-Rigpa practitioner can claim to follow the Tibetan medical tradition, adamantly rejecting a possibility of using any non-Tibetan drug or technique and advocating for guarding Sowa-Rigpa against inauthentic influences, whatever this might mean. In the age when alternative therapeutics and holistic treatments garner commercial prominence, alternative doctors often call for the “purification” of tradition from modern influences.

In India, the statements about authenticity and purity echo century old and politically rooted debates about whether Ayurveda, Unani, and other South Asian traditions should remain “pure” or be “integrated” with biomedicine (Berger 2013; Liebeskind 2002; Wujastyk 2008). In this regard, doctors’ ideas and attitudes to plural medical traditions, to some extent, reflect public discourses and government policy. The delineation of medical boundaries is grounded in the complexity of cultural politics and history, with each historical period offering multiple ways in which therapeutic traditions can be estranged or bundled. In words of Ferzacca (2008), the boundaries of medical practice “are themselves instrumentalities of and for political organization” (p. 49). Moreover, since different alternative medical traditions of India are often linked to specific cultural, religious, regional, and linguistic identities, the configuration of medical pluralism itself is symptomatic of social boundaries. The way medical systems are defined, classified, and talked about sheds light onto the cultural politics, ethnic and religious antagonism, and ideologies of national belonging.

In May 2014, Narendra Modi—a leader of a right wing Hindu nationalist party and a long-standing member of a paramilitary organization known for Hindu chauvinist proclamations—became the Prime Minister of India. Modi’s party, Bharatiya Janata Party (BJP) won the elections with unexpected magnitude, causing the former ruling party to suffer the worst defeat in the history of independent India, which strongly signaled the advance of a Hindu nationalist sentiment across the country. Modi has presented himself as a herald of economic development and modernization but also as a defender of “Indian” values and traditions, including the tradition of Yoga and Ayurveda which in public discourse understood as the traditions of Vedic (Hindu) past. At the same time, Modi acted in a direction of promoting all medical traditions, even those which were not particularly Hindu or “Indian:” in November 2014, he announced the creation of the Ministry for Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy (the Ministry of AYUSH), which previously was a department under the jurisdiction of the Ministry of Health and Family Welfare. In other words, Modi elevated the status of alternative medical traditions, granting them a separate Minister and budget.

This can be taken as a celebration of medical pluralism where all traditions are given equal recognition, but I argue that AYUSH systems are promoted unequally: Yoga and Ayurveda are characterized as more authentically “Indian,” homegrown, and national, whereas other traditions like Unani and Siddha are recognized as restricted to regional and religious communities. Furthermore, although Yoga and Ayurveda are accredited equal cultural value, the position of Ayurveda is exceptional due to its commercialization and repeated representations as the origin of all other traditions (even, in many cases, of Yoga). AYUSH itself as a new category of alternative medicine (since 2003) acts in favor of Ayurvedic exceptionalism rather than signaling medical plurality.

This dissertation examines medical pluralism from a broad range of perspectives, starting with popular media discourse, then moving to government policy, and ending with the stories of medical practitioners. Although focused on India as a country with a plethora of long-standing non-biomedical traditions, this work offers theoretical arguments relevant to any society. It interrogates the government-created categories of medical practice (such as AYUSH opposed to “Local Health Traditions”), arguing that the lives and practices of alternative doctors are so diverse that it is unproductive to treat them as a homogenous entity. Additionally, I theorize about the biopolitics of alternative medicine, demonstrating that non-biomedical traditions are also used to govern people’s life and conduct. I also show how national belonging—and even national loyalty—are produced, consumed, and tested through medical practices and herbal products. More than just about state-sanctioned alternative medicine in India, this project explores the construction of medical categories and boundaries and the practical experience of those who act on these forms of knowledge.

1.1 THEORETICAL FRAMEWORK AND HISTORIOGRAPHY OF MEDICAL PLURALISM

Scholarly interests in non-Western medical traditions date back to the early 20th century (Rivers 2003), but only after the 1950s, with the works of George M. Foster, health and healing practices across various cultural contexts began receiving systematic attention. Foster wrote extensively on humoral medicine and other therapeutic traditions in Latin America and Spain (Foster 1960; Foster 1994), although neither did he examine them as separate bodies of knowledge nor was he interested in their interrelationships.

By the late 1970s–early 1980s, studies of medical pluralism rapidly proliferated (Fabrega and Manning 1979; Janzen 1978; Janzen 1987; Kleinman 1978; Kleinman 1980; Kunstadter 1975; Leslie 1968; Leslie 1973; Leslie 1976a; Leslie and Young 1992; Nichter 1978; Nichter 1980; Press 1980; Unschuld 1975; Waxler-Morrison 1988). To a great extent, this enthusiasm was stimulated by *Asian Medical Traditions* (Leslie 1976a)—an influential collection of essays edited by Charles Leslie. Dedicated to a comparative study of Asian healing traditions, this volume was designed to “open a new field of scholarship” (1976b: 11); therefore, the birth of medical pluralism theory is commonly associated with the name of Charles Leslie. Leslie wrote extensively on medical traditions of South Asian (1963; 1968; 1976b; 1976c) but he profoundly contributed to the field of medical anthropology in general. Although his writings reflect some contradictions as his ideas and arguments developed over time, his works showed a nuanced sensitivity to the complexities of social phenomena and were immensely influential on the following generation of scholars.

In the 1970–1980s, medical pluralism was often described as “differentially designed and conceived medical systems” in a single society (Janzen 1978, xviii) or “the coexistence in one society of divergent medical traditions” (Durkin-Longley 1984, 867). But neither Leslie nor other contributors to *Asian Medical Traditions* defined this concept. While referring to “coexistence” of healing practices and a “pluralistic” structure of medicine, Leslie and other scholars were mainly concerned about “medical systems” and their classification (Dunn 1976; Janzen 1978; Kleinman 1978; Kleinman 1980; Kunstadter 1975; Press 1980). Soon, however, such notions as “coexistence,” medical “system,” medical “tradition,” and even “pluralism” itself proved to be analytically problematic. For example, the concepts of medical tradition and traditional medicine were shown to bear the logic of imperialist approaches to non-Western

societies with an image of frozen-in-time traditions, strange customs, and exotic practices, as contrasted to purportedly rational, neutral, and scientific Western world. As a result, traditional medicine came to signal a lower status than modern or Western medicine. Even today, scaffolded by the hegemonic notions of science, objectivity, and progress, biomedicine enjoys social, financial, and ideological dominance (Adams 2002; Baer 2011; Lock and Nguyen 2010; Naraindas, Quack, and Sax 2014). From this perspective, the idea of medical plurality as the “co-existence” of multiple strands of medical knowledge is deceiving, because it does not account for their hierarchical and contested relations. In words of Ritu Priya (2013), it is not a peaceful co-existence but hierarchical architecture or even undemocratic pluralism.

Postmodern critiques of the notion of culture as a bounded entity and the emergence of theoretical frameworks that emphasized agency have led medical anthropologists to seek new analytical conceptualizations of medical knowledge (Baer 2011, 419–420). On these grounds, the term medical *system* has been criticized as a theoretical abstraction (Leslie 1976a) that obscures that the boundaries between therapies are fluid and can be blurred, reshaped, crossed, or ignored (Adams 2002; Alter 2005b; Attewell 2007; Crandon-Malamud 1991; Khare 1996; Naraindas 2014a; Naraindas 2014b; Nichter 1980; Zhang 2007). In fact, as a result of many decades of anthropological and historical studies, a new vocabulary of medical plurality has been developed. Medical traditions are now described in terms of medical eclecticism, ambiguity, negotiation, conversations, entanglements, braidedness (Mukharji 2016; Naraindas, Sax, and Quack 2013). As I show below, I follow these developments in theorizing about the complexity of medical knowledge and practice, particularly drawing on the notions of entanglement and braidedness, but I also introduce a new analytical lens which I call “therapeutic versatility.”

In this dissertation, I acknowledge the problematic nature of the terms medical

“pluralism” and medical “system,” and therefore use them only in the context of government discourses and institutionalization of medical knowledge. Unlike medical plurality, “pluralism” denotes a situation when the government intervenes in the existing diversity of medical knowledge to delineate distinct medical “systems,” subjecting them to standardization and other regulatory procedures, as the government of India has done in the case of AYUSH. Moreover, not only does the term “medical system” (*cikitsā paddhati*) echo the official rhetoric but it also appears in popular vocabulary of medical practitioners themselves, so I use it when referring to government documents or direct doctors’ arguments. Otherwise, I prefer the terms medical plurality and medical traditions.

Through the investigation of how medical difference—categorized and regulated by the state—is perceived by doctors, I develop a notion of *medical ideologies*. Inspired by the theory of language ideologies (Silverstine 1979; Kroskrity 2000), I envision that each doctor comes to hold a personal set of ideas and beliefs about how medicine should be practiced, including the ideas about therapeutic authenticity, efficacy, legitimacy, modernity, and cultural value. Just as language ideologies, medical ideologies are apparent in the processes of standardization and differentiation as well as in conversations about which therapies are “proper,” “good” and “authentic.” The identification of a medical tradition as “Ayurveda,” “Unani” or “biomedicine” creates a boundary with other traditions. From this perspective, doctors’ medical ideologies influence how they engaged in acts of therapeutic boundary-making or boundary-crossing.

1.2 RESEARCH QUESTIONS AND ARGUMENTS

1.2.1 Therapeutic boundaries and institutionalization

Currently, the Government of India recognizes seven non-biomedical traditions: Ayurveda, Yoga, Naturopathy, Unani, Siddha, Sowa-Rigpa, and Homeopathy, officially designated under the acronym AYUSH. The website of the Ministry of AYUSH (“About the Systems” n.d.) provides an outline of each tradition’s history, underlying principles of disease etiology, diagnosis, and treatment, as well as the associated medical infrastructure—all of which makes AYUSH traditions appear as clearly delineated medical systems. However, medical traditions are ever-changing and heterogeneous fields which do not resemble “systems” and in practice, doctors often transgress the state-mandated boundaries between medical disciplines. Moreover, although the government requires professional education according to set standards, there are still many practitioners who come from families of hereditary healers and engage in approaches to medicine different from those that the government expects.

To understand how therapeutic boundaries are produced and contested, this dissertation juxtaposes the processes of institutionalization and public discourse on medical plurality with the everyday clinical practices of AYUSH practitioners, their attitudes to government policy, and views on therapeutic plurality. How does the institutionalization of alternative medicine affect AYUSH practitioners? Do they conform to or challenge the government identification and delineation of medical traditions in the form of AYUSH? How do doctors understand and translate AYUSH policy into their daily practice? Do doctors, who are identified by the state as practitioners of a specific kind of medicine, articulate a concern for either therapeutic mixing or therapeutic purity? Do they think of themselves as doctors with general expertise or as experts in

a particular kind of medicine? In answering these questions, I introduce both medical practitioners who use medicines that do not correspond to their area of certified expertise, and those who refrain from therapeutic cross-pollination. I show that political, social, and personal circumstances—including doctors’ families and personal commitments—affect practitioners’ decisions on therapeutic choices. Here I pay particular attention to doctors’ narratives, their invocations of culture, authenticity, legitimacy, modernity, and homegrown tradition. By focusing on these notions, I address whether and how doctors’ therapies reflect their concerns about cultural identity and nationhood.

Ultimately, I refute the analytical framework of medical plurality which looks at either therapeutic blending or patrolling of medical boundaries; instead I argue that doctors’ practices are characterized by “therapeutic versatility,” as they situationally adapt their medical strategies in response to patients’ demands, market incentives, family arrangements, government regulations, and public discourses. In other words, it is not that some doctors provide blended treatments while other doctors insist on pure therapies but rather all doctors resort to both blended and pure medicine depending on circumstances. As medical virtuosos, they calibrate their practices in response to individual cases.

1.2.2 Hierarchy of medical pluralism and nationalist discourses

In Indian public discourse, non-biomedical knowledge traditions are imbued with distinct cultural, religious, regional, political, and historical affiliations. Ayurveda is associated with Sanskrit language, Vedic heritage, and the ancient history of the Indian subcontinent; Unani is associated with Urdu, Islam, and the medieval history of the Muslim conquest; Siddha—with Tamil, Tamil culture, and non-brahmanic knowledge; Sowa-Rigpa—with Tibet, Tibetan

minorities in India, and Tibetan Buddhism. Although these associations are historically simplistic (Attewell 2007), socially inaccurate, and politically problematic, they bear influence on how these diverse intellectual traditions of medicine are perceived, which social status they are accorded, and whether they are given national importance. In other words, far from being simply about holistic approaches to health, alternative medicine is embedded in the debates about what and who constitute the nation.

I probe into the hierarchies and “asymmetries” (Naraindas, Quack, and Sax 2014) of the medical plurality by describing the evolution of government policy on alternative medicine since India’s independence and analyzing the categories of “indigenous systems of medicine,” “Indian Medicine,” and “AYUSH.” Due to the recent rise of a right-wing Hindu nationalist party and Narendra Modi’s affiliation with a paramilitary organization founded on the ideology of Hindu supremacy, the meaning of “Indianness” drifts toward Hindu heritage, resulting in a situation where some of AYUSH systems are considered more “Indian” than others. There is a discrepancy between the government’s pledge to equally support all alternative medical traditions and the privileged support for Ayurveda, conspicuously presented as an authentically Indian and homegrown (*swadeshi*) tradition. I show that this tension is entangled with two opposing ideologies of the Indian nation: the ideology of inclusive nationalism, anchored in the Nehruvian principle of unity in diversity; and Hindu nationalism according to which the Indian nation is fundamentally Hindu.

At the same time, while medical traditions are either privileged or marginalized as a result of prevailing nationalist ideologies, alternative doctors of the state-mandated AYUSH disciplines understand and respond to these processed differently. Some of them wholeheartedly support the notion of national Ayurveda whereas others challenge Ayurvedic exceptionalism.

Since any discourse around Hindu heritage is potentially embroiled in Hindu-Muslim antagonism, my analysis is attentive to ways in which non-Ayurveda doctors, especially Unani practitioners, react to Ayurvedic hegemony.

Moreover, since the “state” is not a unified entity but is constructed as such through public discourse and bureaucratic practices, I examine the views of government officials who have also practiced as medical doctors, thus straddling the spheres of medical policy and practice.

1.2.3 Biopolitics of Indian medicine and biomoral consumption

Building on theorizations of biopower and governmentality, I show that that the government officials, public proponents of AYUSH systems, and doctors themselves influence human life and conduct, by circulating certain medical ideologies and prescribing health regimens related to body, diet, and lifestyle. In particular, the promotion of Ayurveda and Yoga is based on discourses that mobilize Indians to act on and discipline their bodies. Although most studies in medical anthropology have examined biopower and biopolitics as enacted by biomedicine, genetics, medicalization, vaccination campaigns, and public health measures (Arnold 1993; Briggs and Nichter 2009; Braun 2007; Fassin 2009; Foucault 1978; Marsland and Prince 2012; Petryna 2002; Rabinow and Rose 2006; Rose 2007; Rose and Novas 2005), these approaches are theoretically incomplete without the examination of non-biomedical regimes of biopower. Alternative medicine, too, is instrumental in biopolitical projects that aim at the management of populations and individual subjects.

As a case study, I analyze the rhetoric of Baba Ramdev—an influential Yoga guru who operates a billion-dollar industry of Ayurvedic pharmaceuticals called Patanjali Ayurved. I

examine his vocabulary, use of pronouns, code-switching, and other discursive strategies to expose Ramdev's construction of the Indian nation, citizens' duty and morality, and the articulations of what might be called dogmatic ayurvedic fundamentalism. I argue that Ramdev skillfully weds nationalist sentiments with consumerist desires, mobilizing Indian citizens to act upon their bodies and consume "homegrown" and "national" Ayurveda. In doing so, Ramdev conveniently omits other AYUSH traditions. Beyond promoting Ayurveda as a regime for improving *personal* health, Ramdev declares that it is the citizens' duty to consume Ayurveda as a means by which to strengthen the *collective health of the nation*. Thus, in addition to being driven by pursuit of health, Ayurveda becomes part and parcel of embodied nationalism and bio-moral consumerism.

The interweaving of the theories of nationalism and biopower provides an excellent framework for understanding the relationships between the state and non-biomedical doctors. Since both state policy and Ramdev's campaigns can be seen as manifesting biopower in terms of disciplining the population with regard to lifestyle, health, and consumption habits, I question to what extent local AYUSH doctors follow and contribute to such biopolitical projects, and whether and how the doctors situate their practice within broader concerns about the health and wellbeing of the Indian nation.

1.2.4 Ayurvedicalization of medical plurality

This study evinces unequal positions of medical traditions within the structure of AYUSH, specifically the marginalization of Unani and the rise of Ayurveda. Ayurvedic exceptionalism is linked to its postulated value as ancient, homegrown, cure-all solution to modern ailments. Moreover, what is happening in contemporary India can be understood as the

“ayurvedicalization” of medical plurality: Ayurveda does not merely occupy the dominant position among non-biomedical traditions; it is gradually taking them over. Many practitioners proclaim that Ayurveda is the origin of all other medical knowledge traditions and that Unani, Sowa-Rigpa, and even Homeopathy are mere derivatives of Ayurveda. Even the very term of AYUSH is frequently misinterpreted as Ayurveda, and an “ayush doctor” is used to refer to an ayurvedic practitioner.

Ayurveda is expanding beyond the domain of medicine. Due to Ramdev’s efforts and marketing strategies of Ayurvedic pharmaceutical companies, any kind of home remedies (*gharelu ilaj*) or herbal-based product in India has come to be understood as Ayurvedic. Clove-based toothpaste, eye drops with ginger extract, whole-wheat instant noodles, and a cow-urine dishwashing detergent—all are marketed as Ayurvedic. Therefore, this dissertation argues that the current discourses and processes pertaining to India’s institutionalized medical pluralism constitute not only the “ayurvedicalization” of plural medicine but even the ayurvedicalization of wellness and body maintenance.

1.3 RESEARCH SITES

This work is informed by 18 months of ethnographic research in North India, carried out between 2012 and 2016. I worked primarily in villages and towns of Uttarakhand, although I also conducted a preliminary study in Himachal Pradesh and collected data on government policy in Delhi. On the following pages, I provide a detailed historical, geographical, and sociocultural overview of the state of Uttarakhand which is, in distinctive ways, both rhetorically and ecologically implicated in discourses on traditional medicine. This is followed by a brief

sketch of Himachal Pradesh and Delhi and a section on research methodology.

1.3.1 Uttarakhand

Uttarakhand is a relatively new state on the map of India: it was created in 2000 by splitting from a very populous state of Uttar Pradesh. Uttarakhand spreads over the foothills and slopes of the Himalayan mountains, and its geography is reflected in its name, which comes from two Sanskrit roots: *uttar*—north or northern, and *khand*—section, part, division. Accordingly, “Uttarakhand” is a customary way of referring to the northern region of the subcontinent. Initially, the government of India decided to christen a new state Uttaranchal—the “northern blessing,” but the name was met with strong political opposition by both common people and political leaders. They demanded a restoration of what they believed was a traditional name of the region—Uttarakhand—as it appeared in ancient scriptures. As a result, the Government of India granted the name change, and in January 2007 the state officially became Uttarakhand.

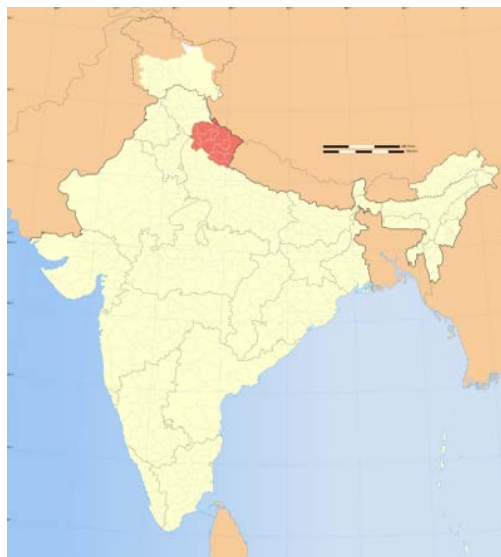


Figure 1. Uttarakhand on the map of India
CC-by-sa PlaneMad/Wikimedia

https://commons.wikimedia.org/wiki/File%3AIndia_Uttarakhand_locator_map.svg

Administratively, Uttarakhand has two divisions, Garhwal and Kumaun, comprised of 13 districts. The state's capital and the largest city is Dehradun with a population of about 500,000 million people—a considerably small city by Indian standards. Other large towns include Haridwar, Roorkee, Rishikesh, and Haldwani. In remote mountainous villages, people primarily, if not exclusively, speak local dialects, but the official language of Uttarakhand is Hindi. Remarkably, Uttarakhand is the only state in India which granted the status of the second official language to Sanskrit. This itself is a significant marker of regional politics, but coupled with the dominance of Hinduism and the movement for renaming of Uttarakhand in accordance to ancient Hindu scriptures, it depicts a strong presence of Hindu majoritarian politics. Within the short history of Uttarakhand and eight election cycles, Indian National Congress has been successful three times and the right-wing Bharatiya Janata Party—five times.

According to the most recent census data (Census of India 2011), the population of Uttarakhand is more than ten billion people which makes it the 20th most populace state in the country. There are about 5.15 billion men and about 4.96 billion women, with the gender ratio 963 women per 1000 men, which is significantly better than an average gender ratio for the country: 940 women per 1000 men (Census of India 2011). Approximately 69.5% of the Uttarakhand population live in rural areas, including many remote and mountainous locations where biomedical facilities are rarely available. The state is a home to many ethnic groups, and is quite diverse in terms of religion: 83% of its population are Hindus, 14% Muslims, 2% Sikhs, and less than one percent are Christians, Buddhists, and Jains. The area around Dehradun and Mussoorie has a noticeable presence of Tibetans who have fled China after 1959 and established several settlements with administrative bodies, monasteries, schools, as well as medical clinics called *men-tsee-khang*.

Uttarakhand has international borders with China and Nepal and domestic borders with Uttar Pradesh, Himachal Pradesh, and Haryana. There is a strong presence of Ayurveda and Yoga establishments including hospitals, wellness retreats, and ayurvedic pharmaceutical units as a direct consequence of Uttarakhand's eco- and biodiversity, abundant with endemic medicinal herbs, roots, fruits, and minerals. With dazzling white peaks and emerald lakes, Uttarakhand's landscape is sacred for many communities, but the state is particularly known for its Hindu pilgrimage sites, especially along the Ganga River. Gangotri Glacier where Ganga originates and Rishikesh where it emerges from the mountains onto the plains are both located within the Uttarakhand boundaries. It is not surprising that Ramdev's Patanjali campus was established not far from Rishikesh.

Uttarakhand was often seen as "underdeveloped hill hinterland" of Uttar Pradesh and, to a large extent, it was "the region's perceived deprivation relative to the more prosperous [Uttar Pradesh] plains that fueled the agitation for statehood" (Galvin 2014, 119). Indeed, once Uttarakhand became independent, it has made a considerable economic progress, becoming the second fastest growing state in India (Statistics Times 2015). Agriculture is the most significant sector of state's economy but the state also relies on revenues from tourism, hydropower, and growing biotechnology and pharmaceutical industry. With a demand for natural and herbal medicine, many pharmaceutical companies and individual dealers make arrangements to get access to Uttarakhand's natural resources which positively contributes to the state economy but also posits a threat to biodiversity from overexploitation of flora and fauna. As a response, the government of Uttarakhand has demarcated 16 protected areas, including six national parks where economic activity, the use of forest resources, and human habitation are highly restricted (Government of Uttarakhand n.d.), though illegal extraction of timber and plants remains a

problem. As a step further, the state authorities have been investing in schemes for the cultivation of “medicinal and aromatic plants,” striving to both attract investors and alleviate a pressure on the wild. In line with these intentions, in 2002, Uttarakhand was declared an “Herbal State” (Kuniyal et al. 2015, 1147). There are also many initiatives, supported by the government, local NGOs, and international organizations for organic farming (Galvin 2014, 119). Moreover, the state promotes itself through an official nickname *Dev Bhumi* (the Land of Gods), which refers to the presence of numerous important Hindu pilgrimage sites such as Kedarnath, Badrinath, Gangotri, Rishikesh and Haridwar. Such promotion as an “herbal state” and the “divine land” points to Uttarakhand’s strategic competition with other North Indian states for claiming a unique cultural and commercially significant role in the Himalayas.



Figure 2. An Uttarakhand village with a view of the Himalayas
Photo by the author

Most of my fieldwork took place in the Garhwal region—at the outskirts of Dehradun and in a settlement I call Chhotapur—but I also visited and spoke to people in Rishikesh, Haridwar and several settlements in the Kumaon region. These visits allowed access to a great diversity of

medical practitioners, each working in different contexts but bound by the same health policies of the Uttarakhand state. A preliminary study in summer 2012 proved that this area was home to many practitioners of AYUSH systems. There is a great number of Ayurvedic private and government hospitals as well as small-scale private Ayurvedic clinics, pharmacies, and dispensaries. There is also substantial presence of homeopathic doctors, and one can still find practitioners of Unani medicine but mostly on the plains, around Dehradun and Roorkee. Additionally, there are several established Yoga schools where world-known Yoga traditions like the Iyengar Yoga are practiced, as well as there is a growing number of naturopathy and Yoga retreats.⁴ As I mentioned, this area also hosts several Tibetan clinics with Sowa-Rigpa practitioners. Although the official residence of the Tibetan government-in-exile is in Himachal Pradesh, several Tibetans settlements have remained in Uttarakhand. The only AYUSH system which is not present in the area is Siddha, but it is rarely found in any part of India beyond Tamil Nadu and Kerala.

Non-biomedical services occupy an important position within Uttarakhand's health care structure: Uttarakhand is one of the states with a higher-than-average rate of AYUSH dispensaries per population in the country (National Health Profile 2012, 40). There are famous Ayurvedic teaching and research institutions such as Rishikul Ayurveda College and Gurukul Kangri College, Haridwar. Moreover, Uttarakhand is committed to numerous government programs⁵ focused on medicinal plants, most of which are key ingredients in AYUSH remedies (Government of India 2002, 5). The extensive cultivation and extraction of medicinal plants

⁴ The number of Yoga and Ayurveda retreats and hospitals in the Dehradun area is much smaller than in Rishikesh, but for my field site I aimed to choose a less tourist-oriented and more residential place.

⁵ For example, the Agri Export Zones (AEZs) program realizes the control over the production, processing, packaging, and subsequent export of medicinal plants.

under these programs are linked to the rising importance of Ayurveda and herbal-based treatments both in the state and in the country.

Uttarakhand is the headquarters of Ramdev's Ayurveda and Yoga enterprise—the Patanjali Yogpeeth. Located on the Haridwar–Roorkee road, the campus of the Patanjali Yogpeeth is spread over 1000 acres (Deka 2016). Housing an ayurvedic manufacturing factory, a research center, a university, a food park, and a hospital with inpatient facilities, the Patanjali Yogpeeth is an employer of nearly 15,000 people, many of whom are Uttarakhand residents. Moreover, Ramdev's ubiquitous portraits on the streets of Uttarakhand's cities, frequently-organized Yoga camps and festivals, Patanjali retail franchises that can be found even in remote mountain villages, and a network of agents who recruit mountain villagers for the collection of medicinal plants—all contribute to the visibility of Ramdev's persona and his rhetoric in the state. In sum, this area provided solid grounds for examining nationalist discourses, ideologies of medical pluralism, and the commodification of traditional medicine.

1.3.2 Additional research sites

In summer 2013 I spent a month in Himnagar hill station (a pseudonym) in Himachal Pradesh where I met and interviewed practitioners of Ayurveda and Homeopathy but did not come across practitioners of other AYUSH systems. The statistics shows that of all registered AYUSH practitioners in Himachal Pradesh, 75.27% are Ayurveda, 24.65% Homeopathy, and 0.08% Unani doctors, whereas in Uttarakhand the numbers are slightly more balanced: 74.34% are Ayurveda, 22.29% Homeopathy, and 3.37% Unani doctors (National Health Profile 2012, 154). In terms of religious diversity too, Himachal Pradesh is much more homogeneous: 95.2% of the population are Hindus (Census of India 2011).

In order to conduct research in India as a foreign scholar, I had to be affiliated with a local university. Since my affiliation was established with Jawaharlal Nehru University in Delhi, I had to be present in Delhi for short visits throughout my fieldwork. It was often rather exhausting, but I took it a good research opportunity. Delhi is the capital of India and one of its largest cities with a population of 16.8 billion people (Census of India 2011). It houses all institutions of the union government, including the Ministry of Health and Family Welfare and the Ministry of AYUSH, as well as major medical institutions such as the Central Council for Indian Medicine, the Central Council for Research in Ayurveda, and the Central Council for Research in Unani. Delhi is conveniently located a 6-hour train ride from Dehradun, which made it possible to visit Delhi whenever I needed. However, since my study became more involved with the issues of government policy, I spent an entire month in the capital, interviewing government officials as well as doctors and professors at established medical institutions such as Hamdard University and the Ayurvedic and Unani Tibbia College.

1.4 METHODOLOGY

1.4.1 Preliminary research

The present work is informed by three preliminary studies. In summer 2012, I carried out a survey of AYUSH clinics in Chhotapur, supplemented by short trips to Dehradun, Rishikesh, and Haridwar. There I conducted interviews with five Ayurveda, one Unani, two Homeopathy, and one Nature cure practitioners, documenting initial information on their training, therapies, and patient populations. In summer 2013, I worked in two towns: Himnagar in Himachal Pradesh,

and Nainital in Uttarakhand. This study was focused on physical spaces of the clinics and material objects associated with AYUSH practice. During this trip, I also began collecting information about Ramdev and visited several Patanjali stores. The third pilot study was carried out in summer 2014 in the United States where I conducted interviews at the main office of the international branch of Patanjali YogPeeth. Additionally, I interviewed students and young professionals from India with regard to their use of non-biomedical treatments such as Yoga, Ayurveda, and Homeopathy, their views on recent political transformations in India and on Ramdev's enterprise. Although this study is not directly related to the present dissertation, it has been valuable for my understanding of the politics and globalization of AYUSH medicines.

1.4.2 Data collection

1.4.2.1 Inventory of local medical resources

In Chhotapur, I compiled an inventory of all medical and health resources (AYUSH and biomedical), in order to understand the scope of medical plurality in the area. I did so by using the following strategies: walking and noting down all hospitals, medical clinics, pharmacies, and dispensaries which appeared on my way; walking into variety stores and examining if they sell medical products; talking to local people and asking where they seek treatment; talking to doctors and asking if they know other doctors in the area; and conducting an online search. A combination of these strategies proved productive: although I noticed and surveyed all major hospitals, clinics, and pharmacies on my own, local people were extremely helpful in directing me to doctors who did not have proper clinics with signs on their doors. Many health providers receive patients at home or the places of worship such as Hindu *mandir*, and thus they are invisible to non-locals. Frequently, my knowledge of local medical resources resulted from

accidental discoveries. For example, after eight months of living in Chhotapur, I accidentally learned about and then interviewed a doctor who every week comes from Saharanpur (a large city in Uttar Pradesh) and treats patients in a local *gurdwara* (a place of worship in Sikhism). On another occasion, when I was talking to a shop keeper about Ramdev, I was told that before a Patanjali franchise was opened in Chhotapur, people had been ordering Patanjali products in bulk from a postman who served as a local distributor.

1.4.2.2 Interview

In-depth semi-structured interviews were the cornerstone of the research methodology. During the course of the fieldwork, I interviewed in length about 110 persons, including 54 AYUSH practitioners,⁶ their patients, eight government officials with AYUSH degrees, other persons in healthcare-related fields (biomedical doctors, pharmacists, medical students, Yoga teachers), and local residents. The interviews were conducted either in English or Hindi, depending on the preference of my interlocutors.

Among AYUSH practitioners, 36 were from Uttarakhand, 13 from Delhi, and five from Himachal Pradesh. In Uttarakhand, the majority were the practitioners of Ayurveda (23), followed by Homeopathy (7), Sowa-Rigpa (3), Unani (2), and Naturopathy (1). This is representative of the state's overall healthcare landscape: there are 543 Ayurvedic, 107

⁶ As I explain in detail in Chapter 5, the complexity of medical training and qualification makes it hard to call all interviewed practitioners “doctors” (e.g. some are institutionally trained, some are taught by fathers or gurus but are registered with state registrars as medical practitioners). For purposes of clarity, I restrict the use of the term “doctor” only in reference to those who have completed full medical training (at least bachelor's education). In contrast, the terms “practitioner” and “provider” are much broader, referring to anyone who provides medical services and is routinely consulted by the local community. “Practitioners” include those trained in short AYUSH courses and those trained in teacher-discipline tradition, whether registered as medical practitioners or not. With regard to Ayurveda and Unani practitioners I also use the emic terms *vaidya* and *hakim* respectively.

Homeopathic, and three Unani hospitals/dispensaries,⁷ three Tibetan medical centers (*men-tsee-khang*),⁸ and no Siddha facilities. There are many Yoga practitioners in Uttarakhand but they are not required to have a registration and most of them are not trained in government institutions; therefore, I did not count them as AYUSH practitioners. All interviews were audio-recorded and lasted 45–110 minutes. With approximately the half of the practitioners I conducted two or three interviews, and with two doctors I developed stronger relationships which included many recorded interviews, informal conversations, home visits, dinners, and spending time with the doctors' families. During the interviews, I collected demographic data on doctors' families, training, specifics of medical practice. A detailed discussion of AYUSH practitioners' age, gender, education, and occupation is provided in Chapter 5.

When I talked to AYUSH doctors, I asked them questions about different non-biomedical practices and rationalities, trying to understand how they view government medical policy and how they position their specializations vis-à-vis other AYUSH traditions: as rivals or colleagues, as all worthy of legitimation or not, as all “Indian” or some more foreign than others. Although my primary goal was to investigate the practices of AYUSH doctors, I quickly observed that every interview and conversation about alternative medicine involved statements about Ramdev, which is how I was drawn into investigating Ramdev's persona and AYUSH practitioners' views of him and his enterprise.

A key to ethnography is as much *forgetting* as it is learning. To paraphrase Johannes Fabian (1995), to do ethnography is to accept that understanding is potentially a

⁷ “State Health Infrastructure,” Uttarakhand Health and Family Welfare Society, Government of Uttarakhand, Department of Health and Family Welfare. Accessed March 20, 2017. http://www.ukhfws.org/details.php?pgID=tp_13.

⁸ “Men Tsee-Khand Branches,” Men Tsee Khang (Sowa-Rigpa) Tibetan Medical and Astro-science Institute. Accessed March 20, 2017. <http://www.men-tsee-khang.org/branch/uttarkhand.htm>.

misunderstanding. As Blommaert and Jie add, Fabian’s analysis “provides ethnography with a peculiar, dynamic and dialectical epistemology in which the *ignorance* of the knower—the ethnographer—is a crucial point of departure” (2010, 10). It is precisely this kind of ignorance that needs to be exercised in a study of I put into practice: How do I know that some medical doctors are “authorized” and some are not? Do patients and doctors also know it? To put this differently, even the boundary between “legitimate” and “illegitimate” medical practitioners needed to be tested. During the fieldwork, I encountered several healers who did not have authorized medical credentials but who were regarded in their neighborhoods as doctors and whose clinical approaches were surprisingly similar to those of certified doctors. Therefore, instead of discounting these cases, I included them into my study, acknowledging that non-certified doctors are as much a product of institutionalization of alternative medicine as are certified doctors.

I also spoke to four biomedical doctors, one Hindu priest, three Indian and two international students from AYUSH colleges, numerous patients of the interviewed AYUSH doctors, pharmacists and shopkeepers who sell non-biomedical pharmaceuticals and related products, and common people whom I got to know during my fieldwork. Additionally, I interviewed eight AYUSH government officials in Delhi and Dehradun. They hold degrees in one of AYUSH disciplines but do not engage in medical practice. Instead, they occupy administrative or research positions at the Ministry of AYUSH, the Delhi Directorate of AYUSH, and the Directorate of Ayurvedic and Unani Services of the Government of Uttarakhand.

One of the difficulties of asking questions in a foreign cultural context is the fact that interviewing can “generate different kinds of speech genres” than genres expected by a

researcher (Coe 2001, 408). Cati Coe describes a series of events during her initial study in Ghana, when she requested to interview and tape-record a local person, expecting to have a casual discussion. Instead, the person insisted on reading out a carefully prepared text in a very formal register. The genre of the ethnographic interview which Coe had in mind was dramatically different from the genre envisioned by her interlocutor. Being aware of such conceptual discrepancies, I often avoided the term “interview,” favoring “conversation” or “talk.” Only once did I forget about this precaution and had a situation reminiscent of Coe’s experience. While speaking on a phone with a highly educated and renowned doctor, I requested to “interview” him. The next day, when I arrived in his office, he warmly greeted me and we chatted for about three minutes while I was describing my research subject. I asked a permission to record our conversation and the doctor agreed, emphasizing that he would be happy to help me as best as he could. As soon as I turned on the recorder and asked him some general question, he almost interrupted me by beginning in an official manner, as if we were participating in a television show: *Thank you very much for visiting our [name of the institution]. Good afternoon. My name is doctor [first and last name], and I am a director of a [name of a department].* Although I had explained that the recording was only for research purposes and it would be used in an anonymized manner, he proceeded with the TV show-style “interview.” This example demonstrates that every “interview” is a co-produced and negotiated interaction, over which researchers do not have sole control.

As I met and spoke with various people, I observed that they assigned different roles to me: a researcher from America, a researcher from Russia, a valued guest, a journalist, a medical specialist, a messenger to the government, a daughter, and often a token of legitimation and prestige for doctors. On one occasion, a doctor insisted on posing for a photograph with me

holding my voice recorder and him answering my questions (I sometimes wonder whether my photograph is now hanging on a wall of his clinic). On a different occasion, after an interview, when I was sharing a ride with a doctor and his daughter, the doctor suddenly asked if I did not mind stopping by his in-laws. I was puzzled why he needed to visit them so unexpectedly, but he gave me a vague answer. My polite attempts to decline the invitation did not result in success, so we went to his in-laws' house. We ended up spending hardly more than 15 minutes there—but just enough for every member of his in-laws' family to touch my hand, exchange a few Hindi phrases, and admire that a foreigner who spoke Hindi came “all the way from America” to interview their son-in-law. Although this family was very kind to me and overall I had an amusing evening, I can imagine why he wanted to “show” me to his in-laws: this doctor does not have a medical degree (only a state registration) and his clinic is almost always empty, so in the eyes of his relatives I might have added a degree of credibility, prestige, and symbolic capital.

Bearing in mind these situations, I am cognizant of the fact that an interview is a situated interaction where not only a researcher but also her interlocutors pursue certain goals and agendas. Here again it is worth recalling Fabian's work (1995) on ethnographic process, where he argues that the idea of “collecting” information and its subsequent “analysis” does not adequately “express what happens when anthropologists do fieldwork,” because “the founding acts of ethnography are *communicative events*” (p. 44, emphasis mine). Although Fabian was concerned with how researchers deal with (mis)understanding in the research process, I believe that the notion of communicative events is valuable methodologically, as it points to the interactive, intersubjective, and sometimes contested nature of ethnographic exchanges.

1.4.2.3 Observation

Another important method of this study was observation in AYUSH clinics. To meet ethical considerations, I conducted observations only in those clinics where there was no clear division of space between a waiting room and an examination room, which ensured that patients who attended such clinics were accustomed to being examined by a doctor in the presence of others (see Langford 2002). Most of such clinics consist of only one room with a doctor's table, one or two chairs for those who are being examined, and a bench for those who are waiting for their turn.

My observations often occurred in conjunction with the interviews because many doctors insisted on talking to me during their working hours and while receiving patients. When doctors spoke to their patients, I typically turned the voice recorder off but took extensive notes, registering language of conversations (English, Hindi), the number of participants (whether a patient was alone or accompanied by relatives), diagnostic procedures (pulse-taking, sleep and diet history), the use of medical technology (stethoscopes, thermometers), prescribed medicine (self-prepared herbal mixtures, branded pills) and other details of clinical practice.

In addition to clinical observations, I also explored local shops, pharmacies, temples, and streets. I visited wholesale spice markets and medicinal gardens where some of the interviewed practitioners procured raw materials. Whenever I had a chance, I also toured AYUSH universities and hospitals to observe their medical facilities and interact with the staff. I personally tried many Ayurvedic, Unani, Homeopathic, and Sowa-Rigpa medicines and therapeutic procedures as well as Patanjali products.

1.4.2.4 Archival research

To a great amusement of many of my secular friends, I became a follower of Ramdev on Facebook and Twitter. It is unclear whether Ramdev himself is in charge of online communication or his social media manager posts messages on Facebook and tweets on Ramdev's behalf. Nevertheless, this strategy of daily following Ramdev's persona on social media allowed me to be instantly informed about his campaigns and speeches. Moreover, I have been monitoring major news reports about Ramdev in the Indian and foreign press,⁹ as well as watching his Yoga shows, interviews, and public speeches. I read and analyzed the websites of organizations founded by Ramdev such as Divya Yog Trust, Patanjali Gramudyog Trust, and Bharat Swabhiman Trust, and read the magazine Yog Sandesh as well as various brochures and books published by his corporation.

From online and library sources, I archived and categorized the data on AYUSH statistics. Additionally, several government officials and university professors allowed me to take photocopies of the documents with AYUSH statistics available in their offices. I also gathered and analyzed central government and state policy documents pertaining to AYUSH practice and infrastructure, such as the National Policy on AYUSH, the National AYUSH Mission, the National Rural Health Mission, Chopra Committee Report, the Indian Medicine Council Act, the Drugs and Cosmetics Act and Rules, as well as other acts, reports, and notifications on educational standards, prescription guidelines, good manufacturing practices, clinical trials, medicinal plants cultivation, etc. Most of the documents are digitalized and available online, while others I accessed at the libraries of Jawaharlal Nehru University in Delhi with which I was affiliated during my fieldwork

⁹ Since October 2015 I have been subscribed to Google Alerts, which deliver new online postings on a chosen topic (in my case "Ramdev") to one's email address.

1.4.3 Data analysis

1.4.3.1 Ethnographic analysis

I have transcribed all interview files with AYUSH practitioners, both conducted in Hindi and English. To ensure the confidentiality of information, each respondent was assigned a unique alphabetic code and a pseudonym, so that the transcription files were de-identified and labeled with a corresponding code. Based on the interview data and field notes, I compiled an Excel catalog of AYUSH practitioners, which included assumed gender, age category, medical field, medical degree, years of practice, job location, secondary occupation, and others. Below is a random sample to illustrate the content of the Excel file:

Table 1. A sample of collected data from interviews

PSEUDONYM	Preet Shukla	Tara Dorjee	Ghalib Hakim
Recoding CODE	PJ-AN-M	SO-T-VR-R	AF-U-GD-D
STATE	Uttarakhand	Uttarakhand	Uttarakhand
LOCATION	Chhotapur	Suratgarh	Dehradun
MEDICAL FIELD	Ayurveda	Sowa-Rigpa	Unani
Use of ADDITIONAL medical fields, therapies, drugs	Naturopathy (considers it part of Ayurveda), Color therapy	no	Occasionally prescribes Ayurvedic branded drugs
DEGREE	BAMS (Kolkata)	BTMS (Dharamsala)	BUMS (Allahabad)
GENDER	m	f	m
AGE group	35-40	30-35	55-60
CURRENT JOB	a doctor and owner of a private clinic, but previously he worked for the state government for three years	a hired doctor at a multi-specialty private retreat	a doctor at a Unani government dispensary
SECONDARY OCCUPATION	runs a Naturopathic hospital	nothing currently	nothing currently
YEARS OF PRACTICE as a doctor	9	5	Officially 35 years, but had been helping his father since childhood
Approach to BLENDED	yes: allopathy and Ayurveda	not herself, but favors integration of multiple therapies, because	medical traditions should not be mixed

THERAPY		thinks that allopathy, Ayurveda and Sowa-Rigpa operate on the same principles	
medical family	yes, father is a <i>Ayurvedacharya</i> , wife is a Naturopathy doctor	no, father was an artist	yes, his father was practicing in the same clinic
wanted to be a biomedical doctor?	Yes, but did not pass the exams	wanted to be any doctor, enrolled in a biomedical course, but felt culturally alienated, so switched to Sowa-Rigpa	no

1.4.3.2 Text and discourse analysis

With regard to Ramdev’s rhetoric, I selected two public speeches to analyze his major arguments and his target audience. The first speech was delivered at the forum “How Should India become Self-Sustainable through a Homegrown Path?” which aired on Sanskar TV in December 2010 and was uploaded to YouTube (Ramdev 2010). The second speech was given during the National Ayurveda Summit in February 2014 in Gujarat, and is also available on YouTube (Ramdev 2014). These speeches were chosen because they directly relate to the articulation of nationalism, *swadeshi* ideology, and Indian medicine. Additionally, they were delivered as social lectures (rather than practical medical lessons of Yoga or Ayurveda). According to Santanu Chakrabarti, “Ramdev presents a remarkably united messaging front” across his live and online public appearances (2012, 159); therefore, the selected speeches are representative of Ramdev’s overall views.

From these speeches, I selected 20-minute excerpts and transcribed them using the *f5transkript* software. Then I administered a textual analysis with the help of MAXQDA to determine and code dominant themes in Ramdev’s narratives. MAXQDA is a software which allows organizing and conducting a mixed-method analysis of written, spoken, and visual data, when a researcher goes through chosen texts, coding them in terms of themes and annotating the

data with memos (comments). Although a quantitative analysis is not included in the present work, MAXQDA can calculate the frequency of occurrence of specific words and themes, it can also display the textual context in which those words and theme appear and can produce charts and other visualization tools. “Themes” are abstract categories which can be found through their expression in the text, images, sounds, and objects, and which can be either *a priori*, when a researcher looks for specific themes based on a chosen theory, or *inductive*, i.e. emerging from the data (Ryan and Bernard 2003, 87). Since I was interested in nationalism, cultural identities, and plural medicine, I relied on many “a priori” themes such as “nation,” “homegrown” but many other themes have emerged from the data such as “foreign control,” “Indianness,” “Indian women,” “duty,” and “ancient India.”

In addition to textual analysis, I also performed a discourse analysis of the selected speeches. Discourse analysis is a data-driven empirical method which analyzes language in use (Johnstone 2008). By language, discourse analysts mean not linguistic rules and abstract structures, but both written and spoken texts in real life situations. It is about how people use language “to do things in the world” (Johnstone 2008, 3). In particular, discourse analysis is concerned with people’s grammatical, lexical, and interactional choices in order to expose social relations and power structures in which the discourse participants operate. Discourse analysis helps to examine “the structure and function of pieces of talk or text” and explain how “the structure of sentences is influenced by how they function in the linguistic and social contexts in which they are deployed” (Johnstone and Eisenhart 2008, 3). For example, studies that use discourse analysis focus on the use of personal pronouns, grammatical tense, passive or active sentence structures, specific terms, repetition, metaphor, code-switching from one language or another, turn-taking in conversation, pauses, and other discursive strategies.

In my examination of Ramdev's speeches, I draw on the studies of the language and rhetoric of politicians and public figures (Beattie 1982; Johnstone 1991; Ritivoi 2008) and more broadly the studies of political and nationalist discourses (Achard 1993; Bassiouney 2012; Billig 1995; Chilton and Schaffner 2002; Coupland 2001; Eisenhart 2008; Fairclough and Fairclough 2012; Musolff 2004; van Dijk 2008; Wilson 2015; Wodak 2011). Irrespective of whether they have an ability to physically exercise power on populations or not, political and social leaders deploy specific discursive strategies to maintain their authority and mobilize the population to think and act in certain ways. Since the speeches of prominent leaders can critically contribute to the politics related to race, religion, communalism, and other forms of social polarization and boundary-making, it is crucial to examine the ways in which they navigate their self-representations and position themselves in relation to a broader audience. For example, when Ramdev says: "our medicine is the best and oldest in the world," to which imagined community (Anderson 1983) does the word "our" refer? What does Ramdev mean by a neologism *bhāratīyatā* (Indianness)? Which identity markers and categories of social differentiation such as "Indian" (*bhāratīya*), "foreign" (*videshī, angrezī*), and "homegrown" (*svadeśī*), domestic (*desī*) does Ramdev use, how often and in which context? The answers to these questions as well as other qualitative findings from textual analysis and discourse analysis are discussed in Chapter 6.

Throughout the dissertation, I use the term "discourse" (in singular) to refer to a body of written and oral text as both a product and a process of knowledge about language. In the words of Johnstone (2008, 3), "[d]iscourse is both the source of this knowledge (people's generalizations about language are made on the basis of the discourse they participate in) and the result of it (people apply what they already know in creating and interpreting new discourse)."

Therefore, it is important to highlight that in discourse analysis, “discourse” refers to ethnographically grounded instances of linguistic communication.

At the same time, in social sciences, the term discourse has a broader scope. Barnard and Spencer (2002) have outlined three levels of its meaning: “the act of talking or writing itself,” “a body of knowledge content,” and “a set of conditions and procedures that regulate how people appropriately may communicate and use that knowledge” (pp. 162–163). Moreover, after Michel Foucault (1990 [1978]), scholars acknowledge that different societies and historical eras produce different kinds of “discourses” (in plural), i.e. socially shared ways of talking and thinking which are encouraged—or silenced—by institutions of power such as church, government, and medical establishment. In *The History of Sexuality*, Foucault argues that in Europe, since the seventeenth century, sexuality has gradually become a discourse—something to confess, talk, and be concerned about; something that needed to be regulated, controlled, and managed by the appropriate authorities (parents, educators, priests, psychotherapists). Discourses are then prominent sets of ideas, practices, and technologies that are circulated in a society, producing meaning and shaping human behavior. From this perspective, not every instance of ethnographic discourse (in singular) is part of cultural discourses (in plural) in the Foucauldian sense, and in this dissertation, I try to maintain this distinction.

1.5 CHAPTER OUTLINE

There are seven chapters, including the Introduction (Chapter 1) and the Conclusion (Chapter 7), organized around two major scopes of inquiry: Chapters 2 through 4 set up the sociopolitical context of alternative medicine in India, investigating public discourse, nationalist ideologies,

and government policy on institutionalization of medical traditions, whereas Chapters 5 and 6 present an account of medical plurality on the ground through the examination of medical practitioners and their clinics. These two scopes help to emphasize the complexity of forces that draw medical traditions together and pull them apart.

Chapter 2 explores the politics of cultural nationalism and the inequality within non-biomedical plurality by focusing on an extraordinarily popular Yoga guru Ramdev who runs a billion-dollar ayurvedic company called Patanjali Ayurved.¹⁰ Ramdev's persona is steeped in controversy and criticism, but he is nevertheless regarded as a religious and wellness authority by millions of Indians. His speeches dominate Indian media, his Yoga camps are attended by thousands of participants, and Patanjali Ayurved is the fastest growing consumer goods enterprise. Given the prominence of religion in India, Ramdev's charismatic authority also extends to the political and social life of the country. This chapter starts with a detailed description of Ramdev's biography, his business network, and several recent initiatives, and then proceeds to the analysis of Ramdev's speeches, arguments, and target audience. Additionally, I bring into the conversation AYUSH practitioners, shopkeepers of Patanjali stores, students and professors at AYUSH colleges, and common people—both Ramdev's followers and skeptics. I argue that Ramdev's campaigns represent a technology of biopower—power over people's conduct and everyday life—through the prescription of specific health regimens related to body and diet. I examine Ramdev's use of the terms of cultural identity such as *swadeshi*, *desi*, *rashtriya*, *hindutva*, and *bharatiyata*, situating them within the history of Indian nationalism, current processes of economic and cultural globalization, the commodification of health, and morality. A substantial discussion is focused on the notion of *swadeshi* and the implications of

¹⁰ A significant part of this Chapter has been published in Khalikova 2017.

swadeshi ideology on AYUSH medicine. By introduction the notion of biomoral consumption, I show that Ramdev's engagement with Ayurveda and Yoga is not only a tool for circulating his truth claims but also a platform for fostering moral subjectivities, as Ramdev mobilizes Indians to consume the homegrown food and medicine in the name of personal and national health, thus asking them to fulfil their duty as biomoral citizens. Thus this chapter unpacks Ayurveda as a political regime that links individual bodies and health to the body of the nation.

Chapter 3 chronicles the history of the institutionalization of non-biomedical plurality in India, elucidating the influences of the anti-colonial and nationalist ideologies, discourses of modernity and science, non-biomedical practitioners' movements for recognition, and India's efforts at positioning itself nationally and internationally. Analyzing the language in which non-biomedical knowledge traditions have been defined, classified, and discussed—such as “indigenous medicine,” “Indian medicine,” “ISM&H,” and “AYUSH”—I argue that state legitimation has contributed to solidification of the hierarchy among India's diverse non-biomedical traditions. Despite the government's purported emphasis on pluralism, Ayurveda has become the dominant alternative medical system, both economically and ideologically. I also argue against the scholarship that sharply separates legitimate or “statist” medicine from unrecognized, “subaltern” healing practices as if state legitimacy elevates the status and routines of AYUSH practitioners in comparison to unauthorized healers. Instead, I draw attention to the fact that AYUSH and practitioners of so-called local health traditions are often similar in their precarious status, strategies of achieving social legitimation, and rhetorical claims about their knowledge.

Chapter 4 scrutinizes the entanglements of medical plurality and the cultural politics of national belonging, by using the material from media, AYUSH infrastructure, interviews with

government officials and AYUSH doctors. I explore the discrepancy between the egalitarian structure of AYUSH and the exceptionalism of Ayurveda to suggest that it parallels the tension between two visions of the Indian nation: inclusive secular nationalism anchored in the principle of “unity in diversity,” and the ideology of Hindu nationalism. I specifically look at the role of religious antagonism and the homecoming movement (*ghar wapsi*) in the promotion of Ayurvedic exceptionalism and in the views of Yoga as Ayurveda’s putative branch or sister tradition. Moreover, I chart out the processes of the “ayurvedicalization” of medical plurality, by which Ayurveda comes to be exclusively defined as “Indian medicine” and the origin of all other AYUSH traditions. While I agree with scholars that AYUSH systems in India are increasingly biomedicalized, I draw attention to the fact that they are also ayurvedicalized: if biomedicine dominates over alternative medicine, then Ayurveda dominates over other traditions. This chapter gives voices to both the practitioners who support this view and those who oppose and feel marginalized by the expansion of Ayurveda. I examine the position of Unani and Islam within India’s contemporary discourses to argue that these discourses construct Unani as pertaining to a single (Muslim) culture and community, whereas Ayurveda is presented as national and even universal medicine.

Chapter 5 analyzes the demographics of the interviewed AYUSH doctors. I introduce some of them in great detail to highlight that AYUSH specialists come from different class and educational backgrounds, have unequal social status, and deal with different degrees of success and precarity. By describing private clinics, places of worship, government hospitals, wellness resorts and other places where AYUSH practitioners work, I argue that a medical degree from a state-recognized university does not guarantee a stable income or reputation. I also point to the fact that Unani practitioners are conspicuously absent from high-end resorts or government

hospitals with co-located AYUSH facilities which again evidences the disparities among institutionalized forms of medical knowledge. Furthermore, with a special attention to female practitioners, I show that professional itineraries, aspirations, and current positions of AYUSH doctors are extremely diverse and unequal. The chapter ends with a discussion of pharmacists, priests, and allopathic physicians who prescribe AYUSH treatments, even though they are not authorized by the government to do so. This further support my argument that it is erroneous to conceive of AYUSH as a well-defined category distinct from both biomedical and non-authorized healing practice.

In Chapter 6, I continue the discussion of the complexity and idiosyncrasies of the Indian therapeutic landscape, but now I shift my gaze to the processes of therapeutic boundary-crossing (when practitioners make use of multiple therapies from a range of AYUSH and non-AYUSH traditions) and therapeutic boundary-making (when doctors insist on keeping a medical practice “pure” and unmixed). I examine such cases with regard to treatment approaches and the use of medical technologies. By describing my observations of clinical encounters and sharing the views of patients, I look at medical plurality as negotiated and embedded in the moment. Moreover, I conceptualize practitioners’ strategies as medical “versatility” arguing that most practitioners engage in situational, heterogeneous, and negotiable practices that are influenced by their families, patients, and economic considerations. In other words, doctors are less concerned about abstract notions of what does or does not constitute the scope of their medical traditions but are more concerned about what might work best in a given case. From this perspective, I contend that the designation of certain drugs as “Ayurvedic” or certain technologies as “biomedical” becomes both impractical and dangerous, as it taps into the debates about cultural identity and cultural appropriation of medical traditions.

In Conclusion (Chapter 7), I summarize the arguments with regard to everyday realities and hierarchies of AYUSH, showing that state legitimation is not a sufficient factor to secure equal recognition and reception of medical traditions. While it is true that many practitioners, especially those who live away from metropolitan centers and big cities, can engage in practices that ignore or dismiss the government regulations, I maintain that the examination of doctors' therapeutic choices, the historical purview of government policies, the choice of the acronym AYUSH, the international and national pharmaceutical market, and the activities of non-state actors such as Ramdev—all of these demonstrate the ayurvedicalization of AYUSH. I argue that both the ideology of Ayurvedic exceptionalism and the expansion of the Ayurvedic market are based on discourses that use the body as a site for interweaving a quest for health with a nationalist sentiment and consumerist desires. Moreover, in public and government discourses AYUSH traditions are rendered distinguishable and ascribed to different cultural or national identities. Unani, Siddha, Sowa-Rigpa are deemed rather “cultural” than “national” in the sense of belonging to Muslim, Tibetan, or Tamil communities, while Ayurveda and, to some extent Yoga as Ayurveda's “sister tradition,” have become political tokens of national belonging.

Along with this, I emphasize that in practice, doctors' therapies are entangled, heterogeneous, and eclectic, sometimes conforming to and sometimes departing from the dominant ideologies of AYUSH and Ayurveda. Despite the existence of state categorization of non-biomedical knowledge in the form of AYUSH, these medical “systems” are not uniformly identified and conceived of by doctors and their patients. Furthermore, doctors cannot be divided into two categories: *either* those who engage in therapeutic boundary-crossing *or* those who contribute to therapeutic boundary-making. Rather, in different contexts and with different participants, medical practitioners employ a broad range of therapeutic strategies: they may

choose to emphasize differences or similarities between theirs and other medical traditions. While the government policy, media, and the ideology of Ayurvedic exceptionalism certainly influence the lived experiences of most doctors; their everyday medical choices can be best understood in terms of therapeutic versatility.

Finally, through the exploration of professional careers, clinical spaces, jobs, aspirations, and social reputation of alternative medical doctors I show that the category of legitimized alternative medicine under the label of AYUSH is amorphous and elusive. The state-sanctioned legitimacy does not translate into a predictable income and social reputation when the current state of the healthcare system is such that therapeutic repertoires, legitimation strategies, income, places of work, and social recognition of some AYUSH doctors are comparable to non-authorized healers. Thus, although this study deals primarily with institutionalized alternative medicine, it also highlights the entanglements and continuity of authorized and unauthorized therapeutics.

2.0 BABA RAMDEV: BIOMORAL CONSUMERISM AND THE BIOPOLITICS OF THE HOMEGROWN

The biggest goal is to bring prestige [*pratishtha*] to India and Indianness [*bharatiyata*]:
both within the country and in the world.
And this journey begins from Yoga, from Ayurveda.

Ramdev 2014

In official and public discourse, Yoga and Ayurveda are routinely featured as the so-called traditional medical systems (*paramparagit chikitsa paddhatiya*) or Indian indigenous traditions that are familiar to everyone. The emphasis on familiarity is particularly evident in the way in which many ayurvedic pharmaceutical companies, government officials, and Yoga gurus such as Baba Ramdev or Sri Sri Ravi Shankar explain their advocacy for Yoga and Ayurveda. They insist that they do not create anything new but simply “remind” Indians that *pranayama* (breathing exercise), basil tea, turmeric water, and other grandma’s remedies are nothing but part of a long-standing “Indian” tradition. However, the number of publications and the insistence on indigeneity and ubiquity of Yoga and Ayurveda is so staggering that one cannot help but ask, why is it emphasized so much? Isn’t it obvious?

The answer to these questions lies in the fact that, until recently, the majority of Indians had a little direct encounter with the institutionalized forms of these traditions, particularly with Ayurveda. It is not that most Indians *preferred* Western medicine (quick pills, injections) but rather they were hardly familiar with what constituted institutionalized Ayurveda. Many of my senior interlocutors in Uttarakhand and Delhi, even those who currently make a living as

Ayurvedic doctors, admitted that they had heard nothing about Ayurveda in their childhood. Ayurveda was not a lost practice to be “reminded” of; as a constituent of Indian identity, it simply did not exist. Jean Langford made similar observations in a clinic of an ayurvedic practitioner she calls Dr. Upadhyay:

Ayurveda is treated by anthropologists as an indigenous system of medicine that is deeply ingrained in Indian society. Researchers have often suggested that Ayurveda has persisted, despite the enormous competition from biomedicine, precisely because it encodes deep-seated cultural experiences and values that extend beyond medical diagnosis and cure (Nordstrom 1989; Weiss et al. 1988; Obeyesekere 1976). Yet Dr. Upadhyay spends a good deal of his consultation time educating his patients about Ayurveda in order to sell it to them... [He] cannot count on invoking a set of cultural essences with which Ayurveda is supposedly suffused (2002, 53).

These observations evince that until recently, Ayurveda used to occupy a marginal cultural niche. Yoga too was and remains at the fringes of the daily life of common Indians. Even though the history of Yoga as a public practice dates back to late 19th century (Alter 2004; Alter 2008; Alter 2011; Singleton and Goldberg 2014); it was never a part of “every” Indian’s lifestyle, as it is promoted today. When I was in Rishikesh, a town at the foothills of the Himalayan mountains where *The Beatles* went to practice meditation and Yoga in 1968 and where a plethora of Yoga and Ayurveda centers have mushroomed for the Western consumption, local residents told me that they rarely engaged in these practices. Most people preferred to rely on biomedical treatment such as vaccines, painkillers, and antibiotics, rather than entrusting their wellbeing to herbal mixtures, meditation, and breathing exercises. Particularly the members of the large working class, whose jobs already involved a great amount of exercise, neither had time to perform Yoga nor had the knowledge of it. It is for these reasons modern proponents of Ayurveda and Yoga go at length attempting to forge a connection between these traditions and Indian identity. Rather than being common practices, Ayurveda and Yoga have been either the occupations of

specialists and ascetics or a new fashion of western-oriented middle-class Indians. Things, however, began to change after the arrival of Ramdev.

2.1 MAKING YOGA AND AYURVEDA GREAT “AGAIN”

Baba Ramdev is arguably the most influential and popular guru in contemporary India. He started his career in the mid-1990s but became widely known in the early 2000s through the daily morning Yoga shows on the TV and, later, through large-scale public Yoga “camps” (*yog shivir*) conducted throughout India (Alter 2008b, 39–40). The scale of these programs and *yog shivirs* was truly astonishing: according to some estimates, Ramdev’s Yoga camps immediately started attracting thousands of participants and already in 2010, he had 85 million followers via his television broadcasts in multiple languages and approximately 170 countries (Sarbacker 2014, 356; Raj 2010, 109).¹¹ Such Yoga camps and daily Yoga shows turned Ramdev into one of the first “tele-gurus,” quickly becoming “a paragon of modern Yoga” and “a modern Yoga revolutionary” (Sarbacker 2014).

