

# **Navigating the Medical Marketplace: Consuming Ayurveda in Delhi**

**by**

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## Abstract

This dissertation examines what is becoming of traditional medicine amongst the middle-class of Delhi following India's transition to neoliberal market policies. My research, based on interviews, conversations, and participant observation conducted in 2004 and 2005-2007, is centred on the consumption of Ayurveda, a two thousand year indigenous medical system.

Scholars who study indigenous medical and consumption tend to equate *medications* with *medical system*. However Ayurveda cannot be reduced to objects such as medications alone. Accordingly, I pursue what my urban middle-class interlocutors identified as "Ayurveda," paying close attention to their therapeutic landscapes of health care. This medical practice is an extensive repertoire of knowledge enacted by a variety of informal and formal experts. I argue that consumption and health care practices cannot be suitably understood if one's analysis is restricted to exchange in the formal market economy. I portray medical practice as an activity system rather than a mere assemblage of objects or technologies (p.508).

I trace the materiality and relationships which enact Ayurveda across the spaces of the household, clinic, and expositions. The household is a site for consumption, which takes place along non-market pathways. Members use their domestic network to access various unofficial practitioners who provide medical resources such as remedies and knowledge. The clinic highlights treatment as a series of activities and verbal narratives. Even as the clinic becomes more marketised, informal repertoires of knowledge continue to be produced both by the patients and practitioners in their quest for health. The expositions foreground Ayurveda as a mass-produced and modern object while relying on tropes of nationhood and authenticity to lend authority to the practice so that it may benefit from the expanding health care market.

The spaces I examine are not self-enclosed; rather they are points of convergence for the objects and relationships which propagate Ayurveda in India's medical marketplace. My project highlights the continued relevance of multiple institutions consisting not only of the market but also the state, family, and neighbourhood in enacting formal and informal health care practices for consumption.

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Iron beaten to a wire  
turns to silver  
Strange – the alchemy of illness  
(Khān-e Ārzu, d.1756, Delhi)

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# 1. Introduction

This dissertation examines what is becoming of traditional medical practices amongst the middle-class of Delhi following India's transitions to a neoliberal reform whereby the logic of mass production configures the production of health care. Issues of access, quality, and efficiency mean that the majority of middle-class Indians pursue treatment from the private rather than the public sector (Nandraj, 1994). Historically, the state has not prioritised healthcare as a national (nor fiscal) concern, and this makes India's private health system one of the largest in the world (p.1680). India's public, or "government", health care institutions are often overcrowded and lacking in staff. Those who cannot afford private care generally resort to them. Health care consumption in India is not a new development, but many private hospitals and clinics were often not much better in calibre than their government counterparts (i.e. in terms of service) before neoliberal reforms. Wilson, who investigated the establishment of corporate hospitals in the state of Kerala remarked that health care in India (in public and private settings) before 1991 were based on the principles of "economicism" whereby the aim of health care delivery was not to accumulate profit, but to keep running costs to a minimum (2010, p.38). To put it differently, while the consumption of health care is not a new development, the economic process of *marketisation* is. By marketisation I refer here,

to the ways in which the provision of health care is being shaped by the globalisation of trade in health services, the commercialisation of the health care industry, the local context of a competitive marketplace, the fashioning of health care as a commodity, and the aspirations of the middle classes for social mobility. (Wilson, 2010, p.38)

With the marketisation of health in India, goods and services are produced to stand out from competitors in the market, and to be consumed by those with the financial means. Thus, at present in India one can witness the use of medical technologies, such as

sophisticated diagnostic equipment and packaged medications, to attract consumers from the burgeoning Indian middle-class, rather than to address the needs of the population at large (Banerjee, 2009; Nandraj, 1994; Wilson 2010).

Rohit, a middle-class Delhi man in his late twenties, reflects on the appeal of Ayurvedic medicines available for purchase today from a major manufacturer, Himalaya Drug Company,

I had jaundice when I was young and they gave me Liv 52 which was in a really shitty yellow-coloured bottle. It looked ugly, it tasted bad. And now the Liv 52 that Himalaya produces, it looks really nice. I mean, even if they put rat's poop in it, I would just have it, you know what I mean? (April 2, 2007)

Here the actual medicinal substance is not being transformed, rather it is fashioned as an appealing consumer good, following the logic of marketisation (Wilson, 2010).

Scholars who investigate the marketisation of Ayurveda, particularly the mass-production of Ayurvedic medicines, suspect that this process will reduce a complex medical philosophy to nothing more than a collection of consumer-friendly commodities (Banerjee, 2009; Bode, 2008). Projit Mukharji (2011), a historian of medicine, understands political scientist Madhulika Banerjee (2009) and medical anthropologist Maarten Bode (2008) as scholars who provide two of the “most fullsome” (p.893) accounts of the medical market. Banerjee (2009) and Bode (2008) investigated the mass production of Ayurvedic medicine in India and considered the cachet of Ayurveda as an authentic therapeutic option for modern consumers, which challenged oppositions between tradition-modern and local-global. However, Banerjee and Bode based the majority of their findings from the perspective of manufacturers and state actors. Their understanding of consumers are mediated through the perspectives of manufacturers and state actors. I concentrate on the perspective of Indian middle class consumers which enables me consider Ayurveda as a repertoire of knowledge and series of activities enacted by a spectrum of formal and informal experts rather than a mere assemblage of objects or technologies. I trace the materiality and relationships which enact Ayurveda

across the spaces of the household, clinic, and expositions, sites which are part of Delhi's medical marketplace.

I argue that the *medical marketplace* is far from a static entity, which hosts goods for purchase (see Chapter 2 for my formulation of the medical marketplace). My ethnographic encounters portray the medical marketplace as a system of interactions in the informal and formal sphere animated by networks of practitioners, entrepreneurs, and consumers who circulate therapeutic resources from one site to the other to enact Ayurvedic medicine.

## **1.1. Ayurveda as a Sociotechnical System**

Bryan Pfaffenberger (1992) observed that during its nineteenth century beginnings, anthropology was closely associated with the comparative study of technology and material culture. This approach was eventually denigrated as 'armchair anthropology', or the study of artifacts with little regard for their cultural context. Anthropologists instead turned their attention to language, social organisation, and rituals to understand humanity (p.491). Meanwhile, the study of technology and artifacts has been pursued by thinkers in other disciplines, such as science and technology studies (STS) or history of technology since the 1960s.

Pfaffenberger (1992) called for a *social anthropology of technology* to bring back this discipline's relevancy to the study of artifacts, an area for which it has much insight to offer. Such studies would be invaluable for challenging the prevailing account of technology in the Western modernist narrative whereby it is assumed to contain both instrumental and symbolic functions, with the latter being of secondary importance. Pfaffenberger argued that instrumental functions were actually not self-evident because "social information is... crudely encoded in artifacts" (p. 510). Furthermore, instrumental qualities cannot be suitably distinguished from an object's symbolic qualities. For example, Stephen Lansing's study of Balinese water temples demonstrated how a local

irrigation apparatus could run successfully without its users needing to distinguish between instrumental and symbolic functions:

By symbolically embedding each local's group's quest for water within the supra-local compass of temple ritual, water temples encourage the cooperation necessary to ensure not only the equitable distribution of water but also the regulated flow of inundation and fallowing that proves vital for pest control and fertility. (Lansing cited in Pfaffenberger, 1992, p. 500)

An outsider visitor may not realise that the Balinese are conducting both a religious ritual and irrigating their rice fields. The multiple functions of an irrigation system (i.e. as a water temple) may be invisible to an onlooker as it is so deeply enfolded into everyday life. A sociotechnical system is a coordination of,

complex social structures, non-verbal activity systems, advanced linguistic communication, the ritual coordination of labor, advanced artifact manufacture, the linkage of phenomenally diverse social and non-social actors, and the social use of artifacts. (p. 513)

I investigate Ayurveda as a sociotechnical system. This concept allows me to understand the objects and technologies of medicine as existing within a system of activities (p.508). Pfaffenberger summed up his understanding of a sociotechnical system by stating, "for the greater part of human history, labour has been more significant than tools, the intelligent efforts of the producer more significant than his simple equipment" (p. 497). This statement seems apt for the two thousand year old system that is Ayurveda.

Anthropologist Ravindra Khare (1992, 1996, 2011) has spent over five decades studying many dimensions of South Asian social life including health care, Hindu cosmology, commensality, and social inequality. Although Khare does not explicitly designate himself as a sociotechnical scholar, his comprehensive research background enables him to speak authoritatively about health care as a cultural practice. Khare explained that Indians engage in a multiform cultural reasoning when negotiating health care and anthropologists must thus consider how their informants' "background cultural

assumptions, ethical values, reasoning patterns, and shared sensibilities” configures their health practices (1996, p. 837).

Scholars observe that the modern disciplinary roots of anthropology are based on distinctions such as mind-body, science-magic, and tradition-modern. Ayurveda speaks to and frustrates all of these binaries: its treatment is based on a coordination of beneficial substances and routines which interrelates “bodily conditions to humours, environmental and climactic factors, psychological dispositions, and moral and spiritual states” (Khare, 1996, p.838). In Hindu cosmology, Ayurveda is a form of divine knowledge, which includes “not only religious knowledge such as codes of practice and ascetic self-discipline, but also the arts and sciences, such as grammar, dance, architecture, astrology, [and] music” (Burghat, 1988, p.296).

Biomedicine, in contrast, is based on an epistemological premise that opposes spirit and matter, mind and body, individual and society, and so on (Lock & Scheper-Hughes, 1987). This Cartesian legacy is still felt by anthropologists who struggle to find specific vocabularies for articulating the interactions between mind, body, and society (p. 210). As a result, analysts remain ensnared in such reasoning even as their work seeks to carefully problematise such distinctions (Pigg, 1996). I conceptualise Ayurveda as a sociotechnical rather than medical system to avoid the tendency of treating Ayurveda as an approximation of biomedicine, and with the intention of acquiring a better understanding of this practice on its own terms.<sup>1</sup>

That said, I do not affiliate myself closely with the typical gamut of sociotechnical thinkers. Most theorists of sociotechnical systems acknowledge the intersection between human activity and technology, but they have a narrow conception of the latter and tend to reduce their analysis to human-machine interactions in the workplace. The term, *sociotechnical system*, was first articulated in the 1950s with Eric Trist’s work on the interactions between humans and machines and their potential to increase efficiency. Many studies have followed suit to examine the organisational culture and work systems

<sup>1</sup> In India, biomedicine or Western medicine is often referred to as allopathy. I will use biomedicine and allopathy interchangeably from this point onwards.

of complex organisations such as hospitals and the forestry industry, (Cherns, 1976; Kolodny, 1980). More recent studies focus on digital technologies such as computers, which now form the basis of many workplace interactions (Kling, 1999; Whitworth & Ahmad, 2012).

I stay close to Pfaffenberger's agency-centred conception of sociotechnical systems as it is most helpful for drawing out the configuration of technologies and techniques (or of objects and knowledge) that is Ayurveda. Moreover, this concept best acknowledges how pharmacological and therapeutic resources emerge locally and resonate with the everyday lives of their users.

The former Chief Information Officer of IBM computers, Irving Waldawsky-Berger, emphasised sociotechnical systems as people-oriented: they are designed, built, and managed by humans (2012). All medical traditions, from Ayurveda to Traditional Chinese Medicine (TCM), and biomedicine are thus "sociotechnical systems": an interface between humans and technology.

Ayurveda however is distinct from these other medical practices because it can be enacted by a diverse spectrum of experts. Both a Bachelor of Ayurvedic Medicine and Surgery degree from a medical college enables one to practice, but this is not the only means of enacting medical authority. Historically, Ayurveda was learnt via apprenticeship in a *guru-sishyan* manner between teacher and student for many centuries before it became institutionalised by the state in the twentieth century (Langford, 2002). As well, Ayurveda may be a part of lay medical knowledge and embedded in an assemblage of home remedies or *desi* (folk or country) medicine. This makes Waldawsky-Berger's (2012) point about the people-centred nature of sociotechnical systems all the more compelling: a variety of participants can enact Ayurveda. Waldawsky-Berger notes that such sociotechnical systems are neither purely biological, nor completely "man-made" or engineered: they require timely human mediation. Perhaps it is this betwixt and between nature of health care which has captured the attention of so many medical anthropologists and STS scholars over the decades.

## 1.2. Outline of Dissertation

With such a conceptualisation of sociotechnical systems in place, what are the implications of this approach for my study on the consumption of healthcare amongst the middle-class of Delhi? Ayurveda is a multi-faceted health practice and efforts to define, pin down, bound, or establish its “real” form ignores how patients and practitioners in India have engaged with it. I follow other scholars in refusing to parse out an authentic Ayurveda (Langford, 2003; Khare, 1996; Smith & Wujastyk, 2008). Instead, I pursue what my interlocutors themselves identified as “Ayurveda,” paying close attention to the therapeutic landscapes of health care.

Chapter 2 introduces the concept of the *medical marketplace*, explaining how this notion suggests that the investigation of Ayurveda as a sociotechnical system should attend to its spatial and relational frames of practice. My field research, which took place in 2004 and 2005-2007, with informal and formal medical actors can be conceptualised as a series of interactions with a permutation of the medical marketplace.

Chapter 3 discusses the emergence of the formal market economy and consumer practices in India from the colonial period to the contemporary era. This chapter portrays neoliberalism, middle class, and Ayurveda as formations derived from historically-contingent circumstances, and constantly remade as new participants negotiate their place in these projects. I argue that consumption needs to be considered as *a process*, rather than a simple financial transaction. My ethnographic investigation of Ayurveda reveals the complexities and nuances of the socioeconomic interactions carried out by patients seeking physical, emotional and spiritual health.

Chapter 4 introduces basic Ayurvedic principles and provides a brief overview to its formation, institutionalisation, and practice as a medical system during the twentieth century. I discuss how cultural symbols intersect with medical authority in the practice of Ayurveda as it is invoked as a tool of political and social commentary by state actors, medical practitioners and patients. The variety of practitioners discussed here showcases the therapeutic options available to the middle class as part of their health seeking strategies.

Chapter 5 is an ethnographic exploration of the marketisation of health care which investigates Ayurveda as a translocal medical practice, connected to wider economic networks, which are animated by a variety of local, national and global actors such as practitioners, state bodies, and private enterprises (i.e. clinics and drug manufacturers). The theme of this chapter is the mobility of medical systems such as Ayurveda, enterprises, and people and the attendant process of translocality. I depict my fieldwork locale, Delhi, as a significant site of convergence for an increasingly mobile medical practice, and its mobile consumers, namely the middle-class and medical tourists.

Chapter 6 portrays the household as a site of on-going reproduction of medical knowledge. Health care practices from the household may be invisible to outsiders -- even what middle-class residents denote as “Ayurveda” is embedded within an assemblage of local or indigenous health care options. However, the domestic network mediates access to therapeutic substances and to a range of informal health care experts ranging from domestic labourers, such as cooks and cleaners, to *gurus* [authoritative spiritual guides]. My exploration of commercial and affective mode of exchange reveals the importance of domestic relationships for health seekers. This focus expands our understanding of the range of informal medical activities that are carried out in the informal economic arena.

In Chapter 7, Ayurveda is foregrounded as an institutional entity and health care services in clinics. Clinics are dense nodes of activity based on verbal and non-verbal interactions between patient and practitioner interactions. I examine the role of the patient-as-consumer in such a setting, and emphasize the attentive-ness to regimen and therapeutics required by them before and after the clinic visit. Although clinics are formal spaces, they condense a spectrum of expertise. I show how this site hosts the circulation of informal repertoires of knowledge via non-monetary forms of exchange (such as apprenticeships) for practitioners.

In Chapter 8, I discuss how public expositions, such as health fairs and yoga camps, motivate the consumption of Ayurveda – by placing themselves at the forefront of the emergent ideas about notions of health and medical care as India becomes more

embedded within the global economy. I investigate two types of expositions, one which showcases herbal products and medical goods and the other which showcases communal bodily practices like yoga. I treat public expositions as sites that coalesce marketing processes.

Health and well-being is seldom ever an assured status. People *consume* Ayurveda to attain or *produce* health for themselves or their kin. As such, the body may express an infinite array of conditions related to appearance, hygiene, energy levels, pain, and suffering that are potentially resolvable by consumption. My examination of the pharmacological and therapeutic practices that sustain Ayurveda reveals the variety and intricacies of consumption, which encompasses the production of goods and services, and traverses the informal and formal spheres of the economy.

## **2. The Medical Marketplace**

This chapter discusses the range of the health care activities carried out by actors in the private health care arena, a zone that I designate as the medical marketplace. The medical marketplace is not a static entity nor a self-evident formation, rather it refers to an array of economically-based relationships between medical actors such as pharmacists, doctors, informal and formal practitioners, patients, consumers, more so than a place (Jenner & Wallis, 2007). This term captured the attention of many scholars especially from the 1980s onwards with the rise of consumer health care culture in affluent nations such as the United States and Great Britain and a variety of social scientists, such as historians, anthropologists, and geographers have theorised on their understanding of the medical marketplace.

My research project on the contemporary practice of Ayurveda, whose production traverses the spheres of health and consumerism is guided by the insights of these scholars. My fieldwork in Delhi, based on participant-observation, conversations, and interviews, can be understood as a series of encounters with one configuration of the medical marketplace.

As Ayurveda becomes more integrated into India's consumer economy, it mobilises the participation not only of medical practitioners, but also of state decision makers, manufacturers, and marketers. This chapter concludes with a discussion these emergent experts or insiders of Ayurveda.

After my arrival to Delhi, I sought to understand the transformation of consumer practices and of Ayurveda's place in it, by taking note of its literal placement in the urban environment. My reasoning was that, if Ayurveda was becoming marketised, surely it would be prominent in the retail cityscape. During my travels, from one part of the city to the other, I often found myself on a major road that snaked through south Delhi, an

affluent middle-class area which featured wide tree-lined boulevards, roads filled with cars, and numerous gated neighbourhoods or “colonies” made up of hundreds of houses. One section of this road was a commercial district dotted with an array of medical facilities offering allopathic, homeopathic, and Ayurveda services interspersed with other small and medium sized-enterprises. After many auto rickshaw rides, I could eventually mentally recall the commercial establishments I would pass in this area. Medical enterprises were interspersed amongst various large and small commercial enterprises:

- Clinic, named Drug Free Centre for Dreadful Diseases (possibly naturopathic)
- Chemists (pharmacy) – three in close proximity
- Homeopathic clinic
- Nursing home (i.e. a small hospital)
- The Hindustan Lever Limited Ayurvedic spa
- Gift shop
- Cell phone shop
- Foreign currency exchanger/travel agency
- Food store (selling frozen food products)
- Baby goods store
- Specialised pet store, named “Fancy Fish”
- Photocopy/Internet zone (3 shops)
- Beauty parlour (recently opened)
- Chemist
- Phone call office (offering local and state-distance phone service)
- Café Coffee Day (recently opened, one of the Indian coffee chains)

My ethnographic memory recalled the spatialisation of commercial establishments and sign boards, noting how health care and Ayurveda merge in the formal marketplace for mass consumption.

Yet, this description does not tell the full story of Ayurveda’s production in Delhi today. Behind these shops were middle-class neighbourhoods or enclaves with residents such as homeowners, renters, and domestic labourers who enacted their own dynamic informal economy (discussed in Chapter 6 on household consumption of Ayurveda). The

depiction above of commercial establishments is a snapshot of south Delhi, an affluent area which is inhabited by the middle class. A walk through the streets of Old Delhi -- perhaps Khari Baoli, or the Spice Bazaar, where one could purchase herbs in bulk -- would reveal a different picture of the 'medical marketplace'.<sup>2</sup>

The continued practice of Ayurveda in informal economies is not surprising when one considers the recent findings by the Organisation for Economic Co-operation and Development which estimates that 1.8 billion people work in the informal sector (cited in Neuwirth, 2011). Even as many countries were increasingly integrated into the formalised global marketplace, the informal sector continues to thrive. In this economic arena, informal practitioners may be domestic workers who are skilled in curing certain ailments in the household, or a hobbyist who dispenses remedies on a part-time basis amongst their neighbours.

Considering this, the term medical marketplace needs to emphasise these important dimensions of health care consumption. If one enters the term 'medical marketplace' onto Google Scholar, 187 000 hits come up and the reader is presented with citations from a cross-disciplinary selection of journals specialising in law, medicine, and health policy. Many of the sources discuss private health care in the United States interrogate the meaning of concepts such as quality of care, competition, health insurance, and trust in a setting where markets rather than governments increasingly regulate social, economic, and health care activity.

We need another way to think about medicine and marketplaces as these practices are culturally embedded and emerge from historically-particular scenarios. Acknowledging this point, medical historians Mark Jenner & Patrick Wallis (2007) undertook a critical examination of the medical marketplace by tracing its emergence from England and its colonies from 1450-1850.

<sup>2</sup> Old Delhi is a bustling wholesale market located in north Delhi. As its name suggests, it is Delhi's oldest area. During the Mughal dynasty (1638-1857) the royalty resided in this area (Darlymple, 1993). Certain monuments and landmarks remain standing and lend this part of the city great character.

As Jenner & Wallis (2007) explain in the introduction of their edited book, the concept of a medical marketplace generates inquiry along a number of lines. Firstly, and most importantly to anthropologists, it valorises the study of medical practices ‘from below’ or ‘on the ground’ by including the perspectives and needs of those who can be designated as patients, consumers, or health-seekers. The case studies in Jenner & Wallis’ edited volume encourages readers to consider the medical marketplace not as a place or thing, but as a assemblage of social and economic networks which are oriented to particular ‘markets’. That is, these networks are oriented towards a configuration of demands and desires which will be different for non life-threatening issues such as minor ailments (i.e. colds or cuts) or momentous event such as childbirth.

Other researchers have noted the commercial dimension of health care practices as well. For medical anthropologists, Vinay Kamat and Mark Nichter (1998), the medical marketplace is built on interactions which take place in Mumbai pharmacies. In their article, “Pharmacies, Self-Medication and Pharmaceutical Marketing in Bombay, India”, they examined negotiations which took place between allopathic pharmacy attendants and their clients so that pharmacies could remain in business despite issues such as pharmacy attendants who were unlicensed to dispense medicine and customers who needed to obtain necessary medications despite a lack of prescriptions or income.<sup>3</sup> Kamat and Nichter explained how these obstacles are negotiated in relation to the commercial sphere made up of wholesalers, pharmaceutical sales representatives, pharmacists, doctors, and consumers, who are engaged in symbiotic mercantile relationships. Even in one country such as India, the medical marketplace undergoes different permutations in relation to which health care practice is enacted, and where.

In the article, “Consumerist ideology and the symbolic landscapes of private medicine” (1997), medical geographers Robin A. Kearns and J.S. Barnett consider the transformations taking place in the medical marketplace of New Zealand following deregulation of medical services as health care shifted from a state responsibility to

<sup>3</sup> *Mumbai* refers to the city formerly known as Bombay.

important an economic activity. As a result, patients were placed on the receiving end of marketing strategies and solicited as consumers. To succeed in such a setting, clinics transformed themselves into appealing sites with, for instance, nice comfortable ambience, to attract patients-as-consumers. This scenario fits with what took place in Delhi, where there is an increasingly conspicuous and intimate linkage between retail and health care following intensification of neoliberal policies.

Pratik Chakrabarti (2007), a historian of imperial medicine provided yet another perspective on the emergence of the medical marketplace. He inquired into how “commerce, markets, trading companies and merchants shape[d] a new material culture of European medicine in eighteenth-century India” (2007, p.197). Chakrabarti maintained that the medical market is an apt metaphor to encapsulate European engagements with India which included commercial, intellectual, and sensual interests (p.204). Chakrabarti found the medical marketplace in the physical space known as the bazaar. This Indian linguistic term for markets referred to commercial areas of different scales ranging from a collection of large buildings clustered together, or a large square in the middle of a village, or a small side-street filled with stalls (p.198). The bazaar brings to the mind of a European, “an exotic, commercial, Oriental world of collection and sale; and a site of chaos and confusion” – a counterpoint to the more rational Western “market” (p.198-199). Yet, the bazaar was also the site for control and intervention by Europeans as they sought to secure an economically viable foothold for themselves in India. Chakrabarti outlined how markets in India were important resources for expanding the therapeutic repertoire of the British English East India Company (EEIC): medical resources in the Indian marketplace were collected, analysed, documented by EEIC medical personnel and incorporated into their allopathic clinical practices and textual repositories. Chakrabarti’s work highlighted the long history of the medical marketplace and its development as a transnational space in India for well over three centuries.

These three research studies show, each in their own way, that the formation and flexibility of the medical marketplace shifts in relation to the economic context and medical material at play. Therapeutic spaces such as households, pharmacies, and clinics

were not atomised locations, they were closely connected to one another in the lived urban experience of specific people.

During my interviews, some interlocutors first described themselves as practicing Ayurveda from their “home”. However, as our conversations progressed, they brought up spaces from beyond outside the household such as the herbal market or ashrams as therapeutic sources in their health-seeking trajectory.<sup>4</sup> The medical marketplace is thus a system of interactions in the informal and formal sphere animated by networks of practitioners, entrepreneurs, and consumers who circulate therapeutic resources from one site to the other and enact Ayurvedic medicine.

As a sociotechnical system, Ayurveda is comprised of multidimensional activities consisting verbal and non-verbal interactions, labour, and exchange of knowledge. All of these aspects referred to more than one thing and are thus more than sum of its parts. Some of these activities could be suitably translated into an economic framework of “goods” and “services” (i.e. verbal interactions and exchange of knowledge can be understood as a service). However, it is impossible to completely designate all the facets of this complex medical system as a “good” or “service” as they are embedded in relationships of care and dependency with an expertise that can be based on familial, or spiritual and religious authority. Ayurveda as a sociotechnical system thus is not fully commensurable with Ayurveda as a formal economic practice.

The concept of a medical marketplace reminds us that health care is a complex and meaningful system which carries valence beyond its economic transaction. The insights from medical geographers and their concept of “therapeutic landscape” (Gesler, 1994) foregrounds the significance of social relations with regards to health care.

Social relations always have a spatial form and spatial content. They exist, necessarily, both in space (i.e. in a locational relation to other social phenomena) and across space. And it is the vast complexity of interlocking and articulating nets of social relations which is social space. (Massey, p. 168, 1994)

<sup>4</sup> Ashram: place of retreat or spiritual activity, such as yoga, usually where a guru resides.

The concept, therapeutic landscape, emerged amongst medical geographers in the early 1990s as they endeavoured to reconceptualise “place” not just as a physical location but as a culturally-mediated category which could lead to enhanced states of health and well-being (Gesler, 1994; Williams, 2003).

For many medical geographers, the therapeutic landscape referred to sites of natural beauty or spiritual attainment such as parks and places of worship having “an enduring reputation for achieving physical, mental, and spiritual healing” (Gesler, p. 17, 1993). Scholars examined the commoditisation of sacred healing spaces such as hot springs in South Dakota for white Western consumers (Geores cited in Wilson, 2003) Palka studied the experiences of restoration and well-being amongst summer recreational campers in an Alaskan national park (1999). These works portrayed how health-inducing places are accessed as a leisure activity.

The medical geographer, Kathleen Wilson (2003) has rejected this approach, criticising studies of therapeutic landscapes to work from narrow concept of what counts as a healing space, and therefore also limited in the healing experiences and populations they examine. She found that many researchers foregrounded the physical or symbolic qualities of a place in their discussion and referred to exceptional rather than quotidian health experiences, such as spa visits and religious shrines. Wilson extended these scholars’ efforts to understand place as a culturally-mediated and health-enhancing category and by studying the everyday interactions carried out on the land of a relatively isolated reserve by the Anishinabek, a First Nations community in Ontario, as they harvested food, gathered medicines, hunted, and conducted ceremonies (2003). Here, place was depicted as a culturally-specific interface of physical, political, economic, spiritual and symbolic relationships. I follow the insights of Wilson (2003) and Massey (1994), and emphasise the importance of everyday interactions as they emerge from local worldviews in relation to consumer ideologies and explore their implications for health-making practices. I depart from typical studies on the “therapeutic landscape” by focusing on urban spaces in India rather than North American rural or natural settings.

My upcoming chapters depict Delhi as a particularly amenable location for the ethnographic exploration of the various permutations of the medical marketplace. The informal economy, invisible and misunderstood from afar, reveals the complexities of exchange when it is examined up close. Also, India's medically pluralist setting officially acknowledges Ayurveda, yoga, naturopathy, Unani (an Arab-Greco medical system) Siddha (a south Indian herbal medical system), and homeopathy and, of course, allopathy. The middle-class urban health-seekers thus have a long history of being active agents who navigate the medical marketplace and negotiate a range of therapeutic options.

## **2.1. Encounters in the Medical Marketplace: Conducting Fieldwork**

My ethnographic research in households, clinics, markets, and public expositions can be understood as a series of encounters and engagements with one permutation of the medical marketplace in Delhi. My encounters/interactions with local users revealed that Ayurveda was widely practiced outside of the formal health care market and thus encompassed more than industrialised products and services. Ayurveda was also a repertoire of knowledge, which could be transmitted as a set of guidelines or therapeutic advice by a spectrum of experts ranging from informal teacher or guru types and official practitioners.

I began to investigate the intersection between healthcare and consumption in 2001, when I conducted my Master's degree project on how patients and consumers understood allopathic drugs in rural Punjab. I was influenced by the work of material studies scholar, Daniel Miller (1995a, 1995b, 1998) and pharmaceutical anthropologists Sjaak Van der Geest & Susan Whyte (1988), who treated consumption as a meaning-making process by investigating how goods were appropriated into the local medical worldviews and everyday lives of people. Health care practices provided commentary on a changing world for the Punjabi patients I spoke with. For instance, they admitted that pharmaceuticals were quick-fix solutions which often led to additional health issues such

as the body becoming imbalanced in relation local humoral frameworks (i.e. many allopathic drugs were deemed too heating) or leading to further weakness of the body. However, these patients reasoned that such drugs could not be avoided as they provided “functional health” and enabled one to carry out work and daily tasks (Halliburton, 2009; Nichter, 1986). Furthermore, Punjabis already considered their agrarian environment, food, and bodies to be polluted with pesticides. Moreover, the term for pesticides and pharmaceuticals was the same, *dwa*. Perhaps, they were fighting fire with fire.

As a doctorate student, I wondered the significance of an indigenous medical system, such as Ayurveda following India’s transition to neoliberal reform. India already had a large private health care sphere, which was becoming marketised as local consumption practices became more integrated into the global market. I was guided by the following questions: What did this mean for the relevance of Ayurvedic medicine? What was the value of Ayurvedic medicine in a society undergoing rapid social transformation? As an indigenous medical system, what kinds of expertise does Ayurveda invoke? What was the place of lay expertise or informal knowledge in relation to the more formalised expertise of medical authorities such as doctors and pharmacists?