The role of media was crucial. Although mass *yog shivirs* most likely date back to the early 20th century (Alter 2008b, 36), it was Ramdev who—through the use of media, particularly television—has shifted the orchestrated Yoga performances from the private level to the national level. In other words, he has elevated Yoga from the periphery to the forefront of public vision, from the margins to the “mainstream of Indian society and global consciousness in

¹¹ The most popular daily Yoga show was called *Om Yog Sadhana* broadcasted on Zee Jagran TV. The show was then moved to Aastha TV where it is called *Yog Shivir*.

unprecedented ways” (Sarbacker 2014, 352). In fact, the core objective of a *yog shivir*—public and collective participation in a ritualized practice—is so easily amplified with the help of the Internet and television and it is so powerful in creating both visceral and visible national unity, that even Prime Minister Modi has deployed it in order to mobilize Indians to perform the nation.



Figure 3. Ramdev with the Prime Minister of India Narendra Modi

Having achieved a considerable authority in Yoga, Ramdev became an active proponent of Ayurveda. Together with an Ayurveda teacher named Balkrishna, Ramdev founded the Patanjali Yogpeeth Trust—a non-profit organization with a large network of affiliated institutions and the headquarters in Uttarakhand. A 1000-acre campus of Patanjali Yogpeeth (Deka 2016) hosts medical facilities, Patanjali University, a publishing house, Patanjali Food and Herbal Park¹² and

¹² The ambition of this project is reminiscent (albeit smaller in scope) of a Chinese government-sponsored project in Macau for the development of Traditional Chinese Medicine: the Guangdong-Macao

a manufacturing unit for Patanjali Ayurved (a multi-million-dollar business for ayurvedic goods and pharmaceuticals). Moreover, there are numerous Patanjali Yoga retreats, schools, and franchised stores throughout the country, even found in remote high-altitude villages. Currently, Patanjali Ayurved operates through 4,000 distributors, 10,000 stores, and 100 mega-marts, and its revenue is around US\$740 million (Business Standard 2016). Beyond India, franchised Patanjali stores operate in the UK, Russia, Mauritius, the U.S., and other countries, extending the outreach and influence of Ramdev’s Yoga and Ayurveda products—as well as his ideology—to the Indian diaspora. Although Ramdev claims to lead an ascetic life and to hold no share in Patanjali Ayurved, it is unquestionable that his “Yoga empire” (Sarbacker 2014) and Ayurveda enterprise have secured him both wealth and an outstanding cultural authority.¹³ So who exactly is this person?

2.1.1 Ramdev’s path to success

Ramdev was born as Ramakrishna Yadav to an illiterate family in a small village of Haryana (Raj 2010). The date and even the year of his birth are unknown, presumably sometime between 1963 and 1975. After studying in some *ashrams* and *gurukuls* (schools), Ramdev is said to have retreated to remote areas of the Himalayas to perform meditation (Raj 2010). In 1993, he returned to the society and settle around Haridwar and Rishikesh—the area with a high

Traditional Chinese Medicine Technology Industrial Park <http://www.gmtcnpark.com/en/index.php> (see Lou 2016).

¹³ It is important to highlight that along with Ramdev’s popularity, there is a significant amount of mistrust and contempt of his endeavor. Many Indians consider him ridiculous, phony, and corrupt; a traditionalist who is interested in his own fame and financial prosperity than in people’s wellbeing. Ramdev has been under the media scrutiny and until recently has faced multiple accusations of adulterating drugs and engaging in corruption, despite his own participation in the broad anti-corruption movement and a passionate critique of the Indian National Congress party. All of this, however, does not undermine the authority and popularity he certainly possesses.

concentration of Yoga gurus, ashrams, and Ayurveda centers. Initially, Ramdev was not very successful. I was told that professors at Rishikul Ayurveda College still remember how Ramdev used to come on a bicycle to the college pharmacy to pick up clay pots with *chawanprash* for further reselling (see also CNN iReport 2011).

Yet very quickly Ramdev has managed to become a nationally prominent, albeit highly controversial, an authority on health and medicine. I contend that Ramdev's success has been embedded in the interplay of several factors: a) Ramdev's ability to recognize the power of media and to use it for popularizing spirituality, Ayurveda, and Yoga; b) protectionism from influential businessmen and political figures, c) sharp political rhetoric carefully tailored to address an Achilles' heel of Indian nationalism and modernity; d) his personal charisma and impressive mastery of language; and e) a seemingly inclusive cultural and national appeal of the practices and products he offers.

Importantly, Ramdev was able to present himself not as an inventor of something new but as a defender of Indian traditions and a person who dared to share the ancient secret of wellbeing with common people. As one of my respondents, a Yoga instructor and a former worker at Patanjali YogPeeth told me: "For many years, Yoga was behind closed doors. It was never offered for the common man. Ramdev has opened it for everyone, has begun teaching Yoga openly, for free.... Other gurus had kept Yoga closed away. If you ask any common man about Maharishi [Mahesh Yogi] they don't know, but everybody knows Ramdev. A real revolution of Yoga has begun with Ramdev." This notion of making Yoga available and appealing to a common Indian has been a typical feature of the Yoga renaissance for over a century (Alter 2004) but Ramdev's success in reaching out to large audiences is truly

unprecedented because it is based on the spread of mass media and the growing availability of communication technologies since India's economic liberalization.

From a procedural point of view, Ramdev's Yoga does not offer anything new. Unlike, for example, innovative Yoga sequences and methodologies of B.K.S. Iyengar, Ramdev remains a "self-initiated" guru without *sampradaya*.¹⁴ His followers are attracted not to Yoga exercises per se, but to speeches and lectures designed around the invocation of cultural heritage, Indian identity, and the condemnation of India's dependence on things foreign. Ramdev claims to aspire for restoring the ancient knowledge and, so to speak, making Ayurveda and Yoga great again. By insisting on the notion that Ayurveda and Yoga were widely practiced in the past and that even today everybody is familiar with these traditions—for example, in the form of kitchen remedies—Ramdev seeks to construct Yoga and Ayurveda as traditional, homegrown (*swadeshi*), and familiar activities. By doing so, he also generates a set of embodied practices that give his rhetoric a sense of visceral potency.

Not only do consumers but even Ayurvedic and other alternative doctors subscribe to Ramdev's authority. Once I was told how a group of international student volunteers wanted to compile a list of medicinal plants available in a hill district of Garhwal Uttarakhand. They went to see a village Ayurvedic *vaid* (healer) but instead of telling them about local flora, the *vaid* pulled out a book of Indian medicinal plants published by Ramdev's Patanjali Yog Peeth!

There are two important features of Ramdev's enterprise: first, he has been able to package Yoga and Ayurveda into a single cultural category, and second, he has expanded their application to unprecedented domains. Yoga and Ayurveda have become the practices of the

¹⁴ *Sampradaya* signifies a system of spiritual knowledge into which a disciple is initiated by his guru and who in turn passes the sacred knowledge on to his own disciple, thus forming a lineage of gurus (Jaffrelot 2011).

everyday: not just the treatments of common modern diseases such as cancer, diabetes, and arthritis but the fundamentals and axioms of the everyday existence. In particular, this is visible in the “everyday-ness” of Ayurveda or the ayurvedicalization of everything, including local herbs, medicines, food products, household supplies, and so on. Of course, it can be argued that ayurvedic pharmaceuticals, beauty products, sexual performance enhancements, and food supplements had entered the lives of Indians long before Ramdev, but as I show below, he has gone much beyond that, by launching everything from ayurvedic sunscreens and “son-generating” pills¹⁵ to ayurvedic soaps, toothpaste, and dishwashing detergent, to ayurvedic ketchup, biscuits, and noodles.

This explosion of goods that bear the label of Ayurveda begs a question of how “ayurvedic” they are, but as I observed, many Indians are not concerned about it. With the exception of few scholars and physicians who do not hide their disapproval of equating everything with Ayurveda, I found that the meaning of Ayurveda is taken for granted. Among AYUSH practitioners, many agree that Patanjali products are Ayurvedic and that Ramdev’s medicines are actually based on classical Ayurvedic recipes. Although some doctors of Ayurveda view Ramdev as a pure businessman, still many more agree that he is doing good for the promotion of Ayurveda among the common people. I remember a conversation with a doctor of Homeopathy who also strongly supported Ramdev. When I asked if indeed all Patanjali products were ayurvedic—including facial creams, for example—the homeopathic physician told me that they certainly were, since were made with *neem* (Indian Lilac) and other natural ingredients.

¹⁵ There is a controversy about new Patanjali medication known as “Putrajeevak beej.” Literally, it can be translated as a “seed which produces sons.” However, Ramdev and his supporters argue that the use of “*putra*” (son) in classical Ayurvedic literature is gender-neutral; hence, *putrajeevak beej* should be understood as a fertility drug, a “seed which produces children.”

Clearly, this is more than the invention of tradition but a case of the ayurvedicalization of wellness when Ayurveda is made familiar, commonplace, and essential while other medical traditions are ignored or subsumed under the umbrella of Ayurveda. Therefore, Ramdev's speeches and campaigns are not only about medicine; they are political discourses. Due to Ramdev's popularity and influence, I argue that it is important to recognize that his rhetoric and campaigns reveal the disparities within medical plurality and the AYUSH sector. On the pages below, I also highlight that by imbuing Ayurveda and Yoga with moral and political meaning, by remodeling them as common and familiar, Ramdev and people who subscribe to his logic contribute (even if they do not consciously do so) to Hindu nationalism and the estrangement of non-Hindu communities.

2.1.2 Political discourse of Ramdev

According to Wilson (2015), "one of the central concerns of political discourse [as a study of political language] is the question of how the world is presented to the public through particular forms of linguistic representation" (p. 776). This includes such questions as "how is language used in attributing meaning to individuals and groups with reference to the performance of their social practices? How are actions and events perceived and described?" (Wilson 2015, 776). My analysis of Ramdev's speeches is driven by similar questions: I am interested in ways Ramdev imparts meanings on Indian citizens, different expectations and moral duties he lays before them, and how he represents the past, present, and future of the Indian nation. Here I interchangeably use the terms "political discourse" and "rhetoric" to refer to forms of language based on persuasion and addressed to a society (not an individual). The notion of representation is also of great importance: in agreement with a broad body of scholarship, I contend that the examination

of language and representations can reveal the disposition of power, signaling whose knowledges and worldviews are promoted and whose—marginalized and silenced (Said 1978). In the words of Wilson (2015), “control and domination of representations allows politicians to generate worldviews consistent with their goals, and to downgrade, negate, or eliminate alternative representations” (p. 777).

The rhetoric of prominent public and political figures has been analyzed in linguistic anthropology, discourse analysis studies, rhetorical studies, and other disciplines (Coupland 2001; Crichton 2007; Hodges n.d., cited in Bucholtz and Hall 2005, 599; Johnstone 1991; Johnstone 2009; Ritivoi 2008; Wodak 2011). From a variety of perspectives, these studies elucidate how politicians and social leaders employ metaphors, figures of speech, personal pronouns, code-switching, and other discursive strategies in order to maintain and reinforce their authority. Especially in the moments of crisis or within an ambiguous political environment, public figures can mobilize vast groups of people and critically contribute to the politics related to race, religion, gender equity, communalism, and other forms of social polarization and boundary-making. Therefore, it is crucial to examine the ways in which they navigate their self-representations and position themselves in relation to a broader audience.

Ramdev’s rhetoric is extremely persuasive, as he draws on emotional cultural symbolism and frequently makes witty remarks about his opponents. When talking to the audience, Ramdev is performative and flamboyant, often laughing, admonishing, skillfully modulating his voice from whisper to loud slogans. Scholars of sociolinguistics have found that “the way we sound has an impact on how people perceive us, and this can range from our attractiveness and intelligence to our trustworthiness and employability (Giles and Powesland 1975; Lippi-Green 1997; cited in Wilson 2015, 186). Unfortunately, this dissertation leaves aside the discussion of

Ramdev's prosodic features and non-verbal communication, although I acknowledge that these modalities are critically important. Instead, I focus on lexical and grammatical choices.

Prominent features of Ramdev's speech are repetition, synonymy, and parallelism both within phrases and across texts. Consider the following example (Ramdev 2010):

The government has established our policies in such a way that the country remains as much impoverished, as much enslaved, as much pitiable, as much helpless... this country's people remain as much weak, remain illiterate, remain uneducated, remain in bad condition, their bad situation remains, remain as much poor, remain hungry, remain illiterate—as much [the government] will be able to rule them.¹⁶

By doing so, Ramdev leaves no room to doubt his argument or disagree with him, since the repetition and synonymy effectively function as the reinforcement of the same meaning by covering a topic with a range of closely related possibilities. As Barbara Johnstone (1991) and others have demonstrated, repetition, parallelism, and paraphrase are important devices of a persuasive discourse across languages and genres in written and spoken text. In Ramdev's speeches, we see that he not only uses repetition to emphasize and draw the audience's attention to the significance of his arguments, but he also uses parallelism to equate human bodies to the body of the Indian nation (Ramdev 2010):

God has made each and every human being, each and every object, each and every nation self-sustaining, has made self-sufficient.¹⁷

This is an important strategy which I will emphasize throughout this chapter. Ramdev argues that Indians are able, independent, and self-sustaining beings, but since they do not make use of their abilities, India is dominated by foreign influence and products. There are many instances related

¹⁶ *Humari nitiyan sarkār ne aisi banāyi rakhi hain ki desh jitna daridra rahe, jitna gulam rahe, jitna bechara rahe, jitna lachar rahe... yeh... desh ke log jitne kamzor rahe, unpadh rahe, ashikshit rahe, badhāl rahe, inki durdasha rahe, jitne gareeb rahe, bhooke rahe, unpadh rahe, utna inke upar zyada shasan kar payenge.*

¹⁷ *Bhagwan ne pratyek insān ko, pratyek vastu ko, pratyek rāshtra ko, swawlambi banāya hai, ātmanirbhar banāya hai.*

to the “foreign control” in terms of food, medicine, youth behavior, oil production, or building materials. Ramdev emphasizes that India needs to become self-sufficient and from this perspective, his company Patanjali is exactly what India needs. These instances are mirrored later when Ramdev talks about India’s potential to become self-sufficient: (again) in terms of food, medicine, youth behavior, oil production, or building materials.

Ramdev understands and speaks some English, especially when he is interviewed outside India or by non-Indians; however, his primary language is Hindi with occasional contextual uses of Gujarati and other regional languages. Additionally, Ramdev is said to be trained in Sanskrit. It is significant how he combines scholarly Sanskritized terms with colloquial phrases and simple sentence structures, but his code-switching between Hindi and English is particularly remarkable. Although he never explicitly mentions this, he appears to urge Indians to use *swadeshi* languages instead of English—a language prevalent in educated, upper-middle class and upper class circles. Consequently, he himself is very careful of not using many English words. In one of the analyzed excerpts (Ramdev 2010), there are only 36 instances of English use, which makes 1.8% of the total content. Among them, 11 instances are the word “company” (and its derivatives, inflected according to Hindi grammar); the rest are “wheelchair,” “Italian,” “control,” “pizza-burger,” “distribution,” “genetic modified,” “arthritis,” “cancer,” “cold drinks,” “diesel,” “petroleum products,” and others. Following (Bassiouney 2012), I argue that Ramdev uses English to mark his “nationalist,” or more precisely *swadeshi*, subjectivity in opposition to the foreign, which has a negative connotation. Consider the following example (Ramdev 2010, an English word is italicized):

God has given us two hands—this is the source of our self-reliance. He has given [us] two legs—through them we are self-sufficient, standing on two legs. Otherwise, we will have to move on a *wheelchair*.¹⁸

By using the English word “wheelchair,” Ramdev signals that the Western countries are not self-sufficient and Indians face a danger of becoming weak as well. A wheelchair cannot have a place in the image of a strong, independent India. Although he could have used a different way of conveying his idea, for example by saying “otherwise, we will have to stay at home and be dependent on others,” he chooses the English word to indicate the foreignness of wheelchair. Similarly, pizza-burger, cold drinks, cancer, arthritis, and genetic modification are not merely English words¹⁹ but foreign realities that should not belong to India. Consider another example (Ramdev 2010, English words are italicized):

Earlier we gave foreign companies the permission to provides us with seeds only... And now *genetically modified* seeds.²⁰

Here, interestingly, Ramdev says “genetic modified *beej*,” using a Hindi word for a familiar item (seeds) and English words for a foreign procedure. Certainly, I do not argue that he always intentionally and consciously uses English to highlight the foreignness of things he is talking about, but this pattern occurs a number of times in the analyzed text.

In addition to using English words to mark foreign phenomena, Ramdev’s code-switching reveals another form of strategic repetition: he employs English to show his knowledge (of English and ultimately of everything he speaks about) as well as to reach out to a

¹⁸ Bhagwan ne hume do hāt de rakhe hai, ye humare swawlamban ke hetu hai. Ye do pair de rakhe hai... isse hum swawlambi apne paio par khadhe hai. Nahi toh hume wheelchair par chalna paRega.

¹⁹ With the exception of some food items, all cited English words have Hindi equivalents, which Ramdev could have used. Although many words are recent inventions from Sanskrit roots, such as *pahiyedār kursee* (“wheeled chair”), *karkaT rog* (cancer disease), *gaThiya* (arthritis), and are uncommon, they would have been entirely appropriate in Ramdev’s speech given his expertise in Sanskrit.

²⁰ *Pehle toh hum ne videshi kompaniyon ko beej hi dene ki anumati di thi. Ab toh genetic modified beej.*

broader audience. For example, some words such as “distribution” and “use” are used as synonyms to Hindi equivalents *vitran* and *prayog* within the same sentence (Ramdev 2010, English words are italicized):

First, starting with cultivation [of crop] and until its *distribution*, its distribution [vitran], we can make our country...self-sufficient.

There is a foreign control of our health care system. All foreign drugs we are *using* [use kar rahe hain], we are using [prayog kar rahe hain].²¹

Here again I follow Bassiouney (2006) who argues that within specific speech events, such as during TV shows that accept calls from the audience or in public speeches, “code-switching can be a marked choice that enables people to position themselves within a wider context and community” (p. 124). Similarly, Ramdev occasionally switches to English and regional languages such as Gujarati (Ramdev 2014) in order to establish cultural affiliations with his audience.

Slightly different is Ramdev’s use of rare Sanskrit words such as *swawlambi* (self-dependence), *swabhiman* (self-pride), *pradheenta* (dependency), *abhāvgrasth* (stringent), *utwād* (edibles), *ādhyatmik* (spirituality), and others. In some instances, he uses Sanskrit words, even though they are very close to their Hindi counterparts: for example, in calling milk *dugdh* instead of more common Hindi *dudh*. The infiltration of scholarly and more sophisticated vocabulary allows Ramdev to reinforce his expertise and influence as an intellectual and learned man, well-versed in Sanskrit. At the same time, because of the extensive repetition, synonymy, and code-switching, rare concepts do not present difficulties in understanding his speech.

²¹ *Pehle toh paida karne se lekar ke aur uske bād me distribution tak, uske vitran tak hum apne desh ko... swawlambi bana sakte hain. [...] Humāri swasthya vyavastha par videshiyon ka kabza hai, sari dawaiyan videshi toh use kar rahe hai hum, prayog kar rahe hai hum.*

2.2 “BY RESTORING THE GLORY OF AYURVEDA, WE WILL RESTORE THE GLORY OF INDIA”²²

Ramdev seeks to propagate a distinctive vision of the Indian nation invoking the principles of self-reliance (*swawlamban*): Indians are urged to free themselves from foreign influence, capital, and products, and return to their cultural roots. In 2009, he initiated a movement called Bharat Swabhiman Andolan that brings together Indians who want to make the nation “self-reliant.” Ramdev argues that India has been deprived of respect due to hundreds of years of foreign colonization and weak post-colonial politics. Because of the lack of self-respect and pride for Indian culture, Indians erroneously aspire to be like Westerners, wear Western clothes, and use Western medicine. Indians have forgotten, as Ramdev proclaims, that India is the greatest and oldest civilization in the world and most benefits of modern life have originated here (Ramdev 2014):

In the past sixty-seven years,²³ Yoga, Ayurveda, Indian knowledge tradition, India and Indian-ness (*bharatiyata*) have been given no honor. If we are to put in one word the decadence and affliction of a thousand years, then [we would say that] this country was filled with remorse. [But] with the glory of Ayurveda—the glory of India will also increase, not only within the country but also in the entire world...

Brothers and sisters, we have been saying that for the whole world the first knowledge of medical science was given by India. If there is any country which gave a health system, education system, judicial system, political system, taxation system—everything to the entire world, then it is the country of India. But today

²² Literally, Ramdev says “from Ayurveda’s glory, India’s glory will increase” but contextually he says it in a reference to the past: Ayurveda was glorified in ancient India and Indians have to restore the original glory.

²³ This is a reference to 1947 when India received Independence from British Empire.

the country of India has been filled with remorse, that whichever worthy things exist—have come from the West.²⁴

According to Ramdev, the best way to reestablish the grandeur of India and impart self-respect to Indians is through the practices of Yoga and Ayurveda:

Brothers and sisters, we have to bring back to the country whatever thousands and millions [of wealth] that have been stolen.... But the biggest goal is to bring prestige to India and Indian identity within the country and the world. And that journey begins from Yoga, from Ayurveda.²⁵

Since the previous governments have failed to create a strong Indian nation, Ramdev argues that the only person who is in a position to do so is Narendra Modi, a Prime-Ministerial Candidate for 2014 elections and the Chief Minister of Gujarat at the time of the speech (Ramdev 2014):

We trust that honorable Brother Narendra Modi will induct Ayurveda, Yoga and his own traditional medical system as a national medical system and will give glory to his own sages.

Certainly, Ramdev is not the first guru to promote Yoga and Ayurveda; nor he is the first person to speak about India's dependence on Western produce and India's aspiration for a Western lifestyle, both of which he sees as highly problematic. Yet, Ramdev stands out from a pantheon of contemporary Indian gurus—at least in North India—as he has become an emblematic public figure whose public persona extends beyond his identity. The ubiquitous portrayals of Ramdev on the streets, frequent references on TV, the Internet, and in printed media, demand for his “ayurvedic” products sold at a growing number of Patanjali shops, his publicly-orchestrated

²⁴ *Pichhle sar-saTh sālō mein yogo ko, ayurved ko, bhārtiya gyan parampara ko, bharat aur bhartiya ko gaurav nahi diya gaya. Ek hazār sālō ke patan ko, peeDa ko, yadi hum ek shabd mein kahen, toh is desh ko ātmglani se bhardiya. Ayurved ke gaurav se Bhārat ka gaurav baDhega, desh nahin, puri duniya mein. Aur uski āj āvashakta hai [...]* Bhai behinon, hum yeh kehte āye the ki puri duniya ko medical science ka pehla gyan Bhārat ne diya. Pure world ko health system, education system, judiciary system, political system, taxation system—sab kuch puri duniya ko yadi kisi deshne diya toh woh Bharat desh hai. Aur āj us Bhārat desh mein glani bhardee gayi, ki joh bhi shubh hai paschim se āya hai.

²⁵ *Bhai-behinon, humein jo ek hazār, lakh, croDe, jo loota hai, woh toh desh ko lautana hai... Yeh kālā dhan toh dilāna hai, bhrashtāchār phir mitāna hai. Lekin sabse baDi bāt Bhārat aur Bhārtiyata ko pratishtha dilāni hai, desh mein aur duniya mein. Aur woh yatra shuru hoti hai yog se, ayurved se.*

performances such as mass Yoga camps or cleaning the Ganga river, numerous publications on health, Yoga, Ayurveda and medicinal plants written not necessarily by him but on his behalf—all of this indicates that Ramdev is not just a person, but as a cultural institution. “Ramdev” is a modern phenomenon, which has tremendously changed the medical ideological and economic landscape in North India, and has recently begun to spread its influence to the South.

Ramdev’s popularity is buttressed by his personal and political ties with Narendra Modi²⁶ and a right-wing BJP which won the 2014 elections. Although the BJP has turned toward the liberalization of the economy and more careful and temperate domestic politics, for a long time it had advocated for economic protectionism and *swadeshi* (domestic) production. Furthermore, it must be remembered that Ramdev’s popularity is reinforced by his connections with members of the RSS, an organization built on the ideology of Hindu supremacy and involved in a number of controversial projects favoring the Hindu majority and pogroms against Muslims. As Joseph Alter (2004, 143) has highlighted, concerns with the body—its health and vitality—are integral to the RSS ideology; therefore, it is not surprising that Ramdev and the RSS share a common language. For example, RSS members have strategically employed a narrative of the greatness of Indian culture, where the term “Indian” is pinned down to *a historical point* (the Vedic past) rather than woven into *a process* of a long history of the mutual interaction of diverse cultural strands on the Indian subcontinent. Similarly, Ramdev relentlessly reiterates that Ayurveda and

²⁶ Modi and Ramdev have appeared together in media a number of times: for example, they presented passionate speeches regarding Yoga and Ayurveda at the National Ayurveda Summit 2014. The close connection between Ramdev and Modi is easily discernible from the fact that, due to a perceived threat to his life, Ramdev was granted a high-level personal protection by a couple of dozens of guards from paramilitary forces and an escort car - <http://www.ndtv.com/india-news/Yoga-guru-baba-ramdev-gets-z-category-security-698943>.

Yoga are traditions of the Indian (Hindu) past,²⁷ conveniently omitting a complex history of Ayurvedic knowledge interconnected with Unani, Siddha, and other therapeutic traditions (Attewell 2007; Sivaramakrishnan 2006).

As I show below, Ayurveda and Yoga do not simply benefit from the Hindu nationalist ideology but operate as its critical constituents. Ramdev's dogmatic rendering of Yoga and Ayurveda and a repeated emphasis on body, consumption, duty, and morality, turns Hindu nationalism, often defined as cultural or religious nationalism, into a biomoral nationalist project. However, before I move to the discussion of nationalism and Indian identity, I discuss the workings of *swadeshi* (homegrown) philosophy. I have chosen to highlight this concept, because in contrast to my expectations of finding many references to *rashtra* (nation) and *rashtriya* (national) in Ramdev's speeches, I found that he instead uses *desh* (land, country), *desi* (domestic) and *swa-desh* (one's own country) and *swa-deshi* (homegrown).

2.3 PHILOSOPHY AND ECONOMY OF THE "HOMEGROWN"

In May–June 2015, Indian consumers were anxiously following the news regarding a controversy over one of their favorite food products—Maggi instant noodles, imported and distributed by Nestle. The Food Safety and Standards Authority of India found that the noodles had a higher than a permissible level of lead and contained monosodium glutamate (MSG) despite the fact that the packaging had a label “No added MSG.” As a result, the authorities of

²⁷ Ramdev often reminds his followers that he has “neither revived nor established” Yoga, “it already existed. I just take it to the people. These are traditional sciences practised by our great hermits” (Chakraborty 2007, 1180).

several Indian states decided to recall the noodles and shortly thereafter the central government of India imposed a countrywide ban on Maggi. Representatives of Nestle claimed that the noodles were safe and appealed to the Bombay High Court, which in August 2015 ordered the re-testing of the noodles for lead and MSG. In November 2015, after several rounds of negotiations and a five-month ban, Maggi returned to the Indian market.

Meanwhile, in October 2015, when the fate of Nestle's instant noodles was still unclear, Ramdev announced that his company Patanjali would launch an Indian response to the popular foreign brand of instant noodles. He claimed that Patanjali two-minute noodles would be cheap (15 rupees, approximately 23 cents) and healthy, made with whole-wheat flour (Gawde, Shetty, and Pawar 2013), instead of white flour used in Maggi, and would have no lead or MSG. Media has already christened the product as Ayurvedic Maggi. Since philosophy and theory of Ayurveda conceptualize food and diet as inseparable from medical treatment, "ayurvedic" noodles seem to make perfect sense.

While this is clearly a well-thought business strategy, it is remarkable how Ramdev rationalized a need for Patanjali noodles: the production of a highly-demanded commodity is promoted as a contribution to the nation, through the advancement of the *swadeshi* economy:

We are working on the principles of swadeshi [sic], where we work for the betterment and health of the country (Firstpost 2015).

Swadeshi is a Sanskrit word which can be translated as "belonging to one's own country," "domestic," or "homegrown." The term was introduced by anti-colonial intellectuals and nationalists at the beginning of the twentieth century. The Swadeshi movement, which originated in Bengal, called for the boycott of foreign (specifically British) goods and for the development of indigenous industries, encouraging production and consumption of local products. However, the *swadeshi* project was much more than an economic strategy. Theorized by Aurobindo Ghosh

as imperative for winning political autonomy and rediscovering the national spirit, the ideology of *swadeshi* was further elaborated by M.K. Gandhi to denote a lifestyle based on individual morality, reorganization of society, and social and political activism based on the embodiment of truth (*satyagraha*) (Alter 2000; Chakraborty 2006; Giri 2004; Sarkar 1973). Later, at the end of the twentieth century, *swadeshi* acquired new meanings. It was appropriated by social activists such as Rajiv Dixit who campaigned against globalization and neo-liberal economic reform, which he saw as the causes of India's dependency on the West, lack of domestic production, the rise of excessive consumerism, the weakening of the agrarian sector, and farmers' suicides (Ramdev 2010).

The leitmotif of *swadeshi* runs across Ramdev's speeches. As Ritivoi argues, "the reliance upon well-established ideologies" is "an important tool in achieving legitimacy" (2008, 34). Similarly, I argue that by deploying the notion of *swadeshi*, Ramdev establishes his own legitimacy. He rhetorically positions himself both as a modern advocate for exploited farmers, local businesses, and the poor, and as a guardian of the Indian nation like Gandhi.

However, by no means should Ramdev be equated with Gandhi. As Sarbacker rightly claims, Ramdev's views are reminiscent of "Bal Gangadhar Tilak's more forceful approach to Indian nationalism" (2013, 353). Moreover, Gandhi and Ramdev have radically different views on consumption and the fundamental goal of a *swadeshi* regime. Gandhi sought to promote a simple life and condemned material desires. Transcending nationalist sentiment, he had a somewhat universal, humanistic vision of *swadeshi* rooted in morality and spiritual integrity. *Swadeshi* was to be practiced not through the consumption of national produce, but through "a reliance on our own strength... the strength of our body, our mind and our soul" (cited in Alter 2000, 14). According to Gandhi, "in its ultimate and spiritual sense, *Swadeshi* stands for the final

emancipation of the soul from earthly bondage” (cited in Alter 2000, 39). This is why Gandhi was instinctively wary of Ayurveda or any other drug-based therapy, rather favoring drug-free Yoga and nature cures.

By contrast, in Ramdev’s reading *swadeshi* is firmly embedded in neo-liberal modernity, nationalism, and the-more-the-better consumerism. Ramdev constructs *swadeshi chikitsa* (homegrown medicine, i.e. Ayurveda) and domestic produce as essential to an economically strong India and physically healthy Indian citizens. The consumption of Ayurvedic drugs, foods, and cosmetics is morally justified and encouraged, both in terms of a responsibility for personal health and a citizens’ duty. This is why I conceptualize Ramdev’s advocacy of *swadeshi* diet and medicine as the doctrine of “biomoral consumerism,” directed primarily at the middle and upper middle classes, for whom even the consumption of processed food—such as Patanjali noodles, biscuits, ketchup, or fruit juice—is not just tolerated but deemed ethical.

It is not hard to imagine that Gandhi would have been appalled by the very idea of *swadeshi* instant noodles, but it strikes the right chord in the hearts of contemporary Indian consumers. What I have noticed is that even people who are skeptical of Ayurveda trust Ramdev and buy his medicine and products. In Uttarakhand, in particular, many people consider him an ultimate authority on Yoga, Ayurveda, traditional medicinal plants, and Indian tradition. Following cases demonstrate this argument well. In winter when Himalayan hill stations get unbearably cold, I spent some time in Rishikesh. Almost every local family in one way or another is engaged in the spirituality-wellness-tourism economy. However, as I discovered, residents of Rishikesh are rather pragmatic about Yoga and Ayurveda. They treat them as a business catered to tourists, not as a way of life for themselves. During my stay, I was hosted by a friend’s family. When I explained that I was researching non-Western medical systems, my

friend's father Jubinji volunteered to drive me to a large ayurvedic *ashram* in the town. On our way, I tried to discern how much Yoga and Ayurveda he practiced, but it quickly became clear that he was not particularly interested in the subject. Then I shifted the conversation to Ramdev and noticed how eagerly Jubinji responded. He said that India had significantly transformed with the arrival of Ramdev, both in terms of lifestyle and material life: "Earlier we used to buy Colgate toothpaste, but now we use local, our own products, even toothpaste. In every house, in every family, you will find Ramdev's products." I asked if he himself was using such products and he replied positively: he buys Patanjali clarified butter, cracked wheat, honey, and many more goods.

Other people, too, often emphasized a change in the consumption pattern from foreign to local, from *videshi* (foreign, a land across the border) to *swadeshi*. In fact, I heard the example of the Patanjali toothpaste versus Colgate so often that it became clear to me that through public camps and TV shows, Ramdev had been able to produce a convincing nationalist narrative, internalized by a large number of people. Apart from some well-educated Indians, lower class Indian Christians and Muslims from Himalayan villages, and migrant workers from Nepal with whom I spoke, nobody expressed a doubt regarding the authenticity and quality of Ramdev's products. When I asked another Patanjali shopkeeper why he believed that the products were indeed natural and genuine, he claimed that not a single customer had ever complained or brought a product back. When I addressed the same question to a middle-class Hindu man, a seller of locally produced foods and clothes, he mentioned that Ramdev's "people" were in every village, asking villagers to collect medicinal plants from the forest—isn't it the most obvious proof that Ramdev uses natural ingredients?

It is hard to talk about a profile of Ramdev's followers without a separate quantitative study, but during my fieldwork, I encountered Indians from different social, economic, caste, regional, and linguistic backgrounds. For example, in one of our first meetings, an English-educated middle-class young mother, who works as a journalist for a local newspaper, directly told me that she prefers Ramdev's products because "it feels good because of doing something good for my nation." On the other hand, a young unmarried shopkeeper of a Patanjali ayurvedic store who does not speak English and has very moderate income proudly stated that he sells ayurvedic products not for making money, but because it is his *seva*²⁸ (duty, service) to the country. He mentioned that it costs him money to deliver Patanjali products from the plains to the hill town, but he does not charge an extra price because he wants people to buy and benefit from those products.

As Chakrabarti argues, Ramdev's public appeal is remarkably broad (2012, 164). Nevertheless, I warn against the view that Ramdev successfully reaches out all sections of Indian society. My interlocutors from rural areas strongly objected to an opinion that Ramdev's projects were cheap: sold in small packets and containers, Patanjali *ghee* (clarified butter), rice, or red chillies are not that affordable. Moreover, a careful examination of Ramdev's use of personal pronouns such as "we" and "our" and the use of "common nouns" (Sacks 1974, cited in Day 1998) such as "nation," "country," "people," "daughters," etc. reveals the complexity of Ramdev's target audience in terms of religion, gender, and social class. Consider the following (Ramdev 2010):

With how much pride [do] people say: "My place is finished with Italian stone."

²⁸ *Seva* has both social and religious connotation. *Seva* is an important category of social obligation which defines all kinds of relationships: army officers do *seva* to the country, children conduct *seva* to their parents, worshipers perform *seva* to gods and the religious community. For more details, see Watt (2005).

With big pride, they say that... But hey, you are Indian. Indian stone is in demand in the countries of the entire world, and you finish your house with foreign stone.²⁹

Clearly this statement shows that Ramdev addresses those who can afford Italian marble for finishing their houses. Similarly, who, if not the middle and upper-middle class, is the target audience for Ramdev's claims that Yoga *asanas* reduce abdominal fat? Interestingly, in Uttarakhand, Patanjali products are commonly sold in organic stores, whose customers are wealthy Indians who are familiar with the global discourses on organic, local, sustainable, and natural produce. Ramdev's instructions to avoid pizza, hamburgers, and cold drinks, and to consume instead more fruit or newly-introduced Patanjali fruit juices are also directed to middle-class consumers. Chakraborty claims that "Ramdev's advocacy for a simple, healthy lifestyle and his vision of public health in India as a low-cost, easily available, self-treatment rings hollow for a majority of Indians. For the starving masses tormented by hunger, the prescription to regularly drink milk and eat fresh fruits and vegetables or fast once a week is both ludicrous and cruel. Evidently, the poor have no place in Ramdev's health programme" (Chakraborty 2006, 388).

At the same time, I also maintain that Ramdev's rhetoric is multifaceted in the sense that it is appealing to many working-class Indians as well. While his development of Ayurvedic products attracts educated wealthy Indians through the conflation of organic and *swadeshi*, it also appeals to the lower-middle class citizens who are persuaded by the more direct nationalism of authentic traditionalism and Vedic purity.

²⁹ *Kitne garv se kehte hain "mere yahān Italian patthar laga hai." Bare garv se kehte hain: dekha... Arre tu hundustani hai... Hindustan ka patthar puri duniya ke mulk mangwa rahe hai aur tu makān ne videshi pattha laga hai.*

2.4 BIOPOLITICS AND BIOMORALITY OF THE HOMEGROWN

According to Fassin (2009), Foucault's use of "biopolitics" and "biopower" relates to the control of populations through regulation on human conduct. Advancing Foucault's ideas, most anthropological studies of biopolitics have centered on biomedicine. Scholars have produced rich and compelling accounts of the ways in which biomedical technology, genetics, vaccination campaigns, family planning, epidemics control, genetic screening and genetic testing, management of disability, and other public health initiatives are implicated in the production of biosocialities, biological or therapeutic citizenship, or other forms of medical subjectivity (Arnold 1993; Biehl 2004; Braun 2007; Briggs and Nichter 2009; Fassin 2009; Foucault 1978; Lock and Nguyen 2010; Marsland and Prince 2012; Nguyen 2005; Petryna 2002; Rabinow 1996; Rapp 1999; Rabinow and Rose 2006; Rose 2007; Rose and Novas 2005). Yet, these theoretical insights would be incomplete without examination of non-biomedical regimes of biopower. I argue that biomedicine is not the only tool for exercising power over life; so is the state-sanctioned alternative medicine.

Dean (1999) argues that biopolitics not only concerns a politics of life but also a politics of "lifestyle." This is a key to understanding the biopolitical dimension of Ayurveda and other non-biomedical systems because "lifestyle" is exactly what they target. Ayurveda and Yoga in contemporary India emerge as a political regime which structures human conduct through the prescription of health regimens related to body, diet, and lifestyle. Ayurveda and Yoga encompass what Marsland and Prince call the techniques of self-care which include "diet, spirituality, [and] indigenous medicine" (2012, 454). In other words, biopower is not a prerogative function of biomedicine. Alternative medicine, too, is deployed in biopolitical

projects that aim at the management of population as well as the promotion of individual self-management.

Medical anthropologists and historians have demonstrated that different health practices such as Yoga, wrestling, or blood donations can be explicitly promoted in the name of the nation and are capable of generating experiences of embodied nationalism (Alter 1994; Alter 2000; Bashford 2004; Chakraborty 2006; Copeman 2009; Mukharji 2011). The studies of embodied or somatic nationalism emphasize the experiences of patients, participants, and users of health programs, but although the experiential aspect is undoubtedly important, I contend that it is equally crucial to look at non-biomedical disciplines as biopolitical projects. To do so, I build on Rabinow and Rose's formulation of biopower as encompassing three dimensions: 1) "a form of truth discourse... and an array of authorities considered competent to speak that truth," 2) "intervention upon collective existence in the name of life and health," and 3) "modes of subjectification, in which individuals can be brought to work on themselves" (2006: 203-204). Modi and Ramdev are precisely such authorities who disseminate "truth discourses" about India's past, heritage, population, current poverty and morbidity, and bright future.

As I mentioned in the previous chapter, Modi's position as Prime Minister casts certain constraints on his rhetoric, causing it to be more circumspect than Ramdev's straightforward and often provocative lectures. But I postulate that they both should be understood as part of the same ideological machinery. Ramdev's personal connections to Modi and the central government's favorable stance towards Ayurveda and Yoga, manifested in the initiation of the International Yoga Day, annual meetings of the World Ayurveda Congress, introduction of free semi-compulsory Yoga classes for civil servants (The Guardian 2015) and the like, leave little

doubt that Ramdev is an agent through which the government pursues its biopolitical and mythopoeic agenda.

In order to encourage national sentiment, Ramdev presents a gloomy picture of India's overall economic dependence of the West and then highlights India's dependency on foreign pharmaceuticals:

Our country's farms are under the control of foreign companies. Country's seeds, country's fertilizers, country's pesticides—everything! From sowing the seeds to purchasing of the seeds—everything has been handed over to foreign companies. Our farms are under the attack from foreigners... Our roti³⁰ is under the control of foreigners. Earlier we gave foreign companies permission to provide us with seeds only... Now genetically modified seeds. If this situation continues, our country's roti is going to be completely under foreign control in a few days. Foreigners have usurped our country's roti. Foreigners have usurped our country's farms. Foreigners have usurped our country's daughters.

The economy of the country is taken over by foreign countries. Economic exploitation, moral exploitation, physical exploitation... [They] create such edibles that, by eating them, millions of the country's people become ill, from cancer, from tuberculosis, from arthritis, [diseases] of liver ... All types of diseases are spreading. From cold drinks.³¹ All those things, from pizza and burger, those all things... from which millions of people of the country would fall sick, eating those [things]. Then, [people] would take their [foreign] medicines. [There is foreign control] on our diet, our ideas, our thinking—all is controlled by foreigners.³²

³⁰ Traditional flatbread.

³¹ Soft drinks

³² *Desh ke khet par videshi companiyon ka {kabza hai}, desh ke beej par, khād par, keetnashakon—sab! Beej bone se lekarke khareedne tak, videshi companiyon ke hāton mein desh ko sopan hua hai. Desh ke khet par videshiyon ka hamla... Roti humari videshiyon ke niyantran mein... Pehle toh hum ne videshi companiyon ko beej hi dene ki anumati di thi. Ab toh genetic modified beej... Desh ke roti puri tarah se videshiyon ke niyantran mein ā jayegi.. kuch dinon mein aur aise hi chalta raha toh.. desh ke roti par videshiyon ka kabza hai... desh ke khet par videshiyon ka kabza hai.. desh ki beti par videshiyon ka kabza [hai].. Desh ke arthvyavastha par videshiyon ka kabjā hai... ārthik {shh} dohan, charitrik dohan, sharirik dohan... aise utwād banate [hain] jisko kha kha karke desh ke croron log bimār padh jāte hai, unko cancer se lekar ke, TB se lekar ke, arthritis se lekar ke, liver ki.. Tamām tarah ki bimāriyan ho jāti hai... cold drinks se lekar ke... tamām voh chizen... pizza burger se lekar ke... voh sa... sari cheezein ... jisse ke desh ke croron log bimār ho jayein unko khā khā karke... Phir unki dawayiyan khāyein.*

The reference to pizzas and burgers is not Ramdev's invention but a trope that many Ayurvedic practitioners use during medical consultations (see Tirodkar 2008, 237). In Hindi, it appears as a single hyphenated word "pizza-burger" which stands for immoderate consumption and Westernized (read: corrupted) values. Thus, by locating the roots of poor health in biomedicine and consumption of Western products, Ramdev sets the ground for the promotion of homegrown Ayurveda and Yoga as a different kind of consumption based on morality. Not merely are these practices best suitable for Indian bodies (for they are built on long-standing "traditions," bear "no side-effects," and take into account customary diet and lifestyle) but they are also critically important for the economic and physical health of the country. In a somewhat similar way, Sanjay Srivastava (2015) describes the discourses about Narendra Modi during the 2014 election campaign, focused on economic growth and consumption. Rather than criticizing consumerist desires of the middle class, Modi's campaign generated a view of "consuming as an act of citizenship" (2015, 336). Srivastava defines it in terms of "moral consumption," within which "there is no condemnation of consumption as illegitimate grounds of identity-formation... or emphasizes on the morality of savings-behavior... Rather, the concern is with "appropriate" participation in consumerist activities" (Srivastava 2015, 335). Like Modi, Ramdev encourages consumption as a moral act and the national duty but in contrast to Modi's focus on globalized consumption, Ramdev is concerned with the consumption of the homegrown Ayurveda.

Thus, Ramdev's endeavors go beyond immediate questions of individual health. As Sarbacker remarks, "here the spiritual resources of Yoga and the health benefits of Ayurveda are applied to the pressing problems of Indian society from government corruption and economic imbalances to water management, poverty eradication, and population control" (2014, 557).

Importantly, Ramdev insists on the importance of everybody's personal responsibility for the prosperity of the entire Indian society (2010):

The nation which [makes complete use] of its own abilities, abilities of its citizens, labor of its citizens, physical labor of the citizens, intellectual labor... the nation which makes complete use of resources of its own country—that nation becomes self-reliant.

Today, we are one billion 150 million people of our own country. This is a human capital of the nation. I am an individual...later. First of all, I am the capital (*sampatti*) of the nation. Therefore, I have rights over this country and I have rights over the resources of this country. Citizens have rights. But citizens also have certain duties.³³

Ramdev's choice of the word *sampatti* is salient because it signifies wealth, capital, resource, or property, i.e. used to describe inanimate belongings. By consciously choosing this word, he again invokes the issues of power, morality, and value: people are the property of the nation; they belong to the nation (not the other way round) and that is their primary role; personal life is secondary. Indian citizens become the nation's biocapital. Importantly, Ramdev talks about duty not only to the current Indian society and its future but also to mythological Indian sages. In an excerpt about restoring glory to India through recognition of Ayurveda, which I discussed earlier, he highlights that this work is important because "it is here where our ancient sages-hermits did work,"³⁴ so we are indebted to them. Presenting Narendra Modi as an exemplar citizen, he claims: "The one who represents India and Indianness, also represents the culture of

³³ *Jo rāshtra apne shaktiyon ka, apne desh ke nagariko ki shaktiyon ka, apne desh ke nagariko ke shram ka, apne desh ke nagariko ke sharirik shram ka, buddhik shram ka, jo apne desh ke sansādhanon ka poora upyog karta hai, woh rāshtra swawlambi ban jāta hai. āj hum apne desh ke ek so pandrah crore log—yeh rāshtriya sampatti hai. Main ek vyakti bād mein hoon. Main pehle rāshtra ki sampatti hoon. Isse desh ke upar mera adhikār hai, aur desh ke sansādhanon par mera adhikār hai. Nagarikon ke adhikār hain. Nagariko ke kuch kartavya bhi hai.*

³⁴ *Humare rishi-muniyon ne yahi toh kām kiya hai.*

sages and the culture of gods.”³⁵

The shuttling between accountability for personal health, responsibility for the country’s economic growth, and moral duty before Indian ancient sages indicates that Ramdev’s project is deeply moralizing. The only way to restore Indian culture, the national and personal wellbeing is through self-discipline, avoidance of fast food and western clothes, the performance of Yoga and meditation, by adhering to traditional diet and ayurvedic herbs for prevention of illness. Ayurveda and Yoga become techniques of governmentality, procedures and philosophies by which Indian subjects govern themselves and are made governable. In agreement with Whyte (2009), I doubt that there is some straightforward “workings” and manifestation of biopower “in bioidentities, subjectivities, and socialities.” Rather I maintain that biopower of alternative therapeutics plays out through the circulation of moralist discourses, for example, those that link individual bodies to past, present, and future of the nation. The actors of biopolitical interventions are not necessarily cognizant of the processes affecting them. From this perspective, alternative medicine influence people’s lives not less than biomedicine, by making people live in certain ways, train and reward their bodies by certain non-biomedical practices because ultimately for many people who live within the pluralistic medical milieu there is no difference between biomedical and non-biomedical intervention.

Rachel Berger has recently argued that scholars of Ayurveda have mistakenly studied it as devoid of political significance, outside the scope of the biopolitical (2013, 1). Addressing this inadequacy, she convincingly demonstrates how the late colonial administration and the early post-colonial government of India gradually began to deploy Ayurveda to meet certain biopolitical goals. She highlights how due to an emphasis on both indigeneity/antiquity and

³⁵ *Jo bharat aur bhariyta ka pranidhitva karte hain, woh rishi sanskriti, dev sanskriti ka pratanidhitva karte hain.*

scientific foundations of Ayurveda, it paradoxically emerged as both an antidote to modern western biomedicine and an ally to the biomedically-oriented state. For example, on the one hand, Ayurveda and Yoga were mobilized by Gandhi in his anti-colonial programs as a way to resist western influence. On the other hand, Ayurveda was quickly endorsed as a socially trusted practice through which the state could implement biomedical interventions such as vaccination, with the help of indigenous practitioners in rural and remote areas to which biomedical doctors did not have access. In both cases, Ayurveda and Yoga were the grounds where the political and the social were interlinked.

Inspired by the work of Berger (2013) and Alter (2000; 2015),³⁶ I seek to highlight the biopolitical implications of Ayurveda, as well as the biomoral nature of Ramdev's Ayurvedic rhetoric. I maintain that Ramdev's promotion of Ayurveda directly targets the issues of body, morality, social responsibility, discipline, spirituality, and religion. Ramdev repeatedly highlights the technological and scientific progress in the field of ayurvedic research, the modern importance of Ayurveda in "curing" diseases such as cancer, arthritis, and obesity. Yet Ayurveda's value is based on its atemporal quality, its universality, because it is proclaimed to have existed since the origin of the world.³⁷ It is believed that Ayurveda was not "developed" by

³⁶ There are significant differences between Berger's and Alter's uses of the term "biomoral". Berger deploys it to describe phenomena which are typically glossed as 'holistic'. She explains that Ayurveda—unlike biomedicine—is biomoral, because it is concerned with the issues of body–mind unity (Berger 2013, 24). Quite differently, Alter writes about "biomoral politics" in relation to health, celibacy, vegetarianism, or fasting, when the biological body becomes a tool for achieving moral and spiritual perfection (Alter 2000; Alter 2015). In this dissertation, I follow Alter to illuminate how the body is acted upon through appeals to duty, virtue, and social service, producing justification for consumerism and radical nationalism.

³⁷ Remarkably, the official website of the Ministry of AYUSH explains that Ayurveda is "the ancient most health care system which originated with the origin of the universe. With the inception of human life on earth Ayurveda started being applied" (Ministry of AYUSH n.d.).

humans or even gods, for that matter, but “remembered” by Lord Brahma and then given to people by Lord Dhanwantri.

2.4.1 Women in Ramdev’s rhetoric

The inescapable ancientness and divine roots of Ayurveda become a powerful rhetorical tool for disciplining Indian citizens as moral subjects who have duties and responsibilities for themselves and the nation, including the nation’s past and the future (Ramdev 2014):

You know, we are accused to be people from the times of Adam. But what, is our old age a disadvantage? Come on, brothers, we have cured blood pressure, we have cured thyroid through breathing exercises, we have cured thyroid, have cured asthma. Only in Ayurveda is there a process of curing. Ayurveda is not just an ordinary knowledge: our ancestors, Carak, Sushruta, Dhanvantri and others, performed so many meditations upon it. [...] If you consume Ayurveda—not only a hundred years, you will live even more than that!³⁸

Within this context, Ramdev again explicitly blames foreigners for lack of morality and urges Indians to avoid foreign things. In particular, Ramdev seems to caution against the marriages with foreign women and rather choosing local (*desi*) brides:

There [in the West]... there is even no philosophy/religious thought there, isn’t it? Their entire philosophy, their entire ideology is centered on business... The things that are making the health of our country bad... things that come from outside do not all happen to be very good. The most excellent things are local/Indian. Indian medicine too is the most excellent, Indian cows are also the best, Indian garments are also the best; Indian brides are also the best. Everything needs to be local/Indian.³⁹

³⁸ *Yeh na, humko matlab ekdam... woh ādam ke zamāne ka samajh liya gaya hai. Hamara purana hona koi yeh hamari kami hai kya? Arre, bhaiya humne BP cure kiya hai, humne thyroid cure kiya hai (breathes heavily) kapalbhati kara ke... BP cure kiya, thyroid cure kiya, asthma cure kiya. Curing ka process kewal Ayurveda mein hai. ...Ayurveda koi sādharan [ordinary] gyān nahi hai, hamare purkhon ne (inc.) Carak, Sushruta, Dhanvantri ādi ne ispe kitna tap kiya hai. [...] Ayurved ka sevan kareng: sau sāl nahi—use bhi zyada jiyenge.*

³⁹ *Wahan koi...wahan woh darshan hi nahi hai na. Unki puri philosophy, unki puri ideology woh vyapar pe kendrit hai. [...] Jo is desh ke swasthya ko kharāb kar rahi hai... bāhar se āyi bhi cheez na sab*

As the second to last sentence illustrates, Ramdev portrays Indian women as national (*desi*) objects for male consumption, along with *desi* clothes and *desi* food. In other contexts, he presents women as mothers and grandmothers—the guardians of traditional knowledge who administer kitchen remedies. In another speech, even though Ramdev is celibate and does not have children, he speaks about “our” daughters, ascribing himself to the category of concerned fathers:

There is foreign control over our *rotis*, there is foreign control over our daughters. From *rotis* to daughters, from the field to the stomach. This way foreign companies have decoyed our country’s daughters. Look at their clothes, look at their attire, their appearance, look at accessories, look at their language, look at their thoughts.

Thus, it appears that in Ramdev’s rhetoric, women are defined by their relationships to men and family; women are not independent agents but relatives whose behavior is a concern to their fathers and husbands. Notably, the rhetoric on the conduct of daughters, and female citizens in general, is tightly interlaced with the patriarchal ideology of *hurdutva* and the biopolitics of Hindu nationalism (Carilli and Campbell 2012, 82; Chatterji 2004).

At the same time, we need to recall that women are also a target audience and the most devout participants of Ramdev’s *yog shivirs* and other campaigns. Therefore, I contend that Ramdev’s biomoral fundamentalism is gendered in complex ways,⁴⁰ since women are constructed as both the subjects and the objects of the homegrown philosophy. Women are both the consumers of Indian local products and the homegrown, local commodities themselves.

A similar delicate balance in representations of women as both respectful mothers and

bahut acchi nahi hoti hai.... Desi cheez sabse badhiya hoti hai... Desi dawa bhi sabse badhiya hoti hai, desi gay bhi sabse achchi hoti hai, desi vastra sabse achche hote hain; desi bahoo bhi sabse achchi hoti hai. Sab desi hona chahiye.

⁴⁰ The gendered nature of biomoral consumption and the homegrown medicine are also at stake in Ramdev’s discussions of homosexuality and Yoga’s ability to “cure” but I leave this subject beyond the current dissertation.

wives and the consumers (a role which is potentially dangerous for women's respectability) has been documented by Srivastava (2015) with regard to Narendra Modi's rhetoric. Srivastava claims that the woman as "the sacrificing figure who facilitated male consumption rather than consumed herself has been a long-standing cultural discourse" in India, but Modi was able to promote consumption among both men and women in a way which did not threaten that image:

while both men and women are offered equal chances of becoming consumers, masculine anxieties over female consumption [...] are, in effect, assuaged through Narendra Modi's 'strong' masculinity. He takes part in the world of consumption while not effacing the world of "tradition." He is the advocate of moral consumption; ergo consumption is good as long as it is "appropriate" to the Indian cultural context (Srivastava 2015, 335).

Ramdev's portrayal of women also fits well within a discursive framework which equates women with Mother India. As Mankekar has revealed through the analysis of popular television series, there seems to be "an imperceptible slide from 'mother' to 'motherland:'"

women are "subjectified" as mothers and held responsible for inspiring their children to safeguard India's honor; at the same time, India is feminized as the mother and made the object of protectionist discourse (Mankekar 1993, 549).

Ramdev too frequently invokes the image of Mother India, by starting his speeches with the slogans of *Bharat Mata ki Jay* ("Victory to Mother India") and *Vande Mataram* ("I salute thee, Mother"). Thus, for Ramdev, the feminine (the Mother India, Indian brides) is something that needs to be consumed and protected, yet the feminine is also itself the protector and consumer. From this perspective, it can be argued that Ramdev's Ayurveda is more nuanced than Ayurveda of many pharmaceutical companies which tap into the narratives of beauty and attractiveness of women Islam (2010, 788). Following Selby (2005, 121–129), Islam argues that in Ayurveda discourse, "women's health concerns have been largely replaced by beauty concerns, and ayurvedic knowledge has been used to create new body images for wellness and beauty." In contrast, although Ramdev's Patanjali offers facial creams and other beauty products, he does

not threaten the respectability of Indian women. It is also imaginable that by referring to “*desi bahūs*” (local brides), Ramdev is addressing not Indian men but Indian mothers who are responsible for finding daughters-in-law.

2.5 INDIANNESS AND HINDU NATIONALISM

In fall 2014, I spent some time in a village in Kumaon part of Uttarakhand. One day I was going down the hill, after visiting a Hindu temple on the hilltop. On the way, I met a group of four Nepali men who had come to India as construction workers. One of the men was slightly sick, so I asked him if he was taking any medication. He said no, there was no hospital nearby. Then I mentioned that there was a Patanjali store on the main road but he remained silent. I asked why wouldn't he go there and get some medicine, didn't he know that there were Ramdev's products. Hardly had I finished saying the name Ramdev, as the sick man's friends began to shout *chor, chor* (thief, thief)! I did not expect such a response and tried to elicit the reasons why these men thought so, but they suddenly became reluctant to talk. I presume they might have thought that I was a supporter of Ramdev, so they were hesitant to share their opinion on him.

I had similar experiences a number of times. It appears that Ramdev's popularity in Uttarakhand is so well established that people can be reluctant to speak the opposite. When I lived in a different hill town, I became close with a group of local Christian women. We rarely talked about my study but one evening, I asked them about their thoughts on Ramdev and Patanjali products. For a minute or so, they seemed to contemplate on how to go about answering my question but then gradually explained that they did not trust him. Neither did they buy his products because they were expensive and of questionable quality. I mentioned that many people

trusted Ramdev, so why didn't they? They replied that they believed in God; therefore, they could not take Ramdev seriously. Confused, I asked if they thought that only Hindus followed Ramdev and bought his products, and they answered that it was very likely so. "But he does not address only Hindus, he is talking about entire India. What about his promotion of *swadeshi* products?"—I wondered. They replied that the *swadeshi* campaign was immoral: Good life is all about exchange and reciprocity; how can a country survive on its own? We need to give something to other countries and receive something from them in return. It would be incorrect to turn India to a *swadeshi* economy.

This statement struck me as a beautiful articulation of nationalism which was not predicated on the antagonizing narrative of *swadeshi* versus *videshi* (home-grown versus foreign) or the hyper-nationalism of Ramdev that is intended to keep India away from foreign influence but spread India's influence (of Ayurveda and Yoga) to the rest of the world. This case also shows that Ramdev's declarations of India's (Hindu) cultural supremacy are challenged inside the pockets of India's populations with different cultural and religious philosophies. This, however, should not be interpreted in the sense that Christians, Muslims, and other groups who do not identify as Hindus would never make use of Ramdev's ayurvedic pharmaceuticals or would not practice Yoga. As I mentioned in the introduction, when a person is sick, she is simply looking for a cure, "shopping" for various doctors and therapies, irrespective of religion, cultural identity, or worldview. In fact, I know practicing Muslims who have tried Ramdev's drugs as part of their long therapeutic journey.

Ramdev's representations of Yoga and Ayurveda are invariably situated within the discourse of a great "Indian" civilization and he is careful to avoid the term "Hindu:" in the two texts I analyzed, there is absolutely no reference to the word Hindu in any form. Moreover,

Ramdev frequently states that Ayurveda and Yoga have nothing to do with religion. Yet I maintain that the language and cultural references of his speeches are unambiguously indicative of his belief in the foundational role of Hindu culture in Indian nation-making. Notwithstanding the differences in praxis, the rhetorical consistency between Ramdev, BJP, and RSS provides substantial grounds to argue that ayurvedic drugs, ayurvedic noodles, toothpaste, breathing exercises, and other health products and practices offered by Ramdev are not merely designed to restore health of individual Indian bodies, but to also nurture the soil of Hindu nationalism. This is unambiguously exhibited in Ramdev’s advocacy for Ayurveda as “national medicine” (*rāshtriy chikitsa*), at the expense of other non-biomedical systems:

All brothers and sisters have come now [to the conference] with great enthusiasm, but even now there exists one calamity: Why do we call Ayurveda an “alternative” medicine? Ayurveda is a native medical system, it is an absolute medical system. [...]

Before completing my speech, I ask all of you, should Ayurveda be declared a national medical system or not? We trust that honorable Brother Narendra Modi will induct Ayurveda, Yoga and his own traditional medical system as a *national* medical system and will give glory to his sages.⁴¹

The fact that Ramdev never uses the term *hindutva* (Hinduness) is not surprising, for it has been deployed in a number of controversial and even explicitly aggressive campaigns against India’s minority groups, especially Muslims. Even in a less violent form, in which “Hindu” is understood not as a religious but cultural category, the doctrine of *hindutva* has cultivated forms of cultural violence, for example, by claiming that all Indian Muslims must acknowledge their Hindu past and convert back to Hinduism. Instead of *hindutva*, Ramdev favors the term

⁴¹ *Ab, sab bhai-behan, khub utsah ke sāth āye hai, aur abhi tak ek vedana hoti hai ki ayurved ko hum ek vaikalpik chikitsa kyu kahate hai? Ayurved mool chikitsa paddhatti hai, ek sampoorna chikitsa paddhatti hai. [...] Main āp sabse puchta hun apni bāt ko poo-capitalcra karne se pehle Ayurveda ko rashtriya chikitsa padhatti ghoShit karna chahiye ki nahi? Ayurved ko, yog ko aur apni paramparāgat chikitsa padhatti ko, hamein bharosa hai, ādar narendra bhai modi rashtriya chikitsa padhatti ke roop mein pratishtapit karenge aur apne rishiyon ko gaurav denge.*

bharatiyata (Indianness, Indian nation, Indian identity).⁴² This is a neologism created by combining the root *bharat* (India) and the suffix *-yata* (-ness) and it is likely that Ramdev has borrowed it from his late teacher and social activist Rajiv Dixit. The term *bharatiyata* functions similarly to but different from politically charged terms *hindutva* (Hinduness) or *Hindu rashtra* (Hindu nation) and I argue that by intentionally using a neutral *bharatiyata*, Ramdev attempts to persuade his devotees in the inclusiveness of the nationalism that he offers.

However, despite the substitution of labels, the rhetoric remains distinctively Hindu. First, as I mentioned, Ramdev's speeches begin with performative greetings from a typically Hindu repertoire: *Bharat Mata ki Jay* and *Vande Mataram*. Both expressions have long and controversial cultural history, directly related to the issues of nationalism and Hindu majoritarianism.⁴³ Ramdev's orientation to the Hindu-background publics is further evident in the use of other cultural references such as Hindu gods and legendary heroes (*Bhagvan*, *Rama*, *Hanuman*, and *Dhanwantri*), insertion of rare Sanskrit words and entire sentences, statistical prevalence of Sanskrit-derived words over Urdu-derived words, and constant invocations of India's mythological past:

What was in Ramrajya [Rama's Kingdom]? In Rama's kingdom, not a single person was sick, nobody was ill, not a single person was poor, nobody died at young age. I entirely believe that since 2014 a similar Rama's kingdom has now begun.⁴⁴

⁴² Interestingly, this term has gained a renewed interest after Sonia Gandhi's speech in which she juxtaposed the Congress' ideology of unity with the BJP's drive for uniformity, which threatens the very foundations of "our Bharatiyata, our Hindustaniyat." <https://www.youtube.com/watch?v=TOa7XJAdmgI>

⁴³ For example, the cry *Vande Mataram* is derived from Bankim Chatterjee's poem written in 19th century. During the independence movement, it was proposed to become a national anthem, but was rejected on the grounds of being offensive to non-Hindu citizens, because the poem depicted the nation as Mother Durga, a Hindu goddess. Finally, the first two verses (which did not have any religious references) were proclaimed a "national song" of India, yet it remained to be closely associated with Hindu nationalist sentiments.