My conceptualisation of Ayurveda as a sociotechnical system required me to analyse objects such as medicines and the various types of people who interacted with it such as producers and consumers. I carried out 15 months of long-term and intensive ethnographic research in a city where I had few social contacts.<sup>5</sup> I relied on snowball sampling to build up a research network from academics, neighbours, local friends, expatriates, and acquaintances from group activities such as running clubs, martial arts, and yoga classes. From these connections, I was eventually able to access advertisers, decision makers from the Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy (or AYUSH, this acronym coincidentally means life or longevity), professors at medical colleges, staff at pharmaceutical factories, and

<sup>5</sup> I conducted fieldwork in November 2004-December 2004; December 2005-June 2006; September 2006-April 2007.

practitioners at Ayurvedic clinics, informal practitioners, and consumers of Ayurveda.<sup>6</sup> Many of the interviews and conversations were conducted in English with some of my informants speaking Hindi, if they did not speak English. Most of the clinical interactions between practitioner and patient were carried out in Hindi. The exposition activities were carried out in Hindi, too.<sup>7</sup>

My participant observation consisted of interactions in Delhi's medical marketplace which were both planned and unplanned; self-initiated or at the invitation of others. I investigated how the sites of household, clinic, and expositions enacted institutional, informal, or commercial invocations of Ayurveda. Upon my arrival to the field, I was taken in as a houseguest with family friends, Neena and her husband, Prem, both of whom grew up in this city. They had two children, a teenage daughter and pre-teen son. Although we had never met, this generous family helped me become familiar with the everyday lives of Delhi's middle-class milieu through the space of the household. I was integrated into domestic activities which took place in the evenings and weekends when everyone was home. I accompanied Neena on various errands such as tailoring, grocery-shopping, picking up children from school, and so on. During the duration of my fieldwork, I was invited to join along in their leisure past times when they went out to movies and restaurants, or entertained family guests in their home who were visiting from nearby Punjab, or more distant locations, such as Australia, England, and Canada. Neena shared details of her family's health care practices and told me about her self-care routines which included going to the gym with her husband in the early mornings, exercises with Ramdev, the Ayurvedic practitioner that she and her parents visited.

<sup>6</sup> Delhi is a multicultural city with a long-established and significant Muslim population who reside in areas such as Old Delhi and Nizamuddin in southern Delhi. Perhaps because of my location in an area of south Delhi inhabited by Hindus and Punjabis, and snowball sampling technique, I encountered only a few Muslim inhabitants of Delhi (Unani practitioners). Ayurveda is considered as part of Hindu philosophy, but it attracts clientele of various religious and ethnic backgrounds – just as Unani medicine draws in a diverse array of patients in their quest for health.

<sup>7</sup> All of the names of people, hospitals, clinics, and expositions have been altered to protect the identities of the research participants.

Ayurveda can be used for a range of needs from spa-based treatment to over-the-counter drugs to long-term treatment from clinics (this will be further discussed in Chapter 3). Ayurveda thus circulates in various retail and health care settings. Accordingly, I visited commercial or retail spaces frequented by the middle class such as shopping arcades and malls, entertainment complexes (with cinemas, cafes, restaurants, and shops), and outdoor markets, such as Khaori Baoli, the Spice Market, described by some of my interlocutors as a place to obtain herbs. I also attended expositions, such as the India International Trade Fair to learn more about public spaces and consumption practices amongst the urban middle-class.

Following neoliberal reform, the Indian government and private players such as drug manufacturers and hospitals dedicate great efforts to translate the workings of Ayurveda into globally recognised parameters of quality control, safety, and efficacy for mass-consumption (Banerjee, 2009; Bode, 2008). As a result, I was a participant-observer to the processes of production and promotion of Ayurvedic medicines and treatment not only in the retail sites mentioned above, but also in the more backstage or exclusive spaces, such as factories and hospitals. I believe I witnessed these processes in part because Ayurveda was becoming more prominent and could be showcased as a medical system, but also because of my position as a foreign researcher, a participant in the global enterprise of Ayurveda.

My participant observation included a range of sites and actors. I observed the production of medications by shadowing a team of inspectors as they visited two indigenous medicine factories (Ayurveda and Unani) to ensure they met regulations.<sup>8</sup> I was invited to attend two workshops, which highlighted emerging scholarship on Ayurvedic medicine, based on the translation of Ayurvedic medicine and treatment to globally-recognised measures of efficacy, such as evidence-based medicine. I visited a medical college in Delhi and met with staff who showed me the facilities (classrooms, offices, laboratories, and a clinic), introduced me to other professors and clinicians for

<sup>8</sup> Unani is a Greco-Arabic medical system, widely practiced in North India, amongst its Muslim population.

brief conversations. I visited a host of other Ayurvedic clinics after seeing them on the street, or hearing about them from local residents. Most of my participant observation was carried out in one clinic located in an allopathic Ayurvedic hospital, which was staffed by Dr. Gupta. I visited his clinic for approximately 3 hours on an average twice a week for a period of 6 months, and witnessed hundreds of short-term patient interactions. I discuss this in further detail in Chapter 7 as I elaborate on the nuances of conducting access and participant-observation in clinics.

As well, I engaged in participant-observation of other healing environments such as ashrams, yoga studios, and Ramdev's yog shivirs or yoga camps (the latter discussed in Chapter 8) after learning about from interviews with my interlocutors. I visited these sites to acquire a more nuanced understanding of their health care experiences.

My participant-observation took place in formalised or defined settings related to the practice of Ayurveda. However, my interviews and conversations revealed the less obvious formal and informal spaces in which Ayurveda was made manifest.

I interviewed six people affiliated with the advertising industry which included: two advertising executives, one marketer, one MBA student, and one event planner. As well, I carried out informal interviews with 10 others who were colleagues of these informants, or who were located in sites promoting Ayurveda such as the expositions or pharmacies. They shared insight on how Ayurveda appealed to consumer subjectivities as they discussed the intersections of health care consumption with homologous markets (beauty care, spas, tourism, and paediatrics).

I had opportunity to conduct repeat interviews with five members of government and international organisations such as the Ministry of Health and Family Welfare (under which AYUSH is located) and the World Health Organisation. I had opportunity to meet with these decision makers at regular intervals for interviews and informal discussions. These informants explained the research priorities of their institutions and discussed projects relating to standardisation of herbs and drugs, international patents, and commercial promotion of indigenous drugs.

I interviewed seven Ayurvedic practitioners (including one pharmacist), all of whom who worked in private clinics except for one (who worked in a medical college). Our exchanges were mainly concerned with the general principles of Ayurveda and practitioner's perspective on its efficacy and relevancy (see Chapter 7). These interviews revealed the wide spectrum of diseases that patients used Ayurveda for, the expanding consumer base of Ayurveda, and new roles and responsibilities required by medical practitioners who wanted to ensure their livelihood as Ayurveda become more commercialised.

I interviewed 12 “patients” of Ayurveda to explore health care consumption practices, informal expertise, and the place of Ayurveda in a medically pluralist setting. I put “patients” in scare quotes because I quickly realised that this was not an accurate description for this group as not all of these people visited Ayurvedic clinics. Rather, they practiced Ayurveda through home remedies, or informal sources of knowledge such as books, herbalists, or gurus. Although these “users” did not have formal training, they did have some basic or informal knowledge of Ayurveda. Certainly these health seekers were involved as “consumers” of Ayurveda as they purchased herbs and sources of medical knowledge and then literally consumed or ingested Ayurvedic treatment. Yet, the term “consumer” does not convey the complexities and nuances of the socioeconomic interactions enacted by patients seeking physical, emotional and spiritual health. Moreover, the reader should keep in mind that most people were not ideologically committed to one system of medicine or the other. My examination of health-seeking practices suggests that Ayurvedic consumption is a complex set of processes reflecting the multiple possibilities for medical engagement for contemporary Delhi citizens.

## **2.2. The Study of Ayurveda as a Consumer Practice: Inviting Many Convergences of People**

India hosts a large diaspora who have become dispersed around the world throughout the twentieth century. Many of these members regularly make return trips to India to keep in touch with their families and place of origin. The neoliberal reforms have eased rules of

entry and stay for members of the diaspora who are now granted certain economic and financial privileges, such as the right to invest and work in India (Foreigner's Division, 2011). Consequently, residents in India's large cities such as Delhi or Bangalore may be locals from the city, out of state, or from abroad as British-Indians, Australian-Indians or Indo-Canadians (such as myself), or else not South Asian at all. The distinction between a citizen, member of the diaspora, and foreigner or insider and outsider is not clear-cut and influenced how I was received in the field. Furthermore, my encounters with various professionals, such as medical practitioners, government officials, manufacturers and advertisers led me to consider additional complexities to what made an "insider" of Ayurveda as it elicited participation from a wider spectrum of experts.

I will start by discussing insiders in an ethnic sense by discussing how I saw myself treated as a "native anthropologist". Anthropologist Kirin Narayan (1993) rejected the essentialising nature of this term and maintained that one was variously configured as an insider and outsider at different moments in fieldwork. She explicated the shifting identities she inhabited in India as an ethnographer of mixed origins (her father was Indian and mother was American and German – who lived in India for over 40 years [p. 673]). Narayan asserted that the term "native anthropologist" always needed to be qualified to specify, what kind of native? I claim my background as a kind of native anthropologist as the offspring of Indian parents from Punjab who immigrated to Canada in the mid-1970s. Growing up in the Indian diaspora, I had a general familiarity with the language, etiquette, dress, cuisine, and music even though I only visited India for the first time in my twenties, for my Master's degree research on allopathic pharmaceuticals in rural Punjab.

The status of a native anthropologist provides a much-coveted entry to a cultural setting and this is described well by Purnima Mankekar (1999) whose decision to conduct fieldwork in the city she grew up allowed her to access the intimate space of the living rooms of her informants and discuss their relationships to narratives from television programs. However, this same status can result in difficulties with negotiating expectations of the "native" versus the "anthropologist". When I was carrying out research for my Master's degree project, my time was divided between my parents'

villages for three months where I was received as a niece or granddaughter. My tasks as an ethnographer were mediated by this status. While I had access to domestic life in households of, say, neighbours, my movements outside the private sphere were controlled by well-meaning family members who were concerned about my safety.

Though my doctorate fieldwork took place in the same country, five years later, it was conducted in a markedly different cultural setting, one in which my status as a native was less obvious. Living in the metropolis of Delhi with almost no familiar network rendered me as an anonymous figure amongst the other millions. Years of colonial presence, the growth of the South Asian diaspora throughout the twentieth century and their frequent returns made the distinction between ‘foreign’ and ‘Indian’ more a spectrum rather than polarisation. I was constructed as Western or Canadian at some times, and other times as Indian or Punjabi. Just as I could be, and was received as, many different sorts of person depending on different social scenarios, so too did my object of study, Ayurvedic health practices, warp and shift according to the circumstances it was located in.

In an increasingly interconnected world, anthropologists no longer exclusively engage in fieldwork with “marginalized people” (Marcus cited in Mazzarella, 2003, p.32). Instead, they may participate in research involving professional interlocutors such as advertisers, bureaucrats, aid workers, doctors, and lawyers. Such professionals may understand anthropologists as similar-minded experts who espouse shared truths and values. Marshall Sahlins points out these similarities are especially pronounced between advertisers and anthropologists because both are concerned with “mapping the hidden correspondences of an already given cultural order” as they try to decipher the “cultural logic” of commodities (cited in Mazzarella, 2003, p.25). However, anthropologists are preoccupied with “culture” as an intellectual exercise rather than marketing purposes.

William Mazzarella’s ethnography, *Shoveling Smoke: Advertising and Globalization in Contemporary India* (2003) portrayed how advertisers position themselves as cultural brokers who articulated insights about the Indian middle-class to multinational manufacturers interested in winning over this new marketing demographic

– but clueless to their cultural sensibilities. The initial failure of corporations such as Kellogg’s to capture the middle-class, which arose from their lack of understanding of the local culinary context, has become a well-known fable amongst Indian advertisers. These stories attested to the cultural chasms that needed to be bridged for a successful entry into the India’s burgeoning marketplace. The role of advertisers as cultural mediators was imperative to this process: as middlemen, they could coax and entice the consumption from the Indian market.

Professionals such as advertisers make their livelihood from communicating to various audiences – which now included social scientists. While anthropologists had traditionally shunned the study of consumer practices, the capitalist-triumphant post-1989 global world order left little doubt to the importance of consumption. Ayurvedic medicine, too, was indubitably commercialised as professionals, such as advertisers, increasingly manage its production. The perspectives of these professionals are crucial for some research projects yet anthropologists valorise in-depth accounts of a social phenomenon which emerge in conversation and interactions. Ethnographers may resent being on the receiving end of “sound byte” statements of busy professionals and then sent off with website links, in-house magazines, and pamphlets. Certainly, some of my interactions with government officials and advertisers were like this. However, such encounters are common and not entirely unproductive – they are grist for the mill, after all. Mazarella admits that he initially dismissed some of his conversations with advertising agents as “depthless and predictable” and then later realised that such interactions were in fact one component of marketing discourses. And, his resultant work, (the ethnography) would constitute yet another nodule in this field (p.33). Similarly, in Chapter 7, I elaborate on how my presence in Ayurveda clinics was negotiated in relation to my potential in validating a certain image of Ayurveda (perhaps one that draws the interest of foreign researchers).

The commercialisation of Ayurveda invites the participation of a wide range of professionals, including government decision makers, corporate executives, advertisers, journalists, along with medical practitioners. These actors are crucial in rendering

Ayurveda visible in the national and global economy: the doctor is no longer the sole gatekeeper to Ayurveda.

Furthermore, Ayurveda invites additional invocations of “insider-ness” because it can be claimed as a locally created practice. As such, it invoked responses amongst my interlocutors that were based on their professional qualifications and their personal experiences. I was thus witness to multiple levels of involvement as they deftly alternated between their immediate experience and professional standpoint, which provided for unexpected and intimate revelations. For instance, advertising executive Jayesh’s explanation of how food was deeply enmeshed with cosmology, health, and social life in India in Chapter 3 was communicated convincingly because his job required that he be a practiced speaker and also because he lived through the culinary sensibilities he discussed (December 2, 2004).

Malvika was another advertising professional who had a wide spectrum of professional and personal engagement with Ayurveda. Some of this was articulated during our meeting with her colleagues at their workplace (see Chapter 5) but I learned more about her interaction with Ayurveda during spontaneous discussions such as the time when she called me one week to check on how I was doing in Delhi. Malvika stated that she had started to remember more details about her relationship with Ayurveda in the days following our conversation at her workplace. In particular, she recalled turning to it at a particularly hard transition point in her life as a young professional when she begun her career in Mumbai but was never in good health and never recovered. It was only when she moved to her home city and then underwent Ayurvedic treatment, which finally brought her good results. During our phone conversation, Malvika explained Ayurveda’s value as a “spiritual” practice which related to the entire person, not just the physical body (November 18, 2004). This professional had multiple involvements with Ayurveda, which included her work as a marketer for a beauty spa, her visits to a particular clinic for skin treatment, and her need for treatment after a long period of instability and ill health. In Chapter 5, I elaborate on the perspectives of two middle-class users of Ayurveda, Sunil and Ramesh, who not only articulated their responses to witnessing the transformation of

Ayurveda as a lucrative consumer practice in their home state of Kerala, but also to their experiences as insiders, or patients, undergoing treatment.

### **2.3. Conclusion**

The medical marketplace highlights healthcare as an entrepreneurial and relational endeavour, taking place in an economic arena. This framework is particularly useful for analysing the production of Ayurveda as a consumable object in Delhi and for acknowledging the various types of participants, such as producers and consumers, involved in its informal and formal exchanges. The following two chapters elaborate on this medical marketplace with discussions of the emergence of consumption practices in India (Chapter 3) and on the various ways Ayurveda was mobilized as a political and cultural tool by its proponents in the twentieth century.

### **3. Entering and Entreating the Market: Capitalist Expansion and Consumption in India**

*India has been invaded by everyone. First, the Mughals, then the British. And it's never changed... now it's the MNCs (multinational corporations).*

Jayesh, advertising executive. December 2, 2004

This chapter reviews the expansion, decline and resurgence of capitalist modalities in India. I focus on India's neoliberal transition after providing a brief review of its colonial history and economic ideologies following its Independence in 1947. In particular, I examine the metamorphosis of long-established formations such as the middle class and Ayurveda in India's new economic setting. The middle class and Ayurveda have become more prominent in India, but they are far from stable configurations: various actors debate on who are the rightful members of the middle class and on what is considered efficacious knowledge for Ayurveda.

My investigation of health seeking behavior reveals the complex process of consumption beyond financial purchase by considering the role of objects, or goods, in producing meaning for its users. My analysis of the intersection between consumer and health care practices provides opportunity to interrogate the term "consumption" as suggested by Graeber (2011). People *consumed* Ayurveda as means to an end, to attain or *produce* health for themselves or their kin. Health is seldom ever an assured or stable condition and can be indefinitely attended to in everyday life via consuming and producing. This chapter concludes with a discussion of this iterative cycle (of consuming and producing) via the literal consumption of food and medicine.

### **3.1. British Colonisation to India's Independence**

To begin this discussion of how we might begin thinking about the contemporary consumer practices of India's middle-class, it is necessary to understand how global economic practices acquired social and political meaning under British colonialism. In this section, I review how India was implicated into British rule by economic imperialism, which eventually culminated in colonial domination. Following this, I go over how Indian freedom fighters engaged in rhetoric of nationhood and cultural revivalism and lend attention to how these movements implicated consumer practices. I then go over closed economy state-controlled policies that were established from the time of India's independence in 1947. This history is necessary to understand consumer practices during India's transition to neoliberal reform.

The British arrived in India in the early seventeenth century with the East Indian Company (EIC) to expand their markets by captivating new consumers for their products, the most important which was British broadcloth (South Asian History, 2004). India, however, already had a very well-established cloth manufacturing industry and EIC ended up exporting items such as spices and cloth back to Britain for trade (Bayly 1995; Frank 1995).

Frank, a historian of global economy and dependency theorist, points out that China and India were important centers of economic wealth long before the arrival of colonial traders (1995). These prosperous countries were "primary centers of accumulation" in the world system. Even in 1750, more than one hundred years after European presence in Asia, this continent's Gross National Product (GNP) was 120 billion compared to the 35 billion of Europe, North America, Russia, and Japan *combined*. (Braudel cited in Frank, 1995).

The riches of Asia were incomparably greater than those of the European states. Her industrial techniques showed a subtlety and a tradition that the European handicrafts did not possess. And there was nothing in the more

modern methods used by the traders of the Western countries that Asian trade had to envy. In matters of credit, transfer of funds, insurance, and cartels, neither India, Persia, nor China had anything to learn from Europe. (Pirenne cited in Touissant, 1996)

Far from the backward people that British expected to entice as captive consumers, India had a thriving and wealthy economy of its own. This country, for example, was one the world's greatest producers and exporters of cloth (Bayly, 1995). However, the subsequent two hundred years of British economic imperialism reduced India to a mere supplier of raw materials, like cotton and jute to be manufactured into cloth in England and then sold back to India with the British accumulating the profits (Morris, 1983; Bose & Jalal 1998).

The East India Company (EIC) expanded their reach and foothold in India during the eighteenth century by forming alliances with local emperors such as the Moghuls, promising them protection from enemies in return for concessions. Their strategy of forming alliances gradually allowed the EIC to transform themselves from trading venture into a ruling enterprise (Bayly, 1986; Bose & Jalal, 1998). In England, cotton mills were built *en masse* in the late eighteenth century, and raw material was then imported from India to be mass-manufactured because it promised greater profit to the British. Also, this mass-manufactured cotton was well received amongst Indian consumers, who enjoyed its cheaper price and appreciated its aesthetic qualities such as the tighter weave which was a welcome contrast to the loose and rough weave of local cloth.

Such a transformation in colonial-metropole economic exchange eventually undermined the roles and livelihood of Indians involved in the industry. Artisan cloth producers had difficulties maintaining their vocation and began to protest against the sale of mass-produced cloth in cities in 1810 (Bose & Jalal, 1998) and British financial institutions, called agency houses, coerced agriculturalists into growing cash crops such as indigo to meet the demand for fashion trends in the metropole such as the 1820s "blue phase" in European military and civilian dress. Although these Indian suppliers' raw goods hardly experienced lucrative financial benefit with these endeavours, the economic downturns experienced by the European markets in the late 1840s and 1860s did

decimate their livelihoods (Bose & Jalal, 1998). Moreover, all landowners under British administration were obliged to pay land rent and tax. The revenue was used by the British to finance construction of India's primary infrastructure such as roads, bridges, railways and the telegraph. This enabled raw goods such as cotton to be transported to port cities such as Bombay and Calcutta and before being shipped to England for manufacture – and then sold back to India.<sup>9</sup> The British derived the greatest economic benefit from the Indian colony between 1854-1914 (Bose & Jalal 1998). However, in the closing decades of the nineteenth century, the detrimental effects of colonial rule became undeniable following events such as Great Indian Rebellion of 1857, and the Great Famine of 1879-1878.<sup>10</sup>

Indian thinkers, writers, and activists began reflecting on an alternative vision of India separate from British domination, and these imaginings revolved around “civilizational, moral-religious, and historical” subjects. The repeated invocation of such religio-nationalist themes were striking their similarity to Orientalist colonial discourse (Jain, 2007): India was upheld as a “grand civilization” similar to ancient Greece, and Hindu mythologies such as the Mahabharat and Ramayana were proof of India's prior glorious existence or the Hindu golden age (Jain, 2007, p.99; Chatterjee, 1993).

These conceptualizations of nationhood and the quiet simmering of discontent of the closing decades of the nineteenth century erupted into a full-blown outburst and demands for an emancipated India following the partition of Bengal state. In 1905, Viceroy Lord Curzon divided Bengal in half to subdue the potential uprisings of its radical nationalist Hindus who had been fighting for their right to exercise greater participation in government. This division triggered great uproar all over the country and became an important moment for unifying what had formerly been a disparate group of nationalists. They began to protest en masse shortly after the partition and expressed their outrage by unifying themselves under the *swadeshi* movement. This term, which

<sup>9</sup> These cities are now called Mumbai and Kolkata, respectively.

<sup>10</sup> The Bengal famine (taking place in 1943) was likened to the Great Holocaust with approximately 3 million deaths resulting from this shortage of rice due to large-scale political corruption (Bengal Famine, 2011).

originated in Bengal, referred to self-sufficiency through the boycott of British “goods and institutions” and support of indigenous artisans and industry (p.118). This term eventually expanded to refer to the cutting off of all “connections with the colonial ruling classes” (Banerjee cited from Bayly, 1995, p.199). The swadeshi movement greatly hindered the British empire’s expansion for the subsequent decades (Bayly, 1986; Bose & Jalal, 1998; Sharma, 2002).

Swadeshi coalesced and amplified imaginings of an alternative India that had been percolating amongst various Indian nationalists in the prior decades. Yet, as alluded to earlier, its proponents appropriated the binaries of tradition and modern; Indian and foreign which were borne of a colonial and Orientalist frameworks (Chatterjee 1993; Jain, 2007; Ram 2010). Claims to categories such as “Indian” and “tradition” and “modern” were constantly debated and refashioned in the following decades, in the political spheres: by proponents of India’s independence, supporters of Ayurvedic medicine, and eventually, in the 1990s, by advocates of neoliberalism.

The support for Ayurveda as a viable and indigenous medical practice in its own right was initially taken up by Indian nationalists under the sentiment of swadeshi in the early decades of the twentieth century (see Chapter 4). This ideology of self-determination paved the path for the later support of Ayurveda as distinctive cultural resource that could support the self-sufficiency of Indian bodies in the Indian nation (see Chapter 8).

Mahatma Gandhi, considered modern India’s founding father, was most successful in personifying and communicating the aims and aspirations of swadeshi to the Indian public at large. Gandhi’s most compelling gesture of nationalist self-determination was his decision to wear Indian home-spun cloth called *khadi*, exclusively. This cloth best-exemplified the swadeshi sentiment of purifying and liberating India from the presence of the British. Its influence continues to be felt to this day with the Indian flag which features the spinning wheel and is legally required to be made of *khadi* (Jha, 2008). The illustration below depicts the precursor to the simple circular wheel featured on the official flag.

**Figure 3.1. Swaraj Flag, officially adopted by the Congress in 1931**



*Note.* Wikipedia Commons, June 15, 2011

*Khadi* was more expensive and also had a coarse and rough weave which initially made it unappealing to many Indian consumers who were used to the finer quality of British cloth. During the 1920s, singers and orators tried to convince the general public about its virtuous qualities: folk songs “associated country cloth with images of motherhood, with thick white rice and curd, and with the goods things of the unpolluted countryside” (Bayly, 1986, p.199). Nationalist leaders such as Sri Aurobindo framed the consumption of *khadi* as a powerful gesture of individual sacrifice for the greater good of the nation. Cloth was a potent means of conjuring and inciting a general cultural revivalist movement (Bayly 1986; Jain 2007).

As a nationalist ideology, *swadeshi* coalesced a variety of consumer practices as expressions of cultural identity. Jain, an art historian who discusses non-secular Indian modernities via the circulation of mass-produced and religious calendar art argues that commodities had power to invoke and embody national identities (2007). She provides an account of freedom fighter, Oza, a Mumbai pharmacist who was imprisoned by the British after following Gandhi’s call for *swadeshi*. He met an activist doctor in jail who suggested that Oza manufacture a medicinal remedy to compete with the foreign, non-*swadeshi* brand. Babuline Gripe Water was henceforth created as an alternative to Woodward’s Gripe Water, the British manufacturer. This mass-produced medical remedy and the homespun *khadi* both “constitute[d] the nation as both market and locus of production” (Jain, 2007, p.116).

Woodward's Gripe Water featured the image of a Hindu deity, baby Krishna, to entice consumers who were part of India's multilingual and largely illiterate market. Western manufacturers such as Woodward's, General Electric and Lever were the forefront disseminators of such religious or mythic imagery in the commercial arena (Jain, 2007). The use of "religio-ritualistic imagery offered valuable resources in endowing brands with the aura they lack for new entrants into the global market", in the years before India's national liberation and then again at the onset of neoliberal reforms (Rajagopal, 1998, p.28).

### **3.2. Independence to Neoliberal Reform**

Once independence was attained in 1947, India's leaders were reluctant to adopt open or capitalist market policies associated with colonial rule. The Indian Congress Party (hereafter, Congress) election manifesto of 1945 outlined their plans for the development of India,

Industry and agriculture, the social services and public utility must be encouraged, modernized and rapidly extended in order to add to the wealth of the country and give it the capacity for self-growth without dependence on others. (India National Congress cited in Sharma, 2002, p.114-115)

Unlike Gandhi, Prime Minister Jawaharlal Nehru of the Congress considered industrialization rather than the propagation of cottage industries as the most viable means of ensuring national self-sufficiency and development. To accomplish this, the Congress introduced a series of Soviet-influenced Five Year Plans to develop the economy. The first of these began in 1951 and focused on the expansion of heavy industries such as steel and coal, along with power and irrigation, education, agriculture and other forms of rural development for the rapidly increasing population (Fernandes, 2006; Nayar, 2001). Medicine was not greatly prioritized, especially not indigenous medicine.

This centralized system of planning led to major developments with respect to India's self-sufficiency between 1950 and the early 1990s. The Green Revolution in the mid 1960s introduced high yielding varieties of seeds following India's food shortage crisis some years earlier, which made the country self-sufficient. In 1973, the Foreign Exchange Regulation Act was put in place and this further restricted the expansion of foreign companies in India unless they were technologically based or export-oriented industries (Nayar, 2001).

In 1984, following the assassination of Indira Gandhi, her son Prime Minister Rajiv Gandhi was elected into power and he began to build up on small efforts towards economic liberalization that Indira Gandhi had begun to initiate. Gandhi was a relatively young politician, in his early 40s and came from a cosmopolitan background: he was a pilot, had married an Italian woman, Sonia Maino (who would later become Prime Minister) who he met while studying in Cambridge, and had an avid interest in computers and technology. He thus began to put forth a new image of India, based on "high technology, managerial efficiency, and global economic competitiveness" (Fernandes, 2006, p.35). Accordingly, taxes on wealth and inheritance were reduced and high technology goods and services such as VCRs, colour televisions and cable channels were freed from licensing and import restrictions and made available for purchase (Wolpert, 1993). These strategies were well-received by the middle class who had only limited access to technology - even if they had the money to purchase goods such as telephones or services such as long-distance telephone calls. As Rohit, a young middle-class Delhiite and MBA student in his twenties recalls,

I remember when I was growing up... and we had to make calls to our aunt in London. We used to go to this small stupid office [and] there would be a queue.<sup>11</sup> And we would make [international long-distance] calls and you'd have to book your calls and then when the number came [it was your turn]. If the other person did not pick up the phone you were fucked up because you had to go back in the queue, you know what I mean? And I remember my father was like a city officer so he would just go there and just stand there and then these guys

<sup>11</sup> The "office" refers to a Public Call Office (PCO), usually quite small boxlike structures which would be manned by an attendant who put telephone calls through for a charge.

would be there and be like “OK, sir, we’ll actually make you jump the queue” and “We’ll do it on priority for you” and all that...

I always wondered... like “What the fuck? How do we have to wait for an hour just to make a call to [the] UK?”...

Having a telephone was such a huge thing. It was like, you had the bragging rights: “We have a telephone, you know that?” (April 2, 2007)

The openings spurred by Ghandi were badly needed according to the otherwise frustrated middle-class, whose needs had historically been disregarded by the state’s economic policies. These new policies, which enhanced the lifestyles of the middle-class set the stage for India’s more full-fledged transition to neoliberalism,

### **3.3. Anthropological Perspectives on Consumption**

Until trade liberalization reforms in the 1990s, the words “India” and “consumerism” were seldom uttered together as consumption was considered antithetical to nationalist values. This changed in mid-1980s when India’s economy opened to permit international trade. Economic liberalization policies had been initiated since the 1980s, but certain key events took place in 1991 which incited the Indian government to adopt neoliberal policies more wholeheartedly (Bhat, 2011). Firstly, the nation experienced a debt crisis with a drop in its foreign reserves which emphasized the need for a new economic strategy – this sentiment was most vocalized amongst the middle class and elite, citizens who had long been dissatisfied with India’s closed-market policies. Moreover, the disintegration of the Soviet Bloc signaled the capitalist triumphant moment, making welfare state economies seem even more inefficient and outmoded. India’s Finance Minister Manmohan Singh and Prime Minister Narasimha Rao took advantage of these events and declared the necessity of economic reform for India’s future, to a receptive audience (p.27). In a short span of time, India’s financial crisis, a major world event, and the interests of powerful decision makers converged to facilitate increased trade liberalization.

This economic transition belongs to a set of processes commonly understood as “neoliberalism” (Harvey, 2007). According to political scientists, Boas and Gans-Morse (2009), the use of this term has flourished over the past two decades, yet its meaning has seldom been analyzed or debated amongst scholars. The authors reached this conclusion after they conducted a content analysis of approximately 150 articles published in major comparative politics, development, and Latin American studies academic journals between 1990 and 2004. Although social scientists enjoyed using the term, neoliberalism (it appeared in “1,000 academic articles annually between 2002 and 2005” [p.138]), the authors could not locate any article entirely dedicated to its definition.

Anthropologist and geographer, David Harvey, understood neoliberalism to be based on a particular set of economic practices, which are discussed in his book, *A Brief History of Neoliberalism* (2007). Firstly, a neoliberal ideology privileged freedom above all other values and purported that society benefitted most when citizens were able to develop their entrepreneurial aspirations without any hindrance (Thorson & Lie, 2006). The government or state was expected to refrain from intervening on such processes. In this economic setting, everything was understood to be potentially purchasable or commodifiable: a framework which “presumes the existence of property rights over processes, things, and social relations, that a price can be put on them, and that they can be traded subject to legal contract” (Harvey, 2007, p.165). The state was expected to open sectors such as health, education, and environment (which were traditionally the responsibility of the state) to the formal market. The neoliberal economy also required private and state partnerships. For instance, the state typically produced legislation and regulatory frameworks that benefitted corporations, such as tax breaks. These partnerships benefitted specific industries that were crucial for the global market such as energy, mining, pharmaceuticals, and agribusiness (Harvey, 2007).