⁴⁴ *Ramrajya mein kya tha? Ramrajya mein koi bhi vyakti beemar nahi tha, rogi nahi tha, koi bhi*

Notice that this speech was delivered three months before the elections in 2014 but Ramdev is strikingly confident in speaking as if Modi has already won and new Ramrajya has begun. By presenting a new political phase as a return of the mythological golden time of Rama's rule, Ramdev equates Modi with a Hindu god-hero. He then strengthens that comparison by metaphorically discussing a political battle between Modi and his opponents at the prime-ministerial elections as the *devāsura sangram*—a mythological war between *devas* (gods) and *asuras* (demons):

At the eve of that 2014 holy battle between gods and demons [i.e. election of Prime Minister], such *amrit* [sacred juice, benefit] will come out from Ayurveda, thereby I said that the future of Narendra Brother Modi would be bright, and the future of Ayurveda would be bright⁴⁵

By analyzing a nationalist rhetoric of Shiv Sena (a right-wing party in Maharashtra) after the destruction of Babur's mosque in Ayodhya followed by Hindu-Muslim riots in 1992, Roy and Rowland (2003) have discovered a certain narrative pattern, which they call a pattern of mythic redefinition and mythic return. Since Hindu philosophy emphasizes peace, tolerance, and non-violence, many scholars of South Asia found it shocking that such atrocities as were done in Ayodhya could be committed in the name of Hinduism. Roy and Rowland argue that it was made possible through a rhetorical redefinition of Hindu people and mythological heroes (such as Rama) not as peaceful and gentle persons but as warriors. Shiv Sena ideologues were able to portray the demolition of Babur's mosque through a narrative of a return to the glorious Hindu past characterized by Hindu heroism.

vyakti daridra nahi tha, aur koi alpayu mein marta nahi tha. Mujhe pura vishwas hai waisa hi Ramrajya ab 2014 se shuru hua hai.

⁴⁵ *Us 2014 ke devāsura sangram dharmyudh ki purv sandhya par yeh ayurved se aisa amrit niklega, us se, maine kaha, narendra bhai modi ka bhi bhavishya ujwal hoga aur ayurved ka bhi bhavishya ujwal hoga.*

Inspired by the works of Mircea Eliade (1963) and Burke's examination of Hitler's rhetoric, Roy and Rowland postulate: "Nationalist movements rely on myths of return to provide the 'nation' with dignity and worldview... Via a myth of return, the perfection that was present at the beginning of the society/nation/religion can be brought to the present day. In doing so, the people can rid themselves of all 'infirmities,' recover identity, dignity, and a 'positive' sense of 'moving forward,' and discover a 'world view' for explaining their place in the universe" (2003, 230–231).

Certainly, Ramdev's speeches are far less radical than the statements of Shiv Sena or Hitler, especially because his nationalism stems from the opposition of homegrown/foreign, rather than from identifying an "internal villain" or vilifying a certain community (such as Muslims or Jews). Nevertheless, the narrative of mythic return to Rama's rule supports the argument of Hindu nationalist underpinnings of Ramdev's ayurvedic rhetoric. As McKean (1996, 1) argues, many spiritual gurus played a crucial role of in Hindu communalist projects:

The activities of many gurus and their organizations during the 1980s and 1990s are related to the simultaneous expansion of transnational capitalism in India and growing support for Hindu nationalism in India and abroad.... As producers and purveyors of spiritual commodities, gurus assist in propagating Hindu nationalism, an ideology that relies on referents to Hindu India's unparalleled spiritual prowess and moral authority.

McKean's words are even more critical with regard to Ramdev because he is not just one of many Indian gurus but an extraordinary influential public figure and entrepreneur with millions of followers in India and abroad. Hence, the "truth discourses" that he generates and disseminates cannot be dismissed as irrelevant.

Finally, it is important to highlight that Ramdev's promotion of *swadeshi* Yoga and Ayurveda are embedded in the processes of commodification and economic globalization. Ramdev openly constructs Ayurveda, Yoga, and domestic produce as essentials for a physically

and economically strong India, as technologies of self (Foucault 1978) advocating for a personal responsibility for one's health and body. Moreover, he insists on the global application of Ayurveda and Yoga and pushes the government for a possibility of spreading them to the world (Ramdev 2014):

In the entire world, not a single person's blood pressure has not been corrected from a biomedical drug. In the entire world, not a single person's blood pressure got cured. But we, by prescribing a breathing exercise and by giving secret knowledge, have cured blood pressure of hundreds of thousands of people.

We do have the knowledge, but for delivering it in a form of science we need a little bit of infrastructure, a little bit of help. Then we can bring health to the entire world, not only to India—we can bring health to the entire world and create the WHO in India itself.

With the help of our sages' knowledge, vitality will establish in the entire world. Just like them, we will do our work, [and] together, we all will make India a nation of sages. In the whole world... there are many poor people who die in the deficiency of treatment; even to them, by means of medicinal herbs found in our nature which is the gift of God, we will bestow a new life.⁴⁶

These passages evince that Ramdev's project is not just national but global. While he is critical of neoliberal reforms which allowed transnational corporations to take over the Indian market, he is also cognizant of lucrative advantages of a globalized economy, such as an opportunity to benefit from a global demand for alternative treatments and herbal pharmaceuticals. Yet, here

⁴⁶ *Puri duniya mein allopathy ki dawa se ek ka bhi BP thik nahin hua. Puri duniya mein ek ka bhi BP cure nahin hua, aur humne anulom velom kara kar ke, guptaviti de kar ek lakhon ka BP cure kar diya. [...] Hamare pās gyān toh hai, lekin usko vīgyān ka roop dene ke liye humein thoda sa infrastructure chahiye, thodi si madad chahiye, Toh hum puri duniya ko kewal bharat nahi, puri duniya ko hum swasth bana sakte hain aur WHO Hindustān mein hi khada kar sakte hain. [...] Hamare rishi muniyon ke is gyān ko sammān milne se puri duniya ko jeewan milega. unhi ke roop-anuroop hamara karya hoga. Hum sab mil karke is bharat ko rishiyon ka desh banayenge. aur puri duniya mein bahut gareeb log jo chikitsa ka abhāv mein dam toDte hain, unko bhi hamari prakriti mein jo bhagwān ki den hai un jadi-butiyon ke dwara unko navjeewan pradan karenge.*

again, his advocacy for alternative medicine is exclusively focused on Ayurveda and Yoga.⁴⁷ In contrast to the government’s emphasis on AYUSH, Ramdev does not even use this category. Occasionally, he makes references to other medical traditions, but these references are extremely rare and Ramdev simply lists them to support his promotion of Yoga and Ayurveda. Consider, for example, the following passage, where Ramdev compares the budget for biomedicine (97%) and alternative medical traditions (3%) (Ramdev 2014):

Within three percent Yoga is included, Ayurveda is included [pause], Siddha, Unani, and Naturopathy, Acupressure—all alternative medical systems.⁴⁸

Here Ramdev claims that the biggest portion of the healthcare budget is given only to one medical system—biomedicine (allopathy), whereas the plurality of other traditions is given only three percent. But it is clear that even with regard to medical plurality, Ramdev primarily speaks of Yoga and Ayurveda and then—after a pause—adds: Siddha, Unani, Naturopathy, Acupressure.

His language (use of Sanskrit-derived words), cultural references (“our” Hindu gods and saints, *amrit*, *kaliyug*), clothing (a saffron robe associated with Hindu ascetics), ritualized performances (such as *yog shivir*)⁴⁹ and, of course, his political alliance—all of this unequivocally points the privileging of Hindu culture. By mobilizing people at Yoga camps and other gatherings in which he promotes Yoga and Ayurveda as survivals of the glorious Hindu past, as practices of the “traditional,” “indigenous” and “familiar,” Ramdev transforms them into

⁴⁷ Some of Patanjali campuses also include Naturopathy facilities but it could be argued that within Patanjali YogPeet, Naturopathy is conceptualized as part of Ayurveda and an Indian tradition of natural medicine (literally *prakritik cikitsa*).

⁴⁸ *Ninety-seven percent budget allopathy ko? Teen percent pe yog ā gaya, ayurved ā gaya, siddha, unani, aur naturopathy, acupressure, sari vaikalpik chikitsa paddhatiya* (Ramdev 2014).

⁴⁹ Alter notes that the term *shivir* “is most often used in the contexts where various groups and institutions are involved in promoting ‘Hindu ideals’ or ‘Vedic heritage’ (or both)” (2008, 36).

a biopolitical project, which not only seeks to discipline Indian bodies but also determines whose bodies count as Indian.

In this chapter, I have demonstrated that Ramdev's success is largely premised on the deployment of media and an ability to refashion Yoga and Ayurveda as "traditions" applicable in modern life. Ramdev has managed to move them from the realm of the strange to the familiar, i.e. from a vocation of ascetics or priests into mass practices grounded in embodied mythology and moral consumption. By advocating for making Ayurveda and Yoga great "again," Ramdev has constructed them as tools of returning to a golden time when nobody was ill or poor, as well as a way of recovering the Indian identity, restoring the glory of Indian culture, and paying respect to Indian sages. By creatively interweaving Ayurveda with the issues of body and morality, indigeneity and nation, mythology and future, medicine and cultural duty, Ramdev has produced a kind of Hindu nationalism that is neither cultural or religious nor even simply medical or embodied but biomoral.

I have examined a specific case of promotion of Yoga and Ayurveda as a technology of discipline that relates to nationalism, biopower, and morality. This perspective complements the theorizations of national rhetoric, media, and the invention of tradition (Anderson 1983; Hobsbawm 1990) by focusing on the biopolitical potential of non-biomedical systems that inscribe nationalism onto the body. Furthermore, it brings in the questions of biopolitics, embodiment, health rhetoric, morality, nationalism, and biological citizenship. I have cautioned about the inadequacy of considering Hindu nationalism as a religious or cultural form of nationalism. Instead, I have offered to pay close attention to the body and morality, as well as to the techniques of self-care and self-discipline which are implicated in the production of biomoral nationalism, i.e. a form of nationalism where Indians are understood as biomoral citizens.

3.0 HIERARCHY OF PLURAL MEDICINE

In many countries non-biomedical traditions have become a rather common feature of institutionalized healthcare. But legitimation of plural medicine—or its denial—is not a simple issue which results from an objective decision about whether a medical tradition is therapeutically valid or not. In contrast, it constitutes a long process of lobbying or contestation by various actors and is often driven by ideological agendas (Adams and Li 2008; Attewell 2007; Brotherton 2012; Cho 2000; Croizier 1968; Ferzacca 2002; Janes 1995; Keshet and Popper-Giveon 2013; Khan 2006; Lambert 2012a; Leslie 1973; Lock 1990; Weiss 2009; Wujastyk 2008). For example, Ferzacca (2002) has described how the Indonesian government manipulated the plurality of medical practices by recognizing only those that fit into the overarching ideology of “development.”

Legitimation of so-called “indigenous” medicine is particularly deeply rooted in ideological ground. It is often explicitly linked to the ideologies of cultural heritage, political autonomy, and nationhood, especially when indigenous medicine is framed in opposition to foreign—colonial or neocolonial⁵⁰—biomedicine (Arnold and Sarkar 2002; Bala 1991; Farquhar 1994; Leslie 1976a; Panikkar 1992; Van Hollen 2005). Often, indigenous healing practices become co-opted by nationalistic rhetoric and constructed as “national” medicine (Alter 2008a),

⁵⁰ Discourses in which biomedicine is contrasted with indigenous medicine are not limited to the periods of anti-colonial struggle and nation-building but also include more recent anti-neoliberal or anti-immigration rhetoric.

but this raises a problematic issue of selection: which one of many medical traditions gets identified as the nation's "indigenous" medicine? This question is critical and not specific to India, because in reality the therapeutic landscape of any country is characterized by a plurality of healing options: there are oral traditions and textual medical disciplines, therapies administered by different healers (shamans, priests, herbalists) and therapies associated with gender or kind of illness (midwives, snake-bite curers, bonesetters). Therefore, it is imperative to pay attention to debates over which—or even "whose"—medical tradition becomes legitimized, since such debates and the following actions reveal important sociopolitical processes.

The term medical pluralism is deceiving because it obscures the selective nature of state legitimation. In a study of bonesetters in Rajasthan, Lambert (2012a) has called for attending to "hierarchies of legitimacy" that result from the government sanctioning of some alternative therapies while discounting the others. For example, she has demonstrated that unlike Ayurveda—a medical tradition based on canonical texts—the practice of bonesetters has not been recognized as a separate category of alternative medicine, and therefore exists at the "margins of state legitimation;" although bonesetters may be endorsed as "experts" by local people, they have to constantly negotiate their legally ambiguous status (Lambert 2012a, 1030).

Clearly, such selective legitimation leads to marginalization and even extinction of unauthorized healing traditions—a situation which has been observed in many parts of the world (Chen 2013; Hampshire and Owusu 2012; Saks 2008). For example, in pre-socialist China there were many diverse therapies but during the socialist reforms of the medical sector, most of those therapies were denied recognition as part of Traditional Chinese Medicine and, subsequently, gradually disappeared (Kleinman 1980). Later in this chapter, I will return to the issue of legitimacy, showing that in addition to official endorsement by the state, there are other sources

of legitimacy (such as lineage and local social networks) that play an important role in enunciating the asymmetries among plural medical traditions. But now I focus on a different issue: even when plural medical systems are *legitimately equal*, i.e. equally sanctioned by the government, disparities between them do not cease to exist. State legitimation of plural traditions of medical knowledge is not a panacea for equality; it does not safeguard from structural and cultural asymmetries which are important but this argument is left unarticulated in most studies of medical pluralism.

A medical tradition (be it biomedicine or any alternative medicine) is not a homogenous entity in which all areas of knowledge and practice are deemed uniformly important. Scholars of biomedicine have shown that there is a hierarchy of biomedical therapies, procedures, and professions in terms of social prestige and remuneration (Gaines and Davis-Floyd 2004). For example, surgery is ranked as a more prestigious area of biomedical practice than nursing. Similarly, some aspects of alternative medicine are prioritized while others are discounted as less valuable. For example, due to ideological pressures from the Chinese government, certain procedures of Tibetan medicine have been pushed to the periphery of practice as being “religious” and “unscientific” (Adams, Schrepf, and Craig 2010). In a similar way, in India, *bhūtavidyā*—one of the eight branches of Ayurveda, which deals with non-human entities—has been relegated by contemporary ayurvedic patients and doctors (Naraindas 2014, 112–113; Hardiman 2009). From this perspective, it is important to keep in mind that Ayurveda, Siddha, Unani, or any other recognized “system” is a product of a long historical and often transregional development, encompassing a multitude of therapeutic genres. Ayurveda, Unani, and other medical traditions should be understood as an eclectic set of healing practices with both elite and lay, codified and folk components (Liebeskind 2002). As Projit Mukharji emphasizes,

knowledge traditions “regardless of how we might affiliate them—‘Western’ or ‘Islamic’ or ‘Indic’ or ‘Bengali’—are always already internally variegated” and “internally plural” (2016, 24).

Nevertheless, the review of the existing scholarship shows that there is a persistent tendency to focus on the tension between traditional medicine and biomedicine, not *within* them (cf. Alter 2005b; Alter 2015; Sivaramakrishnan 2006). In contrast, I highlight the tension that permeates state-sanctioned non-biomedical pluralism, by tracing the history of state policy on plural medicine in India from the 1940s to the formation of the Ministry of AYUSH in 2014.⁵¹ Additionally, I briefly describe the government programs and regulations pertaining to non-codified healing traditions which have been excluded from AYUSH. The chapter ends by bringing in the voices of AYUSH practitioners and users, explaining that the government policy translates down to the clinical interactions in various ways, from not impacting doctors at all to producing a great deal of confusion and misinterpretation.

Overall, this chapter grapples with the production and reception of ambiguous language, such as the officially adopted category of “Indian medicine,” which sometimes includes Ayurveda, Siddha, and Unani, while at other times referring exclusively to Ayurveda. Since the government documents conveniently avoid defining “Indian medicine,” I question whether such ambiguity is intentional. I also seek to understand the implications of a shift from the

⁵¹ The activities of non-government organizations and meetings (such as Nikhil Bharat Ayurveda Vidyapith, All India Vaid-Yunani Tibb Conference, and The Ayurved Sammelan) with regard to the promotion and standardization of non-biomedical disciplines in India are beyond the scope of this dissertation. However, it is important to emphasize that in the pre-independence period, a push for professionalization and institutionalization of non-biomedical systems came overwhelmingly from practicing doctors and scholars of those systems, not (only) from the state. As Kavita Sivaramakrishnan (2006) demonstrates in her detailed study of indigenous medicine in colonial Punjab, Ayurvedic and Unani practitioners strived to organize themselves in professional organizations, using the biomedical model, in order to exercise influence on state medical policy.

bureaucratic category of “Indian Systems of Medicine and Homeopathy” (which existed until 1995 at the national level and is still occasionally in use) to a new category of “AYUSH.” I highlight that the acronym AYUSH echoes a Sanskrit word *ayus* (longevity) which is also a grammatical root in the word Ayurveda (*ayus* and *ved*). By looking at this and other instances in which the government produces terminological confusion which favors Ayurveda, I argue that the current configuration of medical pluralism in India reflects the dominance of Hindu nationalist sentiments. In other words, I show that the politics of Hindu nationalism is manifest in the language used to frame medical pluralism. The focus on discourse and terminology shows how confusion and misunderstanding become part of a political process that includes practitioners who might not necessarily identify themselves as Hindus or have a strong opinion about Ayurveda’s association with the ideology of Hindu nationalism.

3.1 HISTORY OF INSTITUTIONALIZATION OF PLURAL MEDICINE IN INDIA

3.1.1 Early debates about Indian medicine

The evolution of policy on medical plurality in India dates back to the late colonial and early post-colonial periods (Attewell 2007; Bala 2007; Berger 2013; Gupta 1976; Habib and Dhruv 2005; Kumar 1998; Langford 2002; Leslie 1968; Leslie 1973; Liebeskind 2002; Mukharji 2011; Sivaramakrishnan 2006; Wujastyk 2008). The initial efforts of the colonial administration to regulate non-biomedical traditions were directed at only three “Indian” or “indigenous systems of medicine:” Ayurveda, Unani, and Siddha. Those early efforts were quite inconsistent due to an ambiguous attitude of colonial policy-makers to Indian medicine (Arnold 2000). For example,

the attempt to offer Ayurveda and Unani classes at the Sanskrit college and the Calcutta madrasa of the Calcutta Medical College (under the Native Medical Institution) lasted less a decade, from 1826 to 1833.

Both the colonial Indian Medical Services and biomedical establishments in the provinces produced harsh criticism of Unani and Ayurveda as traditions not based on science. In the 1910s, several provincial governments passed Medical Registration Acts, followed by the National document—the Indian Medical (Bogus Degree) Bill, which effectively disqualified Unani and Ayurveda practitioners from legitimate medical practice (Berger 2013, 67-68). In response, Unani and Ayurveda practitioners began public and political campaigns to receive official recognition (Berger 2013; Liebeskind 2002; Shivaramakrishnan 2006). In other words, the period immediately before and after the Independence was characterized by stern disagreements and debates about the place of indigenous medicine.

The first comprehensive document focused on a role of indigenous medicine in a newly created Indian state was the so-called Chopra Report presented by the Committee on Indigenous Systems of Medicine (Chopra Report 1948). The Report proposed the integration of indigenous systems of medicine with biomedicine and described in detail the envisioned structure of education, course curricula, drug standardization, and other aspects of medical training, practice, and research. Although the report was ultimately rejected by the Indian parliament, it created the impetus for developing a government policy and strengthening the state control over non-biomedical practices (Wujastyk 2008).

The task of institutionalization of indigenous medicine took two directions: 1) toward medical research and 2) toward education and practice. This bifurcation mirrored the division of labor in biomedical policy, where educational standards, registration of doctors, and recognition

of medical colleges were managed by the Medical Council of India (established in 1933), whereas the matters of research were delegated to the Indian Council of Medical Research (established in 1949). If we closely look at the documents related to the Indian systems of medicine, we can see that research was prioritized over education. The research-related government bodies were already formed in the 1950s, while the councils for education were created much later, only in the 1970s. The official documents give an impression that the government's focus on research was driven by a perceived need to attest the value of Indian medicine before undertaking further steps. For example, the government's response to the Chopra Committee's proposition to integrate biomedicine and Indian medicine highlights this concern very well:

“the evolution of an integrated system will be possible *only after* the methods of modern scientific research have been applied to the principles and practice of Ayurveda and Unani and *it has been ascertained what is of proven merit and value in these systems.*” (Udupa Report 1958, 5, emphasis added)

Therefore, the government first established the Central Research Institute in Indigenous Systems of Medicine (Pandit Report 1951) and launched a scheme to fund independent research projects on indigenous medicine (Udupa Report 1958, 49). However, the financing of individual research projects was not sufficient, and there was a need to establish a chain of research centers with laboratories and other facilities throughout the country, coordinated by research boards at the state level and an overarching central body (Udupa Report 1958). As a result, in 1962, the government established the Central Council for Ayurvedic Research, expanding it into the Central Council for Research in Indian Medicine and Homeopathy in 1969. The council was given the responsibility to oversee the clinical procedures and research in the Ayurveda, Unani, Siddha and Homeopathy.

Regarding the issues of teaching and practice in indigenous medicine, the government appointed a number of independent committees (Dave Report 1955; Mudaliar Report 1962; Unani Committee Report 1964; Vyas Report 1962), in addition to the already-mentioned Udupa Committee. The most important recommendation of those committees was to establish a statutory body of Indian medicine to deal with the issues of development of uniform course syllabi and other standards of education, unification of medical degrees, registration and inspection of medical colleges, hospitals, museums, gardens, and laboratories attached to teaching institutions. However, it took more than a decade before the statutory body—the Central Council of Indian Medicine—was finally established in 1970. Three years later, in 1973, the Central Council for Homeopathy was also formed. One of the major debates regarding the non-biomedical education was centered on the question of whether the training of “indigenous” doctors should be either “integrated” with modern medicine or should remain independent. With regard to Ayurveda, the latter approach came to be known as the *shuddh* Ayurveda, which can be translated as “pure” Ayurveda. The Udupa Report goes in great detail to discuss the advantages and disadvantages of the two approaches and concludes that both courses of training have the right to existence, especially since the practitioners trained in “pure” Ayurveda or Unani serve as essential health experts in rural areas. Yet the authors of the report also note that even in the field of *shuddh* education there is a need for some form of training in anatomy, physiology, and other important biomedical fields.

3.1.2 Defining Indian medicine

Although initially the terms “Indian medicine” and “indigenous medicine” were used somewhat interchangeably, the former term became a prevailing designation for non-biomedical knowledge

traditions in the country (Indian Medicine Central Council Act 1970). The choice seems well founded: nationalist projects often define medical traditions in relation to the boundaries of independent states, choosing a name to reflect the national or cultural identity. In contrast, the term “indigenous medicine” is too vague and invokes “unbounded inclusiveness” (Alter 2008a, 1166, 1171), whereas “Indian medicine” clearly articulates where it belongs.

The Indian Medicine Central Council Act (1970) defined Indian medicine as “the system of Indian medicine commonly known as Ashtang Ayurveda, Siddha or Unani Tibb whether supplemented or not by such modern advances as the Central Council may declare by notification from time to time.” Although there are many notable parts of this definition, what is striking is the use of a singular form “the system of Indian medicine. Despite occasional appearances of a plural form “systems,”⁵² the qualifier “Indian” is always accompanied by the word “system” in singular. What can we make of this collapse of multiple traditions (Ayurveda, Unani, and Siddha) into a single object?

There are solid reasons to conjecture that the labeling of three healing traditions as a single “system of Indian medicine” was deliberate, as it was an excellent discursive approach which acted at multiple levels. Within the nationalistic logic, it highlighted the existence of a local medical system distinct from biomedicine. Despite the fact that the political elite of the first half of the 20th century varied in their attitude to traditional medicine and many policymakers favored biomedicine (McMillen and Brimnes 2010, 191-192; Khan 2006, 2795), there were many public figures who advocated for *Indian* medicine as one of the foundation stones of an independent nation (Khan 2006). Due to the aspirations to oppose “foreign” with “Indian,” the differences between Ayurveda, Unani, and Siddha were set aside. Moreover, the category of

⁵² For example, when the authors spell out Ayurveda, Siddha and Unani *systems* of medicine.

Indian medicine worked well due to its inclusiveness, which appealed to diverse communities of a new nation. After the violent partition of India and Pakistan and later Bangladesh on the basis of religion, political leaders of a culturally mosaic India could not afford to single out Ayurveda but had to acknowledge “Tamil” Siddha and “Muslim” Unani within the framework of Indian medicine. As such, this term conveniently offered a way of sending a strong message to both national and international audiences, by constructing the national unity and claiming cultural autonomy from the West.

However, already in those early documents we can see a special attention given to Ayurveda in the earliest post-independence documents:

Let us give a full-fledged support [to Indian medicine] and see the results, *instead of blindly following and copying the methods followed by the United Kingdom and the United States of America...* We have pointed out that Government should revue [sic] their present policy and utilise fully the *Ayurvedic practitioners in implementing the nation building activities...* We are confident that an Independent India striving to revive all our ancient culture will not fall behind in *restoring Ayurveda to its pristine glory* and by *trying to absorb the best in other systems of medicine will produce one integrated system of Indian Medicine* as early as possible... Our remarks about the ways and means of improving the method of training etc., in Ayurveda will apply generally to other indigeneous [sic] system of medicine like Siddha and Unani also (Udupa Report 1958, 102-125, emphasis added).

The authors of this and the following reports vacillate between “Ayurveda” and “Indian medicine,” making the documents appear sloppy and inconsistent. Yet I argue that, rather than carelessness, this is a manifestation of the entangled agendas in the promotion of plural medicine: acknowledging the diversity yet favoring the majority. This lack of clarity is ubiquitous even in contemporary official documents, which appears to be strategic because it provides a way to maneuver between various conceptions of Indian nation on the continuum from the “unity in diversity” to Hindu nationalism, as I will discuss in Chapter 5.

3.1.3 New categories of medical plurality: From ISM&H to AYUSH

By the mid-1970s, the government of India had established two types of institutions responsible for non-biomedical care: statutory councils and research councils. This division of labor exists even today, but there has been one notable development in their organizational setup. The statutory councils have remained almost intact, bearing the same names (the Indian Council of Indian Medicine and the Indian Council of Homeopathy)⁵³ but the research councils have undergone multiple reorganizations, which deserves special attention because it sheds light on the ways in which plural strands of non-biomedical knowledge are understood today.

In 1978, the Central Council for Research in Indian Medicine and Homeopathy was dissolved into four independent research councils, each for Ayurveda and Siddha (CCRAS); Unani (CCRUM); Yoga and Nature cure (CCRYN); and Homeopathy (CCRH). As a result, the established triad of Ayurveda-Unani-Siddha under the category of *Indian medicine* was broken, and new systems—Yoga and Naturopathy—were added. Later, in 2010 the CCRAS was bifurcated into the Central Council for Research in Ayurvedic Sciences (which included Tibetan Sowa-Rigpa) and the Central Council for Research in Siddha. In other words, there were three important changes: 1) the separation of Ayurveda from Unani and then Siddha, 2) the pairing of Yoga and Naturopathy, and 3) the addition of Sowa-Rigpa.

This regrouping of plural medical traditions was far from accidental, and although it is hard to identify all the reasons, at least two contributing forces are clear: the politics of cultural identity and the government's desire to profit from global markets of herbal pharmaceuticals. Below I briefly comment on these two factors.

⁵³ The only change is the addition of Sowa-Rigpa to the scope of "Indian Medicine" under the CCIM Amendment Act 2010.

It is noteworthy that Unani was marked as a separate tradition already in 1978, whereas Siddha continued to be clustered with Ayurveda under the government nomenclature (until 2010). This corresponds to a commonly shared understanding that Siddha is just a Tamil “version” of Ayurveda, or “a younger brother of Ayurveda,” according to one officials at the Ministry of AYUSH.⁵⁴ In contrast, Unani is often constructed as culturally different:⁵⁵ unlike Siddha, Unani is said to have originated outside the Indian subcontinent and was brought by Muslim traders and conquerors. Thus, an important catalyzer in delineating medical boundaries was the politics of cultural nationalism (Wujastyk and Smith 2008, 8). From this perspective, the dissociation of Ayurveda from Unani fits well into the Hindu nationalist projects, in which Indian culture is routinely constructed through references to ancient Vedic Sanskritic traditions, casting the long-lasting Muslim cultural legacy as a foreign element.

Besides the cultural politics, there was another important factor in the reclassification of plural medicine. Since the late 1970s, there has been a growing awareness of the lucrative market of herbal pharmaceuticals.⁵⁶ Thus, despite being comparable in their therapy and having analogous medicinal ingredients and formulae, Ayurveda and Unani were allocated separate research councils, arguably to maximize their drug development potential. (But they remained under the roof of the same statutory council, since there was no financial incentive to separately regulate education in Ayurveda and Unani.)

⁵⁴ However, in Tamil Nadu, Siddha is argued to be a distinct medical tradition, especially within Tamil separatist projects (Weiss 2009).

⁵⁵ Attewell (2007) and Sivaramakrishnan (2006) discuss in great detail how the delineation of Ayurveda from Unani and their respective assignment to Hindu and Muslim heritage came into being during the colonial period.

⁵⁶ In 1979, the government of India published regulations for the commercial production of “Indian” medicines under the Amendment of the Indian Drugs and Cosmetics Act (amended in 2002).

Another noteworthy category of state-sanctioned medicine is “Yoga and Naturopathy.” Despite the fact that Naturopathy had been developed in Europe, it became very popular in India in the late 19th and the beginning of the 20th century, particularly due to the influence of Gandhi. Both drugless therapies, Yoga and Naturopathy were understood as almost identical, since the principles of Naturopathy based on the workings of natural elements appeared to fit well into the conceptual framework of Samkhya philosophy, Yoga, and, more broadly, Indian culture (Alter 2015). Therefore, it seems to have made a perfect sense that in the 1980s the government of India clustered Yoga and Naturopathy under the same research council, and even today, it continues to support the joint-degree programs such as Bachelor in Naturopathy and Yogic Sciences.

At the same time, it is important to recognize that although Yoga and Naturopathy are delineated from and even opposed to drug-based Ayurveda, there is also a tendency to represent them as part of Ayurveda. For example, being one of the ancient philosophical schools, Yoga was initially concerned with an internal “joining” of the senses and the mind, but since the 19th century, it has become medicalized in the sense of being oriented towards physical health and fitness (Alter 2004), and today due to the medicalization and commercialization processes, Yoga has come to share a therapeutic niche with Ayurveda. This is manifested in the existence of Ayurvedic enterprises of Yoga gurus such as Baba Ramdev and Sri Sri Ravi Shankar, in the proliferation of spa and detox resorts of Rishikesh and Kerala, in the AyurYoga therapy and other blends of the two traditions (Alter 2005a; Wujastyk and Smith 2008). Moreover, Naturopathy is also claimed to be part of Ayurveda and an inherently Indian tradition, which is symptomatic in the fact that the term Naturopathy is officially translated into Hindi as “natural

medicine” (*prākṛtik cikitsa*—प्राकृतिक चिकित्सा). I conceive of these processes as the “ayurvedicalization” of medical plurality, which I will discuss it in detail in Chapter 5.

In contrast to Naturopathy, Homeopathy retains its foreign⁵⁷ name (*homyopaithī*—होम्योपैथी). For a long time, this differential position of Homeopathy was visibly marked in the official language which distinguished Homeopathy from “Indian medicine.” Originating in Germany and having arrived in India relatively recently, Homeopathy in the eyes of the government was clearly not “Indian.” Moreover, since it did not correspond to any culture or community in India, in a way that Siddha or Unani medicine did, the distinguishing of Homeopathy from “Indian medicine” was an easy and obvious strategy, as there was no danger that it could trigger any ethno-nationalist tension.⁵⁸ In contrast, defining and setting apart the three “indigenous traditions” of Ayurveda, Unani, and Siddha was a more delicate task, because of the commonly shared ethno-cultural conceptions of Ayurveda as a Sanskrit, Brahmanic, and Hindu tradition; Unani as a Muslim tradition, and Siddha as a non-Brahmanic South Indian tradition. In 1995, in order to coordinate the work of statutory and research councils for alternative medicine, the government established the Department of Indian Systems of Medicine and Homeopathy, commonly abbreviated as ISM&H. It was a supreme administrative body for non-biomedical traditions, placed under the Ministry of Health and Family Welfare. Thus, there was a common understanding that Homeopathy was an alternative medicine distinct from

⁵⁷ Naraindas has made an interesting observation that many students of the state sanctioned degree course in Naturopathy were entirely unaware of the German origin of this practice but “traced Naturopathy to the Caraka Samhita, which is now one of the three canonical texts of contemporary Ayurveda” (2014a, 106–107).

⁵⁸ The place of Homeopathy in India is a fascinating subject. Although Homeopathy is technically “foreign,” it did acquire important cultural meanings, especially in West Bengal. For example, Arnold and Sarkar have argued that non-English roots of homeopathy added to cultural nationalistic aspirations of Bengalis. I will return to the discussion of Homeopathy, nationalism, and cultural identity in Chapter 4.

biomedicine, yet also distinct from the so-called Indian systems of medicine. However, in 2003, the department was renamed as the Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy—the Department of AYUSH. So what were the reasons for the shift from the category of IMS&H to AYUSH, and were there any implications for the practitioners of these medical traditions?

My perspective is that the change of names is important. As Lambert (unpublished conference paper) has rightly observed, an official naming of a category does not do *the naming* but *the creation* of a new ethnographic object, just like the official acceptance of the category CAM—complementary and alternative medicine—created a new ethnographic reality. Similarly, can we say that the adoption of a new category of AYUSH by the Indian government has created a new ethnographic subject? Or did the government simply acknowledge and formalize an existing state of affairs? In my view, it was a little bit of both. On the one hand, conceptual absorption of Homeopathy into a unified category of alternative medicine has authorized a popular non-specialist view of Homeopathy as “Indian.” For example, during a Hindi class at a language school in Dehradun, I was translating a text about Ayurveda by Balkrishna,⁵⁹ when I noticed that my teacher referred to Ayurveda as Homeopathy. I asked her whether she thought there was any difference between the two, to which she responded that there was none. She said that local people sometimes called the nearby hospital Ayurvedic and sometimes—Homeopathic. Then I asked whether they knew where Homeopathy originated and she claimed she did not but then added that probably in India. When I explained that, in fact, Homeopathy was developed in Germany, she was very surprised. Finally, she stated that she always thought that “homeopathy” was an English translation of a Hindi word “Ayurveda.”

⁵⁹ Acharya Balkrishna is an Ayurveda specialist and a co-founder of Patanjali with Ramdev.

This case is not simply anecdotal. During the course of my fieldwork, I heard many mundane conversations in which people used the terms “Homeopathy” and “Ayurveda” interchangeably, referring to both as Indian traditional medicine. Hence, from this perspective, the adding of Homeopathy to AYUSH captured and validated the non-specialist view of medical plurality.

On the other hand, the invented category of AYUSH has led to the formation of a new cultural object for policy-makers and scholars alike, as evidenced in the language of government documents and academic texts (include my own). What is even more important is that the change from “ISM&H” to “AYUSH” has ratified a line of popular discourse in which medical plurality is substituted by Ayurveda: as I discuss in the following section, many people interpret the Ministry of AYUSH as the ministry for Ayurveda and even utilize to the word “ayush doctor” when talking about an ayurvedic doctor. However, before unraveling the co-construction and the tension between the categories of “Indian medicine,” “AYUSH,” and “Ayurveda,” I need to address another critical corollary of the legitimation of medical plurality—inevitable marginalization of some healing traditions. The process of defining what does and does not constitute “Indian medicine” (or later AYUSH) unavoidably leads to omission, if not an explicit ban, of some therapeutic modalities. Anthropological literature varyingly refers to such modalities as “folk,” “vernacular,” “non-codified,” “unauthorized,” “non-elite,” or “subaltern.” As some scholars have pointed, the “robust heterogeneity” of these therapeutic forms “makes it difficult to describe [them] within any single category” (Hardiman and Mukharji 2012, 9). Nevertheless, quite recently, the government of India has acknowledged many of such therapeutic forms under a single category of “Local Health Traditions” (abbreviated as LHT). Below I discuss the implications of classifying medical plurality into AYUSH and LHT.

3.1.4 Subaltern therapeutics and Local Health Traditions

According to Hardiman and Mukharji (2012), accounts written by colonial officers in the 1810s give a sense that Indian medical landscape was understood as the three-layer configuration of therapeutic practices in terms of their legitimacy and scientificity. Western biomedicine was unquestionably deemed as the only truly scientific medicine; less trustworthy were textual indigenous traditions of “Hindus” and “Muhammedans” which rested upon some sort of rationality; and underneath there was a layer of non-canonized, eclectic, “folk” therapies administered by practitioners “without... learning, and without books” (Hardiman and Mukharji 2012, p. 6–7).

Such accounts reveal a long history of attempts to distinguish the “expert” forms of Ayurveda and Unani from non-elite therapeutics, and already in the 1860s we can see the first interventions by the colonial state to institute this distinction through the professionalization of Ayurveda and Unani (Lambert 2012a, 1030). As mentioned earlier, the colonial government was quite ambiguous about traditional medicine in general: the few classes of Ayurveda and Unani medicine initiated in the beginning of the 19th century were quickly abolished (Bala 2007, 71–73). However, in the years preceding and following the Independence, the issue of the professionalization of indigenous medicine and its demarcation from “irrational” non-expert practices emerged with a new force (Berger 2013, 121-122, 134-137). This highlights that the institutionalization of “Indian systems of medicine” is not only about traditional medicine vis-à-vis biomedicine but also about elite textual medicine vis-à-vis subaltern therapeutics.

In the beginning of the 20th century, facing the hostility from the colonial Indian Medical Service and other biomedical associations, practitioners of Ayurveda and Unani began to demand the establishment of an official registration system which would ensure the legitimacy of

their knowledge and practice. As a result, several Boards of Indian Medicine were established in different parts of the country. Initially, these boards provided two types of registration: traditional doctors who had received formal training from accredited medical colleges were able to register under the Class A registration, whereas those who had acquired their expertise through experience (without formal qualifications) were eligible for the Class B registration (Berger 2013, 118-119, 147, 151).

In 1925, the government of what is now Uttar Pradesh (of which Uttarakhand was part until 2000) passed the United Provinces Medical Act which specified the procedures and qualifications for the registration of indigenous doctors. The registration was supposed to be done on a voluntary basis, but with a warning that any physician who failed to register himself would be considered a “quack” (Berger 2013, 122). In 1934, the UP government took further steps in institutionalizing Ayurvedic and Unani medicine by establishing The United Provinces [Ayurvedic and Unani Tibbi Systems of Medicine] Act. The Act defined the “qualified” practitioners as only those who had been granted medical degrees in accredited institutions or who had passed medical exams; however, it still left a room for non-institutional medicine by establishing a “list of persons in practice belonging to the indigenous system.” In other words, every person who did not qualify to become a registered medical practitioner still could secure some sort of legitimacy after proving “to the satisfaction of the Registrar that he has been in regular practice of the Indian system of medicine or surgery or midwifery or any of their branches in this [State]” (The United Provinces Act 1939, Part III, article 50).

This ambiguous framework of legitimation did not receive a unanimous welcome: sensitive to the repeated accusations in quackery, especially voiced by “modern” doctors, some elite and politically influential practitioners of Ayurveda and Unani began promoting certain

measures that would ensure dissociation of an informal non-expert healer from a qualified *vaidya* or a *hākīm*. In fact, as Hardiman (2009) has demonstrated, as early as in the 1910s–1930s, some Ayurveda and Unani practitioners attempted to reformulate their regionally, linguistically, and methodologically diverse practices into unified “systems,” grounded in acknowledged texts (*Caraka Samhita* or *al-Qanun fi al-Tibb*) and cultural identities (Hindu or Muslim, respectively), thus banishing any therapeutic method or procedure which could compromise their reputation. Needless to say, these were political rather than “scientific-medical projects” (Hardiman 2009, 276). Since this reformulation and cleansing of heterogeneous medical domains served the interests of a limited fraction of elite *vaidyas* and *hakims*, Hardiman has referred to post-independence Ayurveda and Unani as “syndicated:” “groups—or syndicates—with certain vested interests sought through combination, organization and publicity to establish a particular, limited notion of their practice that set it apart from other forms of practice” (2009, 279).

Gradually, an impetus towards professionalized, standardized, and “purified” medical systems had led to the adoption of the Central Council of Indian Medicine Act (1971) and the creation of Boards of Indian Medicine in different states. As a result, the “experience-based” Class B registration was discontinued, and medical practice of many traditional healers became illegal, although they did not become extinct. As Lambert (2012b) describes with regard to the practice of *hād vaidya* (bone doctors), the established State Boards of Indian medicine were often run by elite Ayurveda and Unani practitioners, who were in a position to deny the registration for many indigenous healers. This fact highlights the contested history of legitimation of indigenous therapeutics and important inequalities within medical pluralism where Ayurveda and Unani are less privileged than biomedicine yet more privileged than many healing traditions (Lambert 2012b, 122).

For many decades, the practice of indigenous healers has been banned; yet, paradoxically, the government did almost nothing to enforce the ban, creating an ambiguous situation in which “unqualified” traditional healers still exist today. For example, in their study of contemporary healers who do not have formal qualifications, Mishra et al. (unpublished conference paper) describe that the healers are well aware of their precarious legal status, that they are neither given a legal status nor entirely banned. Indeed, in private sector, this is a common scenario, with many unauthorized persons practicing medicine and even having clients among government officials. However, I draw attention to a different issue: unlike the person quoted above, not all unqualified healers are aware of their semi-legal status, because not all of them are familiar with the government regulations. I emphasize that the category of “unauthorized” traditional healers is very heterogeneous in terms of a kind of therapy, urban or rural practice, social status, economic class, and prestige. The following two examples illustrate this well.

In one instance, Mishra et al. (unpublished conference paper) mention a traditional healer who practices in a luxury hotel with a monthly salary and reimbursement for travel expenses. In addition to the fact that this case strikingly contradicts a popular image of a traditional folk healer, it also points out that, paradoxically, the absence of state legitimation did not become a roadblock on the way to social recognition and well-paid employment. On the other side of the spectrum, there are unauthorized practitioners who are unaware of their legal status, who practice in rural areas, mostly at home, and do not necessarily receive monetary compensation. During my fieldwork, I was told about many healers who were not authorized to practice medicine but nevertheless did. Many of them resided in small mountain settlements and were known as *vaidas* or *vaidyas* only in the vicinity. For example, one day in a small village an hour away from

Chhotapur I met a *vaid* who was also a *pūjārī* (priest). Perhaps, I would have never been able to meet him, if not taken to that place by my research assistant who happened to be the *vaid*'s neighbor. When we reached his house, I saw a humble shack made of brick, wood, and tin sheets. There was no sign to tell it was a *vaid*'s house, but I noticed several people waiting outside. The door to a dimly-lit front room was ajar and I could see that the *vaid* was talking to a young man, both of them sitting on the mud floor. After some time of waiting and drinking chai, my research assistant and I were invited to talk to the *vaid* in the same room. The *vaid* told us that he had never studied medicine at school, only his father taught him about healing with herbs. During my visit I did not see anyone paying the *vaid*, so later when I was chatting with my assistant, he told me that people typically brought rice or *dāl* (lentils) as a gratitude for the treatment.

These two examples—of a healer working in a luxury hotel with a regular pay and a healer operating from his humble hut without payment—illustrate a spectacular diversity of subaltern therapeutics. These therapeutic traditions have primarily existed outside the statist medicine (both biomedicine and AYUSH) and only recently the government of India has begun implementing programs for their regulation.

In the Eleventh Five Year Plan for 2007–2012, the government explicitly addressed the role of therapeutic traditions which were not based on codified textual knowledge, recognizing them as the “local health traditions” (LHTs) in need of revitalization. According to the official terminology, LHTs do not qualify to be called “medical systems” like canonized AYUSH modalities do. However, the Eleventh Plan equivocally called the LHTs “a new area of AYUSH.” For example, a clause 3.2.17(iv) refers to “revitalization and validation of community-based local health traditions of AYUSH” (Eleventh Five Year Plan 2008, 112). Moreover, on one

occasion the document calls for the “encouragement of tribal system of medicine under AYUSH” (clause 3.1.63) which makes it even less clear how the local health traditions relate to the so-called tribal system of medicine and whether they fall under the category of AYUSH or not. In other words, the document offers very little clarification of what the local health traditions mean, and how exactly the process of revitalization should be taken.

Besides the Eleventh Plan, the local health traditions are acknowledged in the National Rural Health Mission and the Indian Public Health Standards (Priya 2013). Yet, even these documents offer little description of the scope of the local health traditions. As Priya and Shweta suggest, what appears from a national survey under the National Health Rural Mission is that the practitioners of local health traditions include traditional birth attendant (*dais*), faith healers, hereditary folk healers, and “non-institutionally qualified practitioners who learnt a textual system through a hereditary passing on of knowledge, or from an older practitioner” (2010, 140). This appears to be broad and inclusive but scholars contend that not all informal traditions have been endorsed as the LHTs. A review of the activities and agenda of the Foundation for Revitalization of Local Health Traditions indicates that the LHT are predominantly equated with herbal therapies. As Priya (2013) has convincingly demonstrated, the government invests only in those local traditions which have a potential to enrich the ayurvedic corpus of medicinal plants and formulations. In other words, there is a great emphasis on local knowledges and practices which can be monetized. Consequently, other healing traditions—such as ritual and religious healing—are pushed to the margins of legitimacy and even existence.

In an edited volume *Medical Marginality in South Asia*, several scholars have cautioned against the use of the government-imposed categories such as AYUSH and LHT (Hardiman and Mukharji 2012). In contrast, they have suggested that a more insightful way of approaching the

current medical plurality is from the point of view of statist medicine and subaltern therapeutics. By statist medicine Hardiman and others mean both biomedicine and AYUSH systems, whereas subaltern therapeutics denotes everything else which is not recognized by the state. The authors distinguish two clusters of subaltern practices (2012, 9). First is a range of therapies closely associated with professionalized—or “syndicated”—Ayurveda, Unani and other learned cultures but which have been purged from institutional practice as “unscientific,” “dangerous,” or “fraud.” In other words, these are non-elite, non-codified healing methods, approaches, and diagnostic procedures administered by lay *vaidyas*, *hakims*, *kabirajs*, *Siddha* healers, and other practitioners without formal qualifications. For example, Attewell (2007) has shown that urine and pulse diagnostics have been pushed to the periphery of modern state Unani practice, but those diagnostic procedures still exist among vernacular Unani practitioners. This is what Neshat Quazer calls “bazaari Unani,” meaning that this kind of Unani is practiced not in hospitals, but on the streets and the markets.

The second cluster includes what can be called “folk medicine” which is administered by local traditional, often hereditary, experts such as bonesetters (*hād-vaids*), snake-bite curers, masseurs, barber-surgeons (*jarraha*), midwives (*dais*), healers of sexual problems (*gupt rog vaidyas*), and other specialists. This type of medicine is firmly embedded in local communities, sometimes specific to certain religious group or caste, as is the case of Muslims barber-surgeons who traditionally performed male circumcisions.

This concern with regard to the lack of attention to subaltern therapeutics is of crucial importance and overall I agree with them that the categories of AYUSH and LHTs are not always useful. Nevertheless, I want to push this argument further by postulating that even the distinction between statist medicine and subaltern therapeutics does not fully correspond to the

reality. What I encountered during my fieldwork is a strong continuity between formalized state-sanctioned medical “systems,” semi-recognized “local health traditions,” and unrecognized herbal and ritual healing practices. As I describe below, ethnographic realities of medical practitioners in contemporary India challenge our current approaches to legitimacy and therapeutic boundaries.

3.2 LEGITIMACY, PRECARIOUS ECONOMY, AND BLURRED BOUNDARIES

Several recent publications have aimed to analyze the relations among medical practices of various degrees of legitimacy (Bode and Hariramamurthi 2014; Hardiman and Mukharji 2012), claiming that legitimacy is a polysemic construct, which encompasses a broader set of factors than mere government recognition. These studies have inspired me to look more deeply at the presumed differences between AYUSH practitioners and traditional healers, specifically in terms of their reputation and economic status. For example, as I mentioned earlier, Mishra et al. (unpublished conference paper) describe a “traditional” healer who does not have government certification but is employed in a luxury hotel and receives a regular paycheck, but I question whether it is reasonable to consider him traditional and subaltern. Despite his questionable legal status, he continues to offer a wide range of therapies to the public and continues to find clients. Analogously, I question if it makes sense to regard a practitioner with a medical degree from an accredited university as “legitimate” without asking whether that practitioner always feels secure about her status. If a local community is skeptical of a state-certified healer, does it not mean that he is marginalized?

Mishra et al.'s main argument is that the healers draw on multiple kinds of legitimacy, rather than a single legitimacy derived from the government apparatus. Hence, legitimacy could and should be examined beyond the frameworks of state and bioscience. The authors argue that despite the absence of an explicit legal status, unauthorized healers employ several strategies directed at establishing their legitimacy. First is a strategy of emphasizing the authenticity of medical knowledge. This kind of legitimacy is constructed when healers make references to the sacred origins of their practice, its linkage to tradition and nature, as well as its continuity and transmission from generation to generation. Mishra et al. also indicate that such appeals to authenticity are used by generational traditional healers (*paramparik vaidyas*) in order to distance themselves from “native healers” (*nāti vaidyas*) who do not have a family tradition of healing, and therefore regarded as “quacks.” Importantly, I argue that this can be extended to AYUSH-trained doctors as well: for example, some hereditary but unauthorized healers claim that doctors who only have a medical degree but do not come from medical families are not “authentic” because they only practice “allopathic quackery,” not Ayurveda.

The second strategy identified by Mishra et al. is the establishing of professional alliances with other healers and various supporters of local health traditions such as academics, representatives of NGOs, and government agencies. Alliances are built by becoming a member of some association and attending conferences and workshops. The third legitimizing strategy constitutes building a good reputation as a healer, by circulating proud narratives of successful treatment of serious diseases like cancer and having consulted reputable patients such as government officials, film stars, or patients from abroad.

Mishra et al.' study shows a welcome sensitivity to the multiplicity of legitimacy and the struggle for recognition, yet I disagree with a sharp differentiation of informal health traditions

and institutionalized AYUSH medicine. As I argue and illustrate in Chapters 5 and 6, scholars need to go beyond a dichotomous view of “state and local healers,” or statist medicine and subaltern therapeutics. When it comes to daily practices and the ways medical practitioners approach their patients, there is no radical difference between statist AYUSH doctors and unauthorized subaltern healers. For example, different legitimizing strategies and narratives described by Mishra et al. are parallel to the strategies and narratives that I heard from the AYUSH doctors during my fieldwork. It may seem that AYUSH doctors should be in a better position in terms of legitimacy; yet, they often feel insecure about their reputation in a society and thus find themselves compelled to iterate their expertise through the same mechanisms as do traditional healers. Mishra et al. mention that unauthorized traditional healers display various certificates, proofs of attending different workshops or being members of some associations. Similarly, I observed that many private AYUSH doctors decorate the walls of their clinics with numerous certificates, photographs, and letters of gratitude from famous clients, lawyers, and celebrities (even apparently from a former Indian president!). From this perspective, traditional healers and recognized AYUSH doctors might not be so different; therefore, that the state-imposed delineation of LHT and AYUSH or an analytical distinction between statist and subaltern therapeutics—both obscure the complexity of the ways in which medicine is practiced in India

Another phenomenon that blurs the boundaries between statist and subaltern, or legitimate and illegitimate practice is so-called *daktāri* medicine. Mukharji (2011) explains that *daktāri* medicine is popular biomedicine, as practiced by unqualified or semi-qualified healers. Their methods might range from application of intravenous injections of analgesics and provision of antibiotics or glucose drips. During my fieldwork, I encountered a number of

“doctors” who were actually pharmacists or even sales representatives for a medical company, but who through some ingenious ways became to be identified as medical specialists in their neighborhood. I will describe these “doctors” in Chapter 5.

My final note on legitimacy and unauthorized practices has to do with what can be called legitimacy by default. In *Medical Mimesis: Healing Signs of a Cosmopolitan “Quack”* (1999), Langford tells a story of an ayurvedic doctor who makes use of eclectic therapeutic methods. She explores the boundaries between truth and falseness, questioning how people distinguish between “true” and “false” medicine, falsehood and simulation, a legitimate doctor and a “quack.” Langford claims that folk practitioners often imitate Ayurvedic doctors, just as Ayurvedic practitioners imitate Western doctors in the quest for legitimacy. She then mentions an emergence of a kind of legitimacy when a healer offers treatment in areas where other doctors are absent; in the words of an Ayurvedic doctor, some rural healers who do not have medical degrees are still “legitimate because they are healing people in areas where other doctors are not available” (Langford 1999, 35). In other words, the only “available” healer in the area becomes a “legitimate” healer. This passage corresponds to my own field observations. At an interview with a group of government officials at the Uttarakhand Board of Ayurveda and Unani Medicine, I asked whether an AYUSH doctor was allowed to prescribe allopathic medicine. I was told that although it is not allowed, this practice is welcomed in remote rural areas, where allopathic doctors are reluctant to go. To put it differently, these government officials articulated a view that in the absence of a legitimate biomedical doctor, it is fairly appropriate if biomedical drugs are dispensed by an AYUSH doctor who becomes legitimate by default.

3.3 CURRENT AYUSH INFRASTRUCTURE AND POPULAR DISCOURSES

3.3.1 AYUSH and India Branding

When in 2014, Prime Minister Narendra Modi withdrew the Department of AYUSH from the Ministry of Health and Family Welfare and granted it an autonomous status as the Ministry of AYUSH, it meant that non-biomedical traditions would receive a separate budget and a minister directly accountable to the Prime Minister. Indian media greeted the formation of an independent Ministry of AYUSH as “a step forward in reviving traditional medicine” and “a landmark decision” that highlighted Modi’s commitment to supporting the AYUSH systems (Pandey 2014). Indeed, this could be seen as a significant moment for India’s diverse medical traditions, a triumph of medical pluralism so-to-speak. But in reality, non-biomedical practices have remained at the margins of the country’s healthcare structure, especially when it comes to infrastructure and budget.

From a broader political perspective, a new portfolio for AYUSH was but a minor announcement: Modi expanded his government from 44 to 65 ministers, so AYUSH was just one of 21 new developments. Moreover, as a “Minister of State,” the head of AYUSH has a limited political power because only the “Cabinet Ministers” headed by the Prime Minister exercise the supreme decision-making authority in the country.⁶⁰ Furthermore, the creation of a separate ministry did little to the non-biomedical communities in terms of budget. For example, in 2002,

⁶⁰ The AYUSH Minister has a rank of the Minister of State (Independent of Charge), which is a middle-ranked position. India’s highest executive body—the Union Council of Ministers—consists of three ranks of ministers: most senior Cabinet Ministers, then Ministers of State (independent of charge) who oversee a separate ministry and do not report to a cabinet minister, and junior Ministers of State, who assist a cabinet minister and do not have their own ministry.

the “Indian Systems of Medicine and Homeopathy” received 2% of the total health budget of the nation, with the remaining 98% allotted to biomedicine (Government of India 2002, 3). At the National Ayurvedic Congress in March 2014, Modi—who portrays himself as a strong believer and supporter of Indian medicine—proclaimed that in future the ratio between AYUSH and allopathy would be reversed. Therefore, there was an expectation that the budget of a newly created Ministry of AYUSH would significantly increase. However, it did not happen. When the Union budget for 2015–2016 was announced, the AYUSH allotment came as 3.7% of the total allotment for the healthcare sector. Since it was more than 2%, many news channels claim that Modi’s government gave a “special emphasis to the promotion and development of AYUSH” (The Health Site 2015). Yet, statistically, this ratio has resulted from the *decrease* of the overall health budget, while the funds allotted to AYUSH have remained the same.

As some of my interviewees who work in the government and research institutions indicated, the budget allocation is actually not a pressing issue. A real challenge for the development of AYUSH is poor implementation of the existing schemes and inefficient utilization of available resources. If we consider the official statistics, the validity of such statements becomes clear, as the AYUSH budget is yearly underutilized, sometimes even by half. For example, in 2013–2014, the allotted budget was 1,259 crore rupees but the actual use was 936 crore rupees; in 2014–2015, the budget was 1,272 crore rupees, of which only 619 crore rupees was used (Government of India 2015).

It is important to mention that despite the availability of funds, there is a wide-spread view among AYUSH practitioners that the budget is limited and financial resources are insufficient. This view is predicated on the actual experiences of economic precarity. For example, one Unani professor remarked that the majority of lecturers and instructors in her

college were contractors. They do not have a secured position, which results in a perpetual state of looking for different jobs and feeling stressed: “During eleven months [before signing a next year contract] we don’t know if we will be fired or we will be kept. It’s just the mood of the college and mood of the government.” She believes that this situation is a result of scarce budget and the reluctance of the government to regard AYUSH seriously.

Another example of how poorly the financial resources allocated to the Ministry of AYUSH trickle down to AYUSH practitioners comes from a postgraduate student in the Rishikul Ayurveda College. When he was giving me a tour of the college, he mentioned that the students had not been paid the stipends for three months. He explained that the university claimed that the government did not have money for AYUSH. It is hard to establish with certainty whether the government does not allocate sufficient funds to AYUSH colleges or the money is embezzled along the chain of corruption. But in any case, these two examples illustrate why many AYUSH practitioners feel neglected by the state. At the same time the Ministry of AYUSH carries out numerous expensive projects such as the annual Yoga Day. I argue that these projects serves as a political strategy to garner political support within the country and to promote India internationally. I postulate that along with the International Yoga Day and the World Ayurveda Congress, AYUSH in general has become a constituent of India “brand.”

The branding of India through traditional medicine is not a novel approach developed by Narendra Modi. The Indian state policy on plural medicine has always been tuned to the international audience: the desire to both present an appealing image of India (as a country of “unity in diversity,” ancient traditions, and spirituality) and access the global market have greatly influenced the history of institutionalized plural medicine in India. When I asked government officials about the rationale of the state legitimation of so many medical traditions, the answers

often contained the references to India's past and India's diversity of cultures, religions, and medical traditions. I will explore this issue in the next chapter but here I want to emphasize that the government officials I interviewed and government documents I analyzed often link the promotion of AYUSH to the agenda of the WHO (particularly, the Declaration of Alma-Ata 1978 with the goal of *Health for All*) and other international organizations that promote traditional medicine. Consider the following statement in the Eleventh Five Year Plan:

India can be a world leader in the era of integrative medicine because it has strong foundations in Western biomedical sciences and an immensely rich and mature indigenous medical heritage of its own... The major challenge for industry is to transform its global image from that of a raw material supplier to a knowledge products industry (2008, 109).

Thus, the promotion of AYUSH resources and expertise is a clear constituent of the India brand. A glance at funds allocated for AYUSH in 2014–2015 shows that 58% was given to the programs and institutions related to research and promotion of AYUSH, not AYUSH education or infrastructure. Remarkably, the sector for the International Cooperation within the Ministry of AYUSH even provides scholarships to international students to study one of AYUSH systems in Indian universities.

Posing the question of “legitimacy for whom,” Mehrotra (2012) has claimed that the government's goal was to export AYUSH products rather than strengthen AYUSH sector within the country. Although the branding of India through the promotion of Indian medicine is not new, Modi has played this card more strategically and consistently than the previous governments. If we compare the 2014 election manifestos of three parties (Bharatiya Janata Party, Indian National Congress, and Aam Admi Party), we can see that the BJP led by Narendra Modi gave the most extensive promises to advance the Indian Systems of Medicine. Moreover, on many occasions, Modi spoke of his personal commitment to Ayurveda and Yoga and was

featured in many Ayurveda and Yoga-related events. Consider a media report, which aptly illustrates how a medical category of AYUSH is used for ideological purposes:

Creating a special ministry of AYUSH... adds strength to brand India. The charismatic Indian Prime Minister Narendra Modi has been a strong proponent of encouraging the science of Ayurveda and Yoga. He even made a strong pitch for it in the UN General Assembly and called upon all countries present for observing an International Yoga Day. The iconic leader now walks the talk... In a landmark decision, PM Narendra Modi has gone ahead and created a separate ministry - AYUSH... [He] surely has his grand vision of India clear in his mind. A major proponent of Yoga, Narendra Modi has been regularly practicing Yoga since many years. His decision to create AYUSH as an independent ministry echoes his strong conviction to promote and encourage Ayurveda, Yoga & Naturopathy, and Unani, Siddha and Homeopathy across India and the world. It is a powerful step with far reaching trickling benefits. Among them, a major one is that these ancient sciences symbolize unique Indian identity and are very crucial for India to sustain its global image (Hookastar 2014).

After reading such accounts, one is left with a feeling that the Ministry of AYUSH was an important accomplishment. Yet surprisingly, the government is not able to reach out to the practitioners of those medical communities (if it ever intended at all): a large number of AYUSH physicians, especially those in private practice, are unaware of institutional changes. In Chapters 5 and 6, I discuss in great detail how clinical practices, prescribed medicines, and therapies of AYUSH doctors differ from the ways in which the Indian state represents them. The government rhetoric about AYUSH does not reflect the structure of practice in clinics. Talking to medical practitioners, administrators, and educators who work in non-biomedical fields, I frequently found that they had no knowledge of the new ministry. In fact, many of them have not even heard of the Ministry of AYUSH. This includes medical practitioners who live in Delhi, not to mention village doctors and their patients. Those who are literate and have access to newspapers and the Internet generally know something about the government promotion of AYUSH, but as I show below they mostly understand the Ministry of AYUSH as a ministry for Ayurveda. I argue that the government's representation of AYUSH as a collection of different but equal medical

systems obscures the internal hierarchy of institutionalized medical pluralism, particularly the privilege of Ayurveda (or sometime Ayurveda and Yoga as India's two ancient health-related traditions) and the marginalization of Unani.