The widespread dissemination of neoliberal policies in the 1990s coincided with unprecedented advancements in information and communication technology which profoundly altered the infrastructure of the global economy. In the nineteenth century, railways, ships, telegraphs and postal services transported information, objects, and people. However, in the late twentieth century, aviation, telephones, and digital

technology became important infrastructures for the economy because they enabled a much more efficient and cost-effective movement of people, ideas, and goods and (Neogi & Cordell, 2005). Consequently, artificial barriers such as national borders carried less salience as they were more easily traversed following an increasing number of trade agreements between countries which were initiated by the International Monetary Fund and World Trade Organization (Harvey, 2007, p.13). These powerful global actors equated a good business climate with neoliberal economic policies. Indebted nations received loans if they agreed to transform their economies according to the ideology of these international organizations. By 1995, over 100 countries (including India) signed the World Trade Organization agreements in 1995 (WTO, 2012).

Harvey observed that even as many nations were based on neoliberal economies, they did not necessarily resemble one another or function in the same manner,

The uneven geographical development of neoliberalism, its frequently partial and lop-sided application from one state and social formation to another, testifies to the tentativeness of neoliberal solutions and the complex ways in which political forces, historical traditions, and existing institutional arrangements all shaped why and how the process of neoliberalization actually occurred. (p.13)

A Chinese economy thus differed from an Indian economy, which in turn differed from a Spanish economy, even if all adhered to neoliberal policies. For instance, India's particular history of British colonial rule created for a large English-speaking workforce and educational institutions. This infrastructure helped in establishing the production of tertiary service-industries for the global marketplace such as medical tourism and business process outsourcing.

One of the notable changes incurred by neoliberal policies was the loosening of state industrial and trade policies (Ahluwalia, 2002). As a protectionist economy, the India state had restricted the business capacities of investors and limited the sectors and geographic location where investors could function as well as the size and production of industries. Industrial policies were greatly transformed in the early 1990s as the state relinquished controls over various facets of industrial production and opened up sectors

such as “iron and steel, heavy plant and machinery, telecommunications... minerals, oil, mining, air transport services, [and] electricity” to private investment (p.3).<sup>12</sup>

With regards to trade policy, the state simplified its painstaking bureaucratic procedures to allow foreign ownership in many industries and majority private ownership in all industries except “banks, insurance companies, telecommunications and airlines” (p.5). Indian companies took suit and transformed their operations by updating their technology, increasing their levels of production, “restructured through mergers and acquisitions” so they could adapt to the new business climate (p.5).

Additionally, tariff rates were reduced on imports such as petroleum, metals, and cereals: in 1991, the average tariff on imports were 71% and this decreased to 35% in 1997 (Bhat, p.11, 2011). Although import licenses had previously only been granted if goods were deemed essential and unavailable in the domestic market, such controls were eradicated for capital goods such as machinery and reduced for foreign commodities (Ahluwalia. 2002, p.4).

In comparison to other major Asian economies, the transformation to India’s infrastructure was lacking (Ahluwalia, 2002). Sectors such as electricity and roads still needed improvement while moderate advancements were made with civil aviation. The telecommunications industry experienced great advancements, which helped develop India’s knowledge economy, and paved the way for its information-technology industries (p.7). As a result, many corporations conducted their offshore processing work in India.

When India was a closed-market setting, in the decades following its independence, welfare state policies were understood to protect the Indian economy. However, these measures were denigrated as “anti-competitive” by the state in the neoliberal transition (Ahluwalia, 2002, p.3).

India’s population was introduced to these economic changes via mass-mediated visual culture. Image-based idioms are very effective means of communication in a

<sup>12</sup> The three sectors that remained state-protected were: defense aircraft and warships, atomic energy, and railways. (Ahluwalia, 2002, p.3)

country such as India with over 20 official languages and a high rate of illiteracy. Visual anthropologist, Christopher Pinney (2001) remarked on the paradoxical nature of India in how it was both deeply divided through caste, class, languages and yet converged on “shared cultural [visual] idioms” (p.15). Anthropologist Purinima Mankekar (1999) and communications scholar Arvind Rajagopal (2001) carried out influential studies on the intersection of visual mass culture and India’s neoliberal transition and argued that television played a critical role in promulgating consumer culture to the middle class by embedding programming into a Hindu Indian nationalism, especially in the mid-1980s during the onset of neoliberal reforms (I will expand on this in Chapter 8 in my discussion of mass-mediated visual culture).

### **3.4. India’s Middle Class**

India’s middle class is very intimately associated with neoliberal reform as they were the initiators and beneficiaries of these economic changes. The Indian state showcased them as the normative standard for the rest of the nation to aspire to (Fernandes, 2006, p.32). Although the middle class has existed in India for over 100 years, its composition and role is changing during India’s economic transition, and this has created many debates and contestations about who is entitled to be its rightful member.

India’s mass media considers the middle class of 250 million as its national class (Mazzeralla, p.3, 2005). Yet this group is inflected and differentiated by caste, religion, income, and language (Fernandes, 2006; Mazzarella, 2005). Considering this, one might wonder if India can be thought of having a “middle-class” at all. Although there is lack of consensus amongst thinkers and Indian citizens themselves on who or what constitutes the middle class, it nonetheless remains a compelling category.

The middle-class of India, like any other socioeconomic class, is uniquely configured by its historical circumstances. Thompson, author of the influential *The English Working Class* (1963) argued that although “class” is a social formation which originated in Victorian industrial capitalist societies, there was no universal rendition

which was more genuine than others (cited from Liechty, 2003, p.3). Mazzarella (2005) stated that the European-based understanding of the middle-class cannot be suitably applied to the Indian setting as European and North American middle-classes emerged from different histories and made up different proportions of their respective societies: while the middle class was a sizable population, or a “bulge” in the United States, they were actually a minority in India, a country with a population of one billion (p.2).

India’s middle-class is a transnational formation that emerged during colonial rule around the mid-nineteenth century for the British who required a native staff of civil servants or professionals to administer and maintain their bureaucratic, educational, and technocratic infrastructure (Fernandes, 2006; Mazzarella, 2005).<sup>13</sup> Political scientist Leela Fernandes (2006) stated this colonial middle-class inhabited an ambiguous identity: they were distinct from the British, and yet located in a newly carved and tenuous position between local elites and subalterns. The middle-class was thus dominated by the structures of colonialism and yet reproduced prevailing social inequalities (p.27). Their cultural capital was based on their affiliation with Anglophone colonial institutions and signified by their employment, command of the English language, and political leanings (Fernandes, 2006; Mazzarella, 2005).

Many members of the middle-class were financially well-off, however not everyone had abundant financial capital, nor did they showcase their wealth if they did. India’s national political culture was based on a Gandhi-style austerity and a Nehruvian-derived socialism from the time of its Independence until the mid 1980s: conspicuous consumption was considered antithetical to Indian values. During this time, the urban middle class remained invisible as rural development and large-scale industrialization from factories and dams were valorized as the means to modernize the nation. (Fernandes, 2006, p.29-36). The ideology of India’s political national culture began to shift in the mid-1980s as the country’s economy became liberalized and began to

<sup>13</sup> Berger (2008) states that Ayurvedic and Unani practitioners who enrolled in official government medical colleges for their training began to identify themselves as middle-class too as they became employed in government service (p.106).

privileged a different type of citizenry: one that was required to participate as an actor in the free market and expand the economy (Thorson & Lie, 2006). The consumer-oriented lifestyles of the urban Indian middle-class were then portrayed as the standard for citizens to emulate.

Liechty's monograph, *Suitably Modern: Making Middle-Class Culture in a New Consumer Society* (2003) traced the changes to Nepalese society following its opening in the 1950s and argued that middle classness was an identity that was performed rather than inherited. The author followed Max Weber in affirming that consumption, in particular, was an integral practice to expressing and inhabiting a middle-class identity. This socioeconomic group occupied an intermediate position as they were neither producers (i.e. workers who earn wages) nor capitalists (i.e. owners who earn dividends). Rather, the middle-class earned salaries which provided them a "privileged access to goods" and allowed them to engage in distinctive consumption practices (p.17). Liechty asserted that while the middle-class had a predilection to consume, the meanings they attached to objects and so on varied from group to group, and place to place. His book portrayed urban Nepali youth labouring hard to express their middle-classness and dreams of upward mobility via cultural tools at their disposal which included as mass media, fashion, and leisure outings (2003).

India, too, has a large young population who make up the middle class whose preferences and desires can potentially shape Indian consumption practices. I spoke with advertising executive Mr. Bedi early on during my fieldwork about the relevancy of Ayurveda for Indian consumers one quiet weekday morning in his office (I was trying to figure out if my project on the consumption of Ayurvedic medicine was even a possible endeavour). Mr. Bedi began the discussion by showing me a few Power Point slides. One short series was entitled "The Reluctant, Restrained Indian Consumer" and described the older generation who were habituated to the "mind over matter, austere, 'save for a rainy day' rural mindset" sensibilities required for the Nehruvian welfare economy. The younger generation, in contrast were more optimistic and seemed to embrace the changes India was going through. Mr. Bedi remarked,

You have more choices when you study... and women go to work now. You can become a photographer, model, fashion designer... The world is open to the [younger generation] - and they dictate what works at home. MTV started by giving Western music, but now they play Indian pop. And McDonald's has veg burgers and *aloo tikki* [potato-based fried patty snack]. This is a negotiated modernity that is particular to Indians and not to, say, Japan. (November 27, 2004)

Mr. Bedi's comments about the possibilities of becoming a model or fashion designer referred less to the likelihood of the middle class achieving these options and highlighted the importance of cultural industries in neoliberal economies such as advertising, television, cinema, fashion shows, and event planning (Harvey, 2007, p.158-159) and their grip on the imaginations of Indian citizenry. Yet, even the success of these industries and other bastions of globalization, such as McDonalds and MTV, depended on they could accommodate the preferences of the Indian market.

According to Mr. Bedi, the identity of the Indian middle class was enacted and maintained through consumption practices, which the younger generation had embraced much more easily than their parents. The middle class was thus increasingly defined primarily through financial capital and this could be attained by a wider spectrum of the population, (such as entrepreneurs and employees of multinational corporations) instead of being restricted to those who were elite government officers, which was the case for much of the twentieth century (Fernandes, 2006; Mazarella, 2005). As a result, the middle class was also somewhat of an incoherent formation with members who of varying social and intellectual capital (i.e. different educational, linguistic, and socioeconomic backgrounds).

The South Asian middle class is distinct, too, because it relies on close interactions with other members, such as the underclass to maintain its standard of living. A typical household in South Delhi, (an area where much of the Delhi middle-class and upper middle class reside) could employ three or four labourers to perform tasks such as driving, cleaning, and cooking. Manual labour remains relatively cheap and affordable for the middle-class and these workers usually migrated from the poorer states of India to

work in more prosperous regions. This underclass was both excluded from and entranced by the middle-class lifestyles of their employers.

India has long been a sharply stratified society, many thinkers have remarked on the exacerbation (rather than reduction) of social divisions following its transition to neoliberal policies. One female media worker, Supriya, in her fifties criticized the priorities of the Indian government during our interview on India's consumer society and the implications for health care practices one weekday evening at a coffee shop. She remarked,

Government hospitals are basic and filthy... but TVs are everywhere. This is the effect of globalization... a terrible consumer society: it is very dividing. Delhi is now a concrete jungle with four storey houses, more people, and more cars. But there are no parks for kids. There are flyovers [overpasses] but underneath them are poor people who are shivering and keeping warm by lighting motor tires on fire. (November 15, 2004)

Many socioeconomic groups (except for those at the top) experienced these divisions and inequality, albeit in varying intensities. Adiga, author of the best-selling novel *The White Tiger* (2008) captured this troubled divide from the perspective of driver, Balram, who was employed by an affluent Delhi couple and provided pointed commentary on the "India Shining" rhetoric. The temptation of middle-class lifestyles coupled with the social distance that Balram experienced was aptly illustrated by his visit to the shopping mall as he passed time in the parking lot as he awaited his employer's call,

Even as I was walking inside the mall, I was sure someone would say, "Hey! That man is a paid driver! What's he doing in here"? There were guards in gray uniforms on every floor – all of them seemed to be watching me. It was my first taste of a fugitive's life...I was conscious of a perfume in the air, of golden light, of cool, air-conditioned air, of people in T-shirts and jeans who were eyeing me strangely. I saw an elevator going up and down that seemed made of pure golden glass. I saw shops with walls of glass, and huge photos of handsome European men and women hanging on each wall. If only the other drivers could see me now!" (p.128-129).

This underclass was intimately involved with the routines of the middle-class as drivers, cooks, cleaners, and nannies. It is understandable that they could not help but want to partake in the pleasurable aspects of middle class lifestyles. A male chauffeur, such as Balram, temporarily accessed these coveted realities by negotiating a quick entry into a shopping mall. Other members of the underclass, such as female domestic workers, whose movements in public areas were more restricted, had to rely on other means to experience middle-class lifestyles. Later in our interview, Supriya recounted to me, “When I was young, the housecleaner would wear ratty clothing but eat a thick roti with onions and gourd. Now she wears expensive *jutti* (sandals), but drinks Coke and eats bread”. Sandals, bread, and soft-drinks: these are all mass-produced items. In Supriya’s account, the housecleaner seems to automatically value these objects because they are purchasable, according to Supriya. Although the attire has become more sophisticated, the nutritional value of the housecleaner’s diet has diminished due to her preference for manufactured items. The purchase of foodstuffs such as bread and soft drinks, could be considered aspirational acts that enabled the domestic worker to participate in another, bigger, world -- one that her employers were part of. The underclass had resources which the middle class occasionally coveted as well, such as medical knowledge and health care resources. I will discuss in Chapter 6 how the middle class’ ability to consume was thus not based on their financial capital, it included their capacity to mobilize their domestic and social network.

The activities and desires of the underclass revealed the extent to which middle class-ness could be enacted by anyone with ability to consume. This was a threat to the “old” or established middle class who maintained that social and intellectual capital were necessary requirements. One commentator described the new middle class as consisting of “a loud and noisy population of *nouveau riche* puppies [who have] taken over... worse still this loudness and vulgarity impinge[s] on ‘establishment’ Delhi” (Menon cited in Srivastava, 2007, p.243).<sup>14</sup> Such accusations ensued as the old middle class were

<sup>14</sup> “Puppies” is a portmanteau which blends “Punjabi” (who form Delhi’s entrepreneurial class) and “yuppie”.

increasingly threatened by those who could conceivably attain wealth and power on the basis of values which prevailed in a free market setting, such as entrepreneurial skills and strong work ethic.

Although the lower middle class were employed and occupied clerical positions in government or multinational corporations, they were still in precarious economic positions. Mankekar's book, *Screening Culture, Viewing Politics* (1999) investigated how female television viewers in a lower middle class Delhi neighbourhood responded to India's social and economic changes, namely Hindu fundamentalism and economic liberalization in the 1990s. Television was a privileged tool of the consumer economy as it "disseminat[e] information to help circulate goods as well as to socialize members of society" (Rajagopal, 2001, p.4). In Mankekar's ethnography, the women of the households bear the brunt of the consumer-oriented desires invoked in family members by television. One housewife secretly took up a job as a part-time in an upper-middle class neighbourhood to feed her family since her husband used his income as spending money to purchase household consumer goods. Another woman, who was the unmarried eldest daughter of the family had to part with her hard-earned savings so that her younger sister could have an extravagant dowry with electronics and household appliances to present to her in-laws (p. 95-96). The perilous middle-class position of these families revealed how economic reforms and emergent consumer practices reinforced and occasionally deepened prevailing gender and social inequalities.

Fernandes (2006) portrayed how the lower middle class asserted their class identity not only by their consumption of retail goods and leisure past-times, but also through the purchase of skills and credentials that could be obtained by enrolling in a certificate program from the ever-increasing number of unaccredited private colleges popping up in the towns and cities, or public speaking and elocution courses. to approximate the background of the upper middle class (2006, p. xviii). The upper middle class obviously had an advantage with their access to private English language schooling and university degrees, but different factions of the middle class competed for limited resources such as employment and wealth.

Consumption thus refers to an intricate set of processes of person-making, grooming, or cultivation. Middle classness is now a coveted and contested terrain as different groups seek to assure their membership and status. The neoliberal reforms have made the middle class more prominent but this group remains an incohesive formation characterized by conflict and contestations rather than consent (Fernandes, 2006).

I understand the middle class to be a group with the financial ability and social ease to navigate different therapeutic options and settle on treatment which offers not only cure but personable service and approachable practitioners.<sup>15</sup> India's middle class does embrace its distinct Indian identity (perhaps this is amplified amongst enthusiasts of Ayurveda). However, they may be conceptualised as a cosmopolitan group who share the particular aspirations and lifestyles of their distant counterparts residing in affluent North American or European countries more so than the working class inhabitants they see everyday.

### **3.5. Ayurveda in the Formal Market**

Ayurveda, too, has become very prominent in India's new economic setting as it is marketed as a traditional medical system. Readers might perhaps be familiar with how Ayurvedic medicine is marketed to the alternative or New Age global medical marketplace by Deepak Chopra and Maharishi Ayur-Veda (the latter which is the owned by the founder of Transcendental Meditation) (Humes, 2008). The Indian urban middle class, too, are avid consumers of Ayurveda and thus targeted by India's major medicine manufacturers. This group was already accustomed to the various permutations of Ayurveda enacted by its institutional and informal practice from India's medically pluralist setting (Chapter 4 will elaborate on this history of Ayurveda).

The Indian state and Ayurvedic manufacturers understood the importance of industrialisation and pharmaceuticalisation of Ayurvedic medicine well before the

<sup>15</sup> For more elaboration, see my discussion of Kalpana Ram's (2010) work in Section 7.4 Clinical Interactions & Class: Debating Signs and Symbols.

watershed moment of neoliberal reforms in 1991. The Udupa committee, established in 1958, remarked, “it may be recalled that the preparation [of medicines] by hand by individual *vaidyas* was one of the serious handicaps that made Ayurvedic [treatment] less popular to the modern minded people” (report cited by Banerjee, p.1138, 2002). In 1978, following the recommendations of several committees, the Ayurvedic Formulary of India was established with guidelines for standardised manufacture, ostensibly to appeal to consumers who required scientific confirmation (Banerjee, 2002, p.1138).

Certain manufacturers of indigenous medicine, such as Dabur, remained viable enterprises by engaging in parallel processes of expansion and industrialisation. The medicines of Dabur were hand-produced up until the late 1940s, but this became an outmoded means of manufacture as the company expanded. The collaboration of many experts such as engineers (who designed machinery to produce pharmaceuticals), chemists (who assessed the properties of medications) and Ayurvedic practitioners (who translated ancient Sanskrit medical texts into Hindi and English) helped to mechanise Ayurvedic medicine for mass consumption (Banerjee, 2008, p.204).

In the mid-1970s, Ashok Burman, the grandson of Dabur’s founder returned to India after graduating with a business degree from an American university and applied new marketing strategies to make Dabur more prominent in India’s marketplace. Burman selected a few key products, including Chyawanprash, to promote to consumers. Dabur acquired a phenomenal reach to Indian audiences from such tactics which they became a household name (Bode, 2006, p.228).

In 1987, following the 40<sup>th</sup> World Health Assembly, the World Health Organization adopted mandates to establish programmes to systematise the identification, collection, and preparation of herbal medicine in accordance to good manufacturing practices (Banerjee, 2002, p. 1143). The above-described measures established some of the groundwork which further enabled the mass-production of indigenous medicines such as Ayurveda.

My examination of how Ayurveda was marketed to the Indian middle class revealed the multiple and contradictory identities it bears. As a traditional medical

system, Ayurveda was both problematic and captivating for advertisers: it was considered old-fashioned but could also successfully be marketed as an ancient remedy, which was particularly effective against the ailments of modern living.

Bode investigated how Ayurveda was rendered as both an ancient and modern therapeutic option from the perspective of its manufacturers who utilized these qualities and invite the middle class to assert themselves as consumers of traditional culture. While this monograph analyzed the perspectives of manufacturers, Rajagopal (1998) considered how Indian viewers could be invoked to read themselves in the images transmitted and thus identify themselves as consumers in his article, “Advertising, Politics, and the Sentimental Education of the Indian Consumer”. He traced how advertisements rely on “religio-ritualistic imagery” to integrate themselves as “new entrants into the global market” (p.28). For instance, an advertisement for Ganga soap featured a scene of the iconic holy river intercut with a domestic morning scene of a mother anointing herself with vermillion and affixing her sari on her head in manner appropriate for an upper caste orthodox Hindu woman before getting her child ready for school. Sentiment is overlaid with the presence of the brand: “Auspiciousness, purity, and the bond between mother and son, are together sealed with a chaste kiss, and signaled by Ganga soap” (p.14). In this advertisement,

locally rooted relationships of dependence, based on caste, community and gender, are gradually linked in generalized relations of commodity exchange, as more insular regional markets are transformed and consolidated within a more global market. (p.16)

Ganga soap acted on both functional and symbolic registers: the act of “cleansing” referred to the removal of dirt from the body and was semantically connected to Hindu ideas of purity - the latter reinforced by the brand name of “Ganga”, an important sacred river.

Ayurveda is reputed as India’s ancient medical tradition and thus can also invoke multiple significances in the same way as Ganga soap. Bode’s (2008) work showed how manufacturers of Ayurvedic medicine highlighted its capacity to elicit both functional

and symbolic properties. For instance, Ayurvedic medicine was functionally useful as a therapeutic substance which could quell a cough, relieve a headache, and soothe pain. Yet, Ayurveda also carried symbolic value as an indigenous medical system, based on an ancient repertoire of knowledge and particularly effective for Indian bodies.

How was Ayurveda, as an ancient medical tradition, maintained as an alluring option for contemporary consumers in the formal marketplace? Bode's monograph opened with a quip from the director of Ayurvedic drug manufacturer, "packing is everything" (p.1). Packaging was certainly important on a pragmatic level for retaining freshness and purity of a product, but it did much more than serve utilitarian needs. In a competitive economic arena, Ayurveda had to be heavily marketed and packaging represented one step in this process. Packaging helped make products more visually appealing for consumers who may have even developed a relationship with these goods via advertisements before seeing them.

Marketers invested Ayurvedic medicine as containing primordial or pure qualities which were an antidote to the trials and tribulations of modern life. I will trace the marketing practice behind a popular Ayurvedic tonic, Chyawanprash from the late 1800s to present-day to show such qualities were reworked to succeed in the medical marketplace. Chyawanprash is a dense and sticky paste that one dissolves into a glass of milk or water before drinking. As a rejuvenator, Chyawanprash belongs to a class of remedies called *rasayanas* (or Jara Chikitsa), which form one of the eight branches of Ayurveda.

Many manufacturers, large and small, produce Chyawanprash, but it is the flagship product of Dabur, India's largest manufacturer of Ayurvedic medicine. This company was started by a physician, Dr. S.K. Burman in the early twentieth century who initially made biomedical and Ayurvedic medicines. Chyawanprash was originally manufactured as a competitor to biomedicine, more specifically, as an alternative to cod liver oil in the first decade of the twentieth century. However, this remedy was eventually repositioned as a 3 000 year old Indian product, with therapeutic properties that could help with the following issues,

memory, intelligence, appearance, the functions of the organs and digestive powers; confers longevity by preventing a number of maladies such as emaciation, hoarseness, weak heart, dropsy, abnormal thirst, neuralgia, urinary disease, spermatorrhoea, etc. (cited in Bode, 2008, p.98).

This product provides a range of therapeutic benefits and is manufactured by many companies, but is the flagship product of Dabur.

Dabur maintained a strong presence the Indian market by constantly adapting to prevailing social and economic trends taking place and this has enabled it to become the largest manufacturer of Ayurvedic products (Banerjee, 2009). For instance, during the *swadeshi* movement in the 1920s, Dabur promoted itself as a pro-Indian nationalist manufacturer and began to produce indigenous medicines exclusively with half of the company's earnings going towards nationalist causes. The testimonials of Indian nationalists appeared on company brochures (Bode, 2009, p.38). As I stated earlier in this chapter, the "be Indian, buy Indian" ethos of *swadeshi* was most aptly symbolized by indigenous cloth, *khadi*. Health care practices, too, were encompassed into this cultural revivalist moment as proponents drew upon what could be conceptualized as nationalist Indian practices to assert cultural self-determination against British colonial domination which was espoused in foreign-made products.

During India's transition to neoliberal policies, Dabur hired consultancy firm, McKinsey & Company, to transform its organisation and management structure. The company shifted from a family-run enterprise to one led by formally-trained professionals with advanced business degrees. Dabur also expand its product repertoire to include "fast-moving consumer goods" such as packaged food and drink and toiletries in addition to medicines (Banerjee, 2009, p.157). These transitions enabled Dabur to effectively capitalize on the opportunities offered in India's new economy and become a dominant player in the South Asian market.

Dabur has emphasized different qualities of Chyawanprash in its efforts to win over the middle class. This substance had formerly been marketed as a seasonal remedy against the North Indian winters but Dabur promoted it as a daily all-year remedy which

could mitigate against the stresses of daily living and protect against “the health hazards of modern city life and environmental stress such as vitiated air, water, and food” in the mid 1990s (Bode, 2008, p.99). This strategy proved successful with sales doubling from US \$24 million in 1997 to US \$42 million in 2002 (p.99).

I spent one winter morning speaking with an advertising executive, Jayesh, about the relevance of Ayurveda for India’s urban middle class (December 2, 2004). He stated that Ayurveda had a problematic reputation amongst the middle class who were more taken in by the sweeping changes taking place to allopathic medicine with the construction of new hospital facilities whose ambience resembled a hotel more so than a dreary clinical setting. Meanwhile, Ayurveda was associated with back alleys and quacks. Yet, it was unquestionably an ancient Indian tradition and could thus resonate with the desires of the middle class who wanted to assert their Indian identities.

Jayesh informed me that Dabur selected legendary Bollywood actor, Amitabh Bachan, in 2003 as brand ambassador for Chyawanprash. He went on to explain that Bachan was a particularly appropriate symbol for Chyawanprash as he is one of those “icons who succeeded yesterday, but are still here today”. Bachan updated the reputation of Chyawanprash and kept it as a “classic but relevant” product. His image graced Dabur’s headquarters for a few years. Bollywood stars and Chyawanprash are both entities that have been modernized and mass-produced for large audiences for many decades and yet remain unquestionably Indian.

Dabur’s attempts to capture the attention middle class led to the adoption of Bachan – and his eventual replacement by a much younger cricket star, MS Dhoni. As Jayesh had remarked, Bachan was famous, but he was from a bygone era and his appeal was thus restricted to older consumers. If we recall that India’s middle class is a relatively young demographic, the appeal of a cricket star is understandable.

According to Jayesh, Indian consumers acknowledged Chyawanprash as an effective rejuvenator, but it was associated with motherhood and domesticity. This prevented a crucial market segment, namely young men, from purchasing it, although as a group, they were attracted to rejuvenators and aphrodisiacs. Cohen’s ethnography on

aging and senility in Benares, an ancient North Indian city and pilgrimage site briefly discusses the popularity of ginseng amongst young men in the early 1990s. The power of ginseng was based on the young men's belief in the pure and unadulterated power of herbs. Ginseng's exotic origins from the Far East substance lent it further appeal as a powerful substance and helped to dislocate it from the domestic, feminine sphere. Moreover, it could be classified as an aphrodisiac or sexual tonic as its packaging (red pills) resembled other sexual vitality tonics on the market. Cohen remarks that Chyawanprash implied the ingestion of mother's milk, ginseng was associated male body parts (p. 135).

Dabur, too, masculinized Chyawanprash by replacing Bachan with the much younger, and more active, MS Dhoni, as its brand ambassador in 2006. As well, the Chyawanprash changed its tagline from the Hindi "*Zaroorat hai*" (it is necessary) to the English "Fit Body, Active Mind" thereby transforming it from an Indian classic formulation to a substance which was beneficial for contemporary lifestyles (Marketing Practice, 2008).

The brief we got from Dabur was to promote Chyawanprash as the tonic for one's body and mind. Dhoni, the brand, is rooted inside India and stands for a person who is physically and mentally fit. The basic message that we have tried to convey through this campaign is Dhoni's attitude is about perfect balance of body and mind. He explains this formula of winning to kids. (Chakravarty cited in Goorha, 2008, para 5)

As a cricket star, Dhoni's Indian-ness could not be denied. Yet he embodied modern qualities of strength and stamina, required for the fast-paced lives of the middle class.

Bachan and Dhoni both appear in advertisements for a wide range of products from pens to cooking oil to cream for the Indian market. Their appearance in the Chyawanprash advertisements demonstrated the extent that therapeutic options or health care remedies are becoming commoditized as a retail product for consumers.<sup>16</sup>

<sup>16</sup> In fact, one professor of marketing mistook the latest Chyawanprash advertisement as one for Boost as they both use the Dhoni and are similarly packaged in red jars (Marketing Practice, 2008).

The cachet of sports celebrities was made abundantly clear when I interviewed Rohit, an MBA student who was in his late 20s about the transformation of advertising and consumption practices from his childhood to the present day. He had a great love for advertisements as a child and recalled that he loved learning slogans, which he would parrot to his parents in attempt to influence household purchases ranging from shirts to soap. He recalled the tremendous influence of a cricket player, Kapil Dev who advertised Boost, a fortified malt drink that Rohit drank everyday even though he found it unpalatable.<sup>17</sup> He elaborates,

I'm telling you, and I can reiterate this a zillion times. I hated the taste of Boost. Like the shittiest chocolate drink ever. I have no idea why people drank it, but I drank it in my milk because I thought I could bowl faster... and I remember my father actually [scolding] me once 'cause in front of his esteemed guest... he was like my dad's boss or something, I don't know – senior guy, very senior guy... [and he asked me], "Oh, Rohit, what are you doing these days?"...

And I said, "Wo, I am busy taking wickets".

And he'd be like, "Yeah, really?"

And I said, "I am ten wickets short of Kapil Dev's record now"...

And my father said, "What are you saying"?

And I said, "Yes, because I drink Boost everyday. I take wickets every now and then"....

And my father later said, "Why can't you keep your trap shut and talk something sensible when people come visit us"... My father and I laugh about it now... But, it was ridiculous. It had such a monumental impact on my life: I believed that I could overtake Kapil Dev's record playing in my neighbourhood, drinking Boost... And, I'm sure a lot of kids in my generation would have been affected. They show it with [cricket star] Sachin Tendulkar now. He is the legend: "Boost is the secret of my energy". (April 2, 2007)

Despite the unpleasant taste, Boost's association with a cricket star incited Rohit's aspirations and imaginations to an unprecedented degree. Dabur's marketing campaign with MS Dhoni, the cricket star, targets a younger audience by foregrounding power, force, and strength. Dabur's advertisement, featuring Dhoni, targets youth in the hopes of

<sup>17</sup> Boost is owned by pharmaceutical manufacturer, GlaxoSmithKline.

changing Chyawanprash from a remedy that mothers give to their children to a performance-enhancer that young people will purchase for themselves

The increased availability of mass-produced remedies carries great implications for how health is conceptualized and resolved. Here, “functional” health (or the ability to carry daily tasks) takes precedence over “experiential” health with the increased availability of what Nichter categorized as “technical fixes” such as tonics, brain-boosters, and performance-enhancers in the medical and retail environment (1994, p.238). Health becomes commodified as a “state one can obtain through consumption of... medicine” (p.236).

The mass-production of medicines also influences how Ayurveda is understood as a medical system or repertoire of medical knowledge (Banerjee, 2009; Bode, 2008; Naraindas, 2006). The mass production of Ayurvedic medications has only been taking place for the past hundred years or so. Prior to this, practitioners (and perhaps their apprentices) made remedies for their clientele. Berger stated that in such a scenario, medical treatment would be specific to the herbs, medical knowledge, and illnesses found in one geographic region. Treatment for one ailment would thus not necessarily be the same in the south Indian state of Kerala and in the north Indian state of Uttar Pradesh.