3.3.2 Hierarchies of Indian Medicine: AYUSH vs. ayush

In 2010, Tibetan medical tradition Sowa-Rigpa⁶¹ was recognized as an official “medical system” (Kloos 2013), but the name AYUSH remained unchanged (although there are occasional spellings of AYUSH as AYUSSH where Sowa-Rigpa is placed between Siddha and Homeopathy).⁶² Of course, from the vantage point of state bureaucracy, re-naming of the institutional body after every addition of a system is impractical, especially when the chosen acronym AYUSH carries a culturally significant meaning: *āyus* is a Sanskrit word for vitality and longevity. Yet, as I observed, the absence of the letter *S* for Sowa-Rigpa in the acronym AYUSH renders the Tibetan medical system almost invisible. For example, when I asked a homeopath to explain what AYUSH stands for, she recounted all the systems but omitted Tibetan medicine. Then I asked if she knew whether it was also part of AYUSH, to which she replied: “I don't think so. There is no letter for it in AYUSH, right? There would be T letter there.” Hence even today, five years after the recognition of Sowa-Rigpa, many doctors are unaware that Tibetan medicine is an official medical system in India. There are even larger

⁶¹ According to one Sowa-Rigpa doctor I interviewed, there were ardent debates about the name under which Tibetan medicine would be recognized. Some authorities within the Tibetan community in exile insisted on including the designation “Tibetan” in the name of state-recognized medical system. However, the government of India was reluctant to do so, as it could complicate the political relationships with China. Moreover, since Sowa-Rigpa is practiced among indigenous groups of Sikkim, Ladakh, and other parts of India, it was apparently decided to call the system “Sowa-Rigpa” rather than “Tibetan medicine” or “Tibetan Sowa-Rigpa.”

⁶² Interestingly, there are proposals to add an extra letter A for Indian acupuncture and rename the ministry as AAYUSH (Dastidar 2015).

implications of using the name AYUSH to denote plural medical traditions: AYUSH functions not as an acronym that celebrates medical plurality but as a politically correct expression for promoting Ayurveda, which by extension contributes to Hindu nationalism.

The analysis of government documents and media reports (in English) reveals two forms of the ayush discourse. In its inclusionary form, AYUSH (in capital letters) is an icon for state-supported non-biomedical traditions. As discussed above, with the recognition of Sowa-Rigpa, AYUSH ceased to be an acronym but remains a metonymy for institutional medical pluralism. From this perspective, when people talk about a preference for AYUSH over biomedicine, they usually refer to alternative medicine as a whole. It is about this inclusive form that Lambert writes:

AYUSH is simultaneously a singular and a plural entity. Each component is taken to constitute internally unified and historically discrete knowledge traditions, while together they collectively represent the State-recognised alternative to biomedicine, or allopathy... The acronym has rapidly become the accepted single-term referent for all forms of non-allopathic health care among health care professionals, policy makers and academic researchers (2012a, 1030).

In its second form, *ayush* (in small letters) is an exclusionary term which refers to Ayurveda. Grammatically, the word Ayurveda consists of two Sanskrit roots: *ayus* (longevity) and *ved* (knowledge); hence it is unsurprising that the term *ayush* has become a substitute for Ayurveda. The inclusionary discourse on AYUSH is frequently understood as an exclusionary discourse on Ayurveda. The line between these two is quite elusive; it is hard to determine what exactly health care providers, patients, and politicians mean when they mention “*ayush* medicine.” I often heard the term “*ayush* doctor” just to discover that it referred to an ayurvedic doctor. In response to my question about recent changes in the status of AYUSH systems, I was several times informed about the “Ministry of Ayurveda.” The substitution of *ayush* and Ayurveda goes frequently unnoticed.

Certainty, Unani, Homeopathic, and Sowa-Rigpa practitioners are more sensitive to the distinction between *ayush* and Ayurveda. They would often list at least several medical systems while explaining the term AYUSH to me. In contrast, Ayurvedic practitioners tend to omit other traditions altogether. Consider a part of an interview with a private ayurvedic practitioner who claimed to have worked at a local department of AYUSH:

Author: Do you know what ayush is?

Respondent: yeah yeah, I know ayush...

A: So what does it stand for?

R: ayush? Ayush basically... it's All India Ayurvedic National Congress like na? So it's a.. It's a basically... a society, it's a firm, which is dealing with the upliftment of Ayurveda. So they care.... and there was a National Conference for... in November, for all over world, it was held in Delhi... in which the Prime Minister was also called up... So the Prime Minister himself, he had quoted certain things, I will just quote it for you. He said that unless and until the doctors who are... have studied Ayurveda and who are practicing Ayurveda – [unless] they don't have trust in the Ayurveda, Ayurveda cannot uplift [...]

A: But there was also a department of AYUSH, right?

R: there is a department... I have worked with ayush. I was a doctor working under ayush, in [the name of the area]. I worked for three years under the government of [a state]. So Ayush is basically... what Ayush is doing is right now... it's a very good step, but it will take time, basically... it involves many villages, which are almost remote areas, so what they are doing is... or in all the remote areas where allopathic doctors don't want to go... [...] So they are providing... they are keeping BAMS - Bachelors of Ayurvedic Sciences under the Ayush programs in all the PHCs. PHSs are primary health centers and CHCs are combined health centers over there. [...] So they are being provided with allopathic dispensaries over there and... as well as Ayurveda... ayurvedic medicines. And all those medicines come through ayush only.

Common people do not have a clear understanding of the scope and meaning of AYUSH; when asked they suppose that it is a government body for the advancement of one medical system—Ayurveda. Such statements are ubiquitous: I heard them not only from people who occasionally buy ayurvedic products but also from more informed health care providers.

The interpretation of AYUSH as Ayurveda is partly rooted in ambiguous media accounts. Consider a widely circulated headline on the establishment of the Ministry of AYUSH: “India now has a Minister for Ayurveda with a separate AAYUSH portfolio” (Itoozhi Ayurveda 2014). This headline is remarkable not only because it mistakenly names the Minister of AYUSH as the Minister for Ayurveda, but also because of the spelling of *ayush*. It is written in capitals as an acronym, but the double AA—a standard way to transliterate a long vowel “a” in Hindi and Sanskrit—indicates that AAYUSH is not an acronym but the word *ayush* (long life). As a result, the headline becomes doubly confusing to a reader.

Is this a mistake or a manifestation of what is hidden between the lines in the promotion of AYUSH? Is it a mere oversight that the official website of the Ministry of AYUSH spells its name as “the Ministry of Ayush”? Similar to an ambiguous use of different terms in the Udupa Report 1958, current official documents are unclear about what exactly they promote. Consider the Election Manifesto of the Bharatiya Janata Party, which is currently in power.

Yoga and Ayurveda are the gifts of ancient Indian civilization to humanity and we will increase the public investment to promote *Yoga and AYUSH*. We will start integrated courses for *Indian System of Medicine* (ISM) and modern science and *Ayurgenomics*. We will set up institutions and launch a vigorous program to standardize and validate the *Ayurvedic medicine* (Bharatiya Janata Party 2014, 25, emphasis added).

Giving the fact the BJP is a right-wing party which draws on the ideology of Hindu fundamentalism and has been involved in a number of (violent) anti-Muslims and anti-minority projects, it is hard to make sense of the claim “to promote Yoga and AYUSH.” Does it mean Yoga and Ayurveda, or indeed Yoga and all other AYUSH systems? Does the “Indian System of Medicine” (when the “system” is singular) include Unani and Sowa-Rigpa? I argue that it does not.

In contemporary India, Ayurveda is socially and financially privileged among other non-biomedical traditions but this privilege is taken for granted. For example, the hegemony of Ayurveda is at work when Balkrishna, a co-founder of Patanjali, routinely states: “The formation of a separate ministry for ‘ayush’ by the Central Government is a laudable step as it signifies the recognition of Ayurveda” (The Tribune 2014). Similarly telling is a statement by the Minister of Health and Family Welfare regarding the necessity to stimulate the production of ayurvedic herbal pharmaceuticals:

It is a pity that China has captured such a huge share of the world market whereas India’s presence is non-existent. We are determined to develop Brand India through Ayurveda... *With the launch of the National AYUSH Mission, the government will focus in detail on building up a brand value for Ayurvedic drugs manufactured in the country* (The Scitech Journal 2014, emphasis added).

Again, the AYUSH mission is interpreted as a mission to support the development of Ayurveda. In fact, I directed this question to government officials and some of them replied that they did not see any value in the term AYUSH, in which different systems are all bundled together. Similarly, a female Ayurvedic practitioner and former member of the Central Council for Research in Ayurvedic Sciences stated that different medical traditions should not be treated as if they were one thing; particularly, Ayurveda should not be approached as “one of many systems.” She even suggested that there should be a separate Ministry of Ayurveda, so that Ayurveda can get the government’s full attention. Another official in Delhi argued that people’s mistaken perception of AYUSH as Ayurveda stems from a lack of medical literacy. He argued that the government makes a great effort in promoting all AYUSH disciplines but “the thing is the world knows AYUSH as Ayurveda, they forget YUSH... that’s the problem.”

Based on a wealth of similar conversations with medical practitioners, government officials, and common people, I argue that both the government and popular rhetoric on non-biomedical traditions in India reveal and strengthen the hegemonic position of Ayurveda.

3.3.3 AYUSH facilities, the National Rural Health Mission, and the absence of Unani

Not only is Ayurveda rhetorically dominant but it also has the largest infrastructure within AYUSH. According to the most recent publicly available data (Ministry of AYUSH 2010), the number of Ayurveda facilities and practitioners is significantly higher than of other traditions under AYUSH.

Table 2. Number of AYUSH facilities

	Ayurveda	Unani	Siddha	Yoga	Naturopathy	Homeopathy	Sowa-Rigpa
Hospitals	2458	69	75		4	254	
Beds	44820	894	576	5	61	9631	2
Dispensaries	15353	146	41	9	7	6958	53
Manufacturing units	7494	14	38	N/A	N/A	398	
Registered medical practitioners	478750	1067	195		401	246772	

Even by walking on the streets of any city or town in India, the visibility and physical prevalence of Ayurveda become particularly evident in the number of Ayurvedic pharmacies, luxury Ayurvedic boutiques, build boards advertising for with Ayurvedic products. In contrast, there are only occasional homeopathic dispensaries and far fewer ads for homeopathic beauty products (such as creams for acne). Furthermore, Unani enterprises are remarkably absent.

The privileged position of Ayurveda is also evident in the implementation of the National Rural Health Mission (NRHM). The NRHM was designed to address the problematic scarcity of healthcare recourses in rural and remote areas. One of the proposed objectives was to “revitalize local health traditions and mainstream AYUSH into the public health system” (NRHM n.d., 14). This included the appointment of AYUSH doctors in allopathic Primary Health Centers, especially where allopathic officers are absent and the integration of AYUSH facilities within biomedical hospitals and dispensaries. The latter is usually described in terms of “co-location” of AYUSH and allopathic wards under one roof. The NRHM was launched in 2005 and by 2012 more than 450 hospitals, 2400 community health centers, and 8500 primary health centers had been co-located with AYUSH facilities (Samal 2013). However, this is merely an aggregated data which does not disclose the specific number of each of AYUSH disciplines. It raises the question of the proportion of Unani, Siddha, Homeopathy, and other facilities vis-à-vis Ayurveda. During the fieldwork I visited a number of co-located hospitals and dispensaries in Uttarakhand and Delhi and I documented that all visited AYUSH wings provide only Ayurveda and Homeopathy treatments. Not a single hospital had a co-located Unani ward. Similarly, a survey conducted in Uttarakhand has revealed that among 155 medical facilities that have implemented the NHRM scheme, there were no Unani or Siddha wings (Shivdasani et al. 2012, 9).

Since I was interested in popular views of AYUSH disciplines as much as in their actual infrastructure, I often solicited opinions of my interlocutors regarding the overwhelming number of Ayurvedic hospitals, ayurvedic colleges, Ayurveda advertisements on TV, and shops with ayurvedic products in comparison to those of other traditions, particularly Unani. A common response is that Unani is preferred by the Muslim community, whereas Ayurveda is a tradition

that “everybody” is familiar with from childhood; hence, the demand for Ayurveda is bigger and Ayurvedic treatments are more popular.

This explanation is misleading for two reasons. First, even if we assume that the number of medical facilities corresponds to the demands of certain communities, then the ratio of Muslim population would have corresponded to the ratio of Unani facilities in the country, in other words, there would have been at least 15% of Unani hospitals and colleges to cater to almost 15% Muslims in the country, whereas in reality, Unani facilities constitute only 5–8% (Government of India 2010). Moreover, even in places with a sizeable Muslim population like 14% in Uttarakhand (Census of India 2011), there are no co-located Unani wards under the NHRM. Thus, the numerical minority argument, that Unani hospitals are fewer than ayurvedic hospitals because the Muslim population is smaller than the Hindu population, is not supported by statistics. Second, a belief that Unani is practiced and used by Muslims is an endorsement of a communalist logic which implies that cultural affiliation dictates the patients’ choices of medical treatment. However, in reality, many Muslim patients seek treatment at Ayurvedic, homeopathic, and other AYUSH hospitals, while many Hindu and Tibetan patients visit Unani doctors.

It is important to recognize that the claims that Ayurveda is popular among “everybody” are ideological statements which disguise the disparities in representation of different traditions within AYUSH. Not all non-biomedical traditions are considered candidates to represent the nation. When I asked my interviewees to explain the term Indian medicine, they often stated that it “basically meant Ayurveda.” Consider how one ayurvedic doctor responded to my question about the state promotion of many medical systems:

Respondent: See, in India, there are different cultures. It’s a colorful country. Okay? So now, then... there are lots of religions also there. So Unani is more of a Muslim pathy [medicine], okay, and Homeopathy is... obviously, it’s from Germany, but then again there are... it has its own clientele. Homeopathy has its

own clientele. And Ayurveda—it's Indian traditional medicine, it's a tradition also.

Author: Do you mean Indian or Hindu?

R: Same thing. Means Indian, Hindu, and Muslims also. It is Indian.

A: so Unani is for Muslims and Ayurveda for...?

R: Because Unani, Unani... you know the word Unani? Unan is for the Greek, but Indians they've got roots in unan also. Means Mohammedans they are associated with Unani

A: But when you say that Ayurveda is Indian, do you mean Ayurveda is for Muslims, and Hindus, and Sikhs, and Christians also?

R: See, what I've seen in my practice is Muslims are also into Ayurveda... They believe in Ayurveda... It's natural because. I mean both Ayurveda and Unani are natural... The name is different but stuff would be same... That's natural, this is also natural. In that case they are same. Unani medicine is a tradition for Muslims, means it's close to the Muslims... and people who practice it are also Muslims... Most of them, majority. *Hakims*. It's an Urdu word, and you will find very less Hindu people as *hakims*, very less... 99% *hakims* would be Muslims. But in Ayurveda there will be lots of Muslims also.

A: if you say that Ayurveda is for everybody, then maybe the government should only promote Ayurveda properly?

R: They are promoting. They are focusing on Ayurveda, but they cannot leave others... If they leave Unani, Siddha, and Homeopathy behind, there will be lots of clashes...

A: clashes?

R: Clashes in a sense people will object. Means people who are practicing Unani or Homeopathy they will have many objections "why are you neglecting us?" India is a place for everybody... So they can't leave anybody... But they focus on Ayurveda, because that is a tradition, that is Indian tradition, that is Hindu tradition, that is Muslim tradition, that is Indian tradition.

This interpretation is repeatedly reinforced in media as well. Consider how Ayurveda is solely represented as Indian traditional medicine in a recent news article on an establishment of AYUSH services in Dubai:

India has set up Department of Ayush at its Consulate here which will provide free consultation to the public. The Department of AYUSH is purposed with developing education and research in Ayurveda (Indian traditional medicine), Yoga, Naturopathy, Unani, Siddha, and Homoeopathy, and other alternative medicine systems (NDTV 2015).

Ayurveda is repeatedly constructed as the most ancient medicine, and by the virtue of being so, it is claimed to be the origin of Unani, Tibetan medicine, and even Homeopathy and biomedicine. Not only is this argument pervasive among doctors and patients but even the official website of the Ministry of AYUSH introduces Ayurveda as “the ancient most health care system originated with the origin of universe” (“What is the Origin of Ayurveda” n.d.). Even when Ayurveda is not claimed to give birth to all other medical traditions of the world, it is still frequently understood as the only truly Indian medicine. The underlying assumption is that, despite proclaimed Hindu heritage, Ayurveda is not an exclusively “Hindu” medicine but has “national” outreach, whereas Unani, Siddha, and Sowa-Rigpa are not eligible to make such claims.

In sum, there is a strong link between the concepts of “ayush,” “Ayurveda,” and “Indian medicine.” From this perspective, the state rhetoric on AYUSH is misleading because it appears to be inclusive of diverse medical traditions in the country, while de facto it privileges only one tradition—Ayurveda. As shown in the next chapter, Ayurveda is the one which is unquestionably promoted within and outside India under the AYUSH scheme. In contrast, despite being present in the subcontinent for about a thousand years, Unani medical tradition is repeatedly “othered,” which reflects continuous political marginalization of Muslims. The analysis of the documents issued by the central government and online reports from central and regional media exposes profound discursive confusion which favors Ayurveda over the other AYUSH systems. Even if not produced and used intentionally, the terminological ambiguity allows the government of India to paradoxically promote both cultural diversity and a single “Indian” medicine.

4.0 AYURVEDIC EXCEPTIONALISM AND PRECARIETY OF NATIONAL BELONGING

From field notes (June 30, 2015)

Today is a piercing-bright hot summer day. A *rickshawala* drops me at the corner of a dusty market in central Dehradun. Having lived in India intermittently for three years, I do not have trouble navigating through the broken roads, mouthwatering fruit carts of mango and litchi, mounds of litter, dozens of stray dogs pacified by the sun, innumerable human bodies moving sluggishly through the thick humid air, and hundreds of ceaselessly honking cars. Three minutes of hullabaloo and I reach my destination.

Instantly I find myself in a rather dark and chill room of an old Unani dispensary. Right in front of the entrance is a timeworn table, somewhat unkempt and dusty, with piles of papers, a patient journal, a stethoscope, and five or six sachets with ayurvedic drugs of a popular *Himalaya* brand. They look too modern and out of place. On the left there are shelves filled with big white plastic and tin containers bearing names of medicinal herbs handwritten in Hindi and Urdu. An old *hakim* with bushy snowy beard and kind eyes greets me with a questioning look. On the desk I see a metal plate with his name, Ghalib Mohammad Siddiqui (also written in both Urdu and Hindi). I introduce myself and ask whether we could talk. Ghalib ji responds affirmatively and we begin our conversational journey through his family's history and the history of Unani, India's Independence and afflictions of the modern society.

Dr. Siddiqui has officially worked in this clinic for about 35 years, but even before acquiring a formal position, he used to help his father, who was a Unani practitioner too: “used to seat on this very chair” (*isi seat pe bethe the*). Unani is a family occupation, says Ghalib ji, but it is now under a threat, because his children are not interested in it.

Since Ghalib ji calls it a family business, I ask whether the dispensary is owned by him or the government. He replies that it belongs to a city government, and adds that it is the lone dispensary, not just in Dehradun but in all of Uttarakhand. I tell him that I have seen many ayurvedic dispensaries; so why is there only one Unani? The doctor laughs bitterly, falls silent for several seconds, and then remarks that it is a little sensitive topic (*yeh thoda sensitive hai*). He explains that it so happened that Unani became associated with Islam and Mughals, and now suffers from neglect. I request him to elaborate: does he mean that the government does not equally support Unani and Ayurveda? Instead of replying, Ghalib ji turns away and reaches out for a drawer in his table. I wait patiently and after a minute of search, he passes me a folder with photocopies of some reports and cuttings from various newspapers in English and Hindi. I see that they are all about the status of Unani in the country; some papers have tables with the statistics on AYUSH infrastructure.

Ghalib ji draws my attention to a Hindi newspaper which states that in Uttarakhand there are 538 ayurvedic dispensaries but only five Unani. A different newspaper, *Times of India*, gives slightly different numbers: recently the government has established 425 dispensaries of Ayurveda, but none Unani. I have seen similar reports and know that the most common AYUSH system in India is Ayurveda, while Dr. Siddique’s occupation is struggling to “survive on last legs.” He dully remarks that those figures speak for themselves (this conversation is in Hindi but italicized are words in English):

There is no need in my words. There is a *directorate*, the *Ayurveda and Unani directorate*... In entire Uttarakhand, it has opened so many [ayurvedic dispensaries] but not a single Unani dispensary... In AYUSH, A stands for *Ayurvedic*, Y for *Yoga*, after that U is for *Unani*, S is for *Siddha*, H is for *Homeopathy*, but U has completely disappeared. *No representation*... Now this point is not just my words. Wherever you go, ask them, “okay, give me the data, how many Unani *dispensaries* do you have, how many ayurvedic.”⁶³

Dr. Siddiqui is resentful that the government pledges its support for Indian medicine, but support for Unani is only “on paper.” He even postulates that the institutional body of AYUSH is Ayurveda-centric. Unani is greatly underrepresented, just as the Muslim population is underrepresented in the government:

What AYUSH means is *actually ayurvedic*. This, in English, I don’t know, there is a *French or Latin proverb*: it is *de jure* or *de facto*, isn’t it? So *de jure* it is *plural* but *de facto* it is Ayurveda. It is like... they say that everything is equal, everybody will get [support], everybody has *rights*. However, *actually* the thing is that... this [Muslim] *population*, which is 15-20%, has only 2.5% *representation* in the government. The same way, in *Constitution*, we are all equal, but the *actual position* is this [the opposite].⁶⁴

While Ghalib ji talks about numbers of clinics and dispensaries, I think about the Himalaya Drugs Company pills on his table: is not it an ayurvedic company? Does he prescribe ayurvedic drugs too? He explains that many patients demand a treatment in the form of pills, so he tries to meet the demand by having a supply of manufactured drugs at hand. As for the ayurvedic company Himalaya Drug Company, he explains: a representative (*kampaniwala*) comes here and

⁶³ Mere kehne ki zaruri nahin. Yeh jo directorate hai, Ayurveda and Unani directorate hai... Pure Uttarakhand me unhone bahut [ayurvedic dispensary] khola hai, bahut khola hai, ek bhi Unani nahin... AYUSH me A for ayurvedic, Y for Yoga, uske bad U for Unani, S for siddha, H for Homeopathy, par “U” toh pura gayab hai. No representation... Ab toh mere kehne ki bāt nahin hai. āp kahi bhi jake, usse kahiye, accha, āp data de dijiye, kitna Unani āpka dispensary hai, kitna ayurvedic hai.

⁶⁴ Woh actually jo ayush hai, woh ayurvedic hai. Woh English me ek... main nahin janta hoon, French ya Latin proverb hai, woh de jure aur de facto hota hai... hai na? De jure woh plural hai aur de facto woh ayurved hai. Woh jaise ke, woh kehte hain ki sab barabar hain, sabko milega, sabko rights hain. Lekin actually yeh hai ki jo yaha ke population me, jo log pandrah se bis percent hain, unka government me representation 2.5 percent hai. Ussi tarike se toh samvidhan me, constitution me, ham sab barabar hain, par actual position yeh hai.

brings drug samples for marketing that brand. Last time a Himalaya representative brought a gift—a calendar that bears the logo of the Himalaya Drug Company. Stylized as a collection of Mughal miniatures, the calendar describes the history and therapeutic principles of Unani. I feel a little puzzled, but do not yet understand why. Later, when I arrive at home and complete my field notes, realization strikes me: why would an ayurvedic pharmaceutical company produce a Unani calendar? I browse the Himalaya website, trying to find an elucidation, but in vain. The online self-representation of the Himalaya company has no references to Unani whatsoever. My conjecture is that this calendar has been designed specifically for Unani practitioners as a promotional material along with the samples of Himalaya pharmaceuticals. It is a mere business strategy, but symbolically it marks the presence of Ayurveda in the physical space of Unani.

We talk a little about money and future of Unani. Ghalib ji points to a modest interior of the dispensary, emphasizing that the budget is meager, that there is no funding for new tables or shelves; the building itself has not been renovated for ages. He says that his “boss” from the Ayurveda and Unani directorate of the municipal government does not want to invest money in the dispensary, because he thinks that people are neither interested in, nor benefitted by Unani treatment. Dr. Siddiqui mentions that he was also told that as soon as he retires, the dispensary would be shut for good. “But people are benefitted!” – he exclaims, pointing to the patients list, which contains a dozen names under today’s entry.



Figure 4. Inside a Unani clinic

Photo by the author

When I look at the patients' registry, I notice Hindi, Muslim, and Sikh surnames, so I question whether his patients typically come from different religious backgrounds. Ghalib ji smiles and wittingly remarks: "Everybody benefits. This is medicine! You certainly won't be able to say that biomedicine only benefits English people!" (*sabko hi [faida] hota hain, woh toh medicine hai! āpko yeh toh nahin keh sakta ki allopathy sirf angrezi logon ko faida karti hai*). Thus, on the one hand, he feels troubled by the fact that Unani is being constructed as a Muslim therapy: medicine is medicine and should not suffer from cultural biases and the government's neglect (*upeksha*) just because it happens to be brought to India by Muslims. On the other hand, Dr. Siddiqui draws a parallel between the positions of Unani, Urdu, and Indian Muslims. For him, it is all manifestation of the same tendency. Repeatedly he states that Constitution has many good points, but reality is different. The government's promotion of cultural diversity and medical pluralism is just a facade:

This way [the government] needs to show people that we are treating everyone equally. But they don't want it. This is not me saying, this is what the *figures* of all the *ministries* talk about. [...] No, in this, *nobody*, not even a strong *supporter of Ayurveda*, even he cannot *deny* that; these are *facts*, aren't they? This is not my, kind of, some *political statement*. These are the things which are visible. We have one *director*, Unani and Ayurveda have one *director*. We have one *department*. We have one *budget*. Then how is this *disparity*? How is this *injustice*?⁶⁵

The above depiction of the government's neglect and a gradual demise of Unani tradition is just a story told by one *hakim* in Dehradun. As I show below, not everyone—not even every Unani practitioner—agrees with it. Nevertheless, this chapter takes Dr. Siddiqui's views seriously, and grapples with the perceived and factual disparities within AYUSH disciplines. I chose his story to open the chapter because it sheds light onto three features of medical pluralism in India: 1) disjunction between the official rhetoric regarding the uniform promotion of all AYUSH systems and Unani doctors' experiences of marginalization; b) contribution of pharmaceutical companies to the hegemony of Ayurveda; and c) entanglements between medical knowledge, religion, language, and communal politics. By analyzing statistical data, media discourses, and interviews with doctors and government officials, I explore whether Unani is indeed pushed to the margins of therapeutic landscape and which factors account for the expansion of Ayurveda.

I have previously argued that the choice of a Sanskrit word “ayush” as an acronym for state-sanctioned medical pluralism invalidates the claim for equal recognition of medical plurality, instead reinforcing the unspoken authority of Ayurveda. In this chapter, I elaborate on this argument, by examining the cultural politics of national belonging and situating plural

⁶⁵ *Aise ke logon ko dikhana hai, ki hum sabko barabar leke chal rahe hain. Lekin aisa chahte nahi hain. Toh yeh main nahin keh raha hoon, yeh sari ministries ke jo figures hain woh batate hain. [...] Nahin, isme nobody, even hard supporter of Ayurveda, woh bhi isko deny nahin kar sakta, yeh toh facts hain na? Yeh toh mera aisa koi political statement nahin hai. Yeh toh woh cheezen jo woh jo cheeze nazar ā rahi hai. Hamara ek director hai, Ayurveda Unani ka ek director hai. Hamara ek department hai. Hamara ek budget hai. Toh yeh disparity kaise hai? Yeh injustice kaise hai.*

medical traditions within two poles of nationalist ideology: inclusive secularism and Hindu nationalism. Since any rhetoric of Hindu supremacy trickles down to hostility against Muslims (India's largest minority group), I am particularly interested in the state of Unani, which has come to be linked to Muslim population. Touching upon the issues of orientalist constructions of Hindu civilization and ancient medical knowledge, nationalist declarations of cultural diversity, present-day Hindu-Muslim antagonism, the "homecoming" movement (*Ghar Wapsi*), radical political slogans, hindutvic underpinnings of Yoga and Ayurveda promotion, I show how the politics of religion, cultural difference, and national belonging percolates the domain of health and alternative medicine.

4.1 MEDICINE, BODY, AND NATIONALISM

In the late 19th century–early 20th century India, anti-colonial and nationalist projects, concerned with the issues of political independence, cultural autonomy, and attempts to demarcate "Indian" from "foreign," simultaneously generated ardent debates about indigenous and Western medicine (Arnold 1993; Bala 2007; Jeffery 1988; Prakash 1999). Some political leaders urged to embrace biomedicine in order to build strong, modern and healthy India, whereas others advocated for investing in traditional medicine, viewed as one of the corner stones of an independent nation (Khan 2006, 2795). Just as defining the government's take on religion and cultural diversity, or delineating the role of English and Indian languages, choosing a medical tradition was integral to the transformation of Indian colony into an independent polity.

This entanglement between medical practices and nationalist sentiments has become a particularly fruitful topic in medical anthropology. For example, having examined the discourses

around anti-tuberculosis vaccination in 1940s India, McMillen and Brimnes have argued that resistance to a “foreign” vaccine had generated a form of “medical nationalism” (2010, 184). Although the authors have been primarily interested in medical discourses, their study also highlights how the body becomes a vehicle for expressing national allegiances.

This idea is best captured by the concept of “embodied nationalism,” which has been given scrupulous attention by many scholars, particularly those who work in South Asia. Their rigorous work has demonstrated how wrestling, Yoga, Nature cure, acupuncture, Ayurveda, blood donation, fasting, and other manipulations and self-regimens of the body—in many different ways—have drawn on and contributed to multiplex conceptualizations of Indian nation (Alter 1992; Alter 2000; Attewell 2007; Berger 2013; Copeman 2009; Langford 2002; McKean 1996; Weiss 2008). By multiplex conceptualizations I mean different ideologies that stem from political writings of Nehru, Gandhi, Savarkar, Hedgewar, or other theoreticians of Indian nation. For example, Copeman argues that blood donation camps in India epitomize “situational enactments of the Nehruvian post-Independence ideology of ‘national integration’” (2009, 20), because participating blood donors come from diverse cultural backgrounds and their blood goes to anyone, irrespective of caste, class, gender, and religion (Copeman 2009, 168), thus physically and symbolically connecting Indian citizens into one nation. Alter (2000) examines how Gandhi’s ideas about body and morality as applied to Indian nation, self-rule, and democracy, have found expressions in the development of diverse exercise regimens, therapies, and techniques of self-discipline, ranging from wrestling, *surya namaskar* (a Yoga sequence of sun salutation), Nature cure, and auto-urine therapy. Unlike Nehruvian national integration of people from different caste, class, regions, languages, and religions, Gandhian nationalism was focused on the perfection of a “crude” body, so to speak, attempting to connect Indian citizens not as

individuals with cultural identities, but as human beings, i.e. biological and moral subjects.

Although blood donation, fasting, wrestling and other health-related technologies undoubtedly play an important role in the production of nation, it is usually the so-called *indigenous* medicine which occupies a focal place. Nationalist discourses often include assertions about a great value of traditional medicine and its centrality to national identity (Brotherton 2012; Croizier 1968; Ernst 2002; Farquhar 1994; Ferzacca 2002; Kim 2009; Kleinman 1980). For example, speaking about Chinese nation, Mao Zedong referred to traditional Chinese medicine (TCM) as “a great treasurehouse” of Chinese motherland, enabling the positioning of TCM as the “national medicine” with characteristically “national essence” (Farquhar 1994, 12–13). However, such straightforward connections between one nation and one indigenous medicine (as much as between one nation and one language, or one religion) can become very problematic from the point of view of different intellectual tradition and knowledge communities. When a country is home to more than one indigenous traditions of medical knowledge, how do medicine and nationalism interplay?

The story that I seek to tell in this chapter emerges from the fact that different nonbiomedical traditions—collectively or individually—can evoke very different articulations of nationalism. Although this is a crucial issue which exposes how competing visions of nation co-exist in a given society, relatively few studies have looked into it (see Alter 2006; Alter 2014; Arnold and Sarkar 2012; Sivaramakrishnan 2006). For example, in a study that contrasts Ayurveda with Nature cure, Alter (2014) has argued that Ayurveda invokes nationalism through rhetorical connections to the Indian nation. By emphasizing ancient history, Sanskritic textual tradition, and other abstract categories, Ayurveda dissociates the body from the direct experience of belonging, which is integral to the function of national identity. In contrast, through the

practices of sun bathing, soaking in water, and applications of mud, Nature cure produces affective or intimately visceral sense of nationalism.

While Alter's study focuses on the body and embodied experience, Arnold and Sarkar's study of Homeopathy in Bengal examines representations. They intimate how differently Homeopathy and Ayurveda are represented with regard to Indian nation as, inter alia, "colonial," "western," "elite," and "indigenous." Similarly, Sivaramakrishnan's work on indigenous medicine in the early 20th century Punjab reveals that Ayurveda was implicated in two antagonistic nationalist ideologies. Initially, Ayurvedic *vaidyas* collaborated with Unani *hakims* under a single institution (the All India Vaid-Yunani Tibb Conference) in a common struggle for government support, emphasizing that both Ayurveda and Unani were essential knowledge traditions of Indian society. The leaders of Vaid-Yunani Conference, perceived by the public as the "symbols for national regeneration," viewed Indian nation as inherently diverse (Sivaramakrishnan 2006, 9), but later, some ayurvedic doctors established a different organization (Ayurved Sammelan), which considered Ayurveda a distinctly Hindu tradition, "validating the identity of a Hindu nation-in-the-making" (p. 140). Together, these studies lay out an important framework that demands careful investigation of the ways in which nationalist sentiments manifest in diverse medical traditions, including how these traditions are practiced and talked about.

In keeping with this line of inquiry, I seek to compare Ayurveda and Yoga, on the one hand, and "AYUSH," on the other hand, in terms of how they feature in nationalist frameworks. It might be objected that comparing individual traditions like Ayurveda and Yoga with an institutionalized conglomerate of medical plurality like AYUSH is comparing objects of different order, but I contend that it makes sense to do so because AYUSH systems, as I have

shown in Chapter 3, are often understood as a single entity, i.e. “ayush medicine.” Therefore, on the following pages I examine media discourses and medical practitioners’ views on AYUSH, Ayurveda, and Yoga, showing how they relate to two rival conceptualizations of Indian nation: a country founded on the principle of unity in diversity, or a country fundamentally Hindu. In other words, I argue that inclusive nationalism and Hindu fundamentalism are tightly interlinked with the professed equal support for all AYUSH modalities and promulgation of Ayurveda and Yoga respectively.

4.2 AYUSH: UNITY IN DIVERSITY AND INCLUSIVE NATIONALISM

Scholars, journalists, and policy-makers who write about Indian non-biomedical traditions routinely ascribe to them certain historical, religious, linguistic, and ethnic attributes. As I described in the Introduction, Ayurveda has come to be linked to Sanskrit, ancient Hindu traditions and Vedic past,⁶⁶ Unani—to Islam and Urdu; Siddha—to Tamil Nadu and non-brahmanic tradition; Sowa-Rigpa—to current Tibetan minorities and Buddhism. In my conversations with doctors and government officials, they have also frequently alluded to these

⁶⁶ Dominic Wujastyk has convincingly demonstrated that there was no tradition of “Vedic medicine” and that healing approaches mentioned in Vedas differ significantly from therapeutic methods and *materia medica* described in classic ayurvedic texts such as Caraka Samhita and Susruta Samhita. Unlike religious Vedas, Ayurvedic texts were more secular and ascetic (for example, in terms of medical prescriptions of meat and other non-brahmanic foods). Wujastyk further explains: “Recent work has discerned in the classical compendia of Caraka and Susruta a core of world-affirming, pragmatic realism amounting to an early scientific attitude, which has been subjected to a secondary process of religious over-coding. Texts which were originally dedicated wholly to the accurate observation and description of disease, and to healing by whatever means were effective, have been recast in the framework of a dialogue between certain primeval Hindu sages and gods, and a pedigree has been clumsily prefixed to these works which traces the descent of the science of medicine back to the gods themselves” (1995, 21).

associations, making AYUSH systems look like representations of distinct traditions incorporated into an overarching Indian culture. People with whom I have interacted viewed medical diversity as an expression of cultural diversity, that is a cornerstone of Indian society, its essential characteristic. For example, the following passage from an interview with a senior officer at the Ministry of AYUSH displays a typical outlook:

Now we have practically seven systems other than the modern medicine: Ayurveda, Yoga, Naturopathy, Unani, Siddha, Sowa-Rigpa... Sowa-Rigpa was given official recognition in 2010. So that is also part of Indian medicine now... And Homeopathy. Homeopathy has come from Germany but it is now strongly rooted in India... Though these systems have come from outside but now they are totally assimilated into Indian system of medicine. Ayurveda is more or less scattered throughout the country. But Unani, it is more popular in the Muslim communities. Siddha is particularly confined to the Southern states, Tamil Nadu.

Similarly thinks an ayurvedic doctor who lives in Chhotapur hill station:

See, in India there are different cultures. It's a colorful country, okay? So now, then, there are lots of religions. Unani is more of a Muslim pathy, and Homeopathy is... Obviously it's from Germany, but then again there are... it has its own clientele.

Initially I was perplexed why the government of India would legitimize so-many medical systems, including Homeopathy and Naturopathy which do not directly correspond to any cultural community in India (as Unani or Siddha are claimed to do). However, I soon began to suspect that institutional medical pluralism was not intended as a literal representation of the country's cultural diversity, but stemmed from a grand narrative of India's receptiveness to foreign cultures, her ability to absorb and assimilate. In the words of Dr. Bhati whom I cited earlier: "India is one country which has been receptive to good ideas. Anything coming from outside... means, we never opposed that. Rather we tried to assimilate that."

Hardly is the leitmotif of India's openness a new development. Historians and anthropologists have uncovered its deep roots in orientalist constructions of "India" (which were

also quite romanticized and gendered). Ronald Inden has argued that European colonial writers often presented India as a “feminized sponge, passive but with the power to dissolve those who enter it” (1990, xiii). Under the imperialist gaze, the colonizer emerged as characteristically male, whereas the colonized was invariably female or female-like (Ballhatchet 1980; Alloula 1987). Within the discourse of “colonial masculinity” (Sinha 1997; Srivastava 2015), non-European men were represented as incapable of self-government due to their so-called effeminacy.

India thus was seen as a receptive society, only capable of embracing foreign practices, rather than fighting them. Remarkably, in the beginning of the 20th century, the leaders of the Independence movement did not discard this notion of receptivity, but were able to find a new application for it, enabling a positive view of Indian history. Turning the idea on its head, they depicted the presence of diverse religious and cultural communities in India not as its weakness or permeability of its borders, but as something based on India’s openness, moral superiority, and tolerance. Diversity became India’s strength and a prerequisite for future nation. As Gandhi declared, “If the Hindus believe that India should be peopled only by Hindus, they are living in a dreamland. The Hindus, the Muslims, the Parsis and the Christians who have made India their home are fellow countrymen;” moreover, “it is not necessary for us to have as our goal the expulsion of the English. If the English become Indianized, we can accommodate them” (cited in Varshney 2014). But the narrative of diversity and accommodation was just one side of a coin. Diversity would be meaningless without unity.

Paradoxically, orientalist literature aided here too. Some orientalist authors presented “India” as a single entity, downplaying regional conflicts and differences. They assumed “the existence of a homogenous and uncontested moral terrain in India” (Raheja 1996, 497), as if all

Indians were governed by the same sets of values. According to Vanina (2001), colonial writers produced “the imperial approach to Indian past” which emphasized the periods of consolidations rather than the periods of disintegrations. Thus, “India” was constructed not as a land of autonomous and hostile polities, but as a *unity* with diverse parts. Unsurprisingly, these ways of imagining India also found place in writings and speeches of the ideologues of independent India, for whom, according to Varshney (2014), securing national security was one of three main objectives. The founding fathers of Indian nation used (and could not help but use) the idea of “unity in diversity” to cultivate a sense of belonging, shared history, and common goals. Jawaharlal Nehru’s meditations in *The Discovery of India* (1951) illustrates this well:

The diversity of India is tremendous; it is obvious; it lies on the surface and anybody can see it... It is fascinating to find how the Bengalis, the Marathas, the Gujaratis, the Tamils... have retained their peculiar characteristics for hundreds of years... and yet have been throughout these ages distinctively Indian, with the same national heritage and the same set of moral and mental qualities. Foreign influences poured in and often influenced that culture and were absorbed. Disruptive tendencies gave rise immediately to an attempt to find a synthesis. Some kind of a dream of unity has occupied the mind of India since the dawn of civilization. That unity was not conceived as something imposed from outside, a standardization of externals or even of beliefs. It was something deeper and, within its fold, the widest tolerance of belief and custom was practiced and every variety acknowledged and even encouraged (pp. 44–45).

From this perspective, one can easily see that the narratives of unity-in-diversity and openness to foreign cultures lay out a perfect framework for the institutionalization of medical plurality. In its design and everyday representation, AYUSH is a contemporary emblem of inclusive nationalism anchored in the doctrines of national integration, tolerance, and minority rights, where foreign and homegrown traditions coexist, maintaining their own peculiar characteristics, while being or becoming distinctively Indian. These ideas which have guided the legitimation of plural non-biomedical traditions throughout the 20th century are still ubiquitously present in contemporary discourses.

4.2.1 Plural Medicine, One Country: A Case of Tibbia College

In February 2015, I visited the Ayurveda and Unani Tibbia College in Delhi, supposedly the only institution in the country where both Unani and Ayurveda are taught “under the same roof.” My plan was to interview the head of the Unani department and then ask him to introduce me to other faculty members, but he immediately invited three Unani professors to participate in our conversation. Later, approximately 20 minutes into the interview, a professor of Ayurveda—Dr. Lina Arora—walked into the room and joined us. After discussing professors’ background and general situation of non-allopathic traditions in India, I inquired about the history and mission of the Tibbia college. Dr. Lina Arora from Ayurveda was first to respond. Below I cite her response almost in its entirety, as I find it extraordinarily telling and relevant:

It’s a unique institution... Because it’s a diversified country. So there are so many religions, so many castes, so many creeds, many things are there. But still our country is one. “Is one” that means unitedly we are Indians, okay? So the people who laid down the school, Mahatma Gandhi and Ajmal Khan... this was the place where the freedom fighters started their fight to get freed from Britishers’ rule. And they could know this thing very well that if we are not united, we cannot fight back. We can only fight back when we are united and we love each another and we interact each other... So it was a good thing to be here, as the representative of the two religions, that is Islam, or Muslim religion, and Hindu. So they said that these are the religions, and... under the same roof these are the two pathies which belong to India, which belong to Indian system of medicine... Basically, maybe it is from the two religions, maybe [*looking towards Unani faculty in the room*] their language is Urdu and Farsi and all. Our language is Hindi or Sanskrit and all. Only difference of language is there. The feel is the same, the purpose is the same. That’s why they modeled this institution as integrity and diversity of India.

This passage is remarkable, because it so substantially borrows from Nehruvian language and so vividly illustrates the perceived connections between religious, linguistic, and medical diversity of the country. Albeit epitomizing different religions and languages (Islam and Hinduism, Urdu and Hindi), both Unani and Ayurveda are said to “belong to India” and have “the same feel” and

“the same purpose.” Such portrayals of Ayurveda and Unani undoubtedly link back to the 20th century vision of Indian nation but were still resonant in 2015.

Certainly, not everybody concurs with the ascription of Unani to Islam and Ayurveda to Hinduism. Hardly had Dr. Arora described these systems as the “representatives of two religions,” as the head of the Unani department became visibly displeased. In fact, in the beginning of the interview, when a young Unani professor, Dr. Fatima Khan, was talking about the standing of Unani in contemporary India, I noticed that she was choosing her words very carefully, avoiding references to religion. She claimed that the distribution of Unani and Ayurveda simply varied geographically, from state to state:

We, India, you know... it's a country of diversities, and if you see Unani, it's only prevalent in Delhi; in Jammu and Kashmir it is prevalent, but when we go in Kerala, Ayurveda is more prevalent there. So, it is state-wise.

During my research, there were many situations when I witnessed vociferous rejections of a direct link between medical traditions and religions. Yet, I believe that it is precisely the zeal with which people refute the notions of “Hindu” Ayurveda and “Muslim” Unani that reveals how deeply they are rooted in popular discourse.

One might argue that Dr. Arora's understanding of medical plurality as contributive to national unity is somewhat specific to Tibbia College, because the very foundation of the college was part of a nationalist project.⁶⁷ However, I am convinced that the nexus of medical plurality,

⁶⁷ An institution which has become the Tibbia College was founded by Hakim Hafiz Abdul Majeed in 1882, but was developed and extended by Hakim Ajmal Khan (1863-1927), a renowned practitioner and advocate of Unani from an elite family of many generations of educated *hakims*. Ajmal Khan was also famous freedom fighter and an organizer of All India Vaid and Unani Tibb Conference. His motivation for the establishing this college was to bring Hindu and Muslim communities together. In 1921 the college was inaugurated by Mahatma Gandhi. Interestingly, Sivaramakrishnan writes that *hakims* like Hakim Ajmal Khan as well as *vaid* ideologues like Srinivasa Murti and Sankunni Varrier, have been presented as “cultural symbols for national regeneration” (Sivaramakrishnan 2006, 9). See also Barbara Metcalf (1985) and Claudia Liebeskind (2002) on Unani leaders and nationalism.

religious diversity and national integration is something that many medical practitioners across India would easily acknowledge.

4.2.2 Religion and nationalism

I have suggested that AYUSH systems are customarily viewed as representations of religious and ethnic communities (Muslim, Tamil, Tibetan). At the same time, I have stated that AYUSH is *not* a direct representation of the country's cultural diversity, but a symbolic manifestation of the unity-in-diversity paradigm and India's receptiveness to diverse cultures. In other words, although I agree with scholars who argue that religion and communal politics have played an important, perhaps, critical role in legitimation of Indian medical pluralism, I still insist that AYUSH in many ways corresponds to inclusive secular nationalism. Could these claims be reconciled?

In order to answer this question, we have to dovetail several facts. First, we need to bear in mind that AYUSH is a product of a long process, spanning seven decades of sovereign India and many years prior to Independence. Institutionalized medicinal pluralism has been influenced by different ideologies of nation and culture, as scrupulously demonstrated by Langford (2002), Berger (2013), Sivaramakrishnan (2006), Attewell (2007), Weiss (2008), and other scholars.

Second, we have to acknowledge the specifics of Indian secular nationalism. Unlike the western understanding of a secular state as the one distanced from religious affairs, in India the term "secularism" has come to be interpreted as the government's support for all religions. Moreover, inclusive secular nationalism was never free from communal politics. In the mid-1980s, due to the influence of Hindu nationalist leaders, secularism paradoxically began to be evoked in political demands for the state support of Hinduism, as the religion of population

majority. The government was accused of being “pseudo-secular,” because it maintained special provisions for Muslims (such as family law) and other minority groups. McKean (1996) describes the political dynamic typical of that period:

Hindu nationalists argued that the Indian state discriminates against the Hindu majority by pandering to non-Hindu groups. Presenting themselves as defenders of democracy, they maintained that the state’s discrimination against Hindus threatens democracy. They linked democracy with the stability of Indian society, a stability founded on the spirituality taught by Hindu sages. According to Hindu nationalists, because Hinduism emanates from spiritual values, *it is uniquely tolerant of other religions* and is the sole basis of an authentically Indian secularism. Following from these propositions regarding secularism, spirituality, and Hinduism, Hindu nationalists conclude that a Hindu state is necessarily the best guardian of an indigenous Indian secular democracy (pp. 5-6, emphasis added).

Clearly, what McKean depicts has more to do with Hindu nationalism than with Nehruvian inclusive nationalism, but I present it here in order to explain that the politics of unity-in-diversity, minority rights, and secular nation, within which AYUSH is positioned, cannot escape from the majoritarian predicament. The idea of India’s receptiveness to plurality is entangled with the assertion that Hinduism is “uniquely tolerant of other religions.” In other words, what this means is that Hindu society is claimed to be the matrix of India’s diversity. Therefore, it explains why the word *ayush*, derived from Sanskrit and associated with Hindu teachings on longevity, is unquestionably deployed as an acronym for medical plurality.

It must be noted that in my examination of the relations between plural medicine and nationalism, I do not regard the politics of inclusive nationalism as inherently better than the politics of Hindu nationalism. Any political ideology follows certain goals. Scholars of Indian political life have established that the slogans of unity-in-diversity and national integration were deployed to pursue various political agendas, such as justification of the accession of princely states, rationalization of military actions against separatists, and diversification of vote bank

(Bose and Jalal 2011). Although inclusive nationalism declares all citizens to be equally recognized and protected, some communities are inevitably more represented than others, just as some medical traditions receive more importance than others. When it comes to electoral politics, even the proponents of secular nationalism engage with communal sentiments to ensure political support. When I asked Dr. Swati Sharma, a former government officer and a current head of a large ayurvedic hospital in Delhi, about why the government was promoting multiple systems of medicine, she admitted that it had started during the struggle for independence as a political strategy to secure votes from different communities. In her view, by legitimizing Unani, the early political leaders wanted to attract votes from Muslim population, and the current government continues in that direction. Dr. Swati is confident that the government is not interested in actual advancement of the systems but simply wants to secure its vote bank; “the entire talk about AYUSH is just a talk which is unable to benefit the systems.”

Now it is easy to see that AYUSH corresponds to the ideology of inclusive nationalism in complex ways. It has a communal component, for some traditions like Ayurveda and Unani are directly entangled with communal politics and politicians’ desire to attract voters from different communities. At the same time, AYUSH is more than a direct representation of Indian religious and ethnic groups, because the inclusion of Naturopathy, Homeopathy, and Sowa-Rigpa has more to do with the declaration of India’s prowess at accommodating foreign practices. Thus, AYUSH is partially representative and partially metaphoric of India’s cultural diversity.

4.3 AYURVEDA, YOGA AND HINDU NATION

The Ministry of AYUSH pledges to promote all seven medical systems equally but the most financial, social, and ideological support goes to Ayurveda and Yoga. This discrepancy is embedded in antagonistic visions of Indian nation: while the legitimation of diverse medical traditions has been driven by the paradigms of inclusive nationalism and India's openness to cultural diversity, the promotion of Ayurveda and Yoga has been interlinked with Hindu nationalism and its doctrine *hindutva*. Although, as Alter (2005a) importantly argues, it would be a mistake to equate histories of modern Yoga and modern Hinduism, especially within the transnational context where Yoga is often constructed as a secular medical practice, numerous studies highlight that Hindu nationalist ideas critically shape the meanings of Yoga and Ayurveda (Alter 2005; Bala 2007; Berger 2013; Ernst 2002; Langford 2002; McKean 1996; Sivaramakrishnan 2006). Just as Sanskrit language, the epic poems Ramayana and Mahabharata, the worship of cows, or any purportedly Vedic custom, Yoga and Ayurveda have come to be regarded as the pillars of Hindu culture, understood as some sort of uniform culture which has persisted since the imaginary golden age.

In this sense, modern Ayurveda and Yoga are unable to escape "the postcolonial predicament" (Breckenridge and van der Veer 1993), and as Langford comments, a narrative of a "primordial Ayurveda reflecting the glory of ancient civilization" "dovetails in part with a British orientalist scholarship that valorized Aryan antiquity over medieval or contemporary India" (2002, 84). Similarly, Attewell ascertains that "the imagining of 'Indian' medicine resonates with the idea of India as an essentially Hindu domain and is bound with European

indological and orientalist traditions of scholarship which elevated the classical Hindu past over the contemporaneous world of Indian culture (2007, 16).⁶⁸

Hence, the equation of modern Ayurveda and Yoga with the ancient practices of Indian/Hindu civilization traces its roots to orientalist constructions of India. After Sir William Jones, many European scholars of Indian society tended to privilege textual tradition, rather than observing the existing practices as they were. The focus on texts was largely responsible for the production of an image of a highly advanced ancient civilization, which allegedly was ruined by the Muslim rule. Berger (2013) even argues that this image, of which Ayurveda was part, was used to justify colonial intervention:

For Orientalists, and later for the colonial state... Ayurveda represented an ancient Hindu medical tradition... that had sustained Hindus through centuries of Muslim rule. Ayurveda, therefore, was implicated in justification for colonial intervention, and also in the wider project of vilifying Islamic intellectual traditions in the early colonial period. Ayurveda's indigeneity was re-inscribed as being inherently textual, whereas Ayurvedic techniques were thought to have been corrupted by centuries of Islamic rule. [...] The lasting implications of this communalist reading had far-reaching consequences, as Ayurveda was employed to invoke the authentic Indian indigenous (p. 49).

Remarkably, later, in the late 19th–early 20th centuries, some ideologues of Indian nation began to employ the idea of the authentic Indian indigenous against both colonial and Mughal occupation, constructing Indian as Hindu. And gradually Yoga and Ayurveda too have become important tools in the hand of Hindu nationalists.

⁶⁸ In remarkably similar lines, Liebeskind (2002) argues that Unani practitioners too circulated the narrative of “decline,” insisting that the knowledge of Unani in the past was greater than it is today. According to Liebeskind, this ideology was inculcated into all practitioners of indigenous medicine by British orientalist.

4.3.1 Yesterday and today of Hindu nationalism

Hindu nationalism is an umbrella term for a variety of programs and philosophies dedicated to the rights and wellbeing of the Hindu majority. Although Hindu nationalism has long historical roots, its rise began in 1970s, along with the decline of Nehruvian ideology (McKean 1996, 29). Hindu nationalism has been most commonly associated with the activities of BJP, RSS, VHP, ABVP⁶⁹ and other organizations collectively known as Sangh Parivar (“Family of organizations”), whose members present themselves as protectors of Hindu spiritual and social values. Hindu nationalism has been enacted through manifold *modi operandi*, ranging from militant to moderate actions, such as defense of Hindu places and practices, occasionally accompanied by unlawful acts of communal violence, implementation of pro-Hindu laws, rewriting history books, or highly publicized belligerent speeches against non-Hindu minorities. However, the term “Hindu” should not be taken as referring to a follower of Hinduism. Different authors have given different interpretations of who counts and who does not count as Hindu.

During the early 1920s, a pro-independence activist V.D. Savarkar articulated a concept which later became the heart of Hindu nationalist thought. According to him, what united all Indians was not Hinduism but *hindutva* which literally meant “hinduness.” Savarkar wrote about an identity based on beliefs and lifestyle shared among the people born in the Indian subcontinent who, importantly, regarded this land as their holyland (*punyabhumi*). Thus, under this definition Sikhs, Jains, and Buddhists were regarded as Hindus, for India was a holy land for

⁶⁹ BJP (Bharatiya Janata Party)—a right-wing Hindu nationalist political party, currently in power; RSS (Rashtriya Swayamsewak Sangh)—National Volunteer Organization which promotes the vision of India as a Hindu nation; VHP (Vishwa Hindu Parishad)—World Hindu Council, affiliated with the RSS; its mission is oriented towards the preservation of Hindu traditions among Indian diaspora. ABVP (Akhil Bharatiya Vidyarthi Parishad)—All India Student Association, a youth branch of the RSS.

them too. In contrast, the holy land of Muslims, Christians, Parsis and other minorities was located elsewhere; therefore, Savarkar and his followers believed that “the inner conflict between these two commitments—to the fatherland that is India and the holy land that is not India—can only create divided loyalties” (Varnshey 2014, 36).

Hindutva has come to be regarded as a radical political philosophy which claims Hindu supremacy and views Indian nation as foundationally Hindu. After Savarkar, this doctrine was further developed and promulgated by the ideologues of RSS and VHP, who offered their own interpretations of Indian nation and Hindu identity.⁷⁰ In 1989, *hindutva* was embraced as the official ideology of BJP—a party which is currently in power. In May 2014, BJP won the general elections with unprecedented success, being able to secure 51.7% of the Lok Sabha seats (282 seats) on its own.⁷¹ That was a massive rise in BJP popularity from 116 seats in the previous election cycle in 2009.⁷² Notably, the BJP’s leader Narendra Modi did not rely on *hindutva* ideology during the election campaign, but the fact that he was an RSS member, gave him an additional political support.

Today, the *hindutva* doctrine continues to hold a considerable appeal, and is being enacted by certain state governments and volunteer organizations. For example, the state of Maharashtra has placed a ban on beef slaughter, and has even proposed to make the ban national, despite the fact that beef is culturally and economically significant for Muslim communities. Not

⁷⁰ *Hindutva* was also described as the foundation of Hindu “race” (of Indic people born on the Indian subcontinent), “a way of life” (common to followers of Hinduism, Sikhism, Jainism, Buddhism and other native traditions), and a “nationality” (in opposition to British nationality)

⁷¹ Typically, only a coalition of parties can overpass that level. While contesting the general elections 2014, BJP was part of the National Democratic Alliance (NDA), but in fact BJP could have won and formed the government even without the support of the coalition.

⁷² The dynamic of the public support for the BJP goes as following: in 1989 BJP increased the number of seats in the Lok Sabha from 2 to 88. In 1991, the number of seats went even higher to 120, in 1996 -161, and in 1998 to 178. It was a period of increasing Hindu nationalist declarations, but the victory of BJP was never as strong as in 2014—282 seats.

only is it used in consumption, but it also constitutes a major source of income for some occupational groups, such as cattle butchers, who are predominantly Muslims.

Other manifestations of *hindutva* include calls for Hindu women to give birth to four and more children to “keep up” with Muslim population and “protect Hindu religion,”⁷³ demands to remove the epithet “the Great” from the title of Akbar,⁷⁴ proposals to change the signage of the streets named after Muslim leaders to Hindu leaders, suggestions to declare the Hindu text *Bhagwad Gita* a “national scripture,” and so on and so forth. Thus, although since coming to power Modi has taken a course to ideological moderation, “refraining from any profoundly anti-Muslim statements” (Varshney 2014, 40), it is clear that India continues to be torn between the different views of who constitutes the nation. Indian Muslims continue to occupy a precarious position in terms of national belonging.

Radical proponents of Hindu nation view the followers of Islam either as outsiders, whose ancestors conquered the subcontinent, or as the descendants of Hindus who were converted to Islam. Depending on whether Hindu nationalists subscribe to the former or the latter point of view, they leave Muslims with two meager alternatives: if Muslims wish to continue practicing Islam, they must depart India and “go to Pakistan” (*Pakistan chale jao*), or in order to remain in India, they must convert to Hinduism, i.e. “return home” (*Ghar Wapsi*). Undoubtedly, these alternatives are just the extreme poles of hindutvic narratives in contemporary India, and in reality Indian Muslims are not forced to choose between Pakistan and Hinduism. Nevertheless, I will show that these narratives are so prominent that they even manifest in the domain of alternative medicine.

⁷³ This was a statement recently made by Sakshi Maharaj, a lawmaker from the ruling Hindu nationalist Bharatiya Janata Party.

⁷⁴ Akbar was a 16th century Mughal emperor whose rule is commonly considered a period of outstanding political, economic, and cultural advancement.

4.3.2 Singing songs of Pakistan

Recently, the slogan “Go to Pakistan” (*Pakistan jao* or *Pakistan chale jao*) has become a favored expression of the Sangh Parivar members towards those whose position violates the perceived Hindu values and deviates from *hindutva* principles. Probably coined in line with the English idiom “go to hell,” “Go to Pakistan” is a constant in the assortment of hate speech formulas. It has been ferociously used against Muslim opponents and so-called terrorists, but, notably, it was also applied against inter-religious couples, against those who dispute a ban on beef consumption, who raise concerns about religious intolerance in the country,⁷⁵ or practically against any decrifier of the current government.⁷⁶ Nevertheless, a reference to Pakistan is primarily directed at Indian Muslims. Varshney describes the perception of Muslims in the following way

[Muslims are] the primary object of Hindu-nationalist suspicion, partly because the Muslim population is so large, but also because a Muslim homeland, Pakistan, was created by the British when colonial rule ended in 1947. Many Muslim families are divided between India and Pakistan. [...] Thus, in the eyes of Hindu-nationalist ideologues if not all BJP leaders, Muslim loyalty to India is less than complete and inherently suspect (2014, 37).

This is what I describe as the precarity of national belonging. I argue that precarious nature of Muslims’ belonging to India is evident in discourses about Unani and other medical traditions. For example, below I show how the dictum “go to Pakistan” has been used against those who object the introduction of mandatory Yoga classes or who refuse to participate in official Yoga celebrations such as the International Yoga Day.

⁷⁵ See, for example, a recent case regarding a Bollywood filmmaker Amir Khan.

⁷⁶ Other examples include “Those who are dying without beef can go to Pakistan,” “If Muslims want any special treatment as Muslims, they should go to Pakistan,” “Those opposed to Narendra Modi should go to Pakistan;” “If the BJP loses in Bihar, crackers will burst in Pakistan;” “Say ‘Vande Mataram’ or go to Pakistan.”

While researching the Internet posts containing the “Go to Pakistan” expression, I have come across a joke which mocks different statements of the RSS leaders. The joke appears in a verse form and has several variations (some are in Devanagari, others in Roman script, some are more formal, others are simplified) but they invariably go along the following lines:

If you want to eat beef, go to Pakistan
If you don't want to do Yoga, go to Pakistan
If you don't want to do Sun Salutation, go to Pakistan
If you don't like Modi, go to Pakistan.⁷⁷

The joke ends with a witty question about the objectives of the current government: “Are these people ruling the country, or promoting Pakistan's tourism?”⁷⁸

It would be easy to dismiss such examples as a curious but irrelevant witticism of social media users, but anthropologists of humor maintain that jokes are apt reflections of social relations, existing frictions, and forms of power and authority (Krishnan 2016; Radcliffe-Brown 1940). A satirical connection between Yoga practice and anti-Muslim sentiments reveals that *hindutva* adepts have been successful in imbuing Yoga with political messages. Yoga and a sequence of postures called *surya namaskar* (sun salutation) have been turned into a litmus paper of national identity and loyalty to Hindu India, implying that those who do not accept Yoga as a true “Indian” tradition do not deserve to be called Indians. Needless to say, the use of this Yoga nationalism test is extremely unsettling for some Islamic leaders, who consider *surya namaskar* a form of Hindu worship⁷⁹ unacceptable for Muslims. Obviously, many people, especially young

⁷⁷ Beef khana ho to Pakistan jao, Yoga na karna ho to Pakistan jao, Surya Namaskar na karna ho to Pakistan jao, Modi na pasand ho to Pakistan jao

⁷⁸ *Yeh log desh chala rahe hai ya Pakistan tourism promote kar rahe hai?* A different version reads: “In Lok sabha election, did we choose parliamentarians or agents of Pakistan tour and travels agency?”

⁷⁹ In a study of praxis and semantics of *surya namaskar* in relation to nationalism and democracy, Alter (2000, 83–112) mentions that *surya namaskar* is structured on the principle of Vedic ritual, which is

Indians, with whom I have interacted, understand Yoga as fitness rather than a religious practice. Nevertheless, its Hindu communalist underpinnings are so unmistakable that Islamic and Christian organizations repeatedly protest against expansion of Yoga, especially when it comes to compulsory Yoga classes in schools⁸⁰ and mass Yoga festivals. The following situation illustrates this well.

The year of 2015 was particularly significant for nationalization of Yoga: on June 21, the government of India held the first annual celebration of the International Yoga Day. Narendra Modi personally proposed the introduction of Yoga Day during a speech at the United Nation General Assembly in December 2014. Although in a previous century there were efforts to present Yoga as a national symbol, it appears that the election of Narendra Modi has strengthened that tendency, as he is the first Prime Minister to admit being a strong believer and follower of Yoga and Ayurveda. While preparing for the celebrations of the Yoga Day, the Ministry of AYUSH announced a hope to establish two world records: the largest Yoga practice in terms of the sheer number of participants and the number of participating nationalities. In order to meet the requirements for the records, the government invested significant funds and efforts publicizing the event and recruiting participants.