Ayurveda began to be standardized as a repertoire of knowledge via the establishment of state medical colleges throughout India in the twentieth century India (which will be explained in the subsequent chapter). The standardization of Ayurveda is not a new phenomenon, but the mass-production of Ayurvedic medicine for the burgeoning alternative health care industry may compromise it as a repertoire of medical knowledge by making it nothing more than an approximation of biomedicine (Banerjee, 2009; Naraindas, 2006).

Banerjee states that the pharmacology of Ayurveda was quite well established and the classical texts such as *Charakha Samhita* outlined its therapeutic properties for practitioners to follow. (Banerjee, 2009). Not all of these Ayurvedic remedies could be easily adapted to the requirements of mass production. For instance, while a practitioner may be able to store a mixture in an earthenware pot, seal it with clay and then store it in

a dark place for a few days so that a certain temperature can be reached, a manufacturing facility might attempt to replicate this process by storing medicines in rooms with precise temperature controls (Banerjee, 2008, p.202). Obviously some approximations were easy to carry out and standardize for mass production while others were more difficult. Remedies which were easy to replicate may have been mass-produced more so than those which therapeutically beneficial.

The logic of mass production compromised the working of Ayurvedic medicine because its standards for safety and efficacy were in based on biomedical epistemology. For instance, mass-produced Ayurvedic medicine was manufactured in a “tablet-syrup-capsule” form rather than loose powders and decoctions (p.197). This formation was one means of upgrading Ayurveda from a “tedious, slow-moving, eeky-looking, bad-tasting, [and] foul-smelling” remedy (which was how consumers viewed it according to Jayesh) to one that was more aesthetically pleasing.

Banerjee (2009) argued that Ayurvedic medicines resembled biomedical pharmaceuticals not only in terms of appearance but also in their therapeutic activity. The efficacy of Ayurveda has been documented via longitudinal observation studies, but for the mass production, clinical trials were the most legitimate means to measure efficacy. These tests have been a crucial component in the standardization and mass production of drugs since 1948 in Europe and the United States (p. 207-211). These experiments were most widely established means of ascertaining the efficacy of medicine. International regulatory bodies such as the Food and Drug Administration (FDA) and European Medicines Agency (EMA) relied on clinical trials to judge quality control and efficacy. However, Banerjee pointed out that clinical trials originated from a biomedical epistemology and so were not necessarily the most accurate means of measuring the efficacy of a medical system such as Ayurveda (p.198).

To explain briefly, a clinical trial was an experiment whereby patients were randomly selected to take the experimental or conventional treatment and investigators compared the outcomes (p.207). Some epistemological assumptions of these experiments conflicted with Ayurvedic worldviews. For instance, clinical trials assumed that all

bodies were universal whereas Ayurvedic practitioners believed that a patient is a unique configuration, a “non-standard and unstandardisable entity” (Pandit Shiv Sharma cited in Banerjee, 2009, p.214). As one official from Dabur stated,

If you are exporting drugs, then you have to talk science. You cannot at all follow the Ayurvedic format for clinical trials, because for a commercial organisation, the audience is global, the world is a market, so we have to talk in their language... (cited in Banerjee, 2009, p.212-213)

Knowledge seemed to be translated only one way and that was according to the biomedical episteme. Banerjee wondered if Ayurveda was not becoming “biomedicine’s double” as it became mass-produced in accordance to these standards. Naraindas (2006) articulated a similar argument (which I will elaborate in Chapter 7) stating that Indian patients have become socialised into the biomedical episteme, so that even when they consulted an Ayurvedic practitioner, their diagnostic categories (i.e. high blood pressure) and evaluation of cure were based on a biomedical point of reference.

Ayurveda is a malleable formation and captures attention as a consumable option in the marketplace as manufacturers showcase this medical practice as a gentle ancient remedy, as a performance-enhancer, and as an approximation of biomedicine. However, the promotion of Ayurvedic remedies is one step of its biography as an object, the perspective of consumers who engage with it after purchase, and in their everyday lives, needs to be analyzed too. This enables scholars to understand how consumption is a process-oriented and meaning-making practice for those in pursuit in health.

### **3.6. Creating Meaning Through Objects**

*Every human society is a world in the process of becoming, in which people are engaged in the active technological elaboration, appropriation, and modification of artifacts as the means of coming to know themselves...*  
(Pfaffenberger, 1992, p.511)

George Basalla, historian of technology, argued, “it is impossible to identify a class of ‘authentic’ artefacts that directly and rationally address ‘real needs’ ” (cited from Pfaffenberger, 1992, p. 496). In other words, culture, not nature, defined necessity: humans use artefacts to engage in the process of meaning making. My study of the intersection between Ayurveda and consumption proceeds from the assumption that objects themselves do not contain significance, rather humans create meaning through activities that involve objects.

Daniel Miller (1995a), a prominent material studies scholar, pointed out that consumption practices have been under acknowledged by anthropologists despite their potential to express social issues such as identity, power and transformation. Consumption studies entered the concerns of anthropology and sociology relatively late, only during the end of 1970s. Certainly there were antecedents with well-known works on the leisure class and conspicuous consumption by sociologist Thorstein Veblen at the turn of the twentieth century and studies on Melanesian cargo cults by anthropologists since World War II. Ethnographies from 1940s and 1950s occasionally discussed consumption, however it was often placed in the final chapter alongside a treatment on social change and the processes of Westernization (1995a). The works by anthropologists Mary Douglas & Byron Isherwood (*The World of Goods*, 1978) and sociologist Pierre Bourdieu (*Distinction: A Social Critique of the Judgment of Taste*, 1979) acknowledged consumption as a social practice of significance in daily life, rather than exceptional event.<sup>18</sup> Also, they were among the first major thinkers who turned their attention to study the “home” of consumption (i.e. North America and Europe): consumption thus had to be taken seriously because it was an essential aspect of the society under examination.

Douglas and Isherwood (1978) theorized goods as cultural products whose usage extended beyond functionalist needs (i.e. the purchase of clothing to keep one warm) or celebratory needs (i.e. competitive display). Instead, Douglas and Isherwood treated

<sup>18</sup> Coincidentally, Liechty considers the work of Douglas & Isherwood (1979) and Bourdieu (1978) as one of the first examples of class as a process or “practice theory” (2003, p.22)

goods as vehicles which expressed cultural codes and categories and communicated identities and relationships: “goods are neutral, their uses are social; they can be used as fences or bridges” (p. xv, 1978). Bourdieu (1979) theorized consumption as part of an assemblage of aspirational cultural practices. Consumption, along with other social practices such as education and aesthetic taste were theorized as status-making devices which provide various kinds of cultural capital.

The publication of the edited volume *The Social Life of Things: Commodities in Cultural Perspective* (Appadurai, 1986) contributed a meaningful theoretical framework regarding sociality and consumption for anthropologists. Most significantly, the authors of this volume refused to polarize commodities and gifts. The opening chapter, “Introduction: Commodities and the Politics of Value” (1986, p.11), claimed that anthropologists were mistaken in treating consumption as an individualistic and alienating practice by opposing it to gift giving, the latter being considered the definitive mode of exchange that created relationships (Appadurai, 1986). Kopytoff elaborated on this idea in his piece, “The cultural biography of things: commoditization as a process” and emphasized the social aspects of a commodity. Kopytoff defined a commodity as,

a thing that has use value and can be exchanged in a discrete transaction for a counterpart, the very fact of exchange indicating that the counterpart has, in the immediate context, an equivalent value... (1986, p.69)

The close interaction between things and people meant that commodities could be thought of as having life stories, or as “biographies” (1986). The life story of a commodity could be revealed by tracing its movements and inquiring about: where it came from, who it was affiliated with, how was it used, and so on. An anthropologist could trace the answers to these questions by examining people’s interaction with it.

This argument departed from the claims of Marxists who maintained that the value of the commodity was derived primarily from its capacity for exchange which denied the labour and social relations that went into its making (cited in Taussig, 1980, p.175). The Marxist perspective foregrounded the objecthood of a commodity which was assumed to be the source of its power. Although the chapters in *The Social Life of Things*

discussed a range of material objects ranging from prestige consumption goods (Gell, 1986), authenticity and Oriental rugs (Spooner, 1986), and psychoactive beverages such as *qat* (Cassanelli, 1986), the most crucial quality of these commodities was not their “thinginess”, but their capacity to be in motion, to circulate, and be exchanged between people.

Anthropologists became more invested in the study of commodities and consumption following global neoliberal transitions, which was evidenced with a spate of publications concerned with the circulation of commodities such as toiletries (Burke, 1996), soft drinks (Miller, 1998), and cell phones (Mazzarella 2003). Consumption practices were taken seriously as they spoke to the processes of social transformation and cultural change, which were being experienced by more citizens of the world, albeit unevenly. Moreover, the study of consumption also emphasized human agency and meaning making, long-established concerns of anthropologists. Many such studies on consumption highlighted the continuities between the fractures brought on by neoliberal economic transitions to earlier ones such by colonialism. Timothy Burke, for instance, discussed the interplay between consumer practices, with his study on the contemporary marketing of goods such as toiletries in Zimbabwe (1996); and Foster analyzed the role of consumption and advertising for nation making in historically “weak states” such as Papua New Guinea (2002).

Upon first glance, these scholars seemed interested in how non-local or alien objects such as body care products and technology were integrated into the lives of people. However, Miller (1995a) emphasized that anthropologists were not so much interested in the objects themselves, but in how they were embedded in “forces [such as colonialism and capitalism] which come from outside, one cannot properly harness them to one’s own historical project” (p.7). The *swadeshi* movement was one example of how Indians transformed consumption practices under duress, during national liberation struggles. Ayurveda is reputed as India’s national indigenous medicine, but this is a relatively recent formation, which began in the 1920s during *swadeshi* and the national liberation movements (I discuss the institutionalization of Ayurveda in Chapter 4)

(Berger, 2008). This medical system may thus be understood as a transnational entity culminating from a long history of colonialism and capitalism.

The work of Bode (2008) or Banerjee (2009) on Ayurvedic medicine from the perspective of manufacturers showed that one did not necessarily have to study the entry of foreign-produced goods to speak about processes such as standardization, industrialization, and commodification. Consumption was a way of *relating to* objects such as Ayurvedic medicine or Coca Cola or a Nokia phone, not about the *objects* themselves.

My specific interest resides in the consumption of Ayurvedic medicines from one phase of its biography, the “afterlife”, which takes place after financial purchase (Howes, 1996). Graeber (2011) stated that anthropologists worked with a fairly general definition of consumption, as “any activity that involves the purchase, use or enjoyment or any manufactured or agricultural product for any purpose other than the production or exchange of new commodities” (p.491). This understanding of consumption was derived from the work of early political economists such Adam Smith to explain the new division of activities and lifestyles culminating from industrial capitalism whereby goods were produced in the workplace and then consumed in the household. Workers were alienated from the products they made and consumers were alienated from the products they purchased. Habermas’ conceptualization of a consumer emerges from this dichotomy:

I use the term consumer in opposition to the aesthetic ideal of a creative producer. I want to reflect on a condition in which very little of what we possess is made by us in the first instance. *Therefore to be a consumer is to possess consciousness that one is living through objects and images not of one’s own creation.* It is this which makes the term symptomatic of what some at least have seen as the core meaning of the term modernity. (cited in Miller, 1995, p.3 italics mine)

According to Graeber (2011), “consumption” was erroneously defined only in opposition to “production”, and this obfuscated the everyday processes and meaning making involved in this practice. The act of consumption was involved in diverse set of activities ranging from applying make-up, purchasing a shirt, playing in a band, and

buying groceries. Graeber maintained that scholars needed to rethink the dichotomy between production and consumption and consider consumption as a process which may sometimes involve production, even if it was not for the formal market (i.e. the creation of a meal, the making of a health remedy following the purchase of food and herbs [p.502]).

Graeber's invocation illuminates the myriad activities involved in the consumption of Ayurveda. This medical practice is not reducible to commodities such as medications (although they certainly formed an important and lucrative part of its therapeutic repertoire). As a health care practice, Ayurveda was an especially useful vehicle to chart the processes of consumption as people aspire to obtain, or produce, health. This involves an assemblage of health-making practices which encompassed interactions in the formal and informal marketplace ranging from the purchase of a packaged medication, to dietary modifications, to clinical visits, and home remedies. The remainder of this chapter discusses the complexities involved with the literal consumption of medicine and food.

Van der Geest and Whyte, who were responsible for the influential edited volume, *The Context of Medicines in Developing Countries: Studies in Pharmaceutical Anthropology* (1988) extended the analysis of pharmaceuticals beyond the perspectives of Western multinational manufacturers to consider the outlook from its 'on the ground' users (1988). These authors stated that pharmaceuticals carried significant value for their users for several reasons. Firstly, they were highly mobile and powerful substances which provided cure or relief if a doctor was not immediately reachable. Their small size also rendered them discreet objects, which lent its users greater privacy for treating potentially embarrassing or taboo diseases. Basically, pharmaceuticals had the benefit of acting as an extension of the doctor's authority, while, at the same, being separate from this figure. This stood in contrast to other types of treatment where "one cannot separate surgery from the skill of the surgeon, nor acupuncture from the acupuncturist, nor massage from the massager" (p.359). The most enduring contribution from this group of scholars was their analysis of pharmaceuticals as cultural objects whose meaning was not self-evident; rather it was negotiated according to the worldview of its users (1988).

Whyte illustrates the malleability of such objects by pointing out how medicine in an East African setting is classified with respect to its ability to act on other things.

To transform an ordinary dog into a good hunting dog, medicine (not training) had to be given. To get a good cash crop, ‘cotton medicine’ (DDT) was sprayed on the plants. In the Nyole language, one can speak of ‘bicycle medicine’ (the rubber cement used to patch tires), sorcery medicine... as well as curative hospital medicine. (p.218, 1988)

Van der Geest and Whyte (1988) took after the contributors of *The Social Life of Things* (1986) to emphasize goods such as medicines as social objects whose relevance was co-constituted from various human agents such as doctors, pharmacists, pharmaceutical sales representatives, family members and their worldview. The influence of Appadurai’s edited volume is clear with the publication of the similarly titled *The Social Lives of Medicines* (Whyte et al., 2002) which traces the life cycle of pharmaceuticals from manufacture to marketing to consumption and the various human actors who engage with these artifacts.

The epistemological boundaries of medical systems were not uniformly maintained in different social contexts.<sup>19</sup> For instance, allopathic pharmaceuticals could be used and received in unintended ways as people interpreted their physical qualities and effects in ways that resonated with their local semantics of healing (Nichter, 1986, Van der Geest & Whyte, 1988). Burghat (1988) analyzed how the heating and drying qualities of penicillin were integrated with the local humoral framework and medical model for one Indian practitioner, Vaidya Ji. This man was an Ayurvedic practitioner but was unable to eliminate penicillin from his treatment repertoire due to patient demand for this widely efficacious substance. Vaidya Ji thus had little other recourse but to claim that penicillin was originally an Ayurvedic remedy. Vaidya Ji maintained that Ayurvedic texts

<sup>19</sup> Indeed, allopathy itself is transnational formation and part of its development is based on bioprospecting from territories under colonial rule. Chakrabarti (2007), a historian of imperial medical science in South Asia, observes that British colonialists sourced therapeutic substances from the markets or bazaars of South Asia medicine to expand their allopathic medical practice in the 18th century.

were the source of all knowledge, which preceded and included allopathy to assert his relevance as a medical practitioner in a rapidly changing town where allopathic medicine carried greater cachet (p.297).

The ethnographic investigation of pharmaceuticals, from the perspective of its consumers or patients and medical practitioners, briefly presented here shows one way that the adoption of such allopathic technologies does not automatically result in the homologous adoption of its cultural logic. The distinction between ethnomedicine and allopathy continued to be blurred for consumers who could purchase, say, Traditional Chinese Medicine, in the form of mass-produced and packaged ginseng capsules or for Indian patients who applied local humoral medical knowledge to antibiotics. As we can see, the interaction with mass-produced goods such as pharmaceuticals is a meaning-making process which continued beyond the financial act of purchase.