Within the preparation turmoil, All India Muslim Personal Law Board and other Islamic organizations initiated a campaign to oppose participation of Muslims in Yoga Day. In turn, it led to a downpour of criticism from Yoga gurus and Hindu fundamentalist leaders. A sharp controversy was sparked by a statement of a VHP member:

possibly derived from ritualized prostrations performed in a pre-Vedic solar cult. Thus it is easy to see how the sun salutation routine can be objected by non-Hindu participants.

⁸⁰ Such measures have been taken in some states, such as Maharashtra but then it was abandoned after protests.

Those who do not believe in Indian tradition, Indian culture, Indian science and devotion to Indian country, those who do not believe in Yoga, those who eat Indian food but sing Pakistan's song—should leave for Pakistan.⁸¹

In similar lines, a BJP parliamentarian radically claimed that those who oppose Yoga and *surya namaskar* should either leave India or “drown themselves in the ocean” (Hindustan Times 2015). These cases demonstrate that Yoga have been used to segregate Indian population in rather radical ways. What I try to point out is not a simple differentiation of the first-class citizens (Hindus) from the second-class citizens (non-Hindus or “bad” Hindus), but a narrative within which people who oppose Yoga are regarded as non-citizens, as traitors of India who are “singing songs of Pakistan.” From this perspective, the politics of Yoga and Ayurveda taps into the Hindu nationalist understanding of India in which Muslims and other minorities are seen as strangers. This brings me to the second alternative I have outlined above: Hindu fundamentalists insist that if Muslims do not want to be accused of allegiance to Pakistan and want to remain in India, they must acknowledge their Hindu heritage and “re-convert” to Hinduism. This approach has come to be known as the *Ghar Wapsi* (homecoming) movement.

4.3.3 Ghar Wapsi: Homecoming

Jaffrelot highlights that in Savarkar's writings, *hindutva* was conceived as an ethnic community characterized by shared territory, race, and culture, “stemmed from the mythical reconstruction of the Vedic Golden Age” (2009, 27). However, the idea of the Golden Age was not Savarkar's innovation, but dated back to the 19th century proto-nationalist theories of the founders of the

⁸¹ Jisko Bharatya parampara me, Bharatya sanskriti me, Bharatya shastro me aur Hindustan ki desh bhakti me vishvas nahin hain, yog me vishvas nahin hai, jo Hindustan ka khate hain aur geet Pakistan ka gate hain, unhe Pakistan chala jana chahiye. <https://www.youtube.com/watch?v=rSTzgwDgPtM>, accessed June 21, 2016.

organization Arya Samaj (Jaffrelot, 2009, 76). Despite the fact that the notion of a glorious Vedic past was implicated in orientalist and Brahmanic understandings of history, for Hindu nationalists it was a powerful rhetorical tool, as it allowed portraying the years of Mughal rule and British colonization as the periods of corruption of a great Indian culture. The metaphor of the Golden Age was used to draw attention to the violence against Hindus conducted by Christian missionaries and Muslim leaders in the form of conversion. Consequently, ideologues of *hindutva* argued that for making Indian nation strong and united, all non-Hindus should “return home,” to their Hindu legacy.

The *Ghar Wapsi* movement gained its momentum in the 21st century when throughout the country various groups within the Sangh Parivar began to organize re-conversion campaigns. The main target of the *Ghar Wapsi* activists have been poor and disempowered communities of the schedule castes and schedule tribes, many of whom had converted to Islam, Christianity or Buddhism in order to break from the inequalities of caste system, but also due to the promises of financial and material aid. Therefore, it is not surprising that the VHP and RSS leaders have resorted to similar means during the re-conversion campaigns. Sometimes, they have also deployed the strategies of deceit. For example, in 2014 the activists of the Dharm Jagaran Samiti (Religious Awakening Committee, a branch of the RSS) arrived in a Muslim slum in Agra, where they promised the residents to help with housing and food provision, if they agreed to attend a Hindu ceremony. Some 200 people participated at the event, in the end of which they were told that they had now become Hindus. Such campaigns have been occasionally condemned by the government officials and have received immense reproach from the critics of Hindu nationalism who described *Ghar Wapsi* operations as forceful “saffronization” of India.

What I will argue (and what, to my knowledge, has not yet been suggested in the literature) is that the reasoning of the *Ghar Wapsi* movement—as well as the *hindutva* doctrine in general—percolates into the realm of non-biomedical systems. In order to unravel this argument, it is important to recognize that the word *ghar* (“home”) in *Ghar Wapsi* refers not to a geographical location,⁸² but a historical period, some kind of *Ramrajiya* (Rama’s kingdom) which existed in the imagined Golden Vedic Age. Media reports and popular discourses about Yoga and Ayurveda, including speeches of Ramdev, are abundant with references to the glorious past of Indian civilization, when everybody enjoyed health (*arogta*) and long life (*ayush*). As the logic goes, after the arrival of Mughals and Europeans, the knowledge of Ayurveda faded without the state support, and as a result, Indian people became weak. Therefore, it is claimed that in order to restore the strength of Indian society, people must “return” to their cultural roots and revive ancient medical knowledge—just as the *Ghar Wapsi* theoreticians demand all Indian citizens return to their true Hindu identity.

As I see it, the proclamation that all Indians are originally Hindus runs parallel to the declarations that all medical traditions originate from Ayurveda. Many ayurvedic practitioners and government officials I have interviewed stated that Ayurveda is the world’s oldest medical system⁸³ and the origin source of Unani, Siddha, and Sowa-Rigpa. Although Unani is known to be developed in ancient Greece, some people claim that Galen was influenced by ayurvedic texts, brought to Greece from India. For example, when I asked an official at the Delhi

⁸² At the same time, here the notion of *ghar* (home) seems to be congruent with *swadesh* (one’s own land, motherland).

⁸³ Dominic Wujastyk argues that such claims are definitely exaggerated: “The earliest surviving texts date from the first centuries of the Christian era.” Therefore, the “extravagant claims that Ayurveda dates from thousands of years BC can be firmly discounted. Such claims are frequent, and arise from nationalism, religious fundamentalism, a partisan attachment to romantic ideas of India’s spiritual heritage, and other such causes” (1995, 21).

Directorate of Indian Systems of Medicine and Homeopathy whether Ayurveda and Unani were different or similar, he indicated that Unani “was basically Ayurveda which... went to Unan, got translated into Persian and came again to India.” Although it is true that there are references to Ayurveda in medical writings of Arabic and Persian authors who influenced the development of Unani medicine (Attewell 2007, 13), a claim that Unani is “basically Ayurveda” defies the historical complexity and trans-regional mutual influences of medical knowledge.

There are many similar examples which undermine authenticity and significance of Unani or other medical traditions, and reinforce the status of Ayurveda as the oldest and most developed non-biomedical tradition. As I will show below, some practitioners of Ayurveda go even further by suggesting that all medical schools (even Western biomedicine) are derived from ancient ayurvedic knowledge—a statement which I consider to be one of many manifestations of ayurvedic exceptionalism or ayurvedism which occurs through the processes of ayurvedicalization.

4.4 AYURVEDICALIZATION AND THE CULTURAL HEGEMONY OF AYURVEDA

In recent decades, scholars have worked to show that history and current standing of Ayurveda is many ways interlinked with Hindu nationalist projects⁸⁴ (Berger 2013; Langford 2002; Sivaramakrishnan 2006; Bala 2007). In her recent work, Rachel Berger argues that a study of Ayurveda should be situated within the context of communal antagonism, since local

⁸⁴ Sikhs and Jains are functionally encompassed by these projects.

governments continue to “keep Ayurveda Hindu and to maintain the Hindu traditional” (2013, 19). She comments that Ayurveda “remains firmly within the realm of the Hindu, the caste and the classed.” Although I would not put it in those words, because both ayurvedic profession and clientele traverse caste, class and religion boundaries, I agree that Ayurveda is “culturally mainstream (despite the alleged rarity of practice) and easily emblematic of the glory days of Hindu civilization” (Berger 2013, 19). Jean Langford, too, has shown that historiographies of Ayurveda are charged with Hindu nationalist/communalist agendas. Many ayurvedic specialists and revivalists insist that Ayurveda was once “a perfect science” with detailed knowledge of surgery, physiology, and even microorganisms, but it went into decline during the Mughal era.⁸⁵ Langford believes that such historical interpretations “make Ayurveda available to Hindu fundamentalist imagery of Ram Raja [sic], a Hindu golden age... and enforce the Hinduness of Ayurveda” (2002, 94). This supports my argument about a parallel between constructed chronicles of Ayurveda and the *Ghar Wapsi* movement, as both evoke legendary pre-Muslim period of Rama’s rule to which Hindu nationalists urge to return.

Many of Berger’s and Langford’s observations echo my own reflections, and can be applied to both Ayurveda and Yoga. In Modi’s India, Ayurveda and Yoga continue to be featured in the rhetoric of national belonging and exclusion. Nevertheless, I maintain that the position of Ayurveda is different from that of Yoga,⁸⁶ because the former has an attractive lucrative potential in the global pharmaceutical market, which makes the government more

⁸⁵ Remarkably, the same “ideology of decline” was common among Unani *hakeems* of the 1900-1950 when they had to defend Unani from accusations made by the proponents of biomedicine. Hakeems insisted that “once Unani medicine had been great but had come to stagnate and needed to be revived to regain its former high” (Liebeskind 2002: 70).

⁸⁶ In fact, there are different views on the relation between Yoga and Ayurveda. For instance, some of my interviewees think that Yoga and Ayurveda are closely related, but others think that these are two different traditions.

enthusiastically invest in its development. According to Islam, “one of the foremost indicators of the rise in demand for ayurvedic products is the huge sales volume recorded by different companies.” Based on her study in Calcutta, she argues that “The number of patients attending ayurvedic health clinics has also risen significantly” (2010, 786).

We must also be mindful of the fact that Ayurveda has to coexist and indirectly compete with other legitimized cognate traditions such as Unani and Siddha. Their philosophies, methodologies, and *materia medica* are closely interrelated, which necessitates some forms of demarcation. I postulate that there are several narratives that set Ayurveda apart from other therapeutic traditions. Since in North India, it is Unani against which Ayurveda has been specially positioned, below I discuss how those narratives elevate the status of Ayurveda while confining the place of Unani. I show that those narratives contribute to ayurvedic hegemony by intimating the following messages: Ayurveda is ubiquitous, because herbal remedies used in every Indian household are ayurvedic; Ayurveda is the oldest medicine in the world; and despite Ayurveda is the most truly Indian medicine, it is universally applicable.

Many doctors, officials, gurus and other public supporters of Ayurveda have repeatedly used the label of Ayurveda with regard to so-called kitchen remedies. During mass Yoga camps and press conferences, Ramdev frequently comment that Ayurveda is nothing but the use of *amla* (Indian gooseberry), *methi* (fenugreek), and *haldi* (turmeric), i.e. something that every Indian is familiar with in the form of home treatment (*gharelu ilaj*). Ramdev and his allies claim that Ayurveda has always been part of Indian people’s life, even if they did not call it Ayurveda. In other words, Ayurveda is said to be a lifestyle. A government doctor once told me that it was the main difference between Ayurveda and Unani:

That’s a lifestyle. People have been following it, and using it in home. You see, in India they’ve been using turmeric in their food, and it is Ayurveda. If you get a

burn, you just sprinkle turmeric on your burn, it will get healed. That is Ayurveda, that is your lifestyle, na. You've been doing it daily. [But] in Unani you have to adapt.

Modern Ayurveda has acquired totalizing forms in a sense that instead of patrolling the boundaries between professional practice and grandma's remedies, many Ayurveda supporters collapse those differences. In such a way, Ayurveda is said to be ubiquitous and firmly anchored in Indian society. Indians just need to open their eyes and acknowledge the presence of Ayurveda in their lives. This idea is somewhat different but closely entangled with the discourses of "cultural remembering" documented by Manasi Tirodkar (2008): many Ayurvedic practitioners and their patients share a view that the knowledge of and believe in Ayurveda was "lost" due to colonization and globalization of Indian culture, so they must "go back" to their culture and "remember" their traditions. Tirodkar observed that one strategy of "cultural remembrance" used by doctors was reminding that Ayurvedic principles and medicinal properties are linked to home cooking and grandma's remedies (2008, 239). Understanding that something was "heating" or "cooling" was part of the patients' preexisting cultural framework, within which Ayurveda made perfect sense. Tirodkar goes on to say that that patients do not view home remedies as distinctly medical or related to Ayurveda (2008, 240). In similar ways, one *panchakarma* doctor I interviewed noted: "If a doctor prescribes it, then it is Ayurveda; if it is only completely home treatment, then it is not Ayurveda" (*Agar daktar preskraib karte hain, to yeh ayurved hai, agar sirf puri tareeke se gharelu ilaj, Ayurved nahin*).



Figure 5. An Ayurveda boutique in Delhi
Photo by the author

Nazrul Islam (2010) identified two major categories of ayurvedic products: beauty and medicines. In 2016, we can surely add other categories that have become critically important: “ayurvedic” foods (noodles, biscuits, ketchup), household supplies, and other ayurvedic products. Notably, there is no “luxurious Unani.”⁸⁷

Moreover, not only are select kitchen herbs characterized as ayurvedic, but even Indian cuisine and use of spices are said to be based on ayurvedic principals. Ayurvedic cooking classes in Rishikesh and innumerable ayurvedic cookbooks for western and local publics demonstrate this phenomenon well. Islam (2010) also remarks that everything herbal has come to be equated with Ayurveda. She sees the roots of this phenomenon in economic factors:

⁸⁷ I have found only one company (in Spain) which popularizes the name Unani, but even this company simply mentions that “The name of our brand, UNANI, comes from the therapeutic methods of antique mediterranean culture” <http://www.Unani.es/company>, accessed March 22, 2017.

There is steady growth of local and international market for herbal-based drugs, health supplements and beauty products. As a result of this demand, Ayurveda has been propagated as a natural healing system, and ayurvedic medicine/health products are featured as natural remedies, which equates ‘herbal’ with Ayurveda, and people often misunderstand herbal products as ayurvedic products (Islam 2010, 777).

Although I support Islam’s observation that economy plays an important role, I still insist on a great contribution of Indian gurus and ideological supporters of Ayurveda in making it an umbrella for all herbal remedies. Furthermore, Ayurveda has become a catchword for all sorts of beauty products and cosmetic procedures. Already in 1989, van der Geest and White observed that one of the “charms” of medicines is that their packaging and form can forge metonymic relationship with diverse cultural contexts, for example, combining the appeal of western technology and traditional wisdom. Although this remark is applicable to Unani, Sowa-Rigpa, and other medical traditions, it is certain that in India, Ayurveda has been most successful in straddling the modern and the traditional.

The second narrative which contributes to the ideology of Ayurvedic exceptionalism and illustrates the process of ayurvedicalization is a narrative which proclaims that all medical traditions are originated from Ayurveda. What this implies is that not only do home remedies fall under the rubric of Ayurveda but so do the canonized traditions of Unani, Siddha, and Sowa-Rigpa. Remarkably, within this logic, even Homeopathy and biomedicine are considered mere derivations of Ayurveda. For example, when I doubted that Homeopathy had come from Ayurveda, a practitioner at the government dispensary rationalized: “Of course. Ayurveda is the oldest system of medicine in the world, so it is the base for all *pathies*” (see similar findings in Tirodkar 2008, 234–225). Interestingly, when I asked the same doctor whether she had heard of the term *swadeshi chikitsa*, she said it meant home remedies. Then I inquired if Homeopathy

would count as *swadeshi*, she said that since Homeopathy made use of herbs grown in India and since it came from Ayurveda, then it would also be *swadeshi*.

The third narrative constructs Ayurveda as the *prima facie* “Indian” indigenous medicine, which despite (or due to) its Vedic heritage is not “cultural,” but rather national and universal. This is particularly noticeable in the case of Modi’s protégé Baba Ramdev, who advocates for the endorsement of Ayurveda as Indian “national” medicine, while conveniently excluding other AYUSH systems. In contrast to Unani which is routinely limited to Muslim communities, Ayurveda is said to be appropriate to everyone irrespective of ethnicity, race, nationality, or culture. As a result, the prevalence of ayurvedic practice in social life and physical space of India is taken for granted. Unlike other AYUSH modalities, Ayurveda is the most visibly present on the streets of major cities. My observations confirmed other scholarly accounts that highlight that “massive growth of advertisements” for ayurvedic health, beauty and other consumer products that appear on highway billboards, in city centers, shops, salons, on TV and the Internet (Islam 2010, 788; Bode 2008). When I asked a female ayurvedic doctor about Unani, she replied: “I don’t know so much about Unani. It’s a Muslim people thing... People are less aware of Unani. Ayurveda is on the television, Internet and everywhere.” It is therefore not surprising that by using the term *ayush*, many people mean Ayurveda, and that the Ministry of AYUSH is understood as a ministry for Ayurveda. Thus, Ayurveda is qualitatively different from other therapeutic traditions because it is not inhibited by the fetters of culture, but rather projected as national and indeed universal medicine. Therefore, the government of India puts much effort in promotion Ayurveda globally. Conversely, when I asked practitioners and officials whether Unani was also promoted outside India, they remarked that Unani promotion was carried out in Muslim countries, such as Iran and Malaysia.

The final point is critically important. Although I agree with historians and anthropologists of Indian medicine that Ayurvedic exceptionalism is embedded in Hindu nationalist projects, I argue that Ayurveda needs to be understood beyond *hindutva*. As such, global market and neoliberal economy are significantly responsible for Ayurveda's growth. It is one thing to say that Ayurveda is a surviving tradition that represents Golden Age of Hindu civilization, or that Ayurveda is a truly Indian indigenous tradition which should be made national, and it is a different thing altogether to assert that Ayurveda is neither Hindu, nor just for Indians but an ultimate cure for the entire world. In contrast to Ayurveda, Unani does not have a privilege to escape the chains of culture. Therefore, the stories of "Muslim" Unani doctors are crucial for understanding the position of Indian Muslims.

4.5 UNANI, ISLAM AND PRECARIOUS NATIONAL BELONGING

On the preceding pages I have examined a tension between extreme views on the Indian nation as a homeland of Hindus or a country founded on the principles of unity in diversity and receptivity to foreign traditions. I have shown how those nationalist ideologies correspond to a tension between the dominance of Yoga and Ayurveda and purportedly equal support for all AYUSH systems. Additionally, I have specifically looked at the position of Ayurveda, since Ayurveda overshadows other non-biomedical traditions in terms of market share and cultural hegemony, being equated with *ayush* and proclaimed "national" medicine. Now it is the time to address discourses surrounding Unani medicine as well as experiences and views of Unani practitioners. I propose to revisit Ghalib ji's story, which I narrated in the beginning of this

chapter, looking for the factors that will shed light onto his feeling of exclusion and examining whether it is shared by other Unani doctors.

Habib and Dhruv (2005, 76) remark that during the medieval and early modern periods there was no, or very little, tension between Ayurveda and Unani. But all researchers agree that in the 20th century, the pro-independence movement and political anxiety between Hindu and Muslim communities resulted in contraposition of Ayurveda and Unani (Attewell 2007; Berger 2013; Sivaramakrishnan 2006; Chakrabarti 2013, 188; Langford 2002). For example, Sivaramakrishnan (2006) argues that debates within and around the All India Vedic and Unani Tibbi Conference reflect the ways in which Ayurveda and Unani were pitched against each other in the 1920–1930s, despite the fact that they had a common struggle for the government recognition to contest accusations in quackery.

Unfortunately, most notable scholarly works on Unani have been concerned with its history only through the mid–20th century: Attewell (2007) writes about the late colonial era, Alavi (2008) scrutinizes the period of the 1600–1900s, Liebeskind (2002) focuses on the 1900–1950s. Few studies have examined the post-independence development of Unani and its current standing in comparison to Ayurveda. Those who have done so, either traced institutionalization of Unani as part of “Indian systems of medicine” (Wujastyk 2008), or looked at their marketization (Bode 2008; Islam 2010). Therefore, there is a strong need of studies that can disentangle Unani from Ayurveda and AYUSH systems, and can demonstrate whether in the 21st century, the position of Unani is statistically and qualitatively improving or declining.

My field observations and interviews suggest invisibility and gradual marginalization of Unani, especially in comparison to Ayurveda. This imbalance manifests in every sphere: infrastructure and facilities, education, job opportunities, budget allocations, promotion

campaigns, media representations, official discourses, and social acceptance. However, not everybody observes these disparities. Many non-Unani doctors are typically unaware of the problems that Unani is facing, but most surprisingly, even some Unani practitioners categorically dismiss any suggestion of an unequal treatment.

During my visits to the Tibbia College in Delhi, I spoke in length to two Unani and one ayurvedic practitioners, and immediately observed how Unani and Ayurveda faculty diverged in their understandings of the current situation with AYUSH. Professors of Ayurveda told me that everything functioned on an equal basis: both Unani and Ayurveda departments have equal number of allocation of students, salaries of the staff were equal, and research in both medicine were carried out regularly. In contrast, Unani professors, especially Dr. Fatima Khan who also works as a medical officer at the Delhi government, expressed concerns about marginalization of Unani, lack of financial and informational support. When I asked whether she had noticed any increase in the government support of Unani medicine after the establishment of the Ministry of AYUSH, she explained:

It is improving but not at that pace like in the other systems... We are in a hope that much more will be done in our field, but if you see in India, government is more in favor of ayurved. Homeopathy is the second I think, third number we have Unani, then Siddha and all... Our input is same: 40-40 students. But in every ayurvedic college we have PGs [post-graduates], so they have more opportunities to do PG [than Unani students have]. Then in terms of jobs: if we have 20 posts for Ayurveda, then we have only two posts for Unani. We have less opportunities.

Then we spoke about this discrepancy in the number of available postgraduate positions and jobs, and Dr. Khan commented that it was a result of invisibility of Unani, in comparison to Ayurveda that had substantial presence on billboards, TV commercials, and newspaper advertisements for ayurvedic treatment, and had public figures who popularized it:

They have so many role models and people to propagate their system. We don't have, and then proportionately very less amount of people use Unani. And if we

see the data, we have... thousands of Ayurveda hospitals, [but] just in hundreds we have Unani hospitals... Likewise, the outgoing people we have 30,000 Ayurveda practitioners come in the field every year, and in comparison to that we have very few Unani. So we have to struggle and we have a long way to go, but the practical problem is we need to propagate, we need to educate people, we need to make it more acceptable. It's even 50% of India does not know about Unani, so how can we expect *ki* it will go. So lack of dissemination of information, education... We need a platform where Unani can be projected and it can be known to the world.

In other words, Dr. Fatima Khan reveals a long chain of problems rooted in the lack of the government support for Unani: there is no promotion, no social awareness of Unani, no demand for it, no clinics, no jobs for Unani graduates, low enrollment in Unani colleges, and gradual disappearance. Being an optimistic person, she believes that the situation can improve, and that the government has a means of strengthening the state of Unani. She told me that she had seen posters⁸⁸ promoting Unani medicine which meant that the government was at least taking some measures. On the other hand, Dr. Khan admits that the status of Unani has significantly diminished since the time she entered the college:

When I was admitted in 1997, in that time in our Kashmir we had a boom of jobs for Unani. So my father preferred, he said, it's better for you, because you will not have night shifts and all, it's really easy and you will get a job. But now the scenario has changed, people don't have jobs, and this is the reason why students, young generation is not diverted to this pathy, even if they know it has potential and all. So at that time it had a good scope, but day by day the opportunities are decreasing... We are not sure what our generations will do. Either government needs to work for faculty and institutions, or we need to create job opportunities for them. Otherwise, we are losing this golden system of medicine, to be very true.

What is interesting is that Dr. Khan mentions Kashmir—a place where she was born and where her father saw many opportunities for a Unani graduate. During my conversations with doctors

⁸⁸ When I was in Delhi, I observed and took photos of those posters and billboards implemented by the Ministry of AYUSH. Each poster is dedicated to one medical system and bears a short phrase, such as “For healthy living adopt Ayurveda,” “Treat psoriasis with traditional Siddha medicine,” or “Prakritik chikitsa apnayan, swasthya jeevan payen.” They are well-lit, large (from about 10 by 5 feet to 20 by 8 feet), and typically displayed in the metro transit areas and on the streets near bus and metro stations.

and researchers in India, I was often told that in localities with a larger Muslim population, such as Kashmir, I would find more Unani *hakims* than ayurvedic doctors. However, in June 2015 when I briefly visited Srinagar, Kashmir, I observed that Ayurveda was very common. I spoke to Muslim shopkeepers, rickshaw drivers, and the owners of *shikara* (wooden boats), all of whom suggested that local people mostly depended on English medicine, but in rare occasions visited ayurvedic hospitals, but not Unani. That was contrary to my expectations. Certainly, my anecdotal encounters in Srinagar are not representative of an overall situation in the state and require a separate study of AYUSH in Kashmir, but what I argue is that suggestions that in Muslim dominated regions Unani is more prevalent than Ayurveda might be similarly anecdotal.

Asymmetries between Ayurveda and Unani are visible in the differences in admission requirements. For example, in Tibbia College an admission minimum for the BAMS degree is 80–85% (depending on a year), whereas a minimum for the BUMS degree is just about 60%. The lower acceptance score has been implemented in order to attract more applicants to the shrinking Unani program; but it implies that the Unani faculty have to compromise on the quality of prospective students and it gives an impression that Unani is less prestigious than Ayurveda. Notably, since Ayurveda is seen as a field with more employment opportunities, more and more Muslims enter Ayurveda courses. In contrast, just a few applicants with Hindu background choose Unani. On the one hand, this has to do with the lack of available jobs, as I have already mentioned; on the other hand, there seem to be serious language constraints.

Students of the BAMS program are required to read medical texts in Hindi and Sanskrit, whereas the BUMS students are expected to navigate medical literature in Urdu (and ideally Persian and Arabic). While Sanskrit and Hindi are commonly taught in schools, the knowledge

of written Urdu is rare in contemporary India, even among Muslims.⁸⁹ Some institutions like Jamia Hamdard try to break the language constraints, by offering some of the Unani courses in English (hoping to completely transition to the English-medium BUMS program), but due to the paucity of English translations of Unani texts, the knowledge of Urdu remains a pre-requisite for Unani degree programs. Undoubtedly, this excises many potential applicants, translating into the decline of the interest in Unani.

Scholars have done a considerable work to challenge the established language associations between Urdu and Unani, and between Sanskrit/Hindi and Ayurveda, just as they have challenged the associations between language and religion. Anyone familiar with Indian demography is cognizant of the fact that, depending on a region, the first language of a Hindu can be Hindi, Tamil, Bengali, Marathi or Assamese, while the first language of a Muslim can be Urdu, Hindi, Gujarati, Bengali, or Malayalam (Varshney 2014). Similarly, there have been significant regional variations in languages used in medical writings. For example, in Delhi, educated *vaidyas* and Hindu intellectuals used to write in Urdu. In the princely state of Hyderabad, many treatises and commentaries on Ayurveda were also written in Urdu, and conversely, despite the fact that the primary Unani texts were composed in Arabic, Persian and Urdu, Unani medical discourse were also mediated by other languages of the subcontinent (Attewell 2007, 20). Thus, it would be a mistake to assume a connection between medical tradition and language. Sivaramakrishnan's study of indigenous medicine in Punjab also provides an illuminating example of the role of Punjabi and Punjab's indigenous doctors in challenging the Hindi/Ayurveda and Urdu/Unani divide:

⁸⁹ On a side note, I also noticed that the website of Central Council for Research in Unani can be viewed in two languages/scripts: in English (roman) and Hindi (*devanagari*) but not in Urdu.

Since the composition of indigenous medical practice in Punjab did not present the easy binary oppositions of Ayurved/Hindu and Yunani/Muslim found possible in other parts of the country, the projection of Ayurvedic learning as a Hindu science and the representation of its Muslim other by Punjab's Hindu vaid publicists were therefore not always convincing (Sivaramakrishnan 2006, 11)

Nevertheless, the tendency to equate medical knowledge traditions with certain languages and religious communities has been quite tenacious. It permeates all sorts of discourses, ranging from government accounts, doctors' opinions, and medical reports. It even "finds itself unproblematically replicated in most academic writings on medicine in India today," obscuring "the contingent and fluctuating relationships over time between tibb and the varied religious, ethical and political streams of Indo-Islamic culture" (Attewell 2007, 11). During my interviews, too, I was often confronted with straightforward equations of Unani with Islam. In the words of one government officer, "Ayurveda has originated in India and it has got more followers as well. Unani has got its followers, but in some pockets... some place like... maybe Muslims prefer Unani system more. The acceptance is not much among the other sections of society." Such statements should not be taken matter-of-factly, because they become dangerous when used as referents of indigeneity and nationalist ideology. Just as Islam is portrayed as a foreign religion and foreign power which brought an end to a glorious Vedic past, "Islamic" Unani becomes implicated in the decline of ayurvedic knowledge.⁹⁰ Attewell (2007, 14) elaborates:

The histories of tibb and Islam have also been conflated in another brand of an Orientalist civilizational decline paradigm developed in India. The apparent connections between Islam, Islamic rule and tibb as a learned man's discipline, have in some neo-orientalist and/or Hindu nationalist readings of the past been accorded the responsibility for the so-called demise of Ayurveda during Muslim rule.

⁹⁰ However, there is historical evidence to support that Ayurvedic practitioners were supported and patronized by the Mughal rules (Attewell 2007, 15).

My interviews and observations illuminate that Unani doctors are very sensitive to such fundamentalist interpretations of Indian medical history and feel ambivalent towards people who explicitly pursue Hindu nationalist agendas. Some practitioners like Ghalib ji blame the governments, whereas other doctors like Dr. Fatima Khan assume that the government is supportive, but the Indian population is not. In either case, they are aware of disparities within non-allopathic systems and fear further marginalization of Unani.

4.6 ALTERNATIVE STORIES

What Ghalib ji thinks about privilege of Ayurveda and marginalization of Unani is not shared by all Unani specialists. I have noticed that some senior Unani doctors and professors, who hold prestigious, well-paid positions in large hospitals and universities, insist that the government equally supports all systems of alternative medicine. Below I describe a conversation with Dr. Ali Rafis, a Unani professor at Jamia Hamdard (a renowned medical university), and show how his views differ from the views of Dr. Ghalibji and Dr. Fatima Khan. By doing so, I hope to highlight how social class and power (or its absence) shape practitioners' understanding of their profession.

Dr. Ali Rafis is a professor of Unani medicine and the head of the Department of Internal Medicine, but he also holds an important administrative position at the university and serves as a consultant physician at a nearby hospital. Dr. Rafis wears Western-cut suits and speaks excellent English. During the interview, he was carefully crafting sentences and articulating every word, as if addressing a broad audience. (Later I learned that he had given many interviews and talks on India's major television channels such as NDTV and Zee-TV). Dr. Ali Rafis believes that since

the time he started his career, the public perception of Unani and other non-allopathic systems have significantly improved. He attributes this change to the government's support of traditional medicine, overall technological and economic development of the country, and the arrival of more qualified Unani practitioners who offer better services:

The perception toward the system is changed. Input of people. For example, earlier... people who used to manage to come to this particular system [Unani]... were not very bright... not very competent... and the product accordingly was not that bright. The country was not that developed. It got developed much better in last two decades, in social and economic terms, and even in terms of information technology. People are more aware. Because of awareness, they have come to know about allopathy, the adverse effects of it, so gradually their understanding has also changed: what is good for them and what is bad for them, what are their options... And once elite class, people who have wisdom, people who understand, who can choose, realized the potentials of the systems... gradually the impression changed... Accordingly, government also came in support... The government also started pouring a lot of funds into this.

Dr. Rafis' assessments are strongly informed by the discourses of "development" and "modernization." Instead of looking at the signs of decline, he views the changes in Unani's status and practice within broader socio-economic and technological development of the country. Therefore, he places responsibility for a previously low social status of Unani medicine on the shoulders of individual practitioners, who "were not very bright." In the following passage, Dr. Rafis explains that early Unani doctors did not follow scientific parameters, and consequently did not command social respect. But those specialists who had embraced modern methods and improved their qualification have been able to gain social recognition and capital:

You know, you get the attention of the society at the level you desire or deserve. The desire is basically to go with the deserving, and it depends on the individual... There was a problem that many of us, as traditional people, were not well versed with the research... methods. So government of India, understanding this, joined hands with the CSIR, they joined hands with ICMR, the main research bodies of the country... The Council for Scientific Industrial Research, this CSIR body, they joined hands with Unani and Ayurveda. ICMR started giving the guidelines for doing the clinical trials and research. And with that, traditional knowledge, basically subjected to those scientific parameters, with the funding

and patronization of government, is grooming, gradually getting groomed and getting nurtured... You can see many people [of Unani] who are doing much better in social circles. They command equal respect from their counterparts of systems of medicine. This depends on individuals.

When I ask whether the government makes sufficient efforts to promote Unani, Dr. Rafis again highlights that it is mainly the practitioners and ordinary people who should be the catalyzers in the growth of Unani. Certainly, much more could be done with regard to publicizing Unani, but that should be people's initiative:

It [the promotion of Unani] should be down up, from the ground, and this responsibility goes to people, who are stakeholders of the systems. You cannot only blame the government. You need masses to be active who are in the first place the first beneficiary. Let me use my platform for promotion and propagation of the systems.

The above passage is remarkable, because it demonstrates that Dr. Rafis speaks for Unani, Ayurveda and other traditional systems collectively. For him, the distinction in status and popularity between Ayurveda and Unani is irrelevant. What is important is a common struggle of traditional medical practitioners to modernize their systems "for the benefit of the masses." From this perspective, Dr. Rafis stays closer to Dr. Bhati (Ayurveda) and other AYUSH specialists (who are primarily concerned with the divide between modern medicine and traditional medicine) than to Ghalibji and Unani doctors who sharply feel the disparity between Unani and Ayurveda. When I bring a question about the government's decision to legitimize multiple non-allopathic systems, Dr. Rafis explains that the government has come to an understanding that allopathy alone could not address all health problems in the country:

Government of India basically recognized... the individual potential of individual systems... Unani is good in something, Ayurveda may be good in something, Siddha may be good in something... So there are different strengths and different potentials, which could be explored far further... These are the reasons, why all the systems are being placed in the country, and why all of them are equally funded accordingly, why everybody's equally groomed by the country.

Although Dr. Rafis mentions that different medical systems are associated with different cultures, he believes that the main reason for legitimization of medical pluralism has to do with health needs of India's large population, and from this perspective, no disparity exists among the AYUSH systems:

See, for the Ministry of AYUSH all these five-six [systems] are same. They want to promote everybody. They want to promote every system equally, because of the benefit of masses, so that people of our nation and around and outside the country could be catered better for their needs. I think this is the basic idea.

As these passages illustrate, neither does Dr. Rafis want to compare Unani to other systems, nor does he mention any signs of marginalization of Unani. Like other senior AYUSH practitioners, he maintains that the social status of Unani is improving. This interview with Dr. Rafis was very illuminating for me, because all Unani doctors I had previously met gave me mostly dismal assessments of Unani. Remarkably, Dr. Fatima Khan from the Tibbia College sketched a rather disheartening image of Hamdard University where Dr. Rafis teaches:

Hakim Abdul Hameed who was the founder of Jamia Hamdard... was a Unani practitioner, and he established a big university. But nowadays, after him, he expired in 1999, after that what is eventually happening: all other faculties, they are coming up, they have made medicine faculty, all, but Unani... the university is not paying much attention to Unani. So this is the fate... He [Hakim Abdul Hameed] was a single visionary... And now, if you see, the situation of the university, that is also reversing. The condition of Unani practice with which the foundation of the university was laid, that is deteriorating day by day.

In contrast, after the interview, Dr. Rafis gave me a tour of Hamdard University, highlighting how it was growing and how the legacy of Hakim Abdul Hameed was maintained. He pointed that India remained a guardian of Unani knowledge, so that even scholars from Pakistan⁹¹, Iran and other countries visit India in order to consult Indian Unani specialists.

⁹¹ In Pakistan, Hakim Abdul Hameed's younger brother, Hakim Abdul Said founded a network of Unani institutions (clinic, charitable dispensary, college), also named Hamdard, as its Indian counterpart (Alter 2008a). Although Hamdard Pakistan and Hamdard India were founded by the members of the same

Why do Dr. Fatima Khan's and Dr. Ali Rafis' assessments of Unani status and the situation in Hamdard University differ so radically? Perhaps, Dr. Rafis did not want to share internal problems of the university with me. Perhaps, he was not very honest about the place of Unani in relation to other systems. Yet, I believe that both Dr. Rafis and Dr. Khan were telling the truth, and their different views have primarily to do with the differences in social standing. As I have mentioned, Dr. Rafis holds administrative and academic positions, which he combines with clinical practice. Being recognized as an expert in the field of medicine, he is often invited to various TV shows, talks and interviews, and has written a number of newspapers articles on Unani and diabetes, hypertension and other diseases. In other words, he has both social status and a secured job.

In contrast, Dr. Fatima Khan has just managed to obtain a permanent position at the Tibbia College. Previously, for about twenty years, she had worked on a 11-month contract, fearing that it would not be renewed in a following year: "After 11 months we don't know if we will be fired or we will be kept. It's just the mood of the college and mood of the government." She says when an opportunity presents itself, many Unani teachers leave, because they cannot bear to deal with the stress of uncertainty. Similarly, recent graduates of Unani often resort to non-Unani jobs, and "ultimately they are not Unani graduates, that's why we don't have so much Unani practicing people nowadays. Either they turn to allopathy, or they turn to something else... This is the real problem." This is exactly what Ghalibji told me about his position and the future of Unani. Unani clinics and dispensaries are being shut down; consequently, due to the

family, they have developed as separate institutions and connections between them are not very strong. According to Dr. Rafis, Hamdard University Delhi occasionally invites Pakistani scholars to participate in Unani conferences, but I had a sense that it does not happen frequently.

lack of opportunities, younger generation (including his son and daughter) is not interested in Unani.

Apart from socio-economic differences, there are distinct ways in which Unani practitioners talk about the government. If we compare narratives of Dr. Rafis and Dr. Ghalib, we will see how differently they position themselves in relation to state and authority. For example, Dr. Rafis seems to align himself with the government and India as a country, by repeatedly using the pronoun *we*: “We [India] are also coming with the idea of integration, you know. Countries are now working on integration, you may have heard about it... So that concept is now a priority of the government of India, and we are working on it... We are trying to legitimize those [systems], we are trying to validate those studies on the scientific parameters.” Being part of a prestigious university in Delhi, Dr. Rafis have direct avenues for a dialog with the government of India. In contrast, Ghalib does not have access to government apparatus.

Before I move to a closing part of this chapter, I also want to mention a situation that occurred at the Central Council for Research in Unani (CCRUM). Its director’s understanding of the government support of Unani and other AYUSH systems seem identical to the views of Dr. Rafis. When I specifically asked if he had observed any instances of tension or rivalry between Unani and Ayurveda, he categorically refuted this assumption. However, after I left his office, a senior researcher who was present in the room during the interview volunteered to show me a library. While we were speaking about archives, translation work and preservation of Unani knowledge, he suddenly admitted the following:

See, madam, our boss could not say many things, because he occupies a senior government post, and cannot speak frankly. But I will tell you, you see, it is all political. Of course, we are marginalized, of course, nobody gives us as much attention as Ayurveda gets from the government, but we cannot mention it. These are formal views. But informally, of course, we suffer the neglect.

This confession reveals that the question of Unani is politically sensitive, and, therefore, requires a focused and detailed study in future. What I have tried to show is that the biography of Unani is constituted of many stories, situated in different perspectives of different Unani practitioners. Yet, despite the diversity of opinions, I am inclined to think that less empowered practitioners like Ghalibji and Dr. Fatima Khan are probably correct in suggesting that Unani is gradually being driven to the margins of Indian medical landscape.

4.7 CULTURAL OR BEYOND CULTURE

In this chapter, I have examined the politics of cultural nationalism as it manifests in the realm of alternative medicine and highlighted that declarations of the government support for medical pluralism is at odds with an unprecedented growth of Ayurveda and Yoga. The propagation of Ayurveda and Yoga is exhibited in myriad latent and visible instances, such as the introduction and colossal celebrations of the International Yoga Day, an issuance of a special postal stamp,⁹² proposals for making Yoga a required subject in schools throughout the country, compulsory Yoga classes for police officers, support for annual meetings of the World Ayurveda Congress, the growing number of ayurvedic facilities and practitioners, and an appropriation of home and herbal remedies under the umbrella of Ayurveda.

⁹² In 2015 philatelists of India observed many news trends, including the introduction of a commemorative Yoga Day stamp, discontinuation of routine stamps with Indira Gandhi and Rajiv Gandhi, while featuring other RSS-favored figures like Syama Prasad Mookerjee and Deen Dayal Upadhyaya. This highlights how stamp-making reflects political regimes and priorities. Interestingly, Yoga is the only AYUSH modality which has been featured in post stamps (in fact, it even appeared three times: 2015, 1991, and a stamp on Maharishi Patanjali in 2009).

I have postulated that this tension between the nominal recognition of plurality and the dominance of Ayurveda and Yoga parallels two poles of nationalist ideology which, at one end, lauds the country's cultural diversity and, at the other end, favors the Hindu majority. However, the proposed link between Ayurveda, Yoga and Hindu nationalism as well as the link between medical pluralism and inclusive nationalism must be taken with certain caveats. The scholarship on nationalism in India has repeatedly demonstrated the complexity of Hindu nationalist movements (Hansen 1996; Jaffrelot 2009; Rajagopal 2001; van der Veer 1994). In other words, Hindu nationalism is not a homogeneous project, but encompasses different forms and ideologies. Moreover, because of the specifics of Indian definition of "secular," secular nationalism cannot be definitively demarcated from the ideology of Hindu fundamentalism (Bose and Jalal 2011). Chatterjee (1986) has pointed that even Nehruvian secular nationalism still invoked spiritual values and the cult of Bharat Mata, just as Beni (2006) has claimed that "Nehru's conceptualization of nation was unwittingly Hindu" (cited in Copeman 2009, 201). For these reasons it is a Sisyphean task to disentangle secular nationalism from the nationalism of *hindutva* in the ways they imbue different non-allopathic systems.

For example, Alter convincingly shows that due to the efforts of Shri Yogendra and Swami Kuvalyananda, who transformed Yoga into a physical therapy and were motivated by nationalist aspirations and the philosophy of *swadeshi*, Yoga became "a key symbol of Indian civilization and an example of India's cultural sophistication" (2000, 69). Yogendra and Kuvalyananda, although driven by the notion of science and appeal to the Western world, ultimately aimed to define Yoga as distinctly Indian. Alter suggests that such a nationalist discourse regarding Yoga "may be best understood in terms of Nehruvian ideas about progress and secular modernization," but I add that it is also a discourse that enables Hindu nationalist

celebration of Indian civilization. A practice which is understood as Nehruvian and secular in one context can be presented as fundamentalist and communal in another. Since there are multiple schools of Yoga and ways of practicing AYUSH therapies, just as there are plural strains of Hindu nationalism or inclusive secularism, the link between medicine and the nation can be bent one way or another.

This includes two things. First, we cannot assert that AYUSH is purely secular, because the legitimation of some systems has been influenced by communal politics and the name of the institutional body of AYUSH itself draws on Vedic vocabulary (*ayush*). Second, neither can we say that all Yoga performances or uses of Ayurveda are essentially hindutvic. I do not doubt that many people who organized and participated in mass Yoga rituals during the International Yoga Day had no inclinations to Hindu nationalism. The idea of synchronized movements of bodies performing the same Yoga sequences throughout the country might have generated the same kind of “imaginative canvas” of Nehruvian national integration, which Copeman observed at the blood donation camps. According to him, what really mattered in the practices of donation was not the physicality of donated blood but *anonymity* of donation, which served as a unifying framework. In similar ways, anonymous mass participation of individuals (irrespective of castes, class, gender, age, or religion) in the nationally orchestrated Yoga practice could have been felt as an expression of secular nationalism and patriotism.

Thus, I want to make it very clear, that the reality is always messier than the proposition I have made in the beginning of this chapter. We must also be cognizant of the fact that there are competing opinions within the government regarding non-biomedical systems. Bureaucrats and policy-makers at the different tiers of the government structure (central, state, and municipal) may or may not adhere to the mainstream official view on plural medicine. This can be noticed,

for example, in the initial refusal of the state government of Uttarakhand to celebrate the International Yoga Day (The Times of India 2015).⁹³ Moreover, it is important to remember that despite Modi's personal contribution to popularity of Yoga and Ayurveda, there are officials who seriously commit to the idea of medical pluralism and impartial promotion of all AYUSH systems. As far as the ordinary users are concerned, most people I have spoken with do not relate medicine to politics, know very little, if nothing, about AYUSH, and have not heard of characterizing Ayurveda as *rashtriya chikitsa* (national medicine).

In conclusion, the relationships between medical pluralism and nationalism are complex, sometimes contradictory, and entangled with many factors. Therefore, I reiterate those contradictions to demonstrate how they relate to one another. First, I do maintain that Hindu nationalist aspirations has a lot to do with the growth of Ayurveda and Yoga, while the ideology of inclusive secular nationalism is reflected in institutionalized medical pluralism. Second, I nevertheless acknowledge that neither is AYUSH entirely secular, nor are Ayurveda and Yoga entirely bound by Hindu nationalism. Third, Hindu nationalists seem to have managed to paradoxically portray Ayurveda and Yoga as culturally Hindu but also above culture. In other words, they have managed to promote these therapeutic traditions as applicable to everyone irrespective of caste, class, religion and nationality, whereas systems like Siddha and Unani remain unable to escape their cultural identities. Thus, just as many scholars of Indian medicine have noted that Ayurveda had paradoxically emerged as both scientific and spiritual, both modern and traditional (Langford 2002; Smith and Wujastyk 2008), I have highlighted that Ayurveda is paradoxically rendered both cultural and universal, both national and global.

⁹³ This happened when Uttarakhand was led by the Congress government. However, in March 2017, the BJP won the state elections, and it would be interesting to see how it would reflect in the field of AYUSH.

5.0 QUESTIONING AYUSH AS A CATEGORY: THE PLURALITY OF ALTERNATIVE MEDICAL PROFESSION

AYUSH is represented in policy documents and some scholarly accounts as legitimized statist medicine distinct from “local health traditions” and unauthorized folk therapies, but this view obscures the diversity of AYUSH doctors’ professional backgrounds, clinical practices, working conditions, economic status, and social reputation. Rather than unquestionably legitimate statist medicine, the category of AYUSH contains many shades of legitimacy. Repeated perturbations in medical policy described in Chapter 3 had caused situations where formerly recognized degrees from certain institutions were declared invalid and doctors with such licenses became unauthorized. However, some of these doctors with de-legitimized degrees continue their practice, thereby contesting government definitions of expertise and legitimacy. Moreover, there are situations when practitioners of an official non-biomedical system occasionally choose to incorporate elements of another system, or even of unauthorized healing methods. Despite having credentials and training in one field, many doctors navigate through far more pluralistic avenues. In this chapter, I explain why doctors engage with plural therapies and how they are influenced by their patients and families. I highlight both differences and similarities in daily routines of different kinds practitioners and the complexity of their professional biographies.

In her study of Ayurveda in Madhya Pradesh, Manasi Tirodkar (2008) outlines four categories of Ayurvedic practice: 1) “traditional” Ayurveda, administered by practitioners who

are trained in teacher-discipline tradition, use Ayurvedic diagnostic methods such as pulse-taking, and prepare their own compound medicines; 2) “modern” Ayurveda, prescribed by practitioners who are institutionally trained, have official medical degrees, combine ayurvedic diagnosis with biomedical methods, and use manufactured ayurvedic drugs; 3) “commercial” Ayurveda, which exists in the spaces of health spas and consists of oil massages and nutritional counseling offered by practitioners who hold short-term certificates or diplomas; and 4) self-help Ayurveda, as practiced through books and websites, where health-seekers get information about ayurvedic diet and over-the-counter Ayurvedic medicine; in this last form of Ayurveda, the figure of a doctor is almost absent: patients either do not seek professional consultation at all or simply go to a pharmacy and ask a pharmacist for advice (Tirodkar 2008, 227–229).

These four categories give a general outline of the diversity of alternative practices in contemporary India but Tirodkar cautions that in the actual “sociology of utilization,” the reality of “Ayurvedic practice resembles a complex web rather than a neat line or map” (2008, 230). In general, I agree with her reasoning that the uses of Ayurveda are complex and these four categories do not exist in reality; however, we need to dig deeper, reflecting not only on the uses of medicine but also on lives of doctors themselves. Medical plurality is manifested in the ways patients go from one therapeutic form of practice to another, but it is also a characteristic of practitioners’ professional itineraries, backgrounds, ideologies, strategies for success, and therapeutic repertoires. Not only do health-seekers shuttle between “traditional” doctors and “modern” or “commercialized” spaces, but practitioners themselves move across these lines. It is not uncommon when practitioners get taught by their fathers, then attend government colleges, then work in public hospitals or open private clinics, then move to teach at a university or find employment in a prestigious wellness resort, and then resign and write self-help books or go

back to a government hospital. Thus, throughout their lives, practitioners can transform from traditional to modern, from biomedically-minded to tradition-inspired, and from practicing “pure” medical tradition to integrating various therapies. By saying so, I advocate for moving away from analyzing *kinds* of alternative medicine or *types* of practitioners towards attending to practitioners’ lives. Even though AYUSH practitioners are part of “legitimate” and “statist” medicine (Hardiman and Mukharji 2012), they nevertheless worry about financial security, reconsider their professional choices, experiment with different occupations, seek to establish and maintain their reputation, cultural legitimacy, and authority.

On the following pages, I describe the educational background of the interviewed doctors, their training, primary and secondary occupation, sources of income, age, gender, and their aspirations for becoming doctors. I then analyze the position of women in AYUSH, their culturally and personally-grounded conditions for choosing their professions. I then depict physical spaces where practitioners work and interact with patients: private and government clinics, dispensaries, homes, resort, places of worship. This chapter provides an ethnographically thick description of doctors’ background and doctor-patient interactions in order to challenge the representations of AYUSH as a homogenous category.

5.1 MEDICAL QUALIFICATIONS AND CONTESTED LEGITIMACY

The majority (49 persons) of the practitioners I interviewed during my fieldwork were institutionally trained and only a few (five persons) were trained outside the government

institutions.⁹⁴ Among those who were institutionally trained, 46 doctors had bachelor's degrees and higher whereas three doctors had two-year diplomas or certificates.⁹⁵ Interestingly, one of the doctors had a certificate called *Vaidya Vishārd* (Ayurveda Master) conferred by the Hindi Sahitya Sammelan—a public institution for the promotion of Hindi language and literature in Gujarat, closely associated with Arya Samaj (Berger 2013). However, the Indian Medicine Central Council Act (1970) pronounced this institution as eligible for granting medical degrees only for the period of 1931–1967; hence, the *Vaidya Vishārd* certificate issued after 1967 became invalid.⁹⁶ Yet, Hindi Sahitya Sammelan continued the education and issuance of these certificates almost until the early 2000s, which provoked multiple court cases against of this institution as well as petitions in its favor.⁹⁷ In 2010, it was finally ruled that these certificates are no longer recognized, and even if practitioners had been registered as medical practitioners, they

⁹⁴ The number of 54 practitioners of alternative medicine excludes eight government officials with AYUSH medical degrees who are not in practice, two Yoga teachers without government training, one rural Ayurvedic healer/priest, and one young man who has a degree in computer sciences but works at his father's Unani dispensary. Three fourth of the interviewed practitioners were men. In terms of age, they significantly varied from recent graduates with 2–3 years of experience and senior doctors with 35–40 years of experience. An average age of practitioners was 46 years.

⁹⁵ Higher medical degrees include BAMS (Bachelor of Ayurvedic Medicine and Surgery), BAMMS (Bachelor of Ayurveda with Modern Medicine and Surgery—an abolished degree which used to be conferred in the 1960s-1980s but was then replaced by BAMS); MD Ayurveda, PhD Ayurveda, BUMS (Bachelor of Unani Medicine and Surgery), BUMMS (Bachelor of Unani with Modern Medicine and Surgery), MD Unani, BTMS (Bachelor of Tibetan Medical System), BHMS (Bachelor in Homeopathic Medicine and Surgery), and GHMS (Graduate in Homeopathic Medicine and Surgery—a five-year degree course conferred until 1980 and replaced by BHMS). Two-year certificates are DHMS (Diploma in Homeopathic Medicine and Surgery), DNYS (Diploma in Naturopathy and Yogic Sciences), and *Vaidya Vishārd* (Ayurveda Master). Most doctors pursued these degrees away from their homes: Uttar Pradesh was a state where practitioners studied the most, but some also completed degrees in Gujarat, Karnataka, Himachal Pradesh, Andhra Pradesh, and West Bengal.

⁹⁶ The same applies to another certificate *Ayurved Ratna* issued by the Hindi Sahitya Sammelan after 1967.

⁹⁷ See, for example, the following appeal and the decision by the Supreme Court of India (1997), banning the medical practice of holders of the Ayurved Ratna and Vaidya Vishard certificates <https://ccimindia.org/downloads/1%20SC%20Judgment%2017.10.pdf>, and a Petition by the alumni of the Hindi Sahitya Sammelan (2003), demanding to recognize their qualifications <https://ccimindia.org/downloads/9%20Allahabad%20HC%20Judgment%2023.10.2009%20on%20HSS%20Uma%20Kant%20Tiwari.pdf>.

would no longer be eligible for medical practice. The doctor I interviewed received his Vaidya Vishard certificate in the later 1980s, i.e. *after* 1967, which made him illegitimate for medical practice. Yet, when I met him in 2015 he was working as a private doctor in a semi-charitable clinic. Notably, during the interview, he did not hide his education background. In fact, since I had never heard of Vaidya Vishard before, I asked him to repeat the term and he answered several times: Vaidya Vishard, from Hindi Sahitya Sammelan, Allahad, Gujarat.

In other situations, with practitioners who did not have formal training, I observed hesitation and reluctance to name degrees and places. For example, an excerpt from my interview with Hoshiyari demonstrates this well:

VK: Tell me a bit about yourself, your training

Hoshiyari: My father was an *Ayurvedacharya*, means a five-year course in Rishikul Medical Ayurvedic College

VK: Is it the one in Haridwar?

Hoshiyari: Yes, in Haridwar

VK: I see.

Hoshiyari: I have done a two-year course, not five, only two years

VK: Also from there?

Hoshiyari: Yes, from Haridwar

VK: okay, Haridwar... From Rishikul [name of a college]?

Hoshiyari: Not from Rishikul. Another.

When Hoshiyari said “another” and fell silent, it was apparent that he was not going to tell me the name of the diploma or a college where he studied. I had similar cases when instead of naming their degree, practitioners would simply mention a “registration.” In contrast, the doctor with Vaidya Vishard certificate was immediate and frank in his responses. I speculate that he was unaware that his degree was invalid, or, perhaps, did not think that debates on its validity were relevant. In important ways, this case highlights that decisions made at the higher levels of government might not affect or even reach the practitioners on the ground.

The practitioners who were not institutionally trained were either self-taught or trained by fathers, gurus, or other doctors but they all reported to be officially registered as medical practitioners in medical registrars of various states.⁹⁸ For example, many residents of Chhotapur told me that the most respected and skilled doctor is Saklani, who is a practitioner of Homeopathy. I tried to talk to him on many occasions but he was always busy; at any time during the working hours I would find several patients at his tiny clinic (hardly two by three meters). Previously, Saklani had also worked as a doctor in a government military institution, which is evidenced in letters of gratitude and photographs on the walls of his clinic. However, Saklani does not have formal training in Homeopathy or any other branch of medicine. As he told me, fifty years ago he was an intern with a homeopathic (BHMS) doctor from whom he learned the principles of Homeopathy. After completion of the private internship, he registered as a homeopathic practitioner with the Central Council of Research in Homeopathy because, in his words, in those days, a letter of recommendation from a senior doctor was a sufficient evidence of medical qualification. Thus Saklani began his independent practice and is now regarded as one of the best “doctors” in the vicinity. This complexity of medical qualifications and training shows that the category of AYUSH is vague and amorphous, containing many outdated formulations of medical legitimacy.

Another aspect of medical complexity reveals itself when we try to delineate medical disciplines with which practitioners identify. The majority of practitioners I interviewed had a degree in Ayurveda, followed by Homeopathy, Unani, Sowa-Rigpa, and Naturopathy and Yogic Sciences. However, many of them combined medicines and procedures from various AYUSH systems and biomedicine, and some of these combinations were “legitimate” in the sense that a

⁹⁸ See Nahar et al. 2017 about the ambiguous status of “registered medical practitioners” in biomedicine.

medical practitioner was certified in two medical fields: for example, Dr. Gita Verma had both a diploma in Homeopathy and a bachelor's degree in Ayurveda; Dr. Madhukul had a bachelor's degree in Ayurveda and a certificate in Yoga. In contrast, there are also doctors who provide unauthorized services, including non-medical and non-recognized practices such as numerology, "astromedicine," mantras, prayers, or "color therapy."

5.2 PROFESSIONAL ITINERARIES AND STATUS

The biomedical profession is typically associated with prestige and envied economic standing: medical education comes at a high cost and hard work but this burden is expected to be paid off with high salaries. In contrast, when it comes to alternative medical professions, especially in India, there is no expectation of financial security. In fact, professional itineraries of non-biomedical doctors in India are extremely diverse, bordering and crossing the domains of private and government practice, teaching and clinical positions, success and struggle. Hence, it would be a mistake to think of all AYUSH practitioners as medical comrades who occupy uniform social positions and share similar ideologies. These are practitioners who have very little in common.

Below I describe different career paths of alternative medical practitioners. In doing so, I draw on and go beyond the understanding of Ayurveda practitioners described by Jean Langford (2002). In her elegant and detailed analysis, she introduces three Ayurveda doctors who significantly differ in their therapeutic approaches, medical spaces, conceptualizations of Ayurveda and attitudes to allopathy or modern medicine. Being skeptical of categorizing doctors as either "traditional" or "modern," Langford nevertheless shows how certain doctors identify

themselves and are perceived by others. The first doctor is someone whom others call a “traditional practitioner:” a hereditary Ayurvedic doctor with no institutional training, he prepares most of his medicines himself from raw ingredients and herbs. He calls himself a “simple practitioner” who belongs to “the old school of thought” (Langford 2002, 33, 38). The second is a “modernized” doctor educated in a government college, with an extensive experience in a state-run Ayurvedic hospital. He mostly uses branded Ayurvedic drugs and relies on modern diagnostic tools, challenging the canonical interpretation of Ayurvedic philosophy. Finally, the third doctor does not fall neatly under either traditional or modern categories: a son of an Ayurvedic practitioner, he is also trained in modern-style teaching hospitals. He firmly believes in philosophical foundations of Ayurveda, trying to defend them from biomedical trends, but he is also interested in research and the development of Ayurvedic pharmaceuticals. Langford further uses these three examples to highlight that there is no uniformity in how doctors are trained, in which physical spaces they operate, how they interact with patients, which medicines they use, and how they understand their own place.

Contributing to this complexity, I introduce my own examples to further illustrate that the avenues of contemporary non-biomedical practice in India are multiple. I do not propose a classification of medical practitioners because every attempt to classify the complexity of reality threatens to reduce it to a mere abstraction. Instead, the recognition of practitioners’ varied work settings, unequal salaries, and diverse social positions broadens our understanding of the intersectionality of private lives, professional roles, political engagements, and medical ideologies.

5.2.1 Administrative and research positions at government institutions

Some AYUSH practitioners I interviewed are employed at administrative positions at district, state, and union levels of government, including central government institutions such as the Ministry of AYUSH, the CCIM, the CCRAS, and the CCRUM, or state institutions such as the Uttarakhand Directorate of Indian Medicine and Homeopathy. Having begun their career as practicing doctors, these AYUSH degree holders have managed to achieve administrative positions: some of them enjoy the roles of local and national policy-makers, some even work as representatives at WHO and other international organizations. For example, after graduating from an Ayurveda college, Dr. Bhati (BAMS) worked as a teacher of Ayurveda for ten years and then applied and received a position in a government hospital. Another decade later, he was invited to take an administrative job within the central government and subsequently served at the WHO as a consultant for the promotion of traditional medicine. He proudly states that he is “one of the ayurvedists which have seen all the platforms of Ayurveda.” Interestingly, when we spoke about the government’s position on the plurality of medical traditions, Dr. Bhati used the pronoun *we*, speaking both as an Indian citizen (“India is one country which has been receptive to good ideas. Anything coming from outside, means, we never opposed that”) and as a government official (“we have our own law and accordingly we are regulating the [non-biomedical] systems... we have started having memorandums of understanding with other countries”). Such multiple subject-positions make it hard to place Dr. Bhati either in the camp of state or the camp of practitioners, which shows their permeability. In addition to Dr. Bhati, I spoke with nine more persons with AYUSH degrees who were working at government institutions as administrators or researchers. Most of them had prior experience as practicing doctors, but two persons began their work for the government immediately after the graduation.

At the end of Chapter 3, I emphasized that the “state” is not a coherent unified entity but is constructed as such through public discourse and bureaucratic practices. While discussing the state policy on medical pluralism or government’s approaches to non-biomedical practitioners, I remained cognizant of the fact that “the government of India” is not “it” but “they,” a political apparatus constituted of contradictory involvements and multiple levels of authority. Similarly, it is important to understand that the category of “AYUSH practitioners” consists of doctors who command different status and authority, who come from different class, caste, religious and educational backgrounds. Moreover, we should be careful not to antithesize the categories of “state” and “doctors,” because some AYUSH practitioners occupy high positions within the government, which illustrates a broader argument put forward by Akhil Gupta (1995) about the conventional nature of the boundaries drawn between “state” and “society”, or “state” and “people.”

5.2.2 Teaching positions

Another path available to AYUSH graduates is to become professors at private or public AYUSH schools such as Jamia Hamdard in Delhi, Ayurvedic and Unani Tibbia College and Hospital, Uttaranchal Ayurvedic College and Hospital. As evident from these names, medical universities and colleges often have affiliated hospitals where appointed professors are required to receive patients. I was not able to gather precise information on the teaching/medical practice load, but from my conversations with doctors at teaching hospitals I learned that they teach courses, attend and present at conferences, give public lectures, write opinion pieces for newspapers, and publish academic articles. For example, sometimes instead of answering my questions, doctors directed me to their articles online or gave me printed copies of their

publications. Some doctors-professors closely collaborate and are recruited by state or central governments, others work in private colleges and form non-government professional organizations. Many of them could be conceived as modern-day counterparts of “vaid publicists” (Sivaramakrishnan 2006)—ayurvedic doctors who in the beginning of 20th century established periodicals, served as editors, and wrote articles about the role of Ayurveda in the emerging Indian nation.

5.2.3 Wellness industry

Besides teaching, research, or government administrative positions, AYUSH degree holders can choose to become entrepreneurs and open large-scale private wellness resorts. Some of them become very successful and open luxury wellness facilities with wealthy Indian clients (including politicians, movie stars, or businesspersons) as well as medical tourists from all over the world. This is what Tirodkar calls “commercialized Ayurveda” (2008) and Smith and Wujastyk call “New Age Ayurveda” which “has been reimported into India in the shape of ‘wellness’ tourism that caters to foreign tourists and urban, middle-class Indians” (2008, 2–3; also see Langford 2002). Himalayas and Kerala are particularly famous destinations for wellness tourism, and I visited a number of such resorts in Uttarakhand, particularly Rishikesh and Dehradun. AYUSH entrepreneurs have learned to make use of transnational therapeutic networks, advertising their enterprises abroad, searching for new customers and providing consultation to established consumers via the telephone or the Internet. I remember when I arrived at a beautiful Himalayan *āśram* (spiritual hermitage, retreat) with a spectacular view of the Ganges, I heard the owner, Dr. Madhukul, talking on the phone to a client, explaining that the price for a weekly stay and therapeutic procedures was \$400 (since Dr. Madhukul said “dollars,”

I suspected he was talking to a person from overseas). Indeed, when I then spoke to him, Dr. Madhukul confirmed that most of his clients are from abroad. He comes from a family of Ayurvedic doctors and himself has a bachelors' degree in Ayurveda (BAMS). But it turned out that many years ago, he had realized a lucrative potential for globalized holistic medicine and complemented his BAMS education with a Yoga certificate from Yoga Alliance USA. This enabled him to become a successful businessman and a transnational Yoga/Ayurveda specialist: he claimed to have performed therapeutic sessions for Indian political figures including the ex-president of India (2007–2012) Pratibha Patil, Bollywood stars like Priyanka Chopra, members of several royal families in Europe and a number of U.S. officials. The case of Dr. Madhukul demonstrates that the “government” is not only a space in which AYUSH practitioners work, a body which regulates non-biomedical education and research, or an authority which could be evoked or contested in publications, but also a source of income and an assembly of wealthy clients.

In addition to AYUSH doctors who *own* wellness resorts, I also met doctors who *work* at resorts on a monthly salary. For example, I spoke with Dr. Tara Dorjee a young female practitioner of Sowa-Rigpa who is currently employed at SURYA—one of the most high-end therapeutic resorts in Uttarakhand. With a bachelors' degree in Tibetan medicine (BTMS) and a certificate course in botany, Dr. Dorjee had previously worked as a researcher at a Tibetan medical institution and as a physician at *Men-tsee-khang* (a Tibetan government clinic). One day a recruiter from SURYA approached *Men-tsee-khang* doctors. Most of them were skeptical of transferring to a resort, but Dr. Dorjee liked the idea, and after speaking to friends and family, it was decided that a wellness resort with international clientele would provide a good platform for promoting Tibetan medicine. This is why, she says, she joined SURYA. Although she is required

to work six days a week and is rarely able to spend time with relatives, she likes her job, because of the respectable atmosphere, unique practical experience, free housing and meals, and sizable salary.

5.2.4 Government appointed doctors

Despite Uttarakhand's attractiveness for wellness tourism, the described lucrative opportunities are extremely rare. The majority of doctors I interviewed are struggling with regard to income and financial security, and the further the doctor from an urban center, the harder it gets. My sense of it is that the most common itinerary for AYUSH graduates are either to become appointed physicians at government dispensaries and hospitals like Doon Hospital in Dehradun, or to run small-scale private clinics. These doctors are not politically influential, do not publish in professional magazines and seldom read AYUSH-related publications. Most of them are more likely to be versed in local dialects than in English. Working in a public sector has many advantages, and when I asked doctors to explain why they had chosen their current place of work, they cited numerous reasons related to finances, social benefits, convenience, family concerns, location, and other factors. For example, they emphasize stability in terms of wages, proudly stating that the salaries of appointed AYUSH doctors are equal to the salaries of appointed allopathic physicians.⁹⁹ At the same time, I observed that the public sector might not

⁹⁹ This is a contested issue. The National Health Policy recommended state governments to establish parity in salaries of AYUSH and allopathic doctors; however, even today not all states have followed the recommendations. As a result, throughout the country, there are occasional strikes and petitions by AYUSH doctors demanding the equal pay. In contrast, in Uttarakhand I was told by the government officers at the Directorate for Ayurveda and Unani, as well as by doctors at government hospitals that the salaries were equal.

offer the wealth and quality of life that some doctors are seeking, so they tend to supplement their income with private medical practice, receiving patients at home after the working hours.

5.2.5 Small-scale private practice

Entirely private doctors directly depend on the daily volume of patients; therefore, there is always a danger of not earning enough. As a safety net, private doctors may decide to work at two or three locations, open a pharmacy adjacent to the clinic, or take up a secondary job not related to medicine. For example, a son of an Ayurvedic doctor, Hoshiyari runs an Ayurvedic dispensary which he inherited from his father. He does not have a full medical degree, only a two-year diploma in Ayurveda, but local people regard him as a doctor.¹⁰⁰ Hoshiyari refers to Ayurveda as *puṣṭainī kām*—ancestral, patrimonial occupation: his father was an *Ayurvedacharya* (completed a formal five-year course) and taught him the basics of Ayurveda. However, Hoshiyari does not practice Ayurveda full time but only receives patients in the evening when he comes back from his main job—a teacher at a local school. When I asked whether Hoshiyari preferred teaching or treating patients, he remarked that “there is no work in Ayurveda,” because the dispensary was semi-charitable (if a patient is poor, she is given consultation and medicines for free) so it did not provide enough income to support his family.

¹⁰⁰ According to Hoshiyari, people who know him personally call him by his first name, but he is also addressed as *daktar sahib* (literally “Mr. doctor”) by people from nearby villages, or even as *hakim ji* (which is a more common way of addressing a Unani healer than an ayurvedic healer) by Muslim patients.

5.3 PROFESSIONAL ASPIRATIONS

Hoshiyari's shuttling between medical practice and another occupation is quite common in AYUSH, especially among women. I met several female doctors who had completed formal AYUSH education and were offering consultations now and then, but their daily schedule revolved around responsibilities of being mothers and wives. In fact, as one homeopathic doctor told me, when she was choosing a profession, she excluded the option of being an allopathic doctor or nurse, because it would have required long working hours and night shifts. For her that was unacceptable, since she was planning a marriage and children.

In contrast, from my interactions with AYUSH doctors, I trust that AYUSH profession is rarely a preferred choice. Some doctors, despite their degrees in AYUSH disciplines, are exclusively committed to biomedicine as a more reputable and demanded form of medicine. For example, Dr. Thakur—a graduate of a BAMS program and a son of an Ayurvedic doctor—almost never uses Ayurvedic diagnostic procedures or prescribes Ayurvedic medicine. During all my visits and observations in his clinic, I noticed that his consultations resemble little if nothing of Ayurvedic tradition. Although he is knowledgeable about pulse-taking, I never saw him performing it, or using ayurvedic formulas. Instead, a thermometer, blood pressure monitor, painkillers, and antibiotics are his first choice of diagnosis and treatment, in which regard Dr. Thakur resembles many BAMS doctors across India who primarily prescribe Paracetamol or anti-histamines than ayurvedic preparations (Langford 2002; Leslie 1968; Leslie 1976c; Leslie 1992; Naraindas 2006; Nichter 1980; Nisula 2006; Smith and Wujastyk 2008; Welch 2008).

Moreover, many AYUSH physicians I interviewed had initially aspired to become biomedical doctors but were unsuccessful during the entrance exams. Historical studies of medical traditions in India provide evidence that this tendency of turning to an alternative

medicine if one fails in biomedicine has long historic roots: for example, in the early 20th century Bengal, “students of official or ‘allopathic’ medicine who had failed to complete their courses or obtain degrees often turned to Homeopathy as an occupation” (Arnold and Sarkar 2012, 43). Recently, this trend was also observed by Langford who spent months with students at an Ayurvedic teaching hospital:

... students are quite frank about the weakness of their commitment to Ayurveda. Most of them are attending Ayurvedic college only because they did not receive high enough exam scores (or exercise enough influence in high places) to enter biomedical colleges... Until starting college, few of the students had any knowledge of Ayurveda.... Instead they have the background in biology, chemistry, and physics that is required of any medical career track... Many of these students freely admit that they intend to practice a blend of Ayurveda and allopathy after graduation... (2002, 130–131).

Similarly, more than half of the practitioners I interviewed admitted that initially they had applied to a biomedical program¹⁰¹ but did not secure sufficient scores (also see Welch 2008, 130). Many of them confessed that they did not “trust” or “believe” in non-biomedical treatment during their college years, partly because the superiority of allopathy is deeply ingrained in the minds of Indians and parents often cultivate the idea of reputability and success of a biomedical doctor in their children, preparing them for a medical career since early school years. As Langford explains, only students whose parents were Ayurvedic practitioners were likely to enroll in Ayurvedic program willingly; for the rest of the students, there is a strong family pressure to become a *doctor* in a biomedical sense of the term (i.e. not a *vaidya*). According to one Ayurveda professor interviewed by Langford, there is no public interest in Ayurveda, so Ayurveda graduates have no choice but to practice allopathy in pursuit of money or opportunity (Langford 2002, 132). This logic somewhat holds true today as well; however, I want to

¹⁰¹ Mostly MBBS (Bachelor of Medicine and Surgery) but also BPharma (Bachelor of Pharmacy) and BDS (Bachelor of Dental Surgery).

highlight that popular discourses and overall attitude to Ayurveda (unlike to Unani, for example) have been rapidly changing. My conversations with government officials, Ayurveda professors, and practitioners expose a more positive feeling—even enthusiasm—towards Ayurveda, than identified by Langford fifteen years ago. Yet, I also concede that biomedicine undoubtedly offers more opportunities, security, and status than any of the alternative traditions; therefore, it is not surprising that many AYUSH doctors prescribe biomedical drugs and make use of biomedical tools.

Importantly, the practice of allopathy by AYUSH practitioners is a highly contested issue, because there is no comprehensive law specifically focused on the possibility and limitations of practicing biomedicine by AYUSH doctors. Instead, there are government acts—with outdated terminology—which regulate either biomedicine or AYUSH medicine. For example, the Indian Medical Council Act (1956) regulates the practice of “modern medicine”; the Indian Medicine Central Council Act (1970) regulates “Indian medicine,” i.e. Ayurveda, Unani, and Siddha; and the Homoeopathy Central Council Act (1973) regulates the practice of Homeopathy. Respectively, there are separate registers: the “Indian Medical Register” and “State Medical Register” for biomedical practitioners, the “Register of Indian Medicine” for practitioners of Ayurveda, Unani, and Siddha; and the “Register of Homeopathic Medicine” for practitioners of Homeopathy. According to these documents, only a “Registered Medical Practitioner” registered in the “Indian Medical Register” and “State Medical Register” can practice biomedicine (Kumar and Roy 2016; Math et al. 2015).

Although it seems clear that AYUSH practitioners are not legally allowed to practice biomedicine, some lawyers, state politicians and AYUSH supporters appeal to another document—the Drugs and Cosmetics Act, 1940, and Rules 1945 (updated 2002). This document includes

references to Ayurveda, Unani, and Siddha drugs, and according to its Rule 2(ee), a “Registered Medical Practitioner” is a person who satisfies one of the following criteria:

- i. Holding a qualification granted by an authority specified or notified under Section 3 of the Indian Medical Degrees Act, 1916 (7 of 1916), or specified in the Schedules to the Indian Medical Council Act, 1956 (102 of 1956); or
- ii. Registered or eligible for registration in a medical register of a state meant for the registration of persons practicing the modern scientific system of medicine (excluding the Homeopathy system of medicine); or
- iii. Registered in a medical register (other than a register for the registration of homeopathic practitioners) of a state, who although not falling within subclause (i) or subclause (ii) is declared by a general or special order made by the State Government in this behalf as a person practicing the modern scientific system of medicine for the purposes of this Act.

The clauses (i) and (ii) exclude AYUSH degree holders from the category of “registered medical practitioners,” but the clause (iii) is somewhat open to interpretation and, as a result, it has led to numerous Court cases and State government orders. In 2007 the Supreme Court of India decided that the practitioners of Ayurveda, Siddha, Unani, and Homeopathy can prescribe allopathic medicines under the clause (iii) of The Drugs and Cosmetics Rule 2 (ee) “only in those States where they are authorized to do so by a general or special order made by the concerned State Government in that regard” (Math et al. 2015, 296). In other words, the Supreme Court of India left it to state governments to sanction AYUSH graduates as “registered medical practitioners” and allow them to prescribe biomedical drugs. Currently, many states, such as Goa and Kerala, strongly oppose the cross-system practice and do not take any steps towards authorizing AYUSH practitioners for allopathy.

Similarly, in 2016, the High Court of Delhi ruled that under no circumstances can the practitioners of Ayurveda, Unani, and Siddha prescribe allopathic medicine, even if these

practitioners completed integrated courses.¹⁰² In contrast, in other states the prescription of allopathic medicine by AYUSH practitioners has been legalized, but with weighty limitations. For example, most recently, the government of Karnataka issued a government order to allow AYUSH practitioners to practice allopathy but under the following conditions:

- if they are appointed in Primary Health Centers in rural areas of Karnataka,
- undergo an additional six-month course under the supervision of a senior allopath,
- get themselves certified with the respective board,
- and only for patients in “emergency” situations such as heart attack (Suraksha 2017).

In Uttarakhand, the requirements are different: since 2015 certified pharmacists as well as registered Ayurveda and Unani practitioners can prescribe certain allopathic drugs (outlined in Section K of the Drugs and Cosmetics Act, 1945), if they complete additional three-month training and if there is no allopathic doctor available within the one kilometer radius (The Tribune 2015). It is obvious that such half-baked solutions are neither welcomed by AYUSH practitioners nor by biomedical physicians. On the one hand, multiple limitations on the prescription of allopathic medicine ensure that the hands of AYUSH doctors remain tied. On the other hand, biomedical doctors and the general public remain concerned with the safety of such prescriptions. Newspapers, the Internet, and even research articles are filled with horrifying stories of improper use of biomedicine by Ayurvedic, Siddha, Unani and Homeopathic doctors, resulting in patients’ death or severe medical complications (Math et al. 2015; also see, for example, reports collected by the “Anti-quackery wing” of the Indian Medical Association).¹⁰³ As a solution, several years ago officials at the Ministry of AYUSH proposed to design a one-

¹⁰² “Order.” The High Court of Delhi. Accessed March 22, 2017. http://medicaldialogues.in/wp-content/uploads/2016/05/13-may-2016-order_new.pdf.

¹⁰³ http://www.ima-india.org/page.php?page_id=94, accessed March 22, 2017.

year “bridge” course which would equip non-biomedical doctors with required biomedical training but the current fate of the proposal is unclear.

There are many reasons why the central government wants to leave an open door for AYUSH doctors to provide allopathic medicines. One reason is an existing—or perceived (Kumar and Roy 2016)—shortage of qualified biomedical doctors in the country. It is often claimed that India does not have enough allopathic doctors to provide for its sizable population, especially in rural areas; therefore, non-allopathic doctors should be permitted to take some allopathic responsibilities. The same view had surfaced many times during my conversations with Ayurveda and Unani officials at the Uttarakhand government. Although AYUSH doctors are only permitted to prescribe a limited list of biomedical drugs, I was told that in the absence of allopathic doctors any actions of AYUSH doctors that could save people’s lives are justifiable.

5.4 MEDICAL PLACES AND INTERACTIONS WITH PATIENTS

From field notes, June 6, 2015

I am sitting at a local gurdwara where, as I had heard, a doctor from [a faraway city] comes to provide medical consultations every Tuesday. Hidden at the back entrance of the gurdwara, this is a spacious room, which appears to be used as the gurdwara’s sound office, because I see speakers, cables and other sound equipment. There are no religious signs here, no posters or even calendars with Sikh gurus or Hindi deities. On the left, there is a closed door into another room. On the opposite side of the entrance, there is a large table, but the doctor is seated near the table, not at the table. He is about 45–50 years old, quite fit and even muscular. There are seven people right now, but the benches running across the right and front walls can

accommodate at least 10-12 patients. There is a simple wooden bed on the left. Everybody is waiting for their turn, observing the doctor, glancing at me, and one another. Men and women sit together, there are also women with children. It is clear that many of them come for a follow-up, because the doctor asks about improvement since his last visit.

The most prominent object on the table is the doctor's Adidas sports bag, which gives me an impression that the doctor has just arrived and is ready to take off at any movement. I see four packs of Sholiv-DS,¹⁰⁴ five white plastic jars-containers with pills, and a plastic bag with some kind of powder. The doctor mostly listens to complains and immediately dispenses medicine which is primarily ayurvedic. I noticed that he charges between 120 and 250 rupees for every patient—not very cheap. Surprisingly, right now the doctor has gone to the street to get a change, instead of sending somebody else for it. Everybody is waiting.

As long as I have been here, I have not seen the doctor taking the pulse, nor does he uses a statoscope either. Only once he used it to listen to a belly of a young Muslim lady. The doctor first invited her to a side room, but the room was locked, so he had to stay in the main room. He looked around and since at that moment there were only women, he announced that he would examine the young lade right there. She lay on the bed and he listened to her belly with the stethoscope over clothes.

I notice that the doctor does not receive patients strictly by order. Some patients just walk in and proceed directly to the doctor, without waiting for their turn. Many of them carry little pieces of paper—prescription slips, I presume. Some people come with a phone and make the doctor talk to a sick person on the phone. It happened twice within a half an hour. When the doctor invites me to sit at his table, he offers me chai. Although I try to refuse, the doctor insists

¹⁰⁴ It is a liver tonic produced by Shourya Pharmaceuticals, which is not exclusively an ayurvedic phramceutical company, but Sholiv-DS is an analogue of famous ayurvedic medicine Liv-52.

on having chai and immediately recruits a young male patient to bring tea from the market. “Acchi chai lao” (bring a good chai), says the doctor and gives him money. Ten or fifteen minutes later the young man comes back with two cups of chai and then sits back to wait for his turn.

This excerpt from my fieldnotes describes one of the common places where AYUSH practitioners meet their clients: Sikh *gurdwaras* and Hindu and Jain *mandirs*. In Chhotapur, approximately half of the practitioners, including ayurvedic and homeopathic doctors, receive patients both in private clinics and local places of worship.¹⁰⁵ For example, a daily routine of a doctor can comprise of working in his clinic from 10am to 1pm, having lunch at home, consulting patients at a *gurdwara* from 3pm to 5pm, going back to the clinic and working there from 5pm to 8pm. When I asked practitioners why they worked in religious institutions if they had nearby clinics, they explained that the former was their charitable work. Although I cannot compare this information with allopathic doctors, but the tropes of charity (English word) and duty (*seva*) are prominent among non-allopathic practitioners. Yet, I observed that some doctors, like the one described above, charged high prices, but when I asked directly about the compensation, practitioners frequently responded that they only charged for the cost of medicine and did not take consultation fees.

Another important feature of medical spaces in India that the above excerpt illustrates is the public nature of medical consultations. Typically, rooms assigned to doctors at *gurdwaras* and *mandirs* do not have private examination sections. From the perspective of Western subjectivity, this poses a problem of privacy and confidentiality of medical interactions, but as

¹⁰⁵ Only one doctor did not have his own clinic and consulted patients exclusively at a *mandir*.

Langford argued, Indian patients who attend such clinics expect to be examined in the presence of others (Langford 2002). Research in Western biomedical settings demonstrates that as a result of proliferation of vernacularized “self-help” medical texts, medical advertising and “googling,” patients often demand and succeed in getting a desired prescription, exercising significant influence on doctors’ decision-making (Kravitz et al. 2005). However, in India it is not only patients but also patients’ relatives and friends who play a role in clinical decision-making. During my fieldwork, I found that it is considered acceptable when friends, relatives, and even non-related persons—who happen to be present during the examination—intervene and comment on diagnosis and treatment.

The same is true for small-scale private clinics: they typically consist of one room where people wait for their turn and talk to a doctor in the presence of others. Thus, there is no division of space between a waiting room and an examination room. Hence, in order to understand doctor-patient interactions within the context of Indian clinics, it is important to direct our gaze to the intersubjective space created by all participants of medical interactions. My observations point to the fact that a decision on a particular therapy often results from a dialogue—clinical negotiation—between a doctor, a patient and third participants. For example, I once witnessed how a family member answered a doctor’s question about symptomatology and eating habits of an accompanied sick person. On another occasion, I documented how a friend of a sick man asked the doctor to give him “a red tablet which you had given to me last time; it really worked.” Even when private clinics are equipped with examination rooms, they are rarely used. A few times I observed how a doctor invited a patient to an examination room but after the examination was completed they returned to the main room to discuss the problem and available treatment. In such cases, even if the examination is private, the consultation is not. For example, see a photo of

an Ayurvedic clinic below. There are two rooms: in the front room there is a doctor's table and a cabinet with medicines. On the left end of the back wall there is a door into an examination room. The doctor (in grey shirt) is preparing medicine for a young boy (in red) whose brother is standing next to him; additionally, there are two unrelated men (in blue and white) who are waiting for their turn and watching what the doctor is doing.



Figure 6. The interior of an Ayurvedic private clinic.
Photo by the author

What is also remarkable is that people waiting for their turn are not only allowed to offer their opinion but can also be invited to help and perform certain tasks. For example, I have seen how clients in the waiting area were asked by a doctor to pass medicines to him, or, as I described in the case of the *gurdwara*, a visitor was asked to bring tea!

The cited excerpt from my fieldnotes is also an apt reminder that the boundaries between so-called traditional and modern medical practices is elusive. Although this doctor is one of few remaining Ayurveda specialists who prefers to prepare his own medicines from raw ingredients, he nevertheless uses branded medicines such as Sholiv-DS. I once observed a more extreme example of such cross-pollination when I visited a senior third-generation *vaidya* in Himachal Pradesh. His clinic was located in a small concrete building with low ceilings and no windows. The only pieces of furniture were a table and a bench. His diagnostic methods looked the closest to what has been described in books about traditional Ayurveda: he began every examination with taking the pulse, listening to it carefully for full one to two minutes. I noticed that he also took time preparing medicinal powder and distributing it on pieces of newspaper, where each piece is a single required dosage (this practice is common among both Ayurveda and Unani practitioners who make their own medicinal mixtures, as shown in the Figure 5). However, instead of using dried herbs, he often used a manufactured pill, crushing and grinding it into powder.



Figure 7. A Unani doctor prepares medicine
Photo by the author

Some doctors turn their private clinics into spaces that look more like pharmacies, which offer a variety of pharmaceuticals and beauty products, such as the shampoos and facial creams. This *mise-en-scene* is typical of many private clinics I visited. Other practitioners open actual pharmacies. For example, once when I was walking through the market in Chhotapur, I spotted a chemist shop with a sign “Naturopathy.” The interior did not differ from any allopathic pharmacy in the town, with glass shelves running along the walls, filled with pills, drops, ointments, beauty products, and few home appliances. Intrigued, I approached the owner: Najhoi turned out to hold a diploma in Yoga and Naturopathy (DYSN) and a diploma in pharmacy. Since Yoga and Naturopathy are drugless therapies, their combination with pharmacy seemed paradoxical but Najhoi explained that in order to provide naturopathic treatment he needed land, for which he did not have sufficient capital. So he opened a pharmacy with a hope to save money for his future naturopathic facility. Najhoi claimed that people were not interested in slow,

drugless treatment: only two-three visitors a week would come specifically for Naturopathy, while the majority would stop by to get a biomedical drug. The demand for a quick remedy is a common trope in modern India; yet, I wonder to what extent his consumers' conduct was influenced by the appearance and location of Najhoi's shop. Located not so far from a tourist taxi stand, on the main *chowk* (roundabout, plaza), the shop looked like a standard drugstore, calling for a standard pattern of behavior: get what you need and go. As Johannes Quack (2014) reminds us, physical spaces and institutions 'ask for' a particular kind of behavior. So, had Najhoi's store been designed differently, more people might have approached him for Nature cure. In fact, when I spoke to residents of the town, they did not even recall that a naturopathic doctor was there.

Tirodkar (2008, 232) describes that patients who come to private clinics are mostly middle class or higher, although she also points that private doctors can cater to lower class clients and accommodate their "wallets by giving them cheaper medicines." In my experience too, the practice of tailoring the costs and prescription is very common, and in fact patients and their relatives can "bargain" with doctors about therapy, its cost and duration. As a result, it is hard to say that private clinics are for middle class clients. Moreover, it is important to keep in mind that private clinics vary in size and costliness, ranging from quite simple to more elaborate. Some are located in wealthy neighborhoods, others are squeezed between *chai* stalls, fruit carts, variety stores and *dhabas* in the market areas, like in the Figure 5 below.



Figure 8. A private homeopathic clinic in the middle of the market
Photo by the author

While some practitioners shuttle between private clinic and charitable work at religious spaces, other doctors engage in a daytime employment at a government or private hospital and an evening private practice at home. Here it is imperative to look further into the demarcation of private and public space. Criticizing the tendency of Western scholars to draw a boundary between the concepts of “state” and “society,” Akhil Gupta (1995) has remarked that these concepts are built on a belief that bureaucrats operate in offices, courts, and cantonments, i.e. places distinct from people’s private homes. Yet, in India, local authorities and magistrates routinely conduct state affairs from home, receiving citizens, considering complaints and solving disputes, thus collapsing the boundaries between an official and a person (Gupta 1995, 384). In a similar way, many non-biomedical practitioners collapse the boundaries between public and

private (which could be unexpected for Western observers), between a person and a doctor, by practicing medicine where they live. For example, Hoshiyari has turned a state-established dispensary into his home (which he does not own), while Dr. Mahawar (BHMS) has turned the basement of her house into a homeopathic clinic. As I will explain below, medical practitioners, especially female practitioners, may resort to home consultations for various personal and economic reasons, but it is also important to recognize that what is perceived as public and private are embedded in sociocultural settings, which may radically differ across societies. In a similar way, I was initially dazzled by the fact that many doctors display their personal cellphone numbers on the signboards of their clinics.¹⁰⁶

According to Tirodkar, “government-funded hospitals tend to exhibit abysmal conditions in terms of cleanliness, resources, and space. Institutions run by private foundations are generally cleaner and better staffed” (2008, 232). Although I agree with Tirodkar view that overall private hospitals offer more possibilities of quality care, but the recent government financial investment into the “co-location” of AYUSH doctors in major allopathic hospitals has led to availability of AYUSH services within clean and organized spaces. For example, during my visit to the government Doon Hospital in the downtown of Dehradun, I found that the AYUSH ward was well maintained, there were *pancakarma* facilities, a Yoga specialist as well as practitioners of Ayurveda and Homeopathy. There are typical Western-style wards with individual doctors’ offices separated from hallways and waiting areas. They resembled private Ayurvedic hospitals that I visited: in terms of resources, cleanliness, and the number of patients both government-funded and private AYUSH hospitals were quite similar.

¹⁰⁶ Specialists in sexual health (*gupt rog chikitsa* healers) also advertise their services and phone numbers on roadside walls (Joseph Alter, personal communication).

5.5 WOMEN IN AYUSH

Historically, Ayurveda, Unani, Sowa-Rigpa, and other South Asian medical traditions were the male domains, “propagated by men and for men” (Attewell 2007, 237; also Leslie 1976b, 3). Although recent studies suggest that Tibetan medicine was open to women and the transmission of medical knowledge from father to daughter was possible, most practitioners of Sowa-Rigpa were men and the preferred medical lineage was through a male line (Fjeld and Hofer 2011, 176, 178). In Ayurveda, Martha Selby (2005) has convincingly demonstrated the presence of women’s knowledge in gynecological accounts of canonical Ayurvedic texts, but the main authors and the audience of those texts were elite men. Similarly, with regard to Unani, Attewell has highlighted that there might have been some informal “Unani” practices by women for women, but professional female Unani practitioners were rare: before the 20th century, historical accounts mention few women who served the *zenanas* (women’s quarters in noble Muslim households), but those female practitioners were exceptions in a world dominated by male specialists (2007, 195). The same holds true for Homeopathy and Naturopathy, whose medical theories were primarily written by male physicians, and after the arrival in India homeopathic and naturopathic services were mostly provided by men.

Only at the turn of the 20th century did the gendered participation in AYUSH traditions begin to change. As a result of the colonial government’s investment in hygiene and sanitation, women’s health and women’s access to medical services became an important matter of concern, particularly with regard to upper-class noble women, who led a secluded life and were not allowed to be seen by an unrelated man, even if he was a doctor. The expansion of print culture in the late 19th century—the beginning of the 20th century brought about the emergence of “self-

help” medical literature, women’s journals, and household manuals, which gave women opportunities to participate in discussions about health and even advertise for their services (Attewell 2007, 194; Berger 2013). Moreover, special institutions for training of female Unani practitioners (*hakimas/tabibas*)¹⁰⁷ and female Ayurvedic practitioners were established in Delhi and other parts of the subcontinent. By the 1930s, some women had even opened autonomous clinics (Attewell 2007, 194), although these were still rather exceptional cases.

It is difficult to identify a period when participation of women in AYUSH systems became a common practice. Attewell argued that in the 1940-1950s, women’s involvement in Unani took substantial forms (2007, 237) but from scarce references to women in *Asian Systems of Medicine* (1976) we get a sense that even in the 1970–1980s the number of female practitioners in Ayurveda and Unani was marginal. For example, Frederick Dunn briefly mentioned—but did not explain—the existence of some “barriers” to female admission to Ayurvedic and Unani education (Dunn 1976). With regard to Sowa-Rigpa, Fjeld and Hofer have suggested that the 1980s witnessed a considerable growth in female practitioners, and by 2000s the ratio of female students in Tibetan medical colleges across different countries has reached 50% (2011, 187). Currently, in Dharamsala Men-Tsee-Khang, more than half of the students are women (Fjeld and Hofer 2011). My conversations with professors of Ayurveda and Unani in Delhi and Uttarakhand medical colleges in 2015–2016 also point to the prevalence of female students. Moreover, during my interviews, I often asked AYUSH practitioners to recall the proportion of female and male students in their cohort, and I noticed that those who studied in 1970–1990s told me that the majority of their classmates were men, while those who graduated

¹⁰⁷ For example, Madrasa Zenana Tibbiya and Zenana Tibbi Shafikhanah in Delhi, both of which were later attached to the Ayurvedic and Unani Tibbiya College, offered instruction in Unani, Ayurvedic and allopathic approaches to women’s health (Attewell 2007, 219).

in the 2000s often said that the gender ratio was 50/50. A young man who was pursuing his first year of bachelor's studies in Ayurveda stated that among 50 people in his cohort 38–40 are women.

Thus, it seems that within a century AYUSH systems have undergone a dramatic transformation in terms of gender representation: the beginning of 20th century saw the establishment of first institutions where female students could study indigenous medicine, and in the beginning of the 21st female students outnumber males. However, it is important to ask how the number of female students translates into the workforce. To what extent has the role of women in AYUSH provision changed and why? And how does the changing gender ration impact AYUSH systems?

There are no publicly available government statistics on the proportion of women across AYUSH systems but several case studies highlight the fact that even today the overwhelming majority of AYUSH practitioners are men. For example, a survey of health personnel in India administered by the WHO reveals that only 14.8% of Ayurvedic, Unani and Homeopathic practitioners are women (Anand and Fan 2016, 14), while in Uttarakhand this number is halved—7.3% (Anand and Fan 2016, 47).¹⁰⁸ According to a survey sponsored by the World Bank, the proportion of AYUSH doctors in the country is 17.2 % (Rao, Shahrawat, and Bhatnagar 2016, 136). A study of appointed AYUSH doctors who are “co-located” at primary health centers and hospitals of Rajasthan found that female practitioners constituted only 14% (Kumar et al. 2013). These studies demonstrate that despite the increase and even the prevalence of female students in AYUSH courses, women continue to be underrepresented in medical practice. In many ways, this paradox exists in biomedicine too: while there are significantly more

¹⁰⁸ However, this survey did not account for Yoga, Naturopathy, Siddha and Sowa-Rigpa practitioners.

female graduates than male graduates, the proportion of female practicing doctors is only somewhere between 17% and 28% (Anand and Fan 2016, 14; Rao, Shahrawat, and Bhatnagar 2016, 136; Nagarajan 2016). Why is it so? I argue that the answer has to do with women's cultural orientation to marriage and family, the lack of social encouragement and financial means for women-entrepreneurs to set up private clinics, and—specifically in the case of AYUSH—the remaining traces of male-focused transmission of medical knowledge within the *guru-shishya* tradition.

Among my research participants, fourteen were women (26%): six homeopaths, five Ayurvedic practitioners, two Unani practitioners, and one Sowa-Rigpa doctor. This sample is not statistically representative, because I intentionally sought out female doctors. Nevertheless, it provides important insights into a gendered dimension of AYUSH services in rural and semi-urban India. For example, in a hill station of Chhotapur, where I interviewed all AYUSH providers, there was only one woman—a homeopath whose husband and father-in-law were also homeopathic practitioners, and who ran a private clinic owned by her father-in-law. Another female homeopath from Dehradun also works in a clinic jointly co-owned with her husband and son, both of whom are dentists. Dr. Gita Verma from Himnagar practices in a clinic which she inherited from her father. In other words, I have never met a female AYUSH practitioner who owned a private clinic, and this fact exposes the existence of financial and social obstacles for women entrepreneurs in India.¹⁰⁹

Additionally, with an exception of lower classes where both women and men necessarily work for wages, many Indian women are expected to prioritize family and marriage over career. On one level, this translates into the fact that some parents encourage their daughters to go to a

¹⁰⁹ See Sarah Pinto (2004) where she discusses how the wives of doctors provide medical treatment too.

medical school not to become doctors but rather to arrange a marriage with an equally or higher educated husband. On another level, even if a woman voluntarily enrolls in medicine, because she wants to become a doctor, she may ultimately decide to stay at home and raise children. Indian women are still considered primary caretakers of children and other family members, so these social expectations constrain women's opportunities to become practitioners. For example, after I interviewed a reputed *hakim*, I had a chance to briefly talk to his daughter, who had a bachelor's degree in Unani. She said that she grew up helping in her father's clinic and became interested in studying Unani, but after her graduation she got married, and both her husband and father discouraged her from clinical practice. She mentioned that she continued to see female patients at home, but it is unlikely that she would become a full time practitioner.

The need to straddle family responsibilities and medical profession also results in a greater number of women engaging in home or private practice, or setting up clinics within the house. For example, one homeopathic practitioner opened a clinic in the basement of her house, explaining that it made it easier for her to be always around if her children needed her. Although I also met male practitioners who set up clinics adjacent to their houses (typically because of financial consideration), I believe that this is a particular favorable solution for women, who want to offer medical consultations, but whose daily schedule revolves around responsibilities of being mothers and wives. In fact, this is one reason why women might prefer AYUSH over biomedicine. As I mentioned earlier in this chapter, AYUSH disciplines do not deal with emergency cases, nor do they require women to perform night shifts at hospitals, as allopathic nurses and doctors do.

A final factor that contributes to the disparity between the proportion of female medical graduates and female medical practitioners is the matter of safety. If a woman chooses to seek a

government-sponsored medical position, then there is a possibility that she would be posted in a distant or remote area. Since the launch of the NRHM with its goal of co-locating AYUSH doctors at primary and secondary health centers, women must make calculated decisions whether they can work away from familiar towns, and whether their husbands and families would support such a move. Many female practitioners told me that they had to turn down job offers and internship opportunities in distant states because their families were concerned with their safety and wellbeing. For example, when Dr. Gita Verma from Himachal Pradesh wanted to do an internship in Kerala after completion of her bachelor's studies in Homeopathy, her father was strongly opposed to her travelling so far away. Nevertheless, her father always encouraged her to do medical practice and work, and even after marriage Dr. Gita Verma continued to work as her husband was supportive. These biographical details illustrate that in order to understand the position of women in AYUSH, we need to take personal factors into account.

Despite the high enrollment of women in AYUSH courses, AYUSH provision continues to be a male-dominated sphere. Scholars have argued that the discourses on science, modernity and indigenous/traditional medicine are themselves gendered discourses (Cameron 2010; Fjeld and Hofer 2011; Flesch 2010), especially in the sense that women are held to be guardians of cultural "tradition" (Chatterjee 1993; Mankekar 1999; Sunder Rajan 1993). Mary Cameron (2010) has examined an increase in female practitioners of Ayurveda in Nepal, and argued that such "feminization of Ayurveda" has been entangled with the official marginalization of Ayurveda in the context of biomedicine-dominated healthcare system. In other words, the increased acceptance of women as Ayurvedic practitioners and the loss of prestige of Ayurveda are two interrelated processes. In contrast, in India men continue to dominate the practice of Ayurveda, Unani, and other non-biomedical traditions, and the emphasis on a thousand-years-old

knowledge has been a key strategy in increasing a market value of these systems. In the Indian context, there is no forthright way of linking “tradition” to femininity and low status; in fact, some male practitioners are able to negotiate an added value and prestige to their practice by claiming to be part of *guru-shishya* tradition—a strategy which is less available to women. Thus, because of the government promotion of AYUSH and the expansion of pharmaceutical industries which purportedly manufacture “traditional” medicine, the notion of “tradition” in India has become to signal masculinity and status than femininity and marginalization.

5.6 NON-AYUSH: BIOMEDICAL DOCTORS, PHARMACISTS, LOCAL HEALERS WHO PROVIDE AYUSH SERVICES

I would like to end this chapter by going beyond AYUSH practitioners to discuss how AYUSH services are provided by non-AYUSH actors. While there are many studies about AYUSH doctors’ use of biomedicine, my fieldwork led me to an opposite question: do biomedical doctors incorporate non-biomedical forms in their practice? During my interviews with government officials, the issue of integration was always prominent, so in attempt to comprehend the intentions, scope and direction of therapeutic integration, I started asking whether “integration” included proposals to add an AYUSH component into biomedical education. It turned out that such proposals existed, although the prescription of AYUSH drugs by allopathic doctors seems to be considered less problematic. Several government officials I interviewed pointed out that many biomedical doctors do indeed prescribe branded Ayurvedic medicines, for example, a famous treatment for liver diseases, Liv-52. However, according to the Medical Council of India (Professional Conduct, Etiquette and Ethics) Regulations, 2002, Clause 6.5, a physician cannot

prescribe or dispense a drug whose remedial agents or composition he does not know; by extension, this applies to biomedical practitioners who are not trained in alternative medicine and thus cannot prescribe it (Math et al. 2015, 297).

Although this was not the focus of my study, I spoke with several MBBS and MD doctors about their views of AYUSH. Most of them were skeptical and even belittled the “unscientific” treatments, but some allopaths shared their respect for Ayurveda and Homeopathy. One physician explained that he himself had never attempted to use Ayurveda, because it would have required additional training. But he often followed what he called “ayurvedic language” with some of his patients, employing the concepts of hot and cold, the three elements of *vāta*, *pitta*, and *kapha*. He explained that sometimes his patients explicitly told him: “*daktar sahib, yeh goli garam hain*” (doctor, this tablet is hot) or “*mere vata ka problem hai*” (I have a problem with *vata*). Accordingly, he would have to reply in a way understandable to his patients: “If I tell them about proteins and carbohydrates, it won’t make any impact, as it makes little sense to them.” The interest of Indian allopathic doctors in Ayurveda and their use of Ayurvedic medicines remains underexplored in anthropological literature, but in recent years there have been several surveys published in medical journals (Gawde, Shetty and Pawar 2013; Shashikumar and Sheethal, 2015). Priya and Shweta (2010) have documented that approximately 55% of biomedical doctors acknowledge prescribing non-biomedical medicines or referring patients to non-biomedical practitioners.

According to a survey conducted in 2013 among resident biomedical doctors in Mumbai, 99% of the physicians report having no knowledge of Ayurveda and 76% believe that cross-system prescription is dangerous, yet 67% of the same physicians routinely prescribe Ayurvedic medicines such as Liv-52, Shatavari, and Cystone (Gawde, Shetty and Pawar 2013). With regard

to the use of other AYUSH systems by allopathic doctors, I am not aware of any study, but I came across several remarkable cases during my fieldwork. One day in 2013, when I was in Himachal Pradesh, I spotted a building with a signboard which read “Homeopathic Medicines,” with a name of a doctor and his medical degree, which was surprisingly MBBS, not BHMS. Curious, I went inside, hoping to interview this allopath who was running a homeopathic dispensary. Unfortunately, when I approached him, he said that he did not have time for an interview, but directed me to a side room to speak with his wife. As we talked, I learned that she did not have any medical degree, but held a registration for a homeopathic dispensary and was in charge of dispensing medicines which her husband prescribed. She told me that her father-in-law was a homeopathic practitioner, and her husband grew up learning about Homeopathy. So now even though her husband went to a biomedical college and received an MBBS degree, he decided to open a homeopathic dispensary.



Figure 9. Signboards of an ayurvedic/allopathic chemist shop and a private homeopathic clinic
Notice that on the central board beneath the doctor’s name (which I blackened for anonymity), the doctor’s degree is biomedical (MBBS), whereas the advertised clinic is homeopathic.

This example is meaningful for a number of reasons but it is neither extraordinary nor particularly novel. There are interesting historical cases, such as examples from 19th century Bengal, that suggest that it was not uncommon for a graduate of the “allopathic” Calcutta Medical College to switch to Homeopathy (Arnold and Sarkar 2014, 44). According to reports written by one physician in the beginning of the 20th century, there were many “mongrel homoeopaths,” i.e. allopathic doctors who secretly kept homeopathic drugs especially for cholera and use them in the time of emergency (ibid.). Yet what is interesting about my encounter with this biomedical doctor who runs a homeopathic clinic is that he does so with the help of his wife. In the next chapter I will examine more cases of such cross-system family practice, but now I will offer two more situations when AYUSH medicines and therapies are prescribed by non-AYUSH doctors.

In addition to biomedical doctors, AYUSH services and medicines can be provided by persons who either do not have any formal medical qualifications (like so-called traditional healers), or those who have ancillary medical diplomas and certificates (of pharmacists, nurses, paramedics). During my research, I met several people who had a diploma in pharmacy but *de facto* performed the role of Ayurvedic doctors by providing consultations, conducting medical examinations, and writing prescriptions, although this practice is clearly unlawful. I met one such pharmacist in a hill town of Kumaon. It was my third day after arrival and I was asking the residents about Ayurvedic medicine, when they directed me to Nagarjuna. A man in his mid 40s, he was running a small pharmacy, which was centrally located and seemed profitable, as it was well stocked with ayurvedic and allopathic pharmaceuticals but had that look of chaos and neglect so typical of many small shops in India. When I approached Nagarjuna, he introduced himself, in very good English, as a medical chemist. Later he mentioned that he had worked as a

medical representative for a large pharmaceutical company. To my question whether he was merely selling medicines or providing consultations as well, he responded by proudly stating that he consulted and recommended treatment to 20-25% of all visitors. He explained that local people preferred him for medical advice, because they trusted him and knew that he was knowledgeable. Even when people came with a doctor's prescription, Nagarjuna would scrutinize it and give a verdict; he said, very often prescriptions were complete "rubbish," such as a course of antibiotics for five days. Based on experience, Nagarjuna knew that they should be taken for at least two weeks. Curiously, he even told me that he was collecting and "analyzing" other doctors' prescriptions. As a proof, he pulled out a medium-size folder containing various prescription slips. What is even more surprising is that Nagarjuna claimed to have attended a conference in Glasgow where he had shown these prescriptions in order to highlight how uninformed doctors were in India.

Although strictly speaking Nagarjuna is not a doctor, I relay his story, because it illustrates the complexity and idiosyncrasies of the Indian therapeutic landscape, and underscores the fact that, in most cases, from a patient's perspective, the differences between allopathic and non-allopathic medicine, or between a chemist and a doctor are not meaningful. In other words, patients, unlike curious anthropologists, do not necessarily reflect on a mismatch between someone's occupation and qualifications. In that sense, not much has changed since Nichter's (1980) study in South India where he found that villagers visiting a nearby town in search for a treatment "pay little attention to the qualifications boldly written or scribbled under the names of each practitioner" (p. 226). Nichter ascribes this lack of attention to an overwhelming number of random abbreviations:

Abbreviations for cosmopolitan, indigenous professional and integrated (ayurvedic and allopathic) medical diplomas, issued by different states at different points in time are

intermixed with initials designating government legislation, homeopathic correspondence courses, the possession of a university certificate (some cases, certificates of attendance not completion!), foreign training or residence and membership in little known and oft-time bogus professional societies (Nichter 1980, 226).

With the unification of medical degree titles and other steps taken by the central government to bring order to non-biomedical nomenclature, the situation has improved. However, even today, I notice that with the exception of some educated residents who may question whether a doctor is certified or not, most people are generally unaware of practitioners' formal credentials. The only exception is the abbreviation MBBS which symbolizes the most reputed (bio)medical title. In general, doctors' patients do not scrutinize doctor's education and certification, but are more interested in her reputation and the perceived efficacy of her medicine.

Finally, among non-AYUSH and non-doctors who provide non-biomedical services, there are so-called traditional healers. They do not have the government's authorization or even registration, yet they are often addressed as *vaidyas*, *hakims* and even doctors, because they come from families associated with a certain medical tradition. Typically, they receive patients at home or places of worship. The practice of these healers is an example of what Hardiman and Mukharji (2012) call "subaltern therapeutics." Just as with the institutionalized medical systems, traditional healers might gloss their therapies as "Ayurveda" or "Unani" but with quite different epistemology and repertoire of treatment. For example, the *vaid-pujari* I have introduced earlier told me that healing was his family tradition and he was a third generation practitioner, although he did not have a medical degree. When I asked him how he called his therapy, he said "Ayurved" but when I wondered whether he diagnosed an illness by taking the pulse and examining the character of *doshas*, he answered that he had never heard the word *dosh* before. He explained that "Ayurved" was based on *butiyon ki dawai* (herbal remedies), which he learned from his father. However, his education was incomplete because he was afraid of snakes: he

elaborated that in order to become a true *vaid*, he needed to understand the power of snakes, but when his father tried to teach him that, he was so afraid that never learned this part of Ayurveda.

This story exemplifies that Ayurveda itself is a conglomerate of diverse practices, although the drive to professionalize and institutionalize Ayurveda—as well as Unani, Tibetan Medicine and other medical traditions—has resulted in purging out certain traditional healing domains which were perceived as esoteric, religious and unscientific (Adams 2002; Alter 2011; Hardiman and Mukharji 2012; Langford 1999; Naraindas, Quack, and Sax 2014). Since my research was occupied with institutionalized forms of non-biomedical modalities, I did not seek to engage with healers like this *pujari-vaid*. However, it is important to keep this example in the field of vision, because it highlights the cultural architecture within which AYUSH practitioners operate.

In this chapter, I have described different professional itineraries and occupations of people who provide non-biomedical services. I have shown that most of non-biomedical practitioners simultaneously perform multiple roles and occupy multiple positions, such as teaching in a university, serving as a practicing doctor at the university-based OPD (Out-Patient Department), and holding an administrative position, or working in a state-level government hospital during the day and conducting private practice at home in the evenings. Such crossings between government and private practice, theoretical and practical work, formal knowledge and claimed expertise exist in any profession, and it should not be surprising that it is ubiquitous among AYUSH practitioners too.

6.0 VERSATILE DOCTORS AND THERAPEUTIC BOUNDARIES

This chapter examines the ways in which practitioners talk about and engage with different strands of non-biomedical traditions (AYUSH and beyond). Why do some doctors insist on distinctiveness and “purity” of a medical tradition they are licensed to practice, while other doctors incorporate treatments that do not correspond to their designated area of expertise? How do they choose to emphasize differences or similarities between different non-biomedical regimes such as Ayurveda and Unani, Ayurveda and Homeopathy, or Naturopathy and Yoga? What and who influences doctors’ choices of diagnostic tools and therapeutic methods?

At the heart of these questions is a quest for unfolding the processes of therapeutic boundary-making and boundary-crossing, as manifested in daily routines of AYUSH doctors. I seek to understand doctors’ medical ideologies, particularly their motivations for either using heterogeneous therapies or preserving a “pure” tradition. I also examine doctors’ appeals to religious and political communities as well as their concerns with the commodification and cultural ownership of medical knowledge. In other words, I question whether doctors who, for example, contend that Ayurveda is different from Unani, also claim that these systems belong to different “cultures” and thus could be subjected to (mis)appropriation. Special attention is paid to the role of patients and doctors’ families in shaping the configurations of what I call “versatile” practices of medicine—a view wherein medical plurality is taken not as a co-existence of

multiple distinct traditions in a society but as each doctor's versatile and resourceful engagement with multiple therapies and medical technologies.

6.1 BOUNDARY-CROSSING

Three decades ago, in a small South Indian town, Marc Nichter (1980) observed that many formally and informally trained doctors “engage in an eclectic form of therapy which draws from all existing therapy systems” (p. 226). Borrowing an apt expression from his informant, Nichter called this phenomenon *masala medicine* (from *masala*, a mix of spices)—the preparation of a drug “mixed to the taste and pocket” of an individual patient (Nichter 1980, 227). In the next three decades, a wealth of studies from India and other countries have exposed how medical practitioners negotiate a disciplinary corpus of medical traditions, by resorting to eclectic, heterogeneous, and sometimes antagonistic forms of treatment (Adams 2002; Alter 2005a; Ernst 2002; Hampshire and Owusu 2012; Khare 1996; Langford 1999; Leslie and Young 1992; Liebeskind 2002; Naraindas, Quack, and Sax 2014; Nichter 1980; Zhang 2007). In more radical terms, scholars have argued that not only do medical practitioners use eclectic therapies, but every medical tradition itself is already eclectic, plural, and entangled with other traditions. In a brilliant study, Projit Mukharji (2016) develops a concept of “braided” knowledges, drawing on the works of prominent historians such as Ranajit Guha, Gautam Bhadra, Monica Juneja, and Michael Werner and Benedicte Zimmermann (p. 26). The idea of “braidedness” signals that every knowledge tradition has multiple strands which can be pulled out and braided together to create new forms: “If we think of cultures as spools of numerous diverse and different threads, we might envisage their interaction as the braiding of certain threads taken from different reams”

(Mukharji 2016, 26). Analyzing the history of modern Ayurvedic practice in colonial Bengal with regard to the use of medical technologies, Mukharji argues that Ayurvedic physicians “could and did access multiple strands of knowledge from within multiple learned traditions” (2016, 24).

This argument strongly resonates with my own theorization of contemporary AYUSH practices. However, Mukharji’s work and the majority of the scholarship on medical plurality, with few exceptions,¹¹⁰ remain centered on the entanglements of a certain medical tradition with biomedicine. In contrast, I am less concerned with biomedicine and rather inquire into the negotiated, versatile use of multiple strands of therapeutic traditions beyond biomedicine. My research demonstrates that irrespective of whether AYUSH physicians incorporate allopathy or not, they often pick and choose from a large spectrum of non-biomedical healing traditions. What is notable is that my fieldwork took place three decades after Nichter’s observation of *masala medicine* and after sundry decades of the government’s efforts to professionalize, standardize, and regulate the provision of alternative medical care. To reiterate, these syncretic therapeutic modalities are a commonplace in contemporary India, despite and in the context of the fact that the central and state governments have been actively engaged in standardizing and delineating the AYUSH landscape. Therefore, along with the examination of braiding of multifaceted and heterogenous healing practices, it is essential to be cognizant of the impact

¹¹⁰ Several scholars have looked at the differences, similarities and possible historical roots of multiple non-biomedical traditions. For example, Kuriyama (1999) has examined the case of Unani and Chinese medicine; Hausman (2002) and Arnold and Sarkar (2002) have provided insights into the relationship between Homeopathy and Ayurveda; Attewell (2007) has commented on the history of mutual influences between Ayurveda and Unani; Alter (2005b) has examined the cultural production of Ayurvedic acupuncture, and in another work (2015) has analyzed different articulations of nationalism through Ayurveda and Nature Cure. Additionally, there are several studies which interrogate how practitioners of one non-biomedical tradition (typically Ayurveda) engage in ritual healing and so-called folk traditions (Langford 1999; Sax and Bhaskar 2014).

that the state exerts on doctors and their patients. In other words, although we know that medical categories such as “Ayurveda” or “Western medicine” and the boundaries around them are often dismissed, crossed, and blurred, when it comes to actual practice (Alter 2005a, Naraindas, Quack, and Sax 2014, Langford 2002), it is still imperative to remember that the boundaries around medical traditions can be socially and politically enunciated (Attewell 2007, Weiss 2008, Ferzacca 2002, Keshet and Popper-Giveon 2013). To be clear, I do not claim that we can detect a significant change in doctors’ practices before and after the formation of the Ministry of AYUSH; nevertheless, a sharp focus needs to be maintained on the broader context of government regulation and legitimation with its long history as outlined in Chapter 3, so that we can better understand how AYUSH practitioners view their own practice, the practice of other AYUSH doctors, as well as healing modalities which the government considers non-AYUSH.

The complexity and versatility of non-biomedical physicians exist in a tension with a contrary strategy of fortifying the medical boundaries and maintaining the “purity” of a tradition. Thinking about both the processes of boundary-making and boundary-crossing, it might be reasonable to ask how many of AYUSH practitioners provide *masala medicine* and how many of them follow a “pure” tradition. However, if we acknowledge that there is no pure practice and every medical tradition is always already *masala*, blended, and braided, then the posited question becomes nonsensical. Instead of asking “how many”—a question which wrongly presupposes that we can easily demarcate those who practice a blended therapy or a pure tradition—I suggest to ask the questions of which and why: which kinds of therapeutic practices doctors engage in and why do they do so? Thus, I begin by looking at different forms of practitioners’ versatile practice, at their medical ideologies regarding efficacy, authenticity, and legitimacy of medical traditions, and at people who influence doctors’ views and practices such as patients and family.

6.1.1 Family division of therapeutic labor

My work among AYUSH physicians has revealed that fathers and sons, husbands and wives, fathers and daughters, brothers and sisters often receive training and practice in *different* medical systems. I am not aware of any anthropological study on this issue, but I estimate that this situation is quite common: about one-fifth of all interviewed AYUSH practitioners have a family member who engages in a different medical tradition. For example, upon the completion of her training in Homeopathy, Dr. Gita Verma had to share a one-room clinic with her father, an ayurvedic practitioner. Initially, she only had a small table at a corner where she received her patients while the father consulted his patients in another part of the room. This example aptly illustrates that Homeopathy and Ayurveda can coexist—quite distinctly—under one roof: not as a “co-location” within a government hospital, but as a joined practice of a father and a daughter. Only gradually these two systems collapsed into a single braided modality: while working with her father, Dr. Gita Verma learned basic principles of ayurvedic diagnosis and treatment; after the father passed away, she inherited the “Ayurvedic” clinic, and decided to get a formal degree in Ayurveda, in addition to her homeopathic diploma. So although a signboard outside her clinic identifies her as a “homoeopathist,” her actual practice draws on plural traditions.

At the same time, having a family member in a different medical system does not necessarily lead to explicit forms of therapeutic blending. Instead, it can result in a “division of labor” within a family. For example, I have interviewed a female *panchakarma* specialist whose father is a biomedical doctor but who herself claims to never prescribe biomedical pharmaceuticals. Similarly, I have spoken to a female homeopathic practitioner whose brother is an MBBS doctor and who claimed that neither of them engages in cross-practice. In all these examples, doctors emphasized that it was important to them that they came from medical

families, although their approaches to medicine were different from the approaches of their family members.

These cases illustrate that there is some form of medical pluralism within a family, or even a family division of therapeutic labor, which may or may not result in cross-therapeutic approaches.

6.1.2 Clinical bargaining and market competition

In addition to family influences, another impetus for therapeutic blending comes from patients, who may request specific treatments or contest a prescription. It is not that by doing so patients intend to undermine the authority of a doctor; rather, most interactions in South Asia are understood as negotiation, and medical consultations are not exceptions. Patients do not hesitate to communicate their therapeutic preferences and concerns, while medical practitioners are quite willing to accommodate patients' requests. Moreover, doctors do not want to risk losing clients, especially in urban and semi-urban areas, where the pressure of economic competition is high.

During many hours in doctors' clinics, I frequently observed how patients "bargained" with healers about the specifics of therapy, its cost and duration, so much so that the clinics even resembled marketplaces. For example, I observed that patients with modest income often solicited a cheaper medicine or a prescription with a shorter duration. Additionally, I noticed how a young Muslim woman specifically requested a non-alcohol-based medicine, and similarly, some doctors told me that Jain clients could be reluctant to take an animal-derived product. In many occasions, I heard how patients asked for "quicker" drugs in order to get back to work, even though they came to an Ayurvedic practitioner. Doctors whose clinics are located in central

and busy streets confirm that such requests are very common: working class visitors come for a quick relief, so the doctors feel compelled to provide an allopathic medicine. I also observed how doctors themselves asked patients: “For how many days should I give you the medicine?”

As a result of demands from diverse categories of patients, non-biomedical doctors can be motivated to experiment with heterogeneous approaches to healing: not only by combining an AYUSH tradition with biomedicine, but also incorporating elements of one AYUSH discipline into the corpus of another. For example, an Ayurvedic doctor may choose to use a homeopathic remedy, or a Unani practitioner may prescribe an ayurvedic drug of a popular brand such as Patanjali or the Himalaya Drug Company. Furthermore, in conjunction with authorized modalities of medicine, some physicians also adopt numerology, astrology, color therapy, psychology and ritualized forms of healing (see also Tirodkar 2008: 238-239). Again, we should not underestimate that a critical factor why doctors resort to creative, versatile, and *masala medicine* is the competition for clients. Therefore, doctors seek out new therapies, proclaiming that their methods help to achieve cure even in cases where biomedicine is not successful. Consider, for example, the strategies of Dr. Ajay Dixit, a homeopathic practitioner with a bachelor’s degree (BHMS) and almost 30 years of experience. His clinic consists of a tiny dusty room with two benches for visitors and a doctor’s table surrounded by old wooden cabinets with homeopathic paraphernalia. The clinic is located on a busy street, on the second floor of a three-story building which also accommodates a vegetable shop, a mechanic, a lawyer’s firm, and a wine store. Dr. Dixit does not speak English, but he is well educated and writes extensively in Hindi. In the early years of his career, he came across a book written by some Dr. Gopal Bhaskar

Ganpule¹¹¹ who advocated for a therapy called *mānasopcāra* (Marathi: mind therapy)—a kind of psychotherapy in which a patient is asked to share his dreams, daily habits, taste preferences, and social relationships. Dr. Dixit became very interested in this “healing without medicine,” and decided to incorporate into his homeopathic (drug-based!) clinical practice. Moreover, as a diagnostic method, he uses pulse reading and claims to be able to trace the pulse from every organ, which seems to be reminiscent of an ayurvedic procedure. Yet, Dr. Dixit does not employ ayurvedic concepts of *vata*, *pitta*, and *kapha* to describe the pulse patterns. He simply claims that pulse is a person’s “language” and that it is necessary to use this language in order to decode the root of an illness: “if you don’t learn the language, how can you understand the speaker?” In addition to combining Homeopathy, *manosopchar* and ayurvedic pulse-taking, Dr. Dixit routinely recommends praying to Ram, Allah, or another divine power. When I asked him how prayer was related to Homeopathy, he replied that the best way of healing is through *dava aur dua*—by means of “medicine and prayers.”

Dr. Dixit is not alone in this method. Khare (1996) describes an ayurvedic doctor who favored a similar fusion of medical and religious modalities:

...Ayurveda treats the patient as a whole, as a person, situated within his/her daily social situation and moral position in life. In popular practice, morality and religious faith, particularly prayers (*dua*), are known to enhance therapeutic potency of medicines and treatment (pp. 838–839).

Another example comes from Helen Basu’s article (2014) in which she has assessed the *Dava aur Dua* project whose objective was to incorporate psychiatric treatment into a healing shrine in Gujarat. The principle of *dava aur dua* is widely used and recognized among Indians, which according to Quack (2013), exhibits a pragmatic mode of religiosity. Therefore, Dr. Dixit’s

¹¹¹ There is very little information about Gopal Ganpule but it is likely that he was a psychiatrist who was influenced by Atharvaveda and who developed a kind of hypnosis and a sleep therapy. There are two books written by Ganpule: *Manasopchar: Shastra va Paddhati* and *Manasonnati* (both in Marathi).

blending of medical and religious therapeutic approaches fits well into a widespread cultural framework of healing. From this perspective, it makes a perfect sense that some AYUSH doctors consult patients at the spaces of worship such as temples and *gurdwaras*, as I described in the previous chapter.

Sometimes a quest for originality under the market demands leads doctors to rather dubious approaches. For example, one of the interviewed Ayurvedic doctors promoted a “color therapy”—a procedure that requires patients to drink the water of a prescribed color. On another occasion, I met a doctor who weaved together the healing practices of herbal medicine, Yoga, meditation, astrology, and “organic” diet. Dr. Madhukul had a bachelor’s degree in Ayurveda and a certificate in Yoga from the Yoga Alliance USA certificate, which allowed him to open a tourist-oriented resort—which he called an *ashram*—where he combined Yoga sessions with *panchakarma* and other ayurvedic procedures. There was a stark difference between Dr. Dixit’s homeopathic clinic—tiny, somewhat untidy, with the smells from the bazaar where it was located—and Dr. Madhukul’s *ashram*, spacious, quiet, hidden from the roads, filled with the subtle lemongrass fragrance (“We wash the floors with lemongrass water instead of chemical mosquito repellents,” as the doctor explained). Within the *ashram*, there was also a small “organic” medicinal garden. But the most remarkable to me was the fact that Dr. Madhukul insisted on recording his clients’ zodiac signs in order to prescribe a zodiac-specific diet and herbal remedies. He contended that medicinal plants acted differently on people of different astrological nature. Furthermore, he even emphasized the importance of “positive thinking” and a harmonious living with other natural beings. To illustrate this principle, he claimed that cows in the *ashram* were milked only when they were supposedly happy, so that the guests could be served a specialty drink—“happy cow’s milk tea”!

One might question whether *dawa aur dua*, color therapy, zodiac-based herbs, and “happy” animal-derived remedies are more efficacious than biomedicine or standardized AYUSH practices, but what is important to recognize is that there is a profound commercial and social appeal of experimental treatments. Even in the past, unconventional healing techniques were as much condemned and ostracized, as they were sought out, esteemed, and incorporated into therapeutic repertoires. Nowadays, the consumption and provision of unique therapies is also driven by the global wellness discourses, which draw on New Age holism, wholesomeness, spirituality, and organic and natural diet, but which also stand in opposition to institutionalized forms of medicine. In a way, what I am describing here, and what Dr. Dixit and Dr. Madhukul do is the provision of alternatives to alternative medicine, or rather the supplementation of recognized alternative medical practices with unrecognized alternative approaches.

It is impossible to underestimate the almost alchemic promises of such idiosyncratic and versatile healing practices, especially in the context of high rates of cancer, hypertension, autoimmune disorders, chronic fatigue, or stress, for which there is often no satisfactory biomedical explanation. Here I find it useful to dialogue with the work of Laurence Kirmayer (2014), who articulates that the commercial and social currency of alternative medicine reversely correlates with patients’ dissatisfaction with biomedicine, as the latter is “criticized for its failure to engage the personal and cultural dimensions of suffering,” as well as for involving “painful, disorienting, and disturbing treatments aimed not at comfort but biological efficacy” (pp. 38–39). In contrast, alternative medicine invokes “notions of nature, wholeness, and harmony that are reassuring, and interventions may be delivered in pleasant surroundings that evoke feelings of safety, comfort and well-being” (2014, 39). Although Kirmayer describes the difference between biomedicine and alternative medicine in North America, I suggest that this focus on different sensorial

experiences can help to explain why some patients in India would be drawn to healing practices that emphasize “positive thinking,” pay attention to one’s zodiac sign or *doshik* constitution, offer “happy” products, and create healing spaces with gardens, bodies of water, incense sticks and pleasant fragrances, as all of this produces powerful sensorial engagements.

Nevertheless, the question seems to remain: Is there more to this versatile and eclectic medicine than just a market competition for clients? What else motivates doctors’ drive for experimenting with heterogeneous and unauthorized treatments? In posing these questions, we again face the same problem that I have previously mentioned—the problem of assuming that physicians know which treatments are authorized and which are not. In South Asia, the relation between the so-called authorized (“medical,” “scientific”) and unauthorized (“spiritual” and “esoteric”) practices are complex and contested (Adams 2002; Adams 2010; Alter 2004; Alter 2011; Leslie 1976c; Liebeskind 2002; Mukharji 2016; Quaiser 2011; Singleton and Goldberg 2014; Weiss 2009; Wujastyk and Smith 2008). Many methods that are currently deemed unscientific were integral to classical Ayurveda, Yoga, Sowa-Rigpa and other South Asian traditions, but since the 19th century there has been a tendency to wipe out the “esoteric,” “unscientific,” and “irrational” elements. For example, many mystical and tantric aspects of classical Yoga were rejected from the corpus of what has become a modern “sanitized” and “medicalized” practice (Alter 2004; Alter 2011). In other cases, certain branches of knowledge were not expelled but rather reformulated to fit into the discourses of science. For example, *bhutavidya*—the knowledge of non-human beings in classical Ayurveda—is now interpreted in biomedical terms as a study of psychological and emotional disorders.¹¹² In contrast, Siddha practitioners in Tamil Nadu seem to “have far readily retained the metaphysical features of their

¹¹² A online search shows that many websites present *bhutavidya* in biomedical terms as a form of Ayurvedic psychology and psychiatry that deals with mental health issues.

past practices, and they have launched a much stronger critique of science,” than other South Asian traditions (Weiss 2009, 193).

What this shows is that the demarcation of what is acceptable and unacceptable is a relatively recent phenomenon driven by the institutionalization of medical traditions but which has not remained unchallenged. Hence, when certified AYUSH doctors include *mantras* or astrological elements into their clinical repertoires, it is hard to delineate whether they engage in “crossing” the boundaries of their certified expertise, or “staying within” the boundaries of their intellectual traditions. From this perspective, there is no clear line between inventing something new and restituting a previously common practice. Some practitioners can declare skepticism towards what they believe to be novel therapeutic techniques and would rather resort to canonical texts in search of authentic and ancient practices, but in reality, what is conceived of as new and what is old are tightly intertwined.

Moreover, we must not forget that doctors themselves are ordinary people, who fall sick and suffer from ill health. As paradoxical as it sounds, doctors might not be the devout followers of the medical disciplines in which they have been trained and certified. From my conversation with many different practitioners, I can attest that many of them are genuinely dedicated to healing and alleviating people’s suffering; they are aware of the increasing complexity of life and the emergence of new diseases, which they think cannot be combated without integrative approaches. Disenchanted with certain therapies, some doctors like Dr. Dixit (through Homeopathy, *dawa aur dua*, and *manasopchar*), Dr. Gita Verma (through Homeopathy, Ayurveda, and acupressure), or Dr. Shukla (through Ayurveda, Nature cure, and *color therapy*) look for plural treatment materials and methods, fusing, reworking, and incorporating diverse therapeutic modalities into their professional repertoire.

Attempting to explain why people are drawn (or resistant) to alternative therapies, Kirmayer argues that choosing a treatment is not about thinking clearly what works and what does not, but is a matter of “allegiances and commitments to particular systems of knowledge or institutions that warrant specific healing practices,” and such commitments perform the functions of “resource management, social positioning, and identity consolidation” (2014, 33). However, he also cautions that meanings and functions provided by the commitments to certain knowledge systems are “not entirely under the control of the individual, since the dominant cultural meanings of medical practices are shaped by larger social, economic, and political agendas” (Kirmayer 2014, 33). In my view, this reasoning is not only applicable to health seekers but to medical practitioners as well. As trained professionals, AYUSH doctors may be committed to certain systems of knowledge, but they are also subject to broader health ideologies and political circumstances. The daily practices of AYUSH physicians are mediated by patients, family members, state, media, and globalized economy, making their practice ever more entangled and heterogeneous.

6.1.3 Medical technology

Another way of discerning the resourcefulness and versatility of AYUSH practitioners is by examining their use of medical technologies and objects. Inspired by the work of Appadurai (1988) and other scholars of materiality, medical anthropologists have expanded their inquiries of medicine from philosophies, ideologies, and knowledges to physicality and the “agentive properties” of medical objects such as medicaments, documents, medical equipment, and technologies (Berg and Bowker 1997; Burke 1996; Hunt 1999; Langwick 2008; McDonnell 2010; McKay 2012). Within the context of medical pluralism, scholars have looked at how non-

biomedical healers adopt objects that might be associated with other medical traditions, especially with biomedicine. For example, in her work on “institutionally articulated medical pluralism” in Tanzania, Stacey Langwick discusses that a “traditional” healer often uses a syringe and reads patient’s diagnostics tests obtained from biomedical hospitals. She further argues that the presence of such medical technologies in a local healers’ practice “challenge[s] the self-evidence of boundaries between traditional and modern medicine” (2008, 429). In South Asia, the studies of the use of medical technology in modern Ayurveda, Unani, Yoga, and Nature Cure have been particularly detailed and fruitful (Alter 2004; Attewell 2007; Cameron 2009; Khare 1996; Mukharji 2016; Nichter 1980), evincing that although the use of various medical technologies is common, it draws on different rationales and takes different forms. For example, Cameron (2009) has observed an ayurvedic practitioner in Nepal who “employs biomedical technology such as the stethoscope to gain additional information that will confirm his initial dosic reading and to satisfy patients’ demands for modern technology” (p. 248). Nichter has highlighted technology’s indirect uses, more reminiscent of the “laying of hands,” when patients request an Ayurvedic healer to touch an affected part of the body with a stethoscope, believing that just a touch of a stethoscope might have a curative outcome.

In my work I have come across similar situations when AYUSH physicians used technologies and objects that are usually considered biomedical. When I first visited Singhania—an Ayurvedic practitioner who consults patients in the basement of a Jain *mandir*—he invited me to sit on a bench and wait until he finished talking to a young fellow of about 20 years old, accompanied by a man in his 40s (whether a friend or a relative I could not tell). Singhania took the patient’s pulse, listened to his complaints, and then wrote a prescription on a piece of paper. The consultation seemed to be over, but just as the patient began getting up, the 40-year-old man

politely but emphatically told the doctor to check the young man's blood pressure. And the doctor did, using a blood pressure monitor. Initially, this struck me as a case of material eclecticism. Located in a temple, Singhania's room was a rather simple and dim place with a table and two wooden cabinets on either side. Singhania identified himself as a *vaid* who practiced Ayurveda; however, he also made use of a blood pressure monitor. Similarly, although Dr. Madhukul was a specialist in Ayurveda, Yoga, and Astrology, he required his clients to undergo the assessments of their heart rate, blood pressure, stool, urine, and blood, including X-rays and MRI technologies. Such objects as thermometer, stethoscopes, blood pressure monitor, and injections in the hands of an Ayurvedic doctor may seem to be the objects out of place, objects that do not correspond to the doctors' certified area of expertise, but are they indeed out of place? Do these objects evidence a technological hybridization, medical eclecticism, and therapeutic boundary-crossing, or is there a different way of understanding them?

After analyzing letters and publications of Unani intellectuals in the 1900s–1950s, Liebeskind (2002) came to the conclusion that for some *hakims* “biomedical technology, like the subjects of anatomy and surgery, was regarded as a neutral tool that could be integrated into Unani medicine if necessary” (p. 67). To push this argument further with regard to contemporary AYUSH physicians, I suggest that many of them do not even view medical objects and technologies as biomedical. For example, one Unani practitioner scoffed at me when I called a stethoscope “allopathic.” He argued that a medical technology is not part of biomedicine, but it is part of science. If he, as a Unani doctor, wants to use a medical mask in his OPD, it is not modern medicine, it is basic hygiene. If he wants to get an MRI done, it is not allopathy, it is physics. This line of reasoning is quite popular and it represents a remarkable strategy of being able to both promote one's medical tradition and embrace science, without necessarily

embracing biomedicine.

A productive way of looking at the place of medical technology entangled with different medical traditions comes from Mukharji's (2016) study of interactions and braiding of Western science with Ayurveda through technological objects. Mukharji looks at glass bottles, thermometers, stethoscopes, pocket watches for measuring pulse, and other mundane "small technologies" that have become common features of Ayurvedic "technomodernity" since the late 19th century. By drawing on Werner and Zimmermann, on the one hand, and Nicholas Thomas on the other hand, Mukharji argues that every medical objects are always already crossed, relational, and entangled (2016, 24–27). They cannot be clearly defined as Western, biomedical, or Ayurvedic.

At the same time, as I am interested in the perspectives of AYUSH physicians, to simply state that all medical objects and technologies are entangled and already crossed is to silence those doctors who think otherwise and who strongly oppose to any form of "corruption" and "cross-practice." Therefore, I now turn to a discussion of situations in which a perceived acts of therapeutic boundary-crossing are deliberately avoided.

6.2 BOUNDARY-MAKING

If patients go about searching for treatment, "hopping" from one doctor to another, often paying little attention to a fact that these doctors represent different medical philosophies, and if doctors, too, avail themselves of a wide variety of medicines, therapeutic methods, and technologies, then one can justifiably ask whether medical traditions "exist" at all. To put it differently, do we, as researchers, achieve an analytical clarity by asking and writing about "Unani," "Homeopathy,"

and other categories of medicine? By producing books on “Yoga,” “Siddha,” or “Tibetan medicine,” are we not reinventing, reifying, and perpetuating these otherwise heterogeneous, entangled, and versatile practices? Certainly, since the 1950s the scholarship on medical pluralism has progressed significantly, evincing a great sensitivity to the constructed nature of plural categories of medical knowledge. However, I fully endorse Waltraud Ernst’s view that even when scholars declare that a medical “system” is an ideological construct, they nevertheless describe medical pluralism in terms of “interactions,” “encounters,” and “exchanges,” which implies the existence of bounded systems (2002, 3). So how can we find different ways of engaging in conversations about diverse forms of healing? Do amorphous categories such as “traditional medicine” and “alternative healing”—their own shortcomings notwithstanding—have a higher explanatory value in representing people’s quotidian experiences with medicine? Or, are the established categories still valid?

To be clear, I do not argue that the current government’s delineation of medical traditions lacks any impact on non-biomedical practices. In all my interviews and observations, I was particularly attentive to recent circumstances in which medical pluralism in India is officially constructed, and one thing remains clear: medical eclecticism persists, despite the state categorization and standardization of medical knowledge. This paradoxical situation has forced me to consult two bodies of scholarship: the one which is focused on fluid, eclectic, blurred, and negotiated medical practices, and the one which accounts for situations where medical categories are created, patrolled, and reified. Therefore, along with the cases of negotiated treatment, I present the instances of the therapeutic boundary-making.

6.2.1 Boundaries in anthropology

The concept of boundaries is pivotal to understanding human behavior. It lies at the heart of the anthropological discipline (Anderson 1983; Barth 1969; Douglas 1966; Gupta 1995; Nader 1996; Naraindas 2014a) but has also attracted scrupulous attention across social sciences and the humanities (Said 1978; Lamont and Molnar 2002). Whether we attempt to talk about race, gender, faith, ethnicity, nation, or language, we are inevitably faced with a problem of delineation, categorization, and boundary-making.¹¹³ While a non-specialist would “naturally” distinguish a woman from a man, black from white, or Asian from African, an anthropologist would highlight the constructedness of those categories, arguing, for example, that race and ethnicity—as distinct, neat, bounded entities—do not “exist.” Yet, anthropologists are also mindful of the fact that *experiences* associated with race and ethnicity, especially when it comes to oppression and discrimination, do exist and are real. While acknowledging conventionality of the social world, we do not disregard the dangers of the routines through which the difference is codified and delineated. Therefore, it behooves us to posit uneasy questions such as who codifies that difference and who supports such decisions, what is achieved by the delineation of boundaries, what implications it bears on the daily lives of ordinary people, and whether the experiences of people, ascribed to one or another category of difference, are equitable or disparate.

The analytical focus on boundaries is particularly productive, because it highlights both the processes of change and continuity, fixity and fluidity, boundary-making and boundary-crossing. In his immensely influential work on ethnic groups and ethnic boundaries, Frederik

¹¹³ Another problem is “orientalization” and false application of Western categories and classifications to other cultural contexts, as critiqued by Said, Gupta and other scholars.

Barth (1969) was the first to point to this dual functionality of boundaries, highlighting two important arguments:

First, it is clear that boundaries persist despite a flow of personnel across them. In other words, *categorical ethnic distinctions do not depend on an absence of mobility, contact and information*, but do entail social processes of exclusion and incorporation whereby discrete categories are maintained... Secondly, one finds that stable, persisting, and often vitally important social relations are maintained across such boundaries, and are frequently based precisely on the dichotomized ethnic statuses. In other words, *ethnic distinctions do not depend on an absence of social interaction and acceptance*, but are quite to the contrary often the very foundations on which embracing social systems are built. Interaction in such a social system does not lead to its liquidation through change and acculturation; *cultural differences can persist despite inter-ethnic contact and interdependence* (pp. 9–10; emphasis added).

What Barth brilliantly signaled in this statement is a fundamental tension: although ethnic groups distinguish themselves from other groups and maintain the exclusions by creating physical or social boundaries, those boundaries are porous and permeable; reversely, although boundaries are porous and permeable, social distinctions do not cease to exist. My thinking of medical knowledge traditions in India is greatly influenced by a theoretical struggle with the same phenomenon: although the boundaries between Ayurveda and Unani, Ayurveda and Homeopathy, Naturopathy and Yoga, or other traditions are porous and routinely negotiated, crossed, and dismissed by medical practitioners, these distinctions are still persistent. In other words, on the one hand, the “systems of medicine” are theoretical abstractions and mere tools for systematizing the reality. On the other hand, therapeutic boundaries exist when they are believed to exist, when latent boundaries, for instance, between Ayurveda and Unani are articulated and enacted, so that a person’s engagement with the former or the later becomes consequential.

Notably, members of social, ethnic, or medical communities can pursue the strategies of boundary delineation and maintenance, even in situations when the state is minimally involved. The government of India regulates and categorizes AYUSH modalities but does not enforce

those regulations, leaving doctors in an ambiguous position, which is both beneficial and risky. On the one hand, the ambiguity of AYUSH medicine in India opens possibilities for practitioners to experiment with pluralistic healing, inadvertently defying the boundaries charted by the government. On the other hand, the lack of regulation—understood by some Indians as the government’s connivance for unruly, unscientific, and dangerous treatments—puts doctors’ reputation in jeopardy. Acerbic media representations of non-biomedical traditions as “quackery,” “charlatanism,” and “pseudo-medicine,” partially sustained by cases of therapeutic indiscriminateness on behalf of some doctors as I have shown with regard to color therapy and astrology, provoke other physicians to defend what they believe to be true, authentic, pure, and legitimate practice. As I show below, certain cohorts of AYUSH physicians advocate for the need to “purify” their medical traditions, by purging out shameful, unscientific, and inauthentic infiltrations.

By “purification” of a medical tradition I refer to situations when, for example, a Sowa-Rigpa practitioner claims to exclusively follow the Tibetan medical tradition, adamantly rejecting a possibility of using any non-Tibetan drug or technique and advocating for guarding Sowa-Rigpa from inauthentic influences, whatever this might mean. Moreover, the concept of a “pure” tradition such as *shuddh* Ayurveda or *shuddh* Unani is an emic term, employed by non-biomedical practitioners and Indian policy makers since the beginning of the 20th century (Liebeskind 2002; Wujastyk 2008), as I described in Chapter 3.

6.2.2 Medicine and cultural belonging

Medical epistemologies and philosophies can be variously interpreted depending on one’s political agenda. For example, a strong political engagement in Hindu nationalistic movement

can lead a person to a belief that only Ayurveda and Yoga (from a plurality of non-biomedical options) are good, appropriate, and “national” forms of medicine. In other situation, a follower of a Gandhian philosophy can favor Yoga and Nature cure, perceiving them as more nationalistic and authentic than Ayurveda (cf. Alter 2000; Alter 2004). In the introduction to an edited volume *Asian Medicine and Globalization*, Alter (2005) writes that Chinese Medicine, Ayurveda, and other medical knowledge traditions of Asia share “a tremendous amount of historical, theoretical, applied, and practical overlap between key concepts” (p. 2), yet despite this overlap, in modern Asia these traditions are demarcated and assigned to distinct cultures or nation-states. This evidences that cultural identity and nationalistic sentiments play an important role in the reification of boundaries between “our” and “alien” medical traditions. This line of reasoning is also discussed by Weiss (2008) with regard to a “quest for uniqueness” among the practitioners of Siddha medicine in Tamil Nadu. Although for many centuries Siddha had been considered part of Ayurveda, with the rise of Tamil regionalism, non-brahmanic Siddha practitioners started to draw a line between themselves and high-caste Sanskrit-educated Ayurvedic doctors. Thus, Weiss (2008) explains that the boundaries between medical systems could be contextually fortified or dismissed, when the question of nationalism and cultural identity is at stake:

Practitioners of the three generally recognized traditional Indian systems of medicine—Sanskrit Ayurveda, Tamil Siddha, and Islamic Unani—have often affirmed their solidarity when putting up a unified front in their opposition to biomedicine. In other contexts, however, many traditional specialists... have drawn, redrawn, and exploited lines of separation, distinguishing branches of indigenous knowledge in order to promote some practices over others. *These lines closely parallel political divisions that grew with Indian nationalism. Hindu / Muslim tensions are reflected in Ayurveda/Unani formulations, while Tamil separatism has encouraged characterizations of Siddha medicine as absolutely distinct from Ayurveda*” (p. 77, emphasis added).

Another telling example of a politico-ideological drive for medical boundary-making comes from the colonial history of Homeopathy in Bengal where it had the strongest influence. As I

discussed in Chapter 3, Homeopathy has been habitually clustered by the Indian government with the “Indian systems of medicine,” despite Homeopathy’s European origin. Hidden within the category of AYUSH, Homeopathy seems to be closer to “Indian medicine” than even before. According to Arnold and Sarkar (2012), the legal proximity of Homeopathy to Ayurveda and other non-biomedical disciplines has been based on the assumption that Homeopathy is “an almost indigenous form of medicine close to the people” and that Ayurveda and Homeopathy share similar grounds and origin: Hahnemann, the father of Homeopathy, was said to be familiar with the “medical lore of the older India.” Moreover, Arnold and Sarkar add that it was imaginable to claim that Ayurveda and Homeopathy are similar because both emphasize an individualized approach to each patient and the necessity to consider patients’ temperaments and constitution. Yet it is a false assumption. Looking at the colonial India, the authors suggest that the main appeal of Homeopathy was not its similarity with Indian medical modalities, but its potential to “[by-pass] the colonial medical establishment, dominated by the (then almost entirely British) Indian Medical Service (IMS), and the political, racial and cultural authority it represented.” In this argument, they follow Bhardwaj (1980), who first proposed that “[f]rom the viewpoint of many Indians, Homeopathy was Western and modern without being colonial” (p. 214, cited in Arnold and Sarkar 2002). In other words, an argument that Ayurveda and Homeopathy are similar can be a calculative strategy used by those who wanted to distance Homeopathy from the West, the colonial regime, and British allopathy.

At the same time, Arnold and Sarkar draw attention to the fact that, methodologically speaking, Ayurveda and allopathy are much closer to each other, than either is to Homeopathy. Neither Ayurveda nor biomedicine would accept the homeopathic doctrine of “like cures like” or the efficacy of “infinitesimal” doses. Furthermore, complex formulas and compound medications

typical in both Ayurveda and allopathy are in stark contradiction to the advocacy for simple single-ingredient drugs in Homeopathy (2002, 45). This fact that many practitioners I have interviewed argued that Ayurveda and Homeopathy were “the same” beautifully illustrates that people emphasize or downplay therapeutic differences, depending on their own medical conceptions and dominant ideologies.

The cases of Siddha in Tamil Nadu and Homeopathy in Bengal highlight the fact that medical practitioners are often cognizant of cultural and political associations of medical traditions (such as “colonial,” “modern,” “Hindu,” “Brahmanic”) and therefore can choose to engage in either dismissing or fortifying the borders between their practice and other culturally or politically antagonistic traditions.

In India, the differentiation between medical knowledge communities, especially between Ayurveda and Unani, can bear great political and sociocultural implications; therefore, the demarcation of Unani from Ayurveda is deployed as an important strategy. What is most remarkable in the following example is that it occurred within a single family. When I met Dr. Lalit Thakur, he told me that he was a hereditary Ayurvedic practitioner: he is a graduate of a BAMS program and his father was also an Ayurvedic doctor (*vaidya*), who used to practice in the same clinic. However, when I asked about the grandfather, Dr. Thakur stated that his grandfather was a practitioner of Unani. Intrigued, I asked whether his grandfather practiced only Unani or a combination of Unani and Ayurveda, to which Dr. Thakur replied that his grandfather lived and worked in Lahore (currently Pakistan), where Unani was very prestigious, but after the Partition in 1947, he had to move to India and soon “became” an Ayurvedic practitioner.

It must be mentioned that an entangled and braided practice of Unani and Ayurveda is not uncommon, particularly because these two medical systems are highly comparable in their

philosophy and therapy (humoral conception of body and environment, diagnostics through pulse-taking, same medicinal ingredients, etc.). I have met and spoken with several doctors whose official title or treatment included both traditions: Dr. Negi is an “Ayurveda and Unani officer” in a government hospital (although his official degree is only in Ayurveda), while the signboard of Dr. Ahmad Safi’s dispensary advertises for Unani and Ayurvedic medicine (although Dr. Safi has only a degree in Unani). Thus both practitioners and patients may conceive of Ayurveda and Unani as a single intertwined system. Nevertheless, political and cultural-religious allegiances of Ayurveda with Hinduism and Unani with Islam sometimes provokes the need to acknowledge their differences, just as Dr. Thakur’s grandfather felt the need to distance himself from Lahore, Pakistan, and Unani and instead become an Ayurvedic doctor once he moved to a newly created India (or, perhaps, Dr. Thakur himself felt the need to distance his grandfather from Pakistan and Unani and establish him as an Ayurvedic doctor).

6.2.3 “Expansion means exploitation,” or doctors’ responses to commercialization

Since medical decisions are entangled with people’s social and political lives, those who strive for maintaining the medical boundaries can do so because of economic pressures. While some physicians respond to market demands by offering new and eclectic healing methods, others attempt to distinguish their practice from rival therapeutic forms, invoking ideas of “authentic,” “unaltered,” and “original” practice. Importantly, therapeutic boundaries can be delineated not only *between* different traditions of medical knowledge but also *within* a single tradition. As Langford demonstrated with regard to the problem of quackery (1999), it is not only that biomedicine and non-biomedical traditions can be contrasted as “scientific” and “fraud,” but ayurvedic physicians too draw a boundary between “false” and “true” Ayurveda. In less dramatic

ways, practitioners can demarcate other differences of medical knowledge: for instance, in biomedicine, there is a strict differentiation (and hierarchy) of specializations. In Ayurveda too, some doctors are very sensitive to different “schools” of Ayurveda (North Indian versus South Indian, usually represented by Kerala) and different ayurvedic specialties. For example, Dr. Binjola has a bachelor’s degree in Ayurveda, but when we talk, he makes sure I regard him as a doctor of *panchakarma*—a set of cleansing procedures in Ayurveda. Although by no means does he claim that Ayurveda and *panchakarma* are two distinct systems, from his numerous corrections of my questions it is clear that for him, the boundaries of his medical practice are more narrowly defined than for other doctors.¹¹⁴

Such internal boundary marking—as well as more general boundary-marking and crossing in medicine—can be an outcome of economic strategies or the fear of commercialization, i.e. a perceived threat to the integrity of a medical tradition, if the tradition’s borders are not carefully patrolled. For example, a Sowa-Rigpa practitioner told me that she was ambiguous about the government’s endorsement and promotion of Tibetan medicine, because, as she eloquently put it, “expansion means exploitation.”¹¹⁵ These two instances have made me reevaluate the assumption that institutionalization of non-biomedical practices leads to the reduction of their heterogeneity and breadth. In contrast, some doctors view their medical practice in a narrower way than the state-sanctioned categories would permit or the government promotion would encourage.

¹¹⁴ Interestingly, this separation of *panchakarma* and Ayurveda also helps to understand why *panchakarma* has become a kind of a commercial branch that is easily integrated into spa treatments, where it can be combined with acupressure or Nature Cure.

¹¹⁵ In fact, the fear of exploitation and the calls for harnessing the expansion of a medical tradition are particularly strong from the practitioners of Yoga, Ayurveda and Tibetan medicine, which have already emerged on the global arena, and almost non-present among Unani practitioners, who mostly struggle to prevent Unani from sinking into oblivion.

As non-biomedical healing becomes popular, it becomes exposed to forces beyond the control of medical practitioners who might fear the misuse, alteration, or a bad image of their intellectual traditions. For example, Dr. Negi, a government doctor in Rishikesh, contrasted himself with the owners of private Ayurveda centers who charge five-six thousand rupees (about \$100) per visit and often mislead visitors about the prices, especially when the visitors are foreigners (*foreners ke sāth bahut cheating karte hain*). In contrast, Dr. Negi wants to keep *panchakarma* affordable and genuine:

I don't want that any patient is cheated, okay? I want to remedy their illnesses with a big heart, with a big love, that's why I don't want to make them waste money, rob them. There is no *cheating* here [in his hospital] (*Main nahin chahta kisi patient ke sath cheating ho, hai na? Main usko bade dil se, bade pyar se uski bimari theek karna chahta hoon, main isliye kisiko anāp-shanāp paise kharch kara ke usko lootna main nahin chahta hoon. Cheating nahin hai idhar*).

Dr. Negi believes that Ayurveda is a “noble profession” (English words); therefore, the present state of affairs in Rishikesh makes him very despondent (*mereko bahut dukh hota hain*). This distinction between a noble Ayurveda and an Ayurveda of cheating is a good illustration of how the boundaries are drawn within the medical traditions, not between them.

6.3 VERSATILE DOCTORS AND THEIR MEDICAL COMPASS

The above two sections sketch out a broad range of strategies employed by medical practitioners. What is critical to highlight here is that these strategies are not the strategies of *either/or*—of either therapeutic boundary-crossing or therapeutic boundary-making, but rather in different contexts and with different interlocutors, medical practitioners may choose different strategies. In one situation, they may emphasize differences, and in other situations, similarities between

their and other medical traditions. For example, when a practitioner of Ayurveda advocates for better government support vis-à-vis biomedicine, she can unite with other non-Ayurveda physicians under a single umbrella of AYUSH. When she talks to a researcher about the history of her medicine, she may clearly demarcate Ayurveda from Unani or Siddha. When consulting patients, the same practitioner may neglect the perceivable differences and provide treatments across state-sanctioned medical systems. In other words, medical practitioners are very versatile in their clinical practices, their negotiations with patients, interactions with family members, and responses to the government and the market.

Here the notion of “versatility” emphasizes resourcefulness and adaptability to different contexts.¹¹⁶ It signals multifaceted and heterogeneous knowledges and competences, without pointing to any fixed categories of medicine which the words “plural” and “hybrid” might imply (if there is plural, there must be singular; if there is hybrid there must be pure). The framework of versatile medicine is an attempt to write against a totalizing notion of a medical tradition and even of medical pluralism. This is why I find the metaphor of versatility so appealing, although I am equally profoundly inspired by the notions of *masala medicine* and *braided sciences*.

What drives doctors’ versatility? Initially, my thinking about the situations of crossing or patrolling medical boundaries, as well as the vocabulary which I used to describe them, was greatly inspired by theories from linguistic anthropology. In the late 1970s, Michael Silverstein developed a profoundly influential theory of *language ideologies*, defining them as “sets of beliefs about language articulated by its users as a rationalization or justification of perceived language structure and use” (1979, 193). Language ideologies are apparent in the processes of language standardization and language differentiation. Moreover, people’s beliefs about what is

¹¹⁶ This notion fits with many other Indian ways of practicing based on innovation and improvisation, called in Hindi *jugār* (life-hacks).

“proper,” “good” and “aesthetically pleasant” about a language are linked to their social experiences and political-economic interests (Kroskrity 2000, 8). According to language ideology studies, the act of identifying a language presupposes a boundary with other languages (Irvine and Gal 2000, 35–36), so this approach is informative in addressing a question of how beliefs that people hold about a language contribute to, for example, a strategy of language “purification.”

In similar ways, I started thinking about the ways in which medical difference—categorized and regulated by the state—is perceived by patients and doctors. I looked at AYUSH doctors’ therapeutic choices through a lens of *medical ideologies*, conceptualizing that each doctor comes to hold a personal set of ideas and beliefs about how medicine should be practiced. In other words, I conceived of medical ideologies as doctors’ and patients’ beliefs pertaining to therapeutic authenticity, efficacy, legitimacy, modernity, and cultural value, which people articulated in justification of their medical choices from the plurality of therapeutic options. From this perspective, I reasoned that what doctors counted as a legitimate, corrupt, authentic, or fake therapy depended on their medical ideologies, which made impact on whether they engaged in acts of therapeutic boundary-making or boundary-crossing.

However, the notion of ideology is problematic because it indexes a more or less coherent system of ideas, viewpoints, and stances, and is typically given a specific name such as Communism, Hindu nationalism, or Multiculturalism. In medical anthropological literature too, the term medical ideology was used in this totalizing and systematizing sense. For example, one of the scholars who explicitly used the term “medical ideologies” is Libbet Crandon-Malamud

(1991).¹¹⁷ Based on the ethnographic work in Bolivia, she postulated that in Bolivia there are three distinct medical ideologies that correspond to three medical traditions: cosmopolitan medicine, indigenous Aymara medicine, and home remedies (1991, 23–24). Although Crandon-Malamud acknowledged that medical ideologies are systems of knowledge from which people draw different, sometime contradictory, elements, it is still evident that a medical ideology refers to a systematized, coherent, and articulated framework of ideas. But this is exactly what AYUSH physicians do not hold. A possible example of a medical ideology would be scientism or holism, but these concepts are too broad and encompassing to be able to explain the versatile practice of contemporary AYUSH doctors. The notion of ideology precludes the appreciation of negotiable routines that doctors engages in. Therefore, instead of searching for medical ideologies, I find it more productive to highlight practitioners’ braided and situated knowledges as well as their malleable, ever-changing, interactional practices, which, however, are embedded in doctors’ personal medical ethics with regard to what can or cannot be practiced. It is almost as if each practitioner has a personal medical “compass,” akin to an internal moral compass, that guides them through their clinical practice.

My thinking here is inspired by a wealth of scholarship that exposes how doctors resort to different therapies in order to deal with the ambiguity created by personal experiences, expectations from patients, interactions with family members, demands of economic markets, government policies, and other factors (Adams 2002; Khare 1996; Langford 2002; also Trawick

¹¹⁷ Some scholars have remarked that medicine is an ideological domain and that “medical practices are simultaneously ideological practices” (Young 1982, 271, drawing on Comaroff 1980; Taussig 1978). Others have examined the views on therapeutic legitimacy, authenticity, modernity, and efficacy as linked to different ideological rationalities (Alter 2011; Lambert 2012; Langford 2002; Naraindas 2006; Craig 2012; Zhang 2007). However, the term “medical ideology” is a rare finding in anthropological literature. Even in Crandon-Malamud’s work (1991), it appears only briefly and is entirely absent from her earlier publication (Crandon 1986).

1992, 132-133). This ambiguity is well demonstrated in Vincanne Adams' study where she explores how practitioners of Tibetan medicine in China maneuver between the local population, state, international market, and the practitioners' own medical training. Tibetan healers struggle to show that Tibetan medicine is "scientific" (in order to adhere to the state's secularist ideology), but they also emphasize that it is scientific "in its own way," thus sustaining the cultural identity of local Tibetans and demands of the international health market for "unique" Tibetan medicine (Adams 2002, 213; also see Liebeskind 2002 with regard to the negotiation of the scope of Unani medicine). Similarly, AYUSH physicians navigate between patients' demands, economic forces, political allegiances, and cultural expectations, and what helps them in this navigation is their medical compass which guides them through the decisions about what is right and acceptable. Importantly, depending on a context or a purpose, the medical compass can show different directions. Let me share an example which illuminates how people can draw, erase, and redraw the differences between medical traditions within a single hour of conversation.

When I first learned about a wellness institute offering "a path to wellbeing" by bringing together Ayurveda, Sowa-Rigpa, Traditional Chinese medicine, Yoga, in addition to spa, fitness, and aqua therapy, I envisioned it would be a place of incredible *masala* practice, unlike the co-located government hospitals where medical systems are practiced under one roof but separately. I sought out a meeting with Ms. Kaur, the owner of the SURYA retreat which she conceptualized and established (although it turned out that she did not hold a medical degree). This institute is oriented toward global consumers, primarily from European and North American countries, but it also receives a small percentage of Indian clients. At the beginning of the interview, I inquired

about Ms. Kaur's thoughts on the government's regulation of traditional medicine and her reply confirmed my initial impression:

What the Indian Government does is frankly irrelevant anyway. They have only been of the disservice to our traditional systems and are worthless... I ignore AYUSH and everything that they do.

Rather than accepting government delineation of medical "systems," this wellness institute offers a blend of biomedical and non-biomedical modalities. When guests arrive at the institute, they are invited to a general consultation where they and a consultant co-develop a plan of treatment.

Treatment plans vary in their scope and diversity:

Very often the retreat is very focused on one offering, with a little bit of complementarity from the others. Sometimes it's two different streams, working close together. Another time, it's taking from everything.

It is noteworthy that Ms. Kaur does not see any contradictions between philosophies and methodologies of different medical knowledge traditions:

No, they all tie up together in my view. And where there is a contradiction, we resolve it internally. So the full team of specialists and doctors meets every day for a review, and they meet weekly for a more exhaustive, kind of a comprehensive investigation and debate. So everybody [every medical practitioner in the institute] is familiar with the sort of basic contradictions, but I feel that there are very few. Some way or the other, they kind of all tie up.

This may seem to suggest that traditional and non-traditional healing approaches can be easily mixed and mingled, and there is no restriction in the ways in which these therapies are provided.

However, the conversation suddenly turned into the realm of authenticity:

We make no compromise on the offering, so as high-end the environment is, our Ayurveda offering, Sowa-Rigpa offering, TCM offering, Yoga offering is strictly, strictly, strictly by the book. So our abhyanga¹¹⁸ takes from the traditional text, and so does every other Ayurveda treatment. We do not convert it into a wellness version or a spa version.

¹¹⁸ An oil massage in Ayurveda.

Although this wellness institute offers cross-disciplinary treatments, the owner fervently defends the authenticity of the boundaries of each traditions, not allowing it to be collapsed into a spa version:

We don't have an approach to Ayurveda and Yoga, we are taking from the wisdom that has been crude and compounded over centuries in the millennia, which people seem to be ignoring and forgetting. And we are putting it in a context to deliver it, as best as we can, and put with it the right cuisine, the right environment, the right sleep, right attitude, right service, and so on and so forth.

Thus, she is patrolling the boundaries of what she believes constitutes true Ayurveda, yet at the same time does not see a contradiction of mixing a little bit of Ayurveda with aqua-therapy, and Chinese medicine.

6.4 PATIENTS' VIEW OF MEDICINE

In *Asymmetrical Conversations*, a recent work focused on the study of blurred boundaries, edited by Naraindas, Sax, and Quack (2014), the contributors argue that the boundaries and the disposition of power between therapeutic systems are not incontestable. Rather than being clearly demarcated, medical traditions engage in “conversations,” i.e. processes of interacting and competing with one another and with other cultural institutions. As a result, such conversations often catalyze new and creative forms of therapy (Warrier 2014). Moreover, the volume contributors maintain that both patients and healers know how to resist and circumvent the dominant medical ideologies or to blur the therapeutic boundaries altogether. Although I support this view in general, I nevertheless find it problematic, since the term “conversations” and the volume’s discourse on resistance, contestation, and circumvention seem to imply the *intentionality* of people. In contrast, I conjecture that people do not always intentionally bypass

the state-sanctioned categories of medicine; in fact, they are often *unaware* that these categories exist in the first place.

The codification of medical systems is not something “real” but rather based on the apparatus of language and social convention. Just as not all Americans have heard of the term CAM, not all Indians are familiar with the acronym AYUSH. Many have heard nothing about the creation of the Department and then the Ministry of AYUSH. Even “Ayurveda,” “Unani,” “Homeopathy,” and “Sowa-Rigpa” are not always identified, talked about, and differentiated by ordinary people, in the sense that they rarely draw clear-cut boundaries between allopathy, Ayurveda, and Homeopathy, or distinguish between different kinds of doctors. Many people forget, do not know, or do not care what kind of medicine is provided. I remember talking to two young women about different Ayurvedic practitioners in Chhotapur. When I mentioned one doctor’s name, they immediately warned me against taking any medication from him and told me about another practitioner, whom they entirely trusted. As I discovered later, the other doctor was a homeopath. These women were college-educated, English-speaking professionals who knew the difference between Ayurveda and Homeopathy, but that difference was not important to them; they were mostly concerned with the reputation of a doctor. Furthermore, as I mentioned in Chapter 3, another college-educated but non-English speaking woman told me that she always thought that “homeopathy” was an English translation of the Hindi word “Ayurveda.” Importantly, the same idea was conveyed to me a group of four women, recent migrants from the nearby villages to Chhotapur, which illustrates that the tendency to equate Ayurveda with Homeopathy, or disregard their difference, does not correlate with one’s class or social background. Consider an excerpt of our interview about Ramdev (A—Author; R1—First Respondent, R2—Second Respondent, etc.):

- A: What do you think, what is he [Ramdev] doing for India?
āp kya sochte hain ki woh kya kar rahe hain, Bharat ko, Bharat ke liye?
- R1: He is teaching Yoga
Yoga sikha rahe hain
- R2: He is teaching Yoga, pays attention to health... right? And like...
Yoga sikha rahe hain, swasthya ko dhyan dete hain... hai na? Aur jaise...
- R3: Invents very new things
Nayi-nayi cheezon ka avishkar karte hai
- A: What does he do?
Kya karte hai?
- R2: homeopathic... sometimes he [makes] medicines etcetera...
homopatik... kabhi woh dawaiya vagairah...
- R3: Yes, he does [makes] medicines, right?
Hān, dawayia karte hai, na?
- A: Homeopathic?
Homopatik?
- R2: That is like herbal... He... does it, right?
Woh toh jaise jadi-butiyon ka... woh... karte hain na woh?
- A: Okay
Hanji
- R2: He has all homeopathic [drugs]. He has that focus, as a focus on *chawanprash* has been
Unke sare homopathic ki... unka jo chinta hain, jaisa chinta par chawanprash ho gaya
- R1: Home remedies/plants
gharelu aushadhiya
- A: But is it homeopathic?
lekin yeh kya homopatik hai?
- R1: ayurvedic
ayurvedik
- R4: ayurvedic means homeopathic
ayurvedik means homopatik
- R2: (asking others) Is homeopathic different from ayurvedic?
homopatik alag hain ayurvedik se?
- R1: (uncertain) well, homeopathic...
homopatik toh...
- R4: What, isn't it called in English?
English me bola kya na usko?
- R2: (addresses the author) so ayurvedic is that, isn't it? in Hindi it is called ayurvedic
ayurvedic toh woh hai na? Hindi me bola jata hai - ayurvedic
- R4: homeopathic is English
homopatik English hota hai
- R1: Ayurveda means that some herbs and roots and some *exercise* etcetera
Ayurveda matlab hota hai ki kuchh toh jadibutiya aur kuchh exercise vageirah

At the time of the conversation, I thought that these women simply confused the terms

Homeopathy and allopathy (biomedicine), especially in the line where they suggested that “homeopathic is English.” But they in fact conflated Homeopathy with Ayurveda. If we look at the beginning of the interview, we can see that a woman who first mentioned the term “homeopathic” did so in relation to Ramdev’s ayurvedic medicine. Moreover, when I repeated her words—“homeopathic?”—she explained that homeopathic was a treatment from herbs and plants (*woh toh jaise jadi-butiyon ka [ilaj]*). It is true that Homeopathy in India is often presented as herbal medicine, but Homeopathy uses herbal essences, not crude “herbs and plants” (*jadi-buti*) like Ayurveda does.

Patients’ views of medical pluralism can be quite ambiguous. Nevertheless, this is not to say that people are careless or unintelligent. In contrast, they are very careful, wise, and pragmatic, possessing a kind of practical intelligence which does not blindly rely on abstract medical categories (which are also fragile and contradictory). Given the versatility and eclecticism of medical treatments that I have described earlier, health-seekers deploy an advantageous strategy of privileging doctors’ reputation over their designation (a *vaid*, a homeopath, an allopathic physician). In the quest for health, people find nothing inconsistent in combining different forms of therapy. Their blurring of categories is not indicative of their confusion, rather it is indicative of our confusion caused by intellectual categorization.

Thus, people are less ideologically and more economically driven in their pursuit of cure. At the same time, patients, like doctors, also hold certain beliefs and ideas about which type of medicine is “good,” “safe,” “legitimate,” “efficacious,” “original,” and “right” for them. It is not uncommon when health-seekers, especially more educated and familiar with contemporary medical discourses, demand a “purer” or “milder” treatment “without side-effects,” even if a doctor would be comfortable to provide an allopathic medicine. For example, I have interviewed

an ayurvedic practitioner who initially explained that he would prescribe allopathic drugs “whenever required,” but then remarked that with some patients it would not work: “Some patients tell me, ‘we are not interested in allopathy, we are going for only ayurvedic treatment.’ So then I give them ayurvedic treatment.” As you can see in this case, it is the medical ideologies of patients, not of a doctor, which marks a therapeutic boundary.

In fact, a belief that Ayurveda does not have side-effects is a common strand of medical discourse in India, which often motivates patients to demand a “pure” Ayurvedic treatment or seek an “authentic” Ayurveda practitioner. Another common belief is that Homeopathy is “mild” due to the processes of dilution and the use of minuscule dosages—a belief which is circulated by both homeopathic physicians and the government’s initiatives such as the National Campaign on Homoeopathy for Mother and Child Care.¹¹⁹ As a result, many Indian mothers articulate this view in justification for exclusive preference of Homeopathy for their children. All these examples support the view patients play an important role in influencing doctors’ therapeutic offerings, yet patients themselves are also subject to doctors’ thoughts, media discourses, and government projects.

6.5 CULTURAL BELONGING AND APPROPRIATION

The debates about different medical traditions are embedded in the discourses about legitimacy, authenticity, cultural belonging, political commitments, science, and modernity. A galaxy of scholars has demonstrated that treatment choices are not just individual, subjective decisions, but

¹¹⁹ <http://www.ccrhindia.org/pdf/mch.pdf>, accessed March 22, 2017.

are often formed within a search for a cultural identity, resistance to cultural hegemony, and support for a nationalist ideology (Adams 2002; Arnold and Sarkar 2002; Crandon-Malamud 1991; Ernst 2002; Liebeskind 2002). Wayland (2004) reminds us:

Since both traditional and biomedical medicines embody ideas and values, medicinal use and discourse may serve as a form of social commentary. Indeed, eschewing or embracing certain treatment options may provide a means of rejecting or accepting the images or ideologies associated with medicines” (pp. 2410–2411).

Thus, the analysis of negotiations of treatment within a pluralistic context is a powerful tool which opens a window into the whole range of contested domains, and it is clear that medical practices are influenced by contestations over different visions of the Indian nation. However, this should be taken with a caveat. While I do support a proposition that a socio-political context can inform our medical decisions and that medical practitioners can be motivated by a broader ideological reasoning, I still insist that, in most cases, quotidian treatment choices are pragmatic. Here I am sympathetic to Reed’s (2002) argument, put forward in a study of British-born South Asian women, that it is more productive to see medical choices as practical strategies, than a search for some sort of imagined cultural roots and authenticity.

In my view, the best way to tackle this controversial question is to account for both instances of practicality and ideological motifs. For example, doctors’ offers of a particular treatment are strategic, as they want to attract more patients and earn more money, but what they *count* as a good profitable strategy may well depend on their worldviews and ambitions to present themselves as authentic and traditional healers, the defenders of culture, or—vice versa—as modernists, scientists, and reformers. As intermediaries, medical practitioners are constantly negotiating and reconciling their medical knowledge and training with personal and professional interests, government health discourses, and the global market demands. All of

these result in certain stances and opinions which, however, can be set aside, should a context require so. As Kirmayer aptly points, “[t]here are complex and often indirect links between global marketing efforts and local independent practitioners who may be deeply ambivalent about the commercialization of treatments they dispense, even as they profit from and are dependent on these larger business activities” (2014, 32). Similarly, patients’ medical strategies are shaped by consultations with doctors, interactions with family members and friends, consumption of media discourses, as well as personal religious and political beliefs. Although patients want to get treated, preferably with the cheapest but effective medicine, they adhere to certain ideas and principles that determine what they expect from a doctor.

Stemming from this understanding, I welcome the call of Naraindas, Sax, and Quack (2014) for examining the co-constitutive entanglement of *ideas, practices, and institutions*. The approach evinces that people’s thoughts and behaviors are influenced by hospitals, wellness centers, temples, and other institutions—each of which produces, cultivates, and imposes certain ways of thinking and acting. In addition to this focus on ideas, practices, and institutions, I advocate for a need to account for *personal histories* and *life trajectories* that influence the ways people engage with medicine. Whether and how medical practitioners braid together medical traditions can be greatly shaped by doctors’ parents, spouses, childhood memories, and personal grievances.

The notion of versatility, again, is useful to frame the main subject of the present chapter: therapeutic boundary-making and boundary-crossing. Lambert (2012b) reminds us that the very idea of crossing boundaries or borrowing a therapy from a different tradition is misleading because rarely does a practice, a procedure, or a therapy exclusively belong to one medical tradition:

fragments of the therapeutic configuration... are traceable across diverse elite and subaltern domains of therapy... These therapies may not have been consistently practised within one specific tradition identified with a named practitioner type, but may perhaps have been taken up and discarded over time, or... variously provided by more than one kind of specialist and non-specialist (2012b, 109).

In other words, if a certified homeopathic doctor routinely examines the pulse of his patients, claiming that the character of the pulse can identify a problem in any internal organ, does he borrow an “ayurvedic” method? If a licensed ayurvedic practitioner prescribes weekly prayers in a church or a *mandir*, does she cross the disciplinary boundaries and engage in a religious healing? If a Unani *hakim* administers a blood pressure monitor, does he appropriate a “biomedical” technology? Physicians and patients can answer these questions differently, and the way they answer is indicative of their stances and commitments to certain frameworks of knowledge. But as scholars, we have to deconstruct the assumptions behind these questions—the assumptions which stem from the notions of cultural ownership and cultural appropriation.

Only by going beyond these notions, we can appreciate the kind of always already braided and masala medicine which practitioners and patients produce in daily life, and which does fit into the cultural labels of “Ayurvedic,” “Allopathic,” “Unani,” “Indian,” “Muslim,” or “Western.” Consider, for example, the method of pulse-taking, which is widely associated with Ayurveda. Attewell (2007) points to the fact that the pulse-taking was not well formed in classic Ayurveda texts but was “described in depth in the fourteenth-century *Sarngadhara Samhita* and subsequently taken up as a key diagnostic tool in much ayurvedic literature” (p. 17). Reflecting on this historical development and the fact that by the 14th century, Unani medicine had been introduced to South Asia, it is reasonable to argue that one of the origin sources of the “ayurvedic” pulse-taking procedure was Unani (Attewell 2007, 17.). Moreover, Attewell cites other studies that suggest that the experiments with pulse-taking by a prominent Unani author

Ibn Sina might have been influenced by his exposure to Chinese medicine (2007, 17). From this point of view, when a certified homeopath uses pulse-taking, he cannot be said to be “appropriating” an “ayurvedic” diagnostic tool. If we accept a view that any medical tradition and even a medical act is inherently plural and eclectic in itself, then the question of crossing and making the therapeutic boundaries becomes irrelevant. Therefore, unlike the notions of plural medicine or medical plurality, the concept of medical versatility does not leave a room for problematic claims of cultural belonging and cultural appropriation.

Nevertheless, in the contemporary world of commodification and patenting, exacerbated by globally enunciated cases of identity politics and exclusive nationalism, it is rather challenging to adopt a stance of tolerance and inclusiveness. Every day the debates about cultural appropriation strike news headlines, whether it is about the so-called appropriation of rap music by white singers, of Chinese food by Americans, or of Yoga by Western fitness seekers.¹²⁰ In my view, these claims are predicated on historically myopic assumptions that a music genre, food, or therapy is “owned” by one society, but it is hard to engage in constructive discussions of these cases because one immediately runs into the accusations of defending cultural imperialism or neo-colonization. Consider a recent controversy around the decision of the University of Ottawa to cancel free Yoga classes (for students with disabilities), because of it was decided that the way Yoga was taught—as a stretching exercise routine—was culturally insensitive and that Western practitioners need to acknowledge where Yoga comes from. Numerous media channels including Forbes, Washington Post, Time, Huffington Post and others covered the story, debating from different perspectives whether Western Yoga was a form of cultural appropriation. In my

¹²⁰ As an example, see <http://time.com/4124036/Yoga-cultural-genocide-ottawa-oppression/>

opinion, there is a great danger in demands for “acknowledging where a tradition comes from,” because it raises a problematic question of how deep into history one need to look.

If we return to the Indian subcontinent, we can see that people who defend the need to preserve the “purity” of a tradition like Yoga and Ayurveda can—purposefully or inadvertently—promote violence and intolerance. Attempts to “go back” to someone’s cultural “roots” can motivate projects not only of de-colonization but also of so-to-speak de-Mughalization of Indian medicine. These unsettling examples once again expose how state-sanctioned alternative medical traditions are shaped by the cultural politics of national belonging, and how such discourses produce significant hierarchies within AYUSH traditions, which bear profound impacts on lives of medical practitioners and their clients.

7.0 CONCLUSION

The concept of medical plurality signals the universe of medical traditions and conceptualizations of the body, health, and healing. Medical plurality is a reflection of cultural diversity and, ultimately, of multiple ways of being and belonging. Anthropology itself as a discipline is based on the recognition of plurality, as anthropologists work to document epistemologically plural itineraries of knowing and making sense of human experience. Therefore, the studies of plural medicine and diverse approaches to illness and wellness are integral to key concerns of the anthropological discipline, particularly to the examination of category-production and boundary-making. This study has shown how a plurality of alternative medical traditions has been solidified into the category of AYUSH and how one of these traditions—Ayurveda—has come to subsume medical plurality. At the same time, this study has demonstrated that belonging, identity, and knowledge are always already plural and dynamic categories. People’s practices and views on themselves and others are versatile, sometimes alighting with dominant state-sanctioned ideologies and sometimes discounting and circumventing them. Drawing on a wealth of historical, policy, ethnographic, and linguistic material, this project has probed into both the ideologies of medical plurality and exceptionalism, both the processes of institutionalized order and eclectic practice, both public discourses and doctors’ private stories. Four areas of inquiry have emerged over the course of this study.

7.1 MAIN ARGUMENTS AND CONTRIBUTION

7.1.1 Hierarchy and legitimacy

I have argued that the government recognition of plural medical traditions does not automatically translate into their equal status. Despite the state legitimation of medical pluralism in the form of AYUSH, non-biomedical traditions occupy disparate positions in relations to one another. This manifests in differences in their infrastructure, workforce, social prestige, prominent public supporters, government initiatives and funding, and market opportunities. In all these domains, Ayurveda has been shown to hold the most privileged position within the hierarchy of AYUSH. Moreover, the analysis of the official language by which non-biomedical traditions in India have been defined and classified has revealed the existence of ideological and discursive disparity in the terms of ascribed cultural and national value. Not every AYUSH tradition has been unanimously regarded as Indian or homegrown: while the cultural belonging of Ayurveda and Yoga is celebrated, the belonging of Unani, Homeopathy, Siddha, Sowa-Rigpa, and other AYUSH modalities is a site of contestations.

By putting forward the emphasis on AYUSH relations and hierarchies, the present work contributes to a vast and nuanced scholarship on medical plurality, its legitimation and professionalization across the world (Adams, Schrempf, and Craig 2010; Alter 2004; Attewell 2007; Baer 2011; Berger 2013; Bode 2006; Brotherton 2012; Craig 2012; Ernst 2002; Farquhar 1994; Ferzacca 2001; Hardiman and Mukharji 2012; Janes 1995; Kloos 2013; Koss-Chioino 2003; Lambert 2012a; Langford 2002; Leslie 1968; Leslie 1973; Leslie 1976c; Leslie 1980; Lock 1990; Lock and Nichter 2002; Lou 2016; Naraindas, Sax, and Quack 2014; Nichter 1980; Sheehan 2009; Sivaramakrishnan 2006; Singleton and Goldberg 2014; Wujastyk 2008). While

many of these and other studies in anthropology and history of medicine have scrutinized the tension between biomedicine and a single traditional medicine, I have articulated a necessity to look at the relations and tensions across non-biomedical traditions themselves.

This argument calls for caution in generalizing about the institutionalized alternative medicine. In contrast to the theories of bureaucratization and institutionalization, I have claimed that the distinguishing of “statist” medicine from “subaltern” therapeutics, or state-sanctioned AYUSH from Local Health Traditions, runs a risk of negating the similarities in practices of both legitimized and unrecognized practitioners. A critical lens needs to be applied in order to understand the realities of medical practitioners beyond the state sanction, i.e. by acknowledging the multiplicity of legitimizing factors such as doctors’ backgrounds, family influences, personal aspirations, career changes, political and cultural allegiances, and economic incentives. By attending to the current political climate in which medical plurality is situated, I have argued against the duality of institutionalized and non-institutionalized medicine, highlighting that this demarcation does not adequately reflect the intricate ways in which medicine is practiced.

7.1.2 Versatility and plurality

Although the existence of state categorization of non-biomedical knowledge in the form of AYUSH might give an impression that these medical “systems” are uniformly identified and conceived of by doctors and their patients, this project has offered a collection of ethnographic illustrations, showing that practitioners’ repertoires of treatment do not always correspond to their designated expertise and self-identification (as “Ayurvedic” or “Unani” doctors, for example). I have described the cases of therapeutic boundary-crossing in which certified medical practitioners combine therapies from different authorized and unauthorized healing modalities.

By doing so, they challenge, transgress, negotiate, or simply ignore the state-imposed categories of medical knowledge and the nominal boundaries between them.

While many previous studies have examined the entanglements of traditional medicine with biomedicine, my work highlights that—irrespective of whether doctors incorporate biomedicine into their therapeutic repertoire or not—they pick and choose from a spectrum of non-biomedical therapies. In other words, in this dissertation, my interest was not so much in analyzing how AYUSH physicians situate themselves in relation to biomedical doctors but in uncovering how AYUSH practitioners view one another and how they use—or do not use—therapies outside their certified area of expertise.

I have also exposed the processes of therapeutic boundary-making by which practitioners of a medical discipline distance themselves from practitioners of other medical traditions, advocating for pure and authentic practice. Notably, this process can be identified only as long as we look at it from the vantage point of the state (which delineates medical traditions) or from the ideological reasoning of medical practitioners who explicitly articulate a concern about therapeutic mixing, blending, or corruption. In contrast, from an anthropological and historical perspective, there is no “pure” or “authentic” therapy, since every medical tradition is inherently plural and heterogeneous. Here I am inspired by and contribute to the theorization of medical plurality as negotiated, historically conditioned, and always already plural (Alter 2004; Attewell 2006; Mukharji 2016; Ernst 2002).

Moreover, this dissertation is written in conversation with studies that signal that medical practices of each doctor are unique, as they are co-constructed in clinical interactions and contextually adapted (Adams 2002; Nichter 1980; Liebeskind 2002; Quaiser 2016). There are multiple factors and ideologies that influence the ways doctors understand and act upon different

categories of medical knowledge. As mediators among patients, families, sales representatives, researchers, the state, and the media, medical practitioners negotiate their therapeutic repertoires, sometimes choosing to emphasize that their practices are undiluted, pure, and authentic, while at other times producing distinctive and blended treatments. I have proposed to describe this phenomenon in terms of the versatility of medical practitioners who skillfully—but not necessarily intentionally—engage in the “spicing” (from *masala* in Nichter 1980) or “braiding” (Mukharji 2016) of diverse knowledges and practices. In other words, from the perspective of state legal apparatus, it can appear that medical practitioners violate regulations and knowingly bypass the state-sanctioned categories of medicine; yet, I contend that frequently doctors are not even aware that these categories exist.

7.1.3 Ayurvedic exceptionalism and ayurvedicalization

This dissertation has also exposed that medical strategies and therapeutic choices—although unique and situational—are conditioned by cultural allegiances and dominant political discourses. This is particularly visible in the distinction between Ayurveda and Unani, both of which have comparable approaches to health and healing, yet their cultural ascriptions are dramatically different. I have claimed that Ayurveda has emerged in an all-encompassing way as an Indian, national, and homegrown tradition to the exclusion of other non-biomedical systems. Moreover, Ayurveda has also been constructed as neutral and universal in the sense that it is not restricted to any community; in contrast, Unani, Siddha, and Sowa-Rigpa have been assigned to Muslim, Tamil, and Tibetan cultures and thus have remained at the margins of the non-biomedical landscape. The conceptualization of Ayurveda of being both cultural (Indian) and beyond culture is a significant factor that contributes to its exceptionalism.

Certainly, in contemporary India, Yoga, Ayurveda, Unani, and other traditions are understood and practiced in a variety of forms which defy commonly perceived cultural, religious, and linguistic associations of these traditions. Nevertheless, it is important to understand that cultural associations and origin points are selected and reinforced politically. For example, I showed that Ayurveda is linked to the ancient period of a great Indian civilization, and if we follow the same logic, then Unani should be understood as a European tradition since it originated in ancient Greece. Yet, in contemporary India, Unani is pronounced as a Muslim tradition and its potential Europeanness is never highlighted. (In contrast, there are some cosmetics companies in Europe which popularize Unani as an ancient Mediterranean tradition). Moreover, as there are no nation-wide prominent Unani advocates in India such as Hakim Ajmal Khan, Hakim ‘Abd al Latif, and others of the first half of the 20th century (Liebeskind 2002), it becomes harder and harder for Unani to claim national, global, and cosmopolitan significance. While Unani is reinforced being Muslim in a context when Islam remains a “global threat,” it would be hard for Unani practitioners to be visible and promoted. In contrast, Ayurveda has many prominent vocal supporters, in India and abroad, who present an image of spiritual, non-violent, and peaceful therapy.

It is then unsurprising that in the context of doctors’ clinical repertoires, Ayurveda has become a sort of a default alternative medicine: although medical practitioners may use different therapies across AYUSH and non-AYUSH traditions, Ayurveda is the most likely “add-on.” For example, even if a Unani doctor contests the exceptionalism of Ayurveda, he may nevertheless resort to adding Ayurvedic branded drugs to his practice. Similarly, even biomedical doctors in India are likely to add Ayurveda than any other tradition to their treatment offerings.

In the course of seventy years, “Indian medicine” has been expanded and reconfigured into a new category of AYUSH which seems inclusive and neutral. Yet, I have argued that AYUSH has become a code-word for disguising the institutional disparity between Ayurveda and the rest of the systems. For example, the National Rural Health Mission has been designed to mainstream all AYUSH traditions and co-locate AYUSH facilities in biomedical hospitals and health centers, but in reality, only Ayurveda and sometimes Homeopathy are co-located. Other traditions like Unani are conspicuously absent from this scheme.

Apart from the prevalence in the number of medical facilities, registered practitioners, budget allocation, and social support, the dominance of Ayurveda is evident in the conceptual collapse between the terms *ayush* and Ayurveda, as in “ayush doctor” and “ayurvedic doctor,” “ayush clinic” and “ayurvedic clinic,” or the Ministry of AYUSH and the Ministry of Ayurveda. Thus, the institutionalization of medical plurality under the acronym AYUSH has contributed to a process I called the ayurvedicalization of medical plurality. The fact that alternative medicine in India becomes increasingly ayurvedicalized is also supported by an appropriation of home and herbal remedies under the umbrella “Ayurveda.”

7.1.4 Biomorality and nationalism

The debates about legitimate medical systems are often the debates about cultural identity, politics, and modernity. The analysis of medical discourses and versatile negotiations of treatment within a pluralistic context is a powerful tool which opens a window to the whole range of contested domains, including different visions of the Indian nation. This dissertation has examined the politics of cultural nationalism as it manifests in the realm of alternative medicine and highlighted that declarations of the government support for medical pluralism are at odds

with an unprecedented growth of Ayurveda. I have postulated that this tension parallels the two poles of nationalist ideology which, at one end, lauds the country's cultural diversity and, at the other end, favors the Hindu majority. Yet, I admitted that the proposed links between Ayurveda and Hindu nationalism as well as the link between medical pluralism and inclusive nationalism are far from being direct and simple. As a galaxy of studies on nationalism in India has evinced, Hindu nationalism is not a homogeneous project but encompasses different forms and ideologies (Hansen 1996; Jaffrelot 2009; Rajagopal 2001; van der Veer 1994).

Nevertheless, the rhetoric of influential modern gurus such as Baba Ramdev is deeply informed by Hindu nationalist sentiment. Ramdev's representations of Yoga and Ayurveda are invariably situated within the discourse of a great Indian civilization. Although Ramdev claims that Ayurveda has nothing to do with religion, his language and cultural references are unambiguously indicative of his advocacy for the foundational role of Hindu culture in Indian nation-making. I have shown that Ramdev never uses the term *hindutva* (Hinduness), preferring instead the term *bharatiyata* (Indianness), thus attempting to persuade his devotees in the inclusiveness of nationalism he offers. However, his invocations of ancient Hindu sages and concepts like *ramrajya* are constitutive of the ideology of Hindu fundamentalism.

Studies of Ramdev's persona and the truth discourses that he disseminates are important because he is not just one of many Indian gurus but is an extraordinarily influential public figure, an entrepreneur with millions of followers in India and abroad. By paying attention to the issues of the body, morality, and consumption, I have demonstrated that his success is largely premised on his deployment of media and his ability to wed nationalist sentiment and consumerist desires. He seeks to reach out to people from different economic and social classes by skillfully bridging and redefining notions of *swadeshi* and organic, natural and national, local and universal,

traditional and modern. But Ramdev's seemingly inclusive rhetoric is, in fact, exclusionary in the way that it reiterates Hindu nationalist narratives of India's "Golden Age," promoting Yoga and Ayurveda while conveniently omitting other long-practiced medical traditions.

This dissertation has showcased how the ideological, social, and economic strength of Ayurveda is shaped by Ramdev's discourses and practices. Inspired by Ferzacca's claim that medical pluralism is a form of "state rule" (2002, 35), I have look closely at the instances of a biopolitical intervention of non-biomedical traditions. By engaging with theories of biopower, I have claimed that Ramdev is an authority "considered competent to speak the truth" (Rabinow and Rose 2006, 203) who links individual bodies to the nation's collective past, present, and future: to the ancestors whose medical knowledge and legacy must be respected and to the Indian state, whose economic strength and independence from transnational corporations must be protected. I have argued that the promotion of Yoga and Ayurveda represents a technology of discipline that relates to both nationalism and biopower. Previous studies in medical anthropology and sociology have tended to focus on biomedicine, showing how individuals and populations are governed through biomedical technologies and public health programs. In contrast, I have shifted the analytical focus to institutionalized alternative forms of medicine, highlighting the ways in which practitioners of non-biomedical systems such as Baba Ramdev can be involved in structuring human conduct through the reproduction of medical ideologies and the prescription of specific health regimens related to the body, diet, and lifestyle. From this perspective, this study moves beyond the theorization of nationalism through print, media, and the invention of tradition. Instead, it highlights the biopolitical potential of non-biomedical systems that inscribe nationalism and morality onto the body.

7.2 SIGNIFICANCE, LIMITATIONS, AND FUTURE WORK

Plural medical traditions in India have come a long way. What was initially a debate about the endorsement of just three alternative medical systems—Ayurveda, Unani, and Siddha—has culminated in the creation of an independent Ministry in charge of seven traditions. While this broad institutionalization is an obvious development in the legal status of non-biomedical plurality, de facto these traditions remain at the margins of institutionalized healthcare and many problematic aspects of government policy have remained unsolved. In the 1950–1960s, the policy-makers were preoccupied with stimulating research in indigenous medicine in order to prove its efficacy and value. Sixty years later the government seems to be still invested more in research and drug development than in the quality of education and healthcare provision in AYUSH. The current support for research is driven by Indian government’s aspirations to participate in the global pharmaceutical industry and gain a share in the production of herbal pharmaceuticals. The desire to take advantage of the global interest in Ayurveda and other so-called holistic, side-effects-free therapies has been an important catalyzer in the institutionalization of medical plurality in terms of both codified traditions within AYUSH and non-codified folk healing under the LHT.

In addition to market incentives, the process of institutionalization has been directed by ideologies of cultural autonomy and nationalism in the sense that medical diversity is constructed as a reflection of cultural diversity. While in the 1940–1950s, non-biomedical systems were bundled together as “Indian medicine” to create an image of politically and culturally independent India, in the 2010s, the emphasis on India’s cultural heritage and uniqueness is still valid but now it is reinforced by economic liberalization and globalization processes such as the growth of wellness tourism and the quest for herbal-holistic therapy. These processes make the

term “AYUSH system of medicine” (with the *system* in singular) a perfectly sensible category, with no questions about what that category denotes.

Certainly, despite the disparities that continue to exist among non-biomedical traditions, it would be unfair to dismiss a long history of political struggle and the efforts of non-biomedical doctors for recognition as a vain enterprise. The government of India deserves a credit at least for explicitly spelling out so many non-biomedical systems in the name of the established Ministry of AYUSH. This presents a profound contrast, for example, to Nepal where despite the existence of medical plurality, the government has only formed the Department of Ayurveda, or to other countries where non-biomedical disciplines are not given a separate regulatory body at all.

By examining state and public discourse on Indian medicine and AYUSH, I have sought to invert an analytical focus from the hierarchy between traditional medicine and biomedicine to the hierarchy within institutionalized non-biomedical pluralism (although I have acknowledged that non-biomedical traditions function in a perpetual dialog with biomedicine and non-authorized folk healing). I have shown that the legitimation of plural medical traditions neither renders them equal nor safeguards them from internal asymmetries, which is largely symptomatic of a broader sociopolitical environment.

This dissertation leaves behind the discussion of many important aspects of medical plurality in India. Since it is not a historical study, it has only briefly sketched the evolution of government policy and the history of recognition movements of non-biomedical practitioners. Similarly, the place of Homeopathy and a terminological change from the “Indian Systems of Medicine and Homeopathy” (ISM&H) to AYUSH are just touched upon and I welcome a future study which would draw on archival research and a textual analysis of government documents. Moreover, although I have consulted the official websites of the Ministry of AYUSH, the Central

Council of Indian Medicine, and other related institutions, I did not conduct a systematic analysis of the online content. I envision multiple possibilities for other students of Indian medicine to conduct a content analysis of AYUSH websites examining their language, word choices, and images in order to understand the politics of representation of AYUSH and Ayurveda. There are many other fields of inquiry to which this dissertation has opened the doors: medical plurality and the therapeutic division of labor within medical families, the growth of female medical practitioners of AYUSH, the gendered aspects of Ramdev's discourses, a comparison of Patanjali and the Art of Living, social legitimizing strategies of "state legitimized" medical doctors, the use of non-biomedical therapies by biomedical practitioners, the convergence of the discourses on "Ayurvedic," "organic," and "natural," and the theorizations of biomoral consumption and the biopolitics of alternative medicine. It would be particularly valuable to see how the proposed concepts and theoretical approaches can be applied to work outside India.

Ethnographically rich accounts of institutional medical pluralism are an important tool for understanding sociopolitical processes and discourses related to cultural belonging, social exclusion and inclusion, and national ideologies. I hope that this dissertation has provided a multi-layered commentary on the cultural politics and alternative medical practices in India and will advance scholarly understanding of people's pursuit of health and belonging, reflecting upon the discourses about a kind of life worth living in the contemporary world.

APPENDIX A

GLOSSARY OF TERMS AND ABBREVIATIONS

Allopathy—a commonly used way of referring to biomedicine in India. The term was coined by the founder of Homeopathy, Samuel Hahnemann, to refer to a medical principle that a disease is treated by suppressing its symptoms with medication (from ancient Greek: *allos*—other, different and *pathos*—suffering) in contrast to the principles Homeopathy (*homoios*—alike and *pathos*—suffering). A practitioner of allopathy is called an allopath.

Amchi—a practitioner of Sowa-Rigpa, or Tibetan medicine. In India, especially in Ladakh, *amchi* medicine is sometimes used to refer to a medical tradition itself, not just to its practitioners.

Āśrama, ashram—originally: a religious or spiritual hermitage, a retreat where a holy sage lives. Nowadays, *ashram* is also used in reference to a Yoga or Ayurveda retreat or any other institution for relaxation and meditation.

Ayurveda (Sanskrit: the “knowledge of life”) is a South Asian form of healing, codified at least around the Christian era (Zysk 1998, 1). It is historically practiced in the Indian subcontinent and Sri Lanka, but currently Ayurveda centers are available worldwide. Ayurveda is based on an elaborate theory of physiology, disease etiology, diagnostic methods, and

treatment. An important aspect of Ayurvedic theory is an idea that an illness stems from manifestations of *tridoṣa*—three vital faults or invisible to human eye and potentially troublesome elements, which shape human nature, constitution, and temperament but can also produce an illness. Also foundational in Ayurveda is a concept of seven *dhatu*s, or body elements, such as blood, bone marrow, semen, etc. In addition to seven *dhatu*s and *tridoṣa*, the dichotomy of heat and cold states play important role in both diagnosis and treatment. Treatment often constitutes herbal mixtures, sometimes with mineral-based powders, to be taken with specific beverages or food items according to a prescribed regimen. A practitioner of Ayurveda is traditionally known a *vaid* or *vaidya*.

Dawa and dua (literally drug and prayer)—a common idiom that signifies that the best treatment is a combination of medicine with faith.

Devanagari—the name of a script for Hindi, Sanskrit and several other South Asian languages.

Gurdwara, gurudvārā—a place of worship in Sikhism. It is open to followers of any faith and it is not uncommon for a *gurdwara* to provide charitable services like food or medical care.

Hakim (in Urdu)—a respectful title for a learned man, a gentleman. In India, *hakim* is a traditional medical practitioner, typically a physician of Unani, but in the past and occasionally in the present day it can be applied to any doctor of Ayurveda or other traditional medicine.

Homeopathy—a European medical discipline, developed by a German physician Samuel Hahnemann in the late 18th century. Homeopathy became widely spread in India, particularly at the beginning of the 20th century. The treatment principles of Homeopathy are in large contrary to those of biomedicine (often called “allopathy” in India) in the sense that Homeopathy

postulates that a disease should be treated not by countering and suppressing its symptoms, but by the use of a medication which would otherwise produce these symptoms in a healthy person—a principle known as “like cures like” (Frank and Ecks 2004, 308).

Masala—A blend of or a mixture of spices.

MBBS (*Medicinae Baccalaureus, Baccalaureus Chirurgiae*)—a biomedical degree in India: Bachelor of Medicine and Surgery

Naturopathy, Nature cure—a medical discipline of European origin, which nevertheless became an integral practice in India, is *Nature cure*, or *Naturopathy*. Being rooted in medieval practices such as water cures and spiritio-therapeutic bathing (Alter 2004, 109), Nature cure, or Naturopathy, is based on the use of natural elements such as mud, air, water, sunlight, etc. which treat illness by facilitating the body’s ability to heal itself. In India, this medical practice became popular largely due to the efforts of Mahatma Gandhi (Alter 2004, 110; Leslie 1976a, 360). As such, Nature cure provides an important perspective on Indian state nationalism as expressed in a policy of secular medical pluralism.

Panchakarma (five therapies)—a set of procedures outlined in classical Ayurveda texts and widely practiced today in India and abroad. It includes specific techniques for cleansing and what is now glossed as the “detoxification” of the body.

Pujari—a priest in a Hindu temple.

Siddha—a humoral system of medicine, which in addition to herbal mixtures makes great use of metals and minerals. Again, there are many similarities in diagnosis and treatment between Ayurveda and Siddha, but because Siddha is almost exclusively practiced in South Indian state Tamil Nadu, it is often considered a separate tradition of “Tamil medicine”, which is

based on ancient Tamil texts, rather than Sanskrit ones. Nevertheless, both Siddha and Ayurveda seem to have close historical connections if not a common origin (Weiss 2009).

Sowa-Rigpa (also known as Tibetan medicine)—a unifying term for a variety of medical practices in Tibetan part of China, Himalayan region and North East of India, Nepal, and neighboring regions, but in all locations these healing practices retain a strong and heavily marked connection to Tibetan Buddhism (Craig 2011, 11). Theory of Sowa-Rigpa is outlined in Tibetan texts that are partly derived from the texts of the Indic tradition (Craig 2011, 12), thus also having foundational connections to Ayurveda and its central concept of *tridoṣa*, i.e. three humors or “faults.”

Swadeshi (from Sanskrit *svadeśi*)—something of one’s own land, belonging to one’s own country.

Tridoṣa—three “faults” (namely, vata, pitta, and kapha) which determine the composition of a human body and the world around it. A unique configuration of *doshas* defines a person’s constitution and temperament as well as her state of health.

Unani—a medical tradition premised on the theory of humoral balance and the hot/cold distinction. Some of the diagnostic techniques (such as pulse taking) or medicinal recipes are very similar to the ones used in Ayurveda. However, if in contemporary India Ayurveda has come to be associated with Hindu/Sanskrit tradition, Unani is considered to be Islamic medicine, although such a characterization does not accurately capture the complex histories of both disciplines (Attewell 2007, 11). The roots of Unani go back to Greco-Persian-Arab Hippocratic and Galenic traditions of healing, brought to South Asia by the Muslims from the Middle East in the 12-13th centuries as well as by migrants from Central and West Asia displaced by Mongol

incursions around the same period (Attewell 2007, 12). In North India, a Unani doctor is typically known as a *hakim*.

Vaid, Vaidya—a person who has knowledge (from ved—knowledge). In contemporary India, this term is used for a practitioner of Ayurveda or other traditional medicine, typically someone who has received a knowledge of medicine from a father or a guru.

Yoga—a South Asian Indian tradition, which represents one of six ancient philosophical schools (Whicher 1998, 6-7). The foundational ideas of Yoga can be traced back to at least 1200 B.C. Derived from the Sanskrit root *yuj* (to yoke, join, unite), Yoga gradually came to denote an internal “joining” or “harnessing,” i.e. the union between the senses and with the mind (Whicher 1998, 7-8). The classical school of Yoga is associated with the name of Patanjali, a famous practitioner of Yoga of the 2nd–3rd century (thus, is it not surprising that Ramdev has chosen the name Patanjali as the brand name of his Yoga and Ayurveda business enterprise). This school has developed the most elaborate system of practices, which were focused on attaining control over both mind and body/nature (Whicher 1998).

BIBLIOGRAPHY

Achard, Pierre

1993. Discourse and Social Praxis in the Construction of Nation and State. *Discourse & Society* 4(1): 75–98.

Adams, Vincanne

2002. “Establishing Proof: Translating ‘Science’ and the State in Tibetan Medicine.” In *New Horizons in Medical Anthropology: Essays in Honour of Charles Leslie*, edited by Mark Nichter and Margaret Lock, 200–220. New York: Routledge.

Adams, Vincanne and Fei Fei Li

2008. “Integration or Erasure? Modernizing Medicine at Lhasa's Mentsikhang.” In *Exploring Tibetan Medicine in Contemporary Context: Perspectives in Social Sciences*, edited by Laurent Pordie, 105–131. Routledge UK: Needham Research Institute Series.

Adams, Vincanne, Mona Schrempf, and Sienna Craig, eds.

2010. *Medicine Between Science and Religion: Explorations on Tibetan Grounds*: Berghahn Books.

Alavi, Seema

2008. “Medical Culture in Transition: Mughal Gentleman Physician and the Native Doctor in Early Colonial India.” *Modern Asian Studies*, 42: 853–897

Alloula, M.

1987, *The Colonial Harem*, Manchester and Minnesota: Manchester University Press.

Alter, Joseph

1992. *The Wrestler's Body: Identity and Ideology in North India*: University of California Press.

1994. “Somatic Nationalism: Indian Wrestling and Militant Hinduism.” *Modern Asian Studies* 28 (3): 557–588.

2000. *Gandhi's Body: Sex, Diet and the Politics of Nationalism*. Philadelphia: University of Pennsylvania Press.

2004. *Yoga in Modern India: The Body Between Science and Philosophy*. Princeton: Princeton University Press.

ed.

2005a. *Asian Medicine and Globalization*. Philadelphia: University of Pennsylvania Press.

2005b. "Ayurvedic Acupuncture—Transnational Nationalism: Ambivalence about the Origin and Authenticity of Medical Knowledge." In *Asian Medicine and Globalization*, edited by Joseph Alter, 21–44. Philadelphia: University of Pennsylvania Press.

2008a. "Rethinking the History of Medicine in Asia: Hakim Mohammed Said and the Society for the Promotion of Eastern Medicine." *The Journal of Asian Studies* 67 (4): 1165–1186.

2008b. "Yoga Shivar: Performativity and the Study of Modern Yoga." In *Yoga in the Modern World: Contemporary Perspectives*, edited by Mark Singleton and Jean Byrne. London and New York: Routledge.

2011. "Yoga, Modernity, and the Middle Class: Locating the Body in a World of Desire." In *A Companion to the Anthropology of India*, edited by Isabelle Clark-Decès, 154–168. Malden, MA: Wiley-Blackwell.

2015. "Nature Cure and Ayurveda: Nationalism, Viscerality, and Bio-ecology in India." *Body and Society*, 21(1) 3–28.

Anand, Sudhir and Victoria Fan

2016. *The Health Workforce in India*. In *Human Resources for Health Observer Series No. 16*: World Health Organization.

Anderson, Benedict

1983. *Imagined Communities: Reflections on the Origin and Spread of Nationalism*. London: Verso Books.

Appadurai, Arjun

1988. *The Social Life of Things: Commodities in Cultural Perspective*. Cambridge, MA: Cambridge University Press

Arnold, David

1993. *Colonizing the Body: The State Medicine and Epidemic Disease in Nineteenth Century India*. Delhi: Oxford University Press.

2000. *Science, Technology and Medicine in Colonial India*: Cambridge University Press.

Arnold, David and Sumit Sarkar

2002. "In Search of Rational Remedies: Homoeopathy in Nineteenth-Century Bengal." In *Plural Medicine, Tradition and Modernity, 1800-2000*, edited by Waltraud Ernst, 40–57. London and NY: Routledge.
- Attewell, Guy
2007. *Refiguring Unani Tibb: Plural Healing in Late Colonial India*. New Delhi: Orient Longman.
- Baer, Hans
2011. "Pluralism: An Evolving and Contested Concept in Medical Anthropology." In *A Companion to Medical Anthropology*, edited by M. Singer and P. Erickson, 405–424. Malden, MA: Wiley-Blackwell.
- Bala, Poonam
1991. *Imperialism and Medicine in Bengal: A Socio-Historical Perspective*: Sage Publications.

2007. *Medicine and Medical Policies in India: Social and Historical Perspectives*: Lexington Books.
- Ballhatchet, K.A.
1980. *Race, Sex and Class Under the Raj: Imperial Attitudes and Policies and Their Critics, 1973–1905*, NY: St. Martin's Press.
- Barcan, Ruth
2011. *Complementary and Alternative Medicine: Bodies, Therapies, Senses*: Berg.
- Barnard, A., and J. Spencer. 2002. *Encyclopedia of Social and Cultural Anthropology*: Taylor & Francis.
- Barth, Frederik
1969. "Introduction." In *Ethnic Groups and Boundaries. The Social Organization of Culture Difference*, edited by Frederik Barth. Accessed March 22, 2017. http://isites.harvard.edu/fs/docs/icb.topic446176.files/Week_4/Barth_Introduction_Ethnic_Groups_and_Boundaries_.pdf
- Bashford, Alison
2004. *Imperial Hygiene: A Critical History of Colonialism, Nationalism and Public Health*. New York: Palgrave Macmillan.
- Bassiouney, Reem
2012. Politicizing identity: Code choice and stance-taking during the Egyptian revolution. *Discourse & Society* 23(2):107–126.
- Beattie, Geoffrey.

1982. "Turn Taking and Interruption in Political Interviews: Margaret Thatcher and Jim Callaghan Compared and Contrasted." *Semiotica* 39 (1/2): 93–114.
- Berger, Rachel
2013. *Ayurveda Made Modern: Political Histories of Indigenous Medicine in North India, 1900–1955*: Palgrave Macmillan.
- Berg, Marc and Geoffrey Bowker
1997. The Multiple Bodies of the Medical Record: Toward a Sociology of an Artifact. *Sociological Quarterly* 38(3): 513–537.
- Bharatiya Janata Party
2014. "Election Manifesto: Sabka Saath, Sabka Vikas." http://www.bjp.org/images/pdf_2014/full_manifesto_english_07.04.2014.pdf.
- Billig, Michael
1995 *Banal Nationalism*. SAGE Publications.
- Blommaert Jan and Dong Jie
2010. *Ethnographic Fieldwork*. Bristol, UK: Multilingual Matters.
- Bode, Maarten
2006. "Taking Traditional Knowledge to the Market: The Commoditization of Indian Medicine," *Anthropology and Medicine*, 13 (3): 225–36.

2008. *Taking Traditional Knowledge to the Market: The Modern Image of the Ayurvedic and Unani Industry, 1980-2000*. New Delhi: Orient Blackwell Swan.
- Bode, Maarten and Hariramamurthi
2014. "Integrating folk healers in India's public health: acceptance, legitimacy and emancipation." *eJournal of Indian Medicine* 7: 1–20.
- Bose, Sugata and Ayesha Jalal
2011. *Modern South Asia: History, Culture, Political Economy*. Third Edition ed. London and New York: Routledge.
- Braun, B.
2007. "Biopolitics and the Molecularization of Life." *Cultural Geographies* 14: 6–28.
- Breckenridge, C. A., and P. van der Veer
1993. *Orientalism and the Postcolonial Predicament: Perspectives on South Asia*: University of Pennsylvania Press, Incorporated.
- Briggs, Charles and Mark Nichter
2009. "Biocommunicability and the biopolitics of pandemic threats." *Medical Anthropology* 28 (3): 189–98. doi: 10.1080/01459740903070410.

Brotherton, Sean

2012. *Revolutionary Medicine: Health and the Body in Post-Soviet Cuba*. Durham and London: Duke University Press.

Burke, Timothy

1996. *Lifbuoy Men, Lux Women: Commodification, Consumption, and Cleanliness in Modern Zimbabwe*. Durham: Duke University Press.

Business Standard

2016. "Baba Ramdev's Patanjali Aims to Double its Revenue to Rs 10,000 cr in 2016–17," April 27, 2016. Accessed July 12, 2016. http://www.business-standard.com/article/companies/baba-ramdev-s-patanjali-aims-to-double-its-revenue-to-rs-10-000-cr-in-2016-17-116042700061_1.html.

Byrne, Jean

2014. "'Authorized by Sri K. Pattabhi Jois:' The Role of Parampara and Lineage in Ashtanga Vinyasa Yoga." In *Gurus of Modern Yoga*, edited by Mark Singleton and Ellen Goldberg, 107–121. New York: Oxford University Press.

Cameron, Mary

2009. "Untouchable Healing: A Dalit Ayurvedic Doctor from Nepal Suffers his Country's Ills." *Medical Anthropology* 28 (3): 235–267.

2010. "Feminization and Marginalization?" *Medical Anthropology Quarterly* 24 (1): 42–63.

Carilli, Theresa, and Jane Campbell

2012. *Challenging Images of Women in the Media: Reinventing Women's Lives*: Lexington Books.

Census of India

2011. Accessed January 21, 2017. <http://www.censusindia.gov.in/>.

Chakrabarti Santanu

2012. "The Avatars of Baba Ramdev: The Politics, Economics, and Contradictions of an Indian Televangelist." In *Global and Local Televangelism*, edited by Pradip Ninan Thomas and Philip Lee, 149–170. London: Palgrave Macmillan UK.

Chakraborty, Chandrima

2007. "The Hindu Ascetic as Fitness Instructor: Reviving Faith in Yoga." *The International Journal of the History of Sport* 24 (9):1172–1186.

2006. "Ramdev and Somatic Nationalism: Embodying the Nation, Desiring the Global." *Economic and Political Weekly* 41 (5): 387–390. doi: 10.2307/4417755.

- Chatterjee, Partha
1993. "The Nationalist Resolution of the Women's Question." In *Recasting Women: Essays in Colonial History*, edited by Kumkum Sangari and Sudesh Vaid, 233–253. New Delhi: Kali for Women.
- Chatterji, Angana
2004. "The Biopolitics of Hindu Nationalism: Mournings." *Cultural Dynamics* 16 (2-3): 319–372. doi: 10.1177/0921374004047753.
- Chen, Nancy
2013. *Breathing Spaces: Qigong, Psychiatry, and Healing in China*. Columbia University Press.
- Chilton, Paul, and Christina Schaffner, eds.
2002. *Politics as Text and Talk: Analytic Approaches to Political Discourse*. Amsterdam: John Benjamins.
- Cho, Hyo-Je
2000. "Traditional Medicine, Professional Monopoly and Structural Interests: a Korean case." *Social Science and Medicine* 50 (1):123–135.
- Chopra Report
1948. "The Report of the Committee on Indigenous Systems of Medicine." Government of India. Accessed March 20, 2017. <http://dspace.gipe.ac.in/xmlui/bitstream/handle/10973/34220/GIPE-022426.pdf?sequence=3&isAllowed=y>
- CNN iReport
2011. "From Bicycle to Jet Plane: Baba Ramdev Smashing Success." June 21, 2011. Accessed March 22, 2017. <http://ireport.cnn.com/docs/DOC-624778>.
- Coe, Cati
2001. "Learning How to Find Out: Theories of Knowledge and Learning in Field Research." In *Field Methods*, 13 (4): 392–411.
- Copeman, Jacob
2009. *Veins of Devotion: Blood Donation and Religious Experience in North India*. Rutgers University Press.
- Coupland, Nikolas
2001. "Dialect Stylization in Radio Talk." *Language in Society* 30(3): 345–375.
- Craig, Sienna
2011. "'Good' Manufacturing by Whose Standards? Remaking Concepts of Quality, Safety, and Value in the Production of Tibetan Medicines." *Anthropological Quarterly* 84 (2): 331–378.

Crandon, Libbet

1986. "Medical Dialogue and the Political Economy of Medical Pluralism: A case from Rural Highland Bolivia." *American Ethnologist* 13(3): 463–476.

Crandon-Malamud, Libbet

1991. *From the Fat of Our Souls: Social Change, Political Process, and Medical Pluralism in Bolivia*. Los Angeles: University of California Press.

Croizier, Ralph

1968. *Traditional Medicine in Modern China: Science, Nationalism, and the Tensions of Cultural Change*: Harvard University Press.

Dastidar, Avishek

2015. "AAYUSH or AYUSSH? AYUSH minister to consider." *The Indian Express*. December 19, 2015. Accessed March 22, 2017. <http://indianexpress.com/article/india/politics/aayush-or-ayussh-ayush-minister-to-consider>.

Dave Report

1955. "Interim Report of the Committee Appointed by the Government of India to Study and Report on the Question of Establishing Uniform Standards in Respect of Education and Practice of Vaidyas, Hakims and Homoeopaths." Government of India.

Dean, Mitchell

1999. *Governmentality: Power and Rule in Modern Society*. London: SAGE.

Deka, Kaushik

2016. "Power Yogi: How Baba Ramdev Became India's Swadeshi FMCG Baron." *India Today*, March 4, 2017. <http://indiatoday.intoday.in/story/baba-ramdev-patanjali-Yoga/1/714332.html>.

Douglas, Mary

2003 [1966]. *Purity and Danger: An Analysis of Concepts of Pollution and Taboo*. London and New York: Routledge.

Durkin-Longley, Maureen

1984 Multiple Therapeutic Use in Urban Nepal. *Social Science & Medicine* 19(8): 867–872.

Dunn, Frederick

1976. "Traditional Asian Medicine and Cosmopolitan Medicine as Adaptive Systems." In *Asian Medical Systems: A Comparative Study*, edited by Charles Leslie, 133–158. Berkeley, Los Angeles, London: University of California Press.

Eleventh Five Year Plan

2008. *Eleventh Five Year Plan (2007-2012): Social Sector. Volume II*. Planning Commission, Government of India. Accessed March 22, 2017. http://planningcommission.nic.in/plans/planrel/fiveyr/11th/11_v2/11th_vol2.pdf
- Eisenhart, Christopher
2008. "Reporting Waco: The constitutive work of bureaucratic style." In *Rhetoric in Detail: Discourse Analyses of Rhetorical Text and Talk*, edited by Barbara Johnstone and Christopher Eisenhart, 57–79. Amsterdam and Philadelphia: John Benjamins.
- Ernst, Waltraud, ed.
2002. *Plural Medicine, Tradition and Modernity: Historical and Contemporary Perspectives: Views from Below and from Above, 1800–2000*. New York: Routledge.
- Fabian, Johannes
1995. "Ethnographic Misunderstanding and the Perils of Context." *American Anthropologist* 97 (1): 41–50. doi: 10.1525/aa.1995.97.1.02a00080.
- Fabrega, Horacio and Peter Manning
1979. "Illness Episodes, Illness Severity and Treatment Options in a Pluralistic Setting." *Social Science and Medicine* 13 (1): 41–51.
- Fairclough, Isabela and Norman Fairclough
2012. *Political Discourse Analysis*. London: Routledge.
- Farquhar, J. 1994. *Knowing Practice: The Clinical Encounter of Chinese Medicine*. Boulder, CO: Westview Press.
- Fassin, Didier
2009. "Another Politics of Life is Possible." *Theory Culture Society* 26 (5):44–60.
- Ferzacca, Steve
2002. "Governing Bodies in New Order Indonesia." In *New Horizons in Medical Anthropology: Essays in Honour of Charles Leslie*, edited by Mark Nichter and Margaret Lock, 35–57. New York: Routledge.
- Fields, G.P.
2014. *Religious Therapeutics: Body and Health in Yoga, Ayurveda, and Tantra*. New York: State University of New York Press.
- Firstpost
2015. "Baba Ramdev's Patanjali noodles, priced at Rs 15, to be launched next week." October 9, 2015. Accessed March 22, 2017. <http://www.firstpost.com/india/baba-ramdevs-patanjali-noodles-priced-at-rs-15-to-be-launched-next-week-2462716.html>
- Fjeld, Heidi and Theresia Hofer
2011. "Women and Gender in Tibetan Medicine." *Asian Medicine* 6 (2): 175–216.

- Flesch, Hannah
2010. "Balancing Act: Women and the Study of Complementary and Alternative Medicine." *Complementary Therapies in Clinical Practice* 16: 20–25.
- Foster, George
1960. *Culture and Conquest: America's Spanish Heritage*: Wenner-Gren Foundation for Anthropological Research Incorporated.
- Foster, George
1994. *Hippocrates' Latin American Legacy: Humoral Medicine in the New World*: Gordon and Breach.
- Foucault, Michel
1990 [1978]. *The History of Sexuality*. Volume 1: An Introduction, Translated by Robert Hurley. New York: Vintage Books.
- Frank, R., and S. Ecks.
2004. "Towards an Ethnography of Indian Homeopathy." *Anthropology and Medicine* 11 (3):307-332.
- Gaines, Atwood, and Robbie Davis-Floyd
2004. "Biomedicine." In *Encyclopedia of Medical Anthropology*, edited by Carol Ember and Melvin Ember, 95–109. New Haven: Yale University Press.
- Galvin, Shaila
2014. "Organic Designs and Agrarian Practice in Uttarakhand, India." *Culture, Agriculture, Food and Environment* Vol. 36, Issue 2 pp. 118–128
- Gawde, Suchita R., Yashashri C. Shetty, and Dattatray B. Pawar.
2013. "Knowledge, attitude, and practices toward ayurvedic medicine use among allopathic resident doctors: A cross-sectional study at a tertiary care hospital in India." *Perspectives in Clinical Research* 4 (3): 175–180.
- Giri, Ananta Kumar.
2004. "Rethinking the Politics and Ethics of Consumption: Dialogues with the Swadeshi Movements and Gandhi." *Journal of Human Values* 10(1): 43–45.
- Government of India
2002. "National Policy on Indian Systems of Medicine and Homoeopathy. Accessed March 20, 2017. <http://indianmedicine.nic.in/writereaddata/linkimages/7870046089-Ayush%20%20n%20policy%20ISM%20and%20H%20Homeopathy.pdf>.
- Government of Uttarakhand
n.d. "Protected Area Network." Accessed March 20, 2017. <http://forest.uk.gov.in/pages/display/80-protected-area-network>

- Gupta, Akhil
1995. "Blurred Boundaries: The Discourse of Corruption, the Culture of Politics, and the Imagined State." *American Ethnologist* 22 (2): 375–402.
- Gupta, Brahmananda
1976. "Indigenous Medicine in Nineteenth and Twentieth century Bengal." In *Asian Medical Systems: A Contemporary Study*, edited by Leslie Charles. Berkeley: University of California Press.
- Habib, Irfan and Raina Dhruv
2005. "Reinventing Traditional Medicine: Method, Institutional Change, and the Manufacture of Drugs and Medication in Late Colonial India." In *Asian Medicine and Globalization*, edited by Joseph Alter. Pennsylvania: University of Pennsylvania Press.
- Hampshire, Kate and Samuel Owusu
2012. "Grandfathers, Google, and Dreams: Medical Pluralism, Globalization, and New Healing Encounters in Ghana." *Medical Anthropology* 32 (3): 247–265.
- Hansen, Thomas Blom
1996. "Recuperating Masculinity: Hindu Nationalism, Violence and the Exorcism of the Muslim 'Other.'" *Critique of Anthropology* 16: 137–172.
- Hardiman, David
2009. "Indian Medical Indigeneity: From Nationalist Assertion to the Global Market." *Social History* 34 (3): 263–283.
- Hardiman, David and Projit Mukharji, eds.
2012. *Medical Marginality in South Asia: Situating Subaltern Therapeutics*. New York: Routledge.
- Hausman, Gary
2002. "Making Medicine Indigenous: Homeopathy in South India." *Social History of Medicine* 15 (2): 303–322.
- Hindustan Times
2015. "Leave India if You are Opposed to Surya Namaskar: Yogi Adityanath." June 9, 2015. Accessed March 22, 2017. <http://www.hindustantimes.com/india/leave-india-if-you-are-opposed-to-surya-namaskar-yogi-adityanath/story-cBxJTUVD7mbACqy8AWPR5J.html>
- Hobsbawm, E. 1990. *Nations and Nationalism since 1780: Programme, Myth, Reality*. Cambridge: Cambridge University Press.
- Homeopathy Central Council Act

1973. Government of India. Accessed March 20, 2017.
https://www.nhp.gov.in/UploadFiles/microsite/635960641909289061_1.pdf
- Hookastar
2014. "India 'MODI'-fied: Brand India Rising." Accessed June 27, 2015.
<http://www.hookastar.com/brand-india-rising/>.
- Hunt, Nancy
1999. *A Colonial Lexicon: Of Birth Ritual, Medicalization, and Mobility in the Congo*. Durham: Duke University Press.
- Indian Medicine Central Council Act
1970. Government of India. Accessed March 20, 2017.
<http://www.indianmedicine.nic.in/writereaddata/mainlinkFile/File221.pdf>.
- Irvine, Judith, and Susan Gal
2000. Language Ideology and Linguistic Differentiation. In *Regimes of Language: Ideologies, Politics, and Identities*, edited by Paul Kroskrity, ed. Pp. 35–83. Santa Fe: School of American Research Press.
- Itoozhi Ayurveda
2014. "India Now has a Minister for Ayurveda with a Separate AAYUSH portfolio." *Itoozhi Ayurveda*, November 13, 2014. Accessed June 27, 2015.
<http://www.itoozhiayurveda.in/ayurveda/india-now-minister-ayurveda-separate-aayush-portfolio>.
- Jaffrelot, Christophe
2009. *Hindu Nationalism: A Reader*. Princeton University Press.

2011. "Ramdev: Swami without Sampradaya." *The Caravan*. July 1, 2011. Accessed March 21, 2016. <http://www.caravanmagazine.in/perspectives/ramdev-swami-without-sampradaya>.
- Janes, Craig
1995. "The Transformations of Tibetan Medicine." *Medical Anthropology Quarterly*, 9 (1): 6–39.
- Janzen, John
1978. *The Quest for Therapy: Medical Pluralism in Lower Zaire*. Berkeley: University of California Press.
- Janzen, John
1987. "Therapy Management: Concept, Reality, Process." *Medical Anthropology Quarterly* 1 (1): 68–84.
- Jeffery, Roger

1988. *The Politics of Health in India*. Berkeley: University of California Press.
- Johnstone, Barbara
 1991. *Repetition in Arabic Discourse: Paradigms, Syntagms, and the Ecology of Language*. Amsterdam: John Benjamins (Pragmatics and Beyond, New Series, 18).
2008. *Discourse Analysis*. Second Edition. Malden, MA: Blackwell Publishing
- Johnstone, Barbara and Christopher Eisenhart, eds.
 2008. *Rhetoric in Detail: Discourse Analyses of Rhetorical Text and Talk*. Amsterdam and Philadelphia: John Benjamins.
- Kala, Chandra Prakash
 2005. "Indigenous Uses, Population Density, and Conservation of Threatened Medicinal Plants in Protected Areas of the Indian Himalayas." *Conservation Biology* 19 (2): 368–378.
- Keshet, Yael and Ariela Popper-Giveon
 2013. "Integrative Health Care in Israel and Traditional Arab Herbal Medicine: When Health Care Interfaces with Culture and Politics." *Medical Anthropology Quarterly*, 27 (3): 368—384.
- Khalikova, Venera
 2017. "The Ayurveda of Baba Ramdev: Biomoral Consumerism, National Duty and the Biopolitics of 'Homegrown' Medicine in India." *South Asia: Journal of South Asian Studies*, 40(1): 105–122.
- Khan, Shamshad
 2006. "Systems of Medicine and Nationalist Discourse in India: Towards 'New Horizons' in Medical Anthropology and History." *Social Science and Medicine* 62: 2786–2797.
- Khare, R. S.
 1996. "Dava, Daktar, and Dua: Anthropolgy of Practiced Medicine in India." *Social Science and Medicine* 43 (5): 837–848.
- Kim, J.
 2009. "Transcultural Medicine: A Multi-Sited Ethnography on the Scientific-Industrial Networking of Korean Medicine." *Medical Anthropology* 28 (1): 31–64.
- Kirmayer, Lawrence
 2014. "Medicine of the Imagination: Cultural Phenomenology, Medical Pluralism. And the Persistence of Mind-Body Dualism." In *Asymmetrical Conversations: Contestations, Circumventions, and the Blurring of Therapeutic Boundaries*, edited by Naraindas, Quack, and Sax, 26–55.

Kleinman, Arthur

1978. "Concepts and a model for the comparison of medical systems as cultural systems." *Social Science and Medicine* 12: 85–93.

1980. *Patients and Healers in the Context of Culture*. Berkeley: University of California Press.

Kloos, Stephan

2013. "How Tibetan Medicine in Exile Became a 'Medical System.'" *East Asian Science, Technology and Society: An International Journal* 7 (3): 381–395.

Kravitz, Richard, R. Epstein, M. Feldman, C. Franz, R. Azari, M. Wilkes, L. Hinton, and P. Franks

2005. "Influence of Patients' Requests for Direct-to-Consumer Advertised Antidepressants: A Randomized Controlled Trial." *Journal of the American Medical Association*, 293(16): 1995–2002

Krishnan, Sneha

2016. "Agency, Intimacy, and Rape Kokes: An Ethnographic Study of Young Women and Sexual Risk in Chennai." *Journal of the Royal Anthropological Institute* 22 (1): 67–83.

Kroskrity, Paul

2000 Regimenting Languages: Language Ideological Perspective. In *Regimes of language: Ideologies, politics, and identities*. Paul Kroskrity, ed. Pp. 1-34. Santa Fe: School of American Research Press.

Kumar, Anil

1998. *Medicine and the Raj: British Medical Policy in India, 1835-1911*. New Delhi: Sage Publications.

Kumar, A., Keerti, C. P. Sharma, S. Sharma, K. Garg, and R. Jain.

2013. "Assessment of Knowledge and Performance of AYUSH Doctors Posted in Collocation under National Rural Health Mission in Udaipur Division, Rajasthan." *National Journal of Community Medicine* 4 (4): 608–612.

Kumar, Raman and Pritam Roy

2016. "Deregulation of Allopathic Prescription and Medical Practice in India: Benefits and Pitfalls." *Journal of Family Medicine and Primary Care* 5.2: 215–219.

Kuniyal, Chandra, Vinod Bisht, Jagmohan Negi, Vijay Bhatt, Dhan Bisht, Jitendra Butola, Rakesh Sundriyal, and Satish Singh

2015. "Progress and Prospect in the Integrated Development of Medicinal and Aromatic Plants (MAPs) Sector in Uttarakhand, Western Himalaya." *Environment, Development and Sustainability* 17:1141-1162.

Kunstadter, Peter

1975. *The Comparative Anthropological Study of Medical Systems in Society: East-West center.*

Kuriyama, Shigehisa

1999. *The Expressiveness of the Body and the Divergence of Greek and Chinese Medicine.* Boston: Zone Books.

Lamont, Michèle and Virág Molnár

2002. "The study of boundaries in the social sciences." *Annual Review of Sociology*: 167–195.

Lambert, Helen

2012a. "Medical Pluralism and Medical Marginality: Bone Doctors and the Selective Legitimation of Therapeutic Expertise in India." *Social Science and Medicine* 74 (7): 1029–1036. doi: 10.1016/j.socscimed.2011.12.024.

2012b. "Wrestling with Tradition: Towards Subaltern Therapeutics of Bonesetting and Vessel Treatment in North India." In *Medical Marginality in South Asia: Situating Subaltern Therapeutics*, edited by David Hardiman and Projit Mukharji, 109–125.

Langford, Jean

1999. "Medical mimesis: Healing signs of a cosmopolitan 'quack.'" *American Ethnologist* 26 (1): 24–46.

2002. *Fluent Bodies: Ayurvedic Remedies for Postcolonial Imbalance.* Durham: Duke University Press.

2003. "Traces of Folk Medicine in Jaunpur." *Cultural Anthropology* 18 (3): 271–303

Langwick, Stacey

2008. "Articulate(d) Bodies: Traditional Medicine in a Tanzanian Hospital." *American Ethnologist* 35(3): 428–439

Leslie, Charles

1968. "Division of Anthropology: The Professionalization of Ayurvedic and Unani Medicine." *Transactions of the New York Academy of Sciences* 30 (4 Series II): 559–572. doi: 10.1111/j.2164-0947.1968.tb02498.x.

1973. "The Professionalizing Ideology of Medical Revivalism." In *Entrepreneurship and Modernization of Occupational Cultures in South Asia*, edited by M. Singer, 216–242. Durham: Duke University Press.

, ed.

1976a. *Asian Medical Systems: A Comparative Study.* Berkeley, Los Angeles, London: University of California Press.

1976b. "Introduction." In *Asian Medical Systems: A Comparative Study*, edited by Charles Leslie. Berkeley, Los Angeles, London: University of California Press.

1976c. "The Ambiguities of Medical Revivalism in Modern India." In *Asian Medical Systems: A Comparative Study*, edited by Charles Leslie, 356–367. Berkeley, Los Angeles, London: University of California Press.

Leslie, Charles and Allan Young, eds.

1992. *Paths to Asian Medical Knowledge*. Berkeley and Los Angeles: University of California Press.

Library of Congress

1997 "ALA-LC Romanization Tables," last modified February 24, 2016. <https://www.loc.gov/catdir/cpsd/roman.html>.

Liebeskind, Claudia

2002. "Arguing science: Unani tibb, hakims, and biomedicine in India, 1900–1950." In *Plural Medicine, Tradition and Modernity, 1800–2000*, edited by Waltraud Ernst, 58–75. London and NY: Routledge.

Lock, Margaret

1990. "Rationalization of Japanese Herbal Medication: The Hegemony of Orchestrated Pluralism." *Human Organization* 49 (1): 41–47.

Lock, Margaret and Vinh-Kim Nguyen

2010 *An Anthropology of Biomedicine*. Malden, MA: Wiley-Blackwell.

Lou, Loretta

2016. *Beyond Miracles: How Traditional Chinese Medicine Establishes Professional Legitimacy in Post-colonial Macau*. *Somatosphere*. Accessed March 9, 2017.

Mankekar, Purnima

1993. "National Texts and Gendered Lives: An Ethnography of Television Viewers in a North Indian city." *American Ethnologist*, 20: 543–563.

1999. *Screening Culture, Viewing Politics: An Ethnography of Television, Womanhood, and Nation in Postcolonial India*. Durham: Duke University Press.

Marsland, R., and R. Prince

2012. "What Is Life Worth? Exploring Biomedical Interventions, Survival, and the Politics of Life." *Medical Anthropology Quarterly* 26 (4):453–469.

Math, Suresh Bada, Sydney Moirangthem, Naveen Kumar, and Maria Christine Nirmala

2015. "Ethical and legal issues in cross-system practice in India: Past, present and future." *National Medical Journal of India* 28 (6): 295–299.
- McDonnell, Terence
2010. Cultural Objects as Objects: Materiality, Urban Space, and the Interpretation of AIDS Campaigns in Accra, Ghana. *American Journal of Sociology* 115(6): 1800–1852.
- McKay, Ramah
2012. Documentary Disorders: Managing Medical Multiplicity in Maputo, Mozambique. *American Ethnologist* 39(3): 545–561.
- McKean, Lise
1996. *Divine Enterprise: Gurus and the Hindu Nationalist Movement*. Chicago: University of Chicago Press.
- McMillen, Christian and Niels Brimnes
2010. "Medical Modernization and Medical Nationalism: Resistance to Mass Tuberculosis Vaccination in Postcolonial India, 1948–1955." *Comparative Studies in Society and History* 52 (1): 180–209.
- Mehrotra, Narendra
2012. "The Overall Structure of the Health Care System in India and Regulation (with defining of AYUSH, Ayurveda and Local Health Traditions)." International Workshop *Integrating Traditional South Asian Medicine into Modern Health Care Systems*, Jawaharlal Nehru University, New Delhi, October 4-6.
- Metcalf, Barabara
1985. "Nationalist Muslims in British India: The Case of Hakim Ajmal Khan." *Modern Asian Studies* 19 (1): 1–28.
- Ministry of AYUSH
n.d. "About the Systems." Accessed on January 17, 2017. <http://ayush.gov.in/about-the-systems>.
- Ministry of AYUSH
n.d. "FAQ: What is the Origin of Ayurveda?" Accessed April 2, 2015. <http://indianmedicine.nic.in/faqdet.asp?fid=9&lang=1>
- Ministry of AYUSH
2010. "Summary of Infrastructure Facilities under AYUSH." Accessed June 25. <http://indianmedicine.nic.in/showfile.asp?lid=44>.
- Mudaliar Report
1962. The Report of the Health Survey and Planning Committee. Government of India.
- Mukharji, Projit

2011. *Nationalizing the Body: The Medical Market, Print and Daktari Medicine*. London: Anthem Press.

2016. *Doctoring Traditions: Ayurveda, Small Technologies, and Braided Sciences*. Chicago: University of Chicago Press.

Musolff, Andreas

2004. *Metaphor and Political Discourse: Analogical Reasoning in Debates about Europe*. New York: Palgrave Macmillan.

Nader, Laura

1996. *Naked Science: Anthropological Inquiry Into Boundaries, Power, and Knowledge*. New York: Routledge.

Nagarajan, Rema

2016. "More Women Study Medicine, but Few Practise." *The Times of India*. January 11, 2016. Accessed March 22, 2017. <http://timesofindia.indiatimes.com/india/More-women-study-medicine-but-few-practise/articleshow/50525799.cms>.

Nahar Papreen, N.K. Kannuri, Sitamma Mikkilineni, G.V.S. Murthy and Peter Phillimore

2017. "At the margins of biomedicine: the ambiguous position of 'Registered Medical Practitioners' in rural Indian healthcare." *Sociology of Health and Illness*, 39 (4): 614–628

Naraindas, Harish

2006. "Of Spineless Babies and Folic Acid: Evidence and Efficacy in Biomedicine and Ayurvedic Medicine." *Social Science and Medicine* 62 (11): 2658–69. doi: 10.1016/j.socscimed.2005.11.043.

2014a. "Nosopolitics. Epistemic Mangling and the Creolization of Contemporary Ayurveda." In *Medical Pluralism and Homeopathy in India and Germany (1810–2010)*, edited by Martin Dinges, 105–136. Stuttgart: Franz Steiner Verlag.

2014b. "My Vaidya and My Gynecologist: Agency, Authority, and Risk in Quest of a Child." In *Asymmetrical Conversations: Contestations, Circumventions, and the Blurring of Therapeutic Boundaries*, edited by Naraindas, Quack, and Sax, 118–161.

Naraindas, Harish, Johannes Quack, and William Sax, eds.

2014. *Asymmetrical Conversations: Contestations, Circumventions, and the Blurring of Therapeutic Boundaries*. Berghahn Books.

National Health Profile

2012. "National Health Profile (NHP) of India," Government of India. Accessed March 20, 2017. <http://cbhidghs.nic.in/index2.asp?slid=1256&sublinkid=1163>.

NDTV

2015. "AYUSH Services Becomes Operational in Dubai." NDTV. September 28, 2015. Accessed October 13, 2015. <http://www.ndtv.com/indians-abroad/ayush-services-becomes-operational-in-dubai-1223874>.

Negi, Sharad Singh

1995. Uttarakhand: Land and People. New Delhi: M.D. Publications.

Nehru, Jawaharlal

1951. *The Discovery of India*. London: Meridian Books Ltd. Original edition, 1946.

Nichter, Mark

1978. "Patterns of Resort in the Use of Therapy Systems and their Significance for Health Planning in South Asia." *Medical Anthropology* 2:29–56.

1980. "The Layperson's Perception of Medicine as Perspective into the Utilization of Multiple Therapy Systems in the Indian Context." *Social Science and Medicine* 14 (4): 225–233.

Nisula, Tapio

2006. "In the Presence of Biomedicine: Ayurveda, Medical Integration and Health Seeking in Mysore, South India." *Anthropology and Medicine* 13 (3):207–224.

NRHM

n.d. "National Rural Health Mission: Meeting People's Health Needs in Rural Areas. Framework for Implementation 2002-2015." Accessed March 22, 2017. <http://nrhm.gov.in/images/pdf/about-nrhm/nrhm-framework-implementation/nrhm-framework-latest.pdf>.

Pandey, Kundan

2014. "Separate Ministry for AYUSH to Revive Traditional Medicine." *DownToEarth*, 11 November, 2014. Accessed August 27, 2015. <http://www.downtoearth.org.in/news/separate-ministry-for-ayush-to-revive-traditional-medicine-47304>.

Pandit Report

1951. The Report of the Committee to Advise on Steps to be Taken to Establish a Research Centre in the Indigenous Systems of Medicine and Other Cognate Matters. Government of India.

Panikkar, K. N.

1992. "Indigenous Medicine and Cultural Hegemony: a Study of the Revitalization Movement of Keralam." *Studies in History* 8 (2): 282–308.

Petryna, Adriana

2002. *Life Exposed: Biological Citizens after Chernobyl*. Princeton: Princeton University Press.

- Pinto, Sarah
2004. "Development without Institutions: Ersatz Medicine and the Politics of Everyday Life in Rural North India." *Cultural Anthropology* 19(3): 337–364.
- Prakash, Gyan
1999. *Another Reason: Science and the Imagination of Modern India*. New Jersey, West Sussex: Princeton University Press.
- Press, Irwin
1980. "Problems in the Definition and Classification of Medical Systems." *Social Science and Medicine* 14 (1): 45–57.
- Priya, Ritu
2013. "Status and Role of AYUSH Services and Use of Local Health Traditions under the NRHM: A Health Systems Study across 18 States." *The IAS Newsletter* 65: 24–25. Accessed March 2, 2017.
- Priya, Ritu and A.S. Shweta
2010. Status and role of AYUSH services and use of Local Health Traditions under the National Rural Health Mission: Report of a Study. National Health Systems Resource Centre, Government of India. Accessed March 22, 2017. http://nhsrcindia.org/pdf_files/resources_thematic/Public_Health_Planning/NHSRC_Contribution/index.php?option=com_content&view=article&id=286.
- Quack, Johannes
2013. "‘What do I know?’ Scholastic Fallacies and Pragmatic Religiosity in Mental Health-Seeking Behaviour in India." *Mental Health, Religion & Culture* 16 (4): 403–418.
- Rabinow, Paul and Nikolas Rose
2006. "Biopower Today." *Biosocieties* 1: 195–217.
- Radcliffe-Brown, Alfred
1940. "On Joking Relationships." *Africa: Journal of the International African Institute* 13 (3): 195–210.
- Raheja, Gloria Goodwin
1996. Caste, Colonialism, and the Speech of the Colonized: Entextualization and Disciplinary Control in India. *American Ethnologist* 23(3): 494–513
- Raj, Ashok
2010. *The Life and Times of Baba Ramdev*. New Delhi: Hay House India.
- Rajagopal, Arvind
2001. *Politics After Television: Hindu Nationalism and the Reshaping of the Public in India*. Cambridge University Press.

Ramdev

2010. "Shri Rajiv Dixit and Swami Ramdev on Swadeshi se Swawlambi Bharat—Bharat Swabhiman Andolan," YouTube. Delivered in December 2014, Gujarat. Accessed November 22, 2016. <http://www.youtube.com/watch?v=XcC-62kAnUg>.

2014. "Baba Ramdev's Speech at National Ayurveda Summit 2014, Gandhinagar," YouTube. Delivered in February 2014. Accessed March 23, 2016. <https://www.youtube.com/watch?v=qEnDhbV5IPg>.

Rao, Krishna, Renu Shahrawat, and Aarushi Bhatnagar

2016. "Composition and Distribution of the Health Workforce in India: Estimates Based on Data from the National Sample Survey." *WHO South-East Asia Journal of Public Health* 5(2): 133–140.

Reed, Kate

2002. "Local-Global Spaces of Health: British South Asian Mothers and Medical Pluralism." In *Plural Medicine, Tradition and Modernity, 1800–2000*, edited by Waltraud Ernst, 171–183. London and NY: Routledge.

Ritivoi, Andrea

2008. "Talking the (Political) Talk: Cold War Refugees and Their Political Legitimation through Style." In *Rhetoric in Detail: Discourse Analyses of Rhetorical Text and Talk*, edited by Barbara Johnstone and Christopher Eisenhart, 33–56. Amsterdam and Philadelphia: John Benjamins

Rivers, W. H. R.

2003 [1924]. *Medicine, Magic, and Religion: The Fitzpatrick Lectures Delivered before the Royal College of Physicians of London in 1915 and 1916*. London and New York: Routledge.

Rose, Nikolas

2007. *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century*. Princeton, NJ: Princeton University Press.

Rose, Nikolas and C. Novas

2004. "Biological Citizenship." In *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*, edited by Aihwa Ong and S. J. Collier, 439–63. Oxford: Blackwell

Roy, A., and R. Rowland

2003. "The Rhetoric of Hindu Nationalism: a Narrative of Mythic Redefinition." *Western Journal of Communication* 67 (3): 225–248.

Ryan, Gery and Russell Bernard

2003. "Techniques to Identify Themes." *Field Methods*, 15 (1): 85–109.

- Said, Edward
1978. *Orientalism*. London: Penguin Group.
- Saks, Mike
2008. "Plural Medicine and East-West Dialogue." In *Modern and Global Ayurveda: Pluralism and Paradigms*, edited by Dagmar Wujastyk and Frederic Smith, 29–41. New York: State University of New York Press.
- Samal, Janmejaya
2013. "Role of AYUSH Doctors in Filling the Gap of Health Workforce Inequality in Rural India with Special Reference to National Rural Health Mission: A Situational Analysis." *International Journal of Advanced Ayurveda, Yoga, Unani, Siddha and Homeopathy*, 2(1): 83–89.
- Sarbacker, Roy
2014. "Swami Ramdev: Modern Yoga Revolutionary." In *Gurus of Modern Yoga*, edited by Mark Singleton and Ellen Goldberg, 351–371. New York: Oxford University Press.
- Sarkar, Sumit
1973. *The Swadeshi Movement in Bengal: 1903–1908*. New Delhi: People's Publishing House.
- Sax and Bhaskar
2014. "A Healing Practice in Kerala." In *Asymmetrical Conversations: Contestations, Circumventions, and the Blurring of Therapeutic Boundaries*, edited by Naraindas, Quack, and Sax, 200–236.
- Selby, Martha
2005. "Narratives of Conception, Gestation, and Labour in Sanskrit Ayurvedic Texts." *Asian Medicine: Tradition and Modernity*, 1(2): 254–275.
- Shashikumar, B.M. and M.P. Sheethal
2015. "Knowledge, Attitude And Practices Regarding AYUSH Among The Allopathic Doctors In Mandya District." *National Journal of Integrated Research in Medicine* 6 (4): 68–71.
- Shivdasani, J. P., N. Chanana, U. Datta, and J. Das.
2012. "Evaluation of AYUSH Health Care Units in Uttarakhand." *Health and Population—Perspectives and Issues* 35 (1): 1–10.
- Silverstein, Michael
1979 Language Structure and Linguistic Ideology. In *The Elements: A Parasection on Linguistic Units and Levels*. Paul Clyne, William Hanks, and Carol Hofbauer, eds. Pp. 193-247. Chicago: Chicago Linguistic Society.

- Sinha, M.
1997. The “Manly Englishman” and the “Effeminate Bengali” in the Late Nineteenth Century. New Delhi: Kali for Women.
- Singleton, Mark and Ellen Goldberg
2014. *Gurus of Modern Yoga*. New York: Oxford University Press.
- Sivaramakrishnan, Kavita
2006. *Old Potions, New Bottles: Recasting Indigenous Medicine in Colonial Punjab (1850-1945)*. New Delhi: Orient BlackSwan.
- Srivastava, Sanjay
2015. “Modi-Masculinity: Media, Manhood, and ‘Traditions’ in a Time of Consumerism.” *Television & New Media* 16 (4): 331–338.
- Statistics Times
2015. “Indian states by GDP Growth.” Accessed March 3, 2017. <http://statisticstimes.com/economy/gdp-growth-of-indian-states.php>.
- Sunder Rajan, Rajeshwari
1993. *Real and Imagined Women. Gender, Culture and Postcolonialism*. London: Routledge.
- Surakhsha, P.
2017. “Who Will Train State’s AYUSH docs in Allopathy?” *The New Indian Express*, January 15, 2017. Accessed March 22, 2017. <http://www.newindianexpress.com/cities/bengaluru/2017/jan/15/who-will-train-states-ayush-docs-in-allopathy-1559756.html>
- The Guardian
2015. “Indian Civil Servants to Get Free Daily Yoga Lessons.” March 20, 2015. Accessed March 23, 2017. <http://www.theguardian.com/lifeandstyle/2015/mar/20/indian-civil-servants-to-get-free-daily-Yoga-lessons>
- The Health Site
2015. “Union Budget 2015–16: Experts Disappointed by the 5.7% Drop in Healthcare Spending.” *The Health Site*, March 01, 2015. Accessed October 20, 2015. <http://www.thehealthsite.com/news/union-budget-2015-16-experts-disappointed-by-the-5-7-drop-in-healthcare-spending/>.
- The Scitech Journal
2014. “Government to Push for Standardization in Ayurvedic Drug Production.” *The Scitech Journal*. Accessed June 27, 2015. http://www.thescitechjournal.com/admin/includes/print_version/2014-25-1154742c921f39c.pdf.

The Times of India

2015. "Uttarakhand won't be part of Yoga-Day Celebration: Rawat." June 17, 2015. Accessed March 22, 2017. <http://timesofindia.indiatimes.com/india/Uttarakhand-wont-be-part-of-Yoga-Day-celebration-Rawat/articleshow/47709925.cms>.

The Tribune

2014. "Ministry for Ayush a Recognition of Ayurveda, Says Balkrishan." *The Tribune*, December 15 2014. Accessed June 27, 2015. <http://www.tribuneindia.com/news/uttarakhand/community/ministry-for-ayush-a-recognition-of-ayurveda-says-balkrishan/18090.html>.

2015. "Govt order creates confusion for ayurvedic docs, pharmacists." *The Tribune*, May 22, 2015. Accessed March 22, 2017. <http://www.tribuneindia.com/news/uttarakhand/community/govt-order-creates-confusion-for-ayurvedic-docs-pharmacists/84016.html>

Tirodkar, Manasi

2002. "Cultural Loss and Remembrance in Contemporary Ayurvedic Medical Practice." In *Modern and Global Ayurveda: Pluralism and Paradigms*, edited by Dagmar Wujastyk and Frederic Smith. New York: State University of New York Press, pp. 227–242.

Udupa Report

1958. The Report by the Committee on Ayurveda Research Evaluation. Government of India.

Unani Committee Report

1964. The Report of the Suddha Unani Education Committee. Government of India.

United Provinces Act

1939, "The United Provinces [Ayurvedic and Unani Tibbi Systems of Medicine] Act." Accessed March 20, 2017. http://bimup.org/bcp_file/bcp_eng.pdf

Unschuld, Paul

1975. "Medico-Cultural Conflicts in Asian Settings: an Explanatory Theory." *Social Science and Medicine* 9(6): 303–312.

van der Veer, Peter

1994. *Religious Nationalism: Hindus and Muslims in India*. Berkeley: University of California Press.

van der Geest, Sjaak and Susan Reynolds Whyte

1989. "The Charm of Medicines: Metaphors and Metonyms." *Medical Anthropology Quarterly*, 3(4): 345–367.

van Dijk, Teun

2008. *Language and Power*. Houndmills: Palgrave Macmillan.

van Hollen, Cecilia

2005. "Nationalism, Transnationalism, and the Politics of 'Traditional' Indian Medicine for HIV/AIDS." In *Asian Medicine and Globalization*, edited by Joseph Alter, 88–106. Philadelphia: University of Pennsylvania Press.

Vanina, Eugenia

2001. "India: The Whole and Its Parts in Historical Perspective." *The Indian Historical Review* 28(1–2): 84–111

Varshney, Ashutosh

2014. "Hindu Nationalism in Power?" *Journal of Democracy*, 25 (4): 34–45

Vyas Report

1962. *The Report of the Shuddha Ayurvedic Education Committee*. Government of India.

Warrier, Maya

2014. *Ayurveda in Britain: The Twin Imperatives of Professionalization and Spiritual Seeking*. In *Asymmetrical Conversations: Contestations, Circumventions, and the Blurring of Therapeutic Boundaries*, edited by Naraindas, Quack, and Sax, 237–260.

Watt, Carey

2005. *Serving the Nation: Cultures of Service, Association, and Citizenship*.

Waxler-Morrison, N. 1988. "Plural Medicine in Sri Lanka: Do Ayurvedic and Western Medical Practices Differ?" *27 (5):531-544*.

Weiss, Richard

2008. "Divorcing Ayurveda: Siddha Medicine and the Quest for Uniqueness." In *Modern and Global Ayurveda: Pluralism and Paradigms*, edited by Dagmar Wujastyk and Frederic Smith, 77–99. New York: State University of New York Press.

2009. *Recipes for Immortality: Healing, Religion, and Community in South India*. New York: Oxford University Press, USA.

Welch, Claudia

2008. "An Overview of the Education and Practice of Global Ayurveda." In *Modern and Global Ayurveda: Pluralism and Paradigms*, edited by Dagmar Wujastyk and Frederic Smith, 129–138. New York: State University of New York Press.

Whicher, Ian

1998. *The Integrity of the Yoga Darsana: A Reconsideration of Classical Yoga*. Albany: State University of New York Press.

Wilson, John

2015. "Political Discourse." In *The Handbook of Discourse Analysis*, edited by Deborah Tannen, Hamilton Heidi and Deborah Schiffrin, 775–794. Chichester, US: Wiley-Blackwell.
- Wodak, Ruth
2011. *The Discourse of Politics in Action*. Basingstoke: Palgrave Macmillan.
- Wujastyk, Dominik
1995. "Medicine in India." In *Oriental Medicine: An Illustrated Guide to the Asian Arts of Healing*, edited by Jan Van Alphen and Anthony Aris. London: Serindia Publications, pp. 19–37.
2008. "The Evolution of Indian Government Policy on Ayurveda in the Twentieth Century." In *Modern and Global Ayurveda: Pluralism and Paradigms*, edited by Dagmar Wujastyk and Frederic Smith. New York: State University of New York Press.
- Wujastyk, Dagmar and Frederick Smith, eds.
2008. *Modern and Global Ayurveda: Pluralism and Paradigms*. New York: State University of New York Press.
- Young, Allan
1982. "Rational Men and the Explanatory Model Approach." *Culture, Medicine and Psychiatry* 6(1): 57–71.
- Zhang, Everett
2007. "Switching between Traditional Chinese Medicine and Viagra: Cosmopolitanism and Medical Pluralism Today." *Medical Anthropology* 26 (1): 53–96.
- Zysk, Kenneth
1998. *Medicine in the Veda: Religious Healing in the Veda: with Translations and Annotations of Medical Hymns from the R̥gveda and the Atharvaveda and Renderings from the Corresponding Ritual Texts*. New Delhi: Motilal Banarsidass.