Consumption and production can thus understood as iterative processes if one investigates how consumers purchase and integrate them into their health making practices, according to their local worldviews. Further complexities that may emerge with the consumption of mass-produced products can be articulated by negotiations take place in relation to substances which are not only literally consumed, but physically-transformed after purchase, such as food.

### **3.7. Food and Medicine, Meals and Remedies: Consumption as a Transformative Process**

The definition of consumption remains unclear amongst scholars, perhaps this is why anthropologists continue to debate the importance of *consumption* in relation to *production* and *exchange* or the significance of social units such as *households* and *families* in relation to *individuals* (Colloredo-Mansfeld, 2005, p. 210). My concluding section on food and medicine illuminates the complexity of these debates.

Ingestible substances, such as food and medicine, act on the body in intimate ways and this can render them as either profoundly beneficial or harmful agents. Its consumption thus has to be carefully regulated and mediated. Anthropologists have long noted that food is an intensely social fact (in the Durkheimian sense) as it coalesced “technological conditions; production and exchange; prosperity and lack” (Appadurai, 1981, p.494). Food involved, expressed, and regulated many relationships between humans and their physical, social, and spiritual environment:

[It is] regarded as important media of contact between human beings; in a society that rests on the regulation of such contact, food is a focus of much taxonomic and moral thought. Cuisine is highly developed and highly differentiated, and even modest peasant diets have some variety. Feasting and fasting have powerful associations with generosity and asceticism. Food avoidances, for different persons in different contexts, are developed to a remarkably high degree and can signal caste or sect affiliation, life-cycle stages, gender distinctions, and aspirations toward higher status. (p.145)

In the Hindu worldview, food was revered as a cosmological substance, as a medium between humans and gods, and great care had to be taken to ensure its appropriate preparations and purity before ingestion.

The anthropological investigation of food and medicine which requires mediation through constant preparation, cooking, and serving showcases its dynamic “afterlife” following the financial purchase. This process reveals how people reconcile the fundamental contradiction of contemporary society, by being “forced to redefine the alienable objects of mass production into the inalienable objects of community and selfhood” (Colloredo-Mansfield, 2005, p.218). The ethnographic study of ingestible substances such as food and medicine exemplifies how consumption is “a culture making process [and] ordering of society”, where power and authority may be expressed or contested (p.223)

Food is actually a central therapeutic resource in Ayurveda and considered as ‘medicine’. When I spoke with Delhites about my research project, their response was to claim to Ayurveda as a particularly and uniquely Indian practice. This came not from its

status as an ancient medical system but from its use for home remedies or in, cooking, for example. Advertising executive, Mr. Bedi, described the middle class as understanding Ayurveda to be an old-fashioned “grandma’s medicine” which consisted of home remedies, such as warm milk and turmeric (*haldi*) (November, 27, 2004). As one man explained to me during break while we attended workshop on Indian indigenous medicine, “I’ll tell you why [people use Ayurveda], it’s because it’s in their tradition... It is found in their kitchens... *elaichi* [cardomon], *ajwain* [Bishop’s weed], *soomph* [fennel]... If you are sick... you can always take these”. (January 31, 2007).

The intimate overlap between food and medicine is quite evident if one considers the source of these items. Khari Baoli is a well-known wholesale market in Old Delhi for purchasing Ayurvedic medicine is also known as the Spice Market and offers turmeric, ground ginger, dried fruits, almonds and herbs for wholesale and retail consumers.

In an Ayurvedic text, foods such as nuts contained certain therapeutic properties: they were “sweet, heavy, hot, oily, aphrodisiac and strengthening” (Svoboda, 1992, p. 136). Cumin seed was similarly therapeutic: “Known as ‘the Digester’ in Sanskrit, cumin is... slightly hot, and pungent after digestion” (p.142). These thermodynamic or humoural properties were apparent in every living thing according to the Ayurveda schematic, including people and this affected their dietary practices.

In Ayurveda, the bodily constitution of patients was categorized and treated according to how firey (*pitta*), windy (*vata*), or earthy (*kapha*) they were. This constitution influenced many dimensions of a person from their physical appearance, sleeping habits, emotions, and predisposition to suffer from certain ailments. Pitta-types, for instance, were “hot”, quick to anger, and prone to inflammation and heartburn. They thus required more cooling foods than those with other constitutions. Taste qualities such as “sour” or “pungent” were not only aesthetic, they carried therapeutic value as well: for pitta-types, sweet and bitter foods were beneficial. Food was considered the basic building block of health in Ayurveda: “the idea of remedy and that of nourishment are thus both parallel and complementary; pharmacy and cuisine are two aspects of medical activities regarded as a single set” (Zimmerman, 1987, p.203).

Food and herbs were not understood as being healthy simply on the basis of the above-mentioned attributes. Their beneficial qualities had to be harnessed by preparation and cooking. As substances ingested by the body, they ideally required human mediation: certainly vegetables or herbs were obtained from a market, but their transformation into meals and therapeutic remedies relied on the productive and creative capacities of its users.<sup>20</sup> This activity depended on household labour arrangements, or relied on ritualized or specialized knowledge. Food and medicine were accordingly better conceptualized as practices which were enfolded into a sociotechnical system rather than discrete objects.

Culinary habits were often heavily differentiated in India because of gender, religion, class, caste, and geography, and this inhibited people from consuming food that was anonymously prepared. I came across several instances which validated this during the time I conducted fieldwork in rural and urban India.

In Autumn 2001, I lived in Punjabi village and stayed with relatives while researching indigenous understandings of allopathic pharmaceuticals for my Master's degree. My integration into the village as a family member exposed me to many routines of everyday rural life. During harvest, I witnessed my uncle making multiple scooter trips back and forth from the market where he sold his crops, so that he could have meals at home. This commuting seemed inconvenient, but I attributed this to his obligations as a religious Sikh who maintained a specific set of rules for eating. It was only years later, that I understood that my uncle's reticence to eat food from outside the home as being part of a broader Indian concern.

This sentiment was made echoed to me in Spring 2007, when I was living in Delhi and meeting up with a local friend, Anil, at a relatively newly-built cinema complex. I was hungry and searching for a snack after spending the previous days ill and housebound. Anil and I stood in the evening swirl of activity which included people strolling, a group of vendors seated on the ground with blankets that displayed the plastic-wrapped books and magazines, and various stalls and kiosks selling hair trinkets,

<sup>20</sup> Note that I use the word 'ideally'. I do not claim that all Indians consume Ayurvedic medicine which they prepare by hand at home.

cigarettes, Nestle tea, and fast food (both Indian and non-Indian). I decided to get a falafel as they were vegetarian and seemed a tasty novelty in India. As we waited in line, Anil shook his head to himself a few times while looking at the stall and said that he never ate food “from outside” (*bahar ka khana*) when he was not feeling well. The falafel seemed relatively innocuous to me in terms of ingredients – chickpea batter with raw onions and tahini on pita bread. I did not realize at first that the entire snack was categorically dismissed as unhealthy because of the depersonalized or anonymous preparation.

Until recently, eating in restaurants was seldom a viable option for the urban middle class because of similar reservations. Office workers in Mumbai were famous for employing the service of *dhabawallas*, deliverymen who formed part of complex delivery chain to provide a hot lunch cooked by the wives of office workers everyday (Conlon, 1995). Indian marketers acknowledged this cultural sensibility even as they strived to profit from it. For instance, an advertisement for Dabur’s Chyawanprash opens with a spokesperson describing the ailments that their product is an antidote for: “change of season, *pollution*, or eating from outside (*bahar ka khana*)”. Although eating out has become a need for urbanites and also a newly status-infused form of consumption (I would conclude, based on my reading of the food court on a Friday night at one of the big Delhi entertainment complexes), its negative effects can be resolved by the Ayurvedic products available in the medical marketplace.

I spoke to advertising executive, Jayesh about the relevancy of Ayurveda for Indian consumers and he brought up the many complexities invoked by the consumption of food. Our interview had begun on a quite optimistic and somewhat clichéd note as he announced the opportunities which were available for the burgeoning middle class market. He then went on to discuss oversights and misunderstandings from multinationals especially with respect to Indian culinary practices. He articulated these points quite compellingly which was presumably due to his local or first-hand experience and his profession. William Mazzarella’s ethnography, *Shoveling Smoke: Advertising and Globalization in Contemporary India* (2003) portrayed how advertisers position themselves as cultural brokers who articulate insights about the Indian middle-class to

multinational manufacturers interested in winning over this new marketing demographic – but clueless to their cultural sensibilities. Jayesh exemplified this role to me, a social scientist interested in Indian culture and he had probably spoken with many other professionals interested in Indian culture, albeit for more financially-oriented motives than a dissertation project.

Jayesh brought up the famous example of the failure of Kellogg's Corn Flakes cereal in the Indian market, and elaborated on all the dimensions in which it had failed to resonate. Kellogg's, Jayesh pointed out, is a cold, packaged, and sweet product that stands on all points in contrast to typical local breakfasts which are hot and savoury: a north Indian breakfast would feature hot *paraanthas* which would be consumed with *dahi* (yogurt) or *aachar* (spicy pickled items such as unripe mango, lime, carrot) while a south Indian breakfast would feature *idlis* [savoury small white cake made from fermented rice and lentils] to be consumed with savoury condiments.<sup>21</sup> Additionally, all of these foods were consumed hot, minutes after they have been cooked.

A bowl of Kellogg's Corn Flakes figured incongruously in this scenario as it violated many deeply-seated ideas about a proper Indian morning meal: it was sweet, it came from a package and was therefore prepared by unknown hands (or machines); and it was uncooked and cold, although some Indians took it with hot milk. Jayesh closed his thoughts on the Kelloggs's failure of enticement by stating, "Paraanthas... make you flourish. Cooking involves the mother's hand... Food is very intimately linked to who you are, how you feel, and your deepest need for care and survival" (December 2, 2004). Here, the process of consumption (after monetary purchase) not only transformed anonymous objects of food into the domestic ritual of a meal but it also expressed social status, and mobilized relationships of caring and dependency.

The health-giving qualities of food depended on human mediation and manipulation. This was signified by food being cooked and served as a hot meal. This was made clear with Jayesh's disparagement of salad as something more suitable for

<sup>21</sup> Paraanths are a North Indian savoury breakfast item – a thick flatbread which may be stuffed with vegetables such as potatoes. A rice and lentil mini-pancake.

four-legged animals. While a salad might be considered chock-full of nutrients in the North American common-sensical view precisely because it is raw, this very same quality renders it unsuitable for human bodies according to Indian culinary sensibilities. Heat equals healthy. Even more offensive are cold cuts which are not only uncooked animal flesh, but also preserved or cured. Jayesh voiced his disapproval to such a dish, “You have the *gall* to introduce me to foreign stale foods?”. The violation of categories here was too overwhelming: an uncooked and cured animal food product (which translate into ‘stale’) can lead to Indian consumers feeling affronted. The routines of preparing and cooking, which imbued food with health-giving qualities, were more important than scientized or standardized nutritional measures such as vitamins.

In Ayurveda, both the act of preparation and digestion were understood as a series of “cookings”; these processes are part of a continuum that transforms food into an ever-more refined substance (Zimmerman, 1992). Severntine (1992) describes South Asian concern with cooking and food as distinct from that of other locales such as China or North America where food is cooked but “retains a close affinity in both flavour and texture to their uncooked state”, such as stir-fried vegetables or a rare steak. In South Asia, the concern with cooking is quite extensive and expansive with all ingredients requiring a long immersion into heat which renders many of its dishes as a soft *mélange*: “The slow simmering [...] enable[s] the spices, salt, and other ingredients to penetrate the raw items totally and bring about their transformation, thereby reducing, in the logical extreme of the style, the raw items into mere flavours such as spiciness and saltiness” (1992, p.191). The cooking metaphor carries onto bodily processes: a person’s ability to digest depends on one’s digestive “fire” (Svoboda, 1992, p.113). A strong, firey digestive transforms food into a nourishing substance called “*rasa*”, which can be translated as the “the nutrient liquid that moves ceaselessly throughout the body bathing in each cell in its fertilizing flow” (p.70).

Ayurvedic remedies, too, require some amount of human handling to become therapeutic:

A common... prescription whereby water is to be cooled overnight in a copper vessel and drunk at dawn [*ushah-pana*] does not mean that the water so cooled is pure and fresh by nature. It has been purified and freshened by the material of culture, inorganic chemistry and the agency of human intervention. (Alter, 1999, p. S52).

Ayurvedic treatment is based on more than organic substances: the coordination of material, knowledge and labour expresses Ayurveda as a sociotechnical system. Preparation of food and remedies are a necessary, labour-intensive, and expensive component of care and health-making which will be highlighted in my chapter on household production of Ayurveda (Jenner & Wallis, 2007).

This overview on the importance of human intervention on food and medicine reveals the intricate process of consumption, something involving more than financial purchase. It also reveals that consumption is a form sociality by virtue of people's interaction with objects. Food and medicine are particularly interesting because they are objects that people transform into meals and remedies for themselves and their kin. Here, 'consumers' were engaged in an iterative process of

consuming (a herb) → producing (a remedy) →

consuming (the remedy) → producing (health)

Because Ayurveda is a medical practice that invokes clinical, religious and humoral frameworks, any one aspect of it is more than the sum of its parts. Jayesh reflected on the cosmology of Ayurveda and the challenges it provided for marketers who may, for instance, wish to promote the herb *bel* which is useful in a palliative sense as a laxative and purgative. Yet, *bel* was also of great religious significance and used in ritual offerings to the Hindu god: its cooling effect is believed to soothe Shiva's fiery temper (December, 2, 2004). This makes it difficult to establish it on terms of exchange that are fully commensurable in the formal market which may classify the workings of *bel* in relation to its therapeutic properties as determined by biomedically-derived measures of legitimacy such as clinical trials.

Francis Zimmerman (1987), structuralist anthropologist who specialized in Sanskrit epistemologies and Ayurvedic texts, best elucidated on this type of a cosmological outlook of Ayurveda in his monograph, *The Jungle and Aroma of Meats: an Ecological Theme in Hindu Medicine*. He showed how the classification of Ayurvedic medicine as outlined in classic texts such as the *Caraka Samhita* and *Susruta Samhita* upheld Hindu philosophical tenets which did not require distinctions between the profane and sacred. For instance, food was understood as part of the chain of living, where all living things ate one another (i.e. humans ate animals who are plants) for their survival and sustenance. This was a quite straightforward understanding of the life cycle. Zimmerman explained what food allowed humans to *do*, and also what humans needed to do *to* food. For Hindus, Zimmerman stated, “food is the basis for all human activities, not only those leading to prosperity... but also those leading to heaven” (p.205). By this he meant that Ayurveda made a person healthy so that they could achieve the four goals of life (*purusharthas*): desire, *artha* [material prosperity], *dharma* [social and cosmological harmony], and deliverance (p.205). As well, it referred to the sacrifices that one needed to make to living things such as *bel*, which were conducted regularly throughout one’s life stages. In Hindu thought, food was a powerful vehicle that expressed relationships through eating and sacrifice, on earth and in heaven.

In contemporary usage, the multiple properties of *bel* can lead to discrepancies of value in exchanges between producer and consumer who invest it with different meanings. Appadurai states that every commodity exchange is negotiated within different regimes of value – this term does not refer to value *coherence*, but to the *discrepancies* of value amidst different levels of exchanges and types of commodities (1986, p.15). And these discrepancies in the Indian context produce negotiations that were never, in my experience, set in their outcomes.

When one reflects on Appadurai’s important observation about the difficulty in distinguishing between gifts and commodities, Ayurvedic medicine presents itself as a strange kind of commodity and strange kind of gift. It stands between the two categories and this is I think what Appadurai is trying to get at: this in-betweenness is productive of a constant negotiation of sociality. It is part and parcel of what makes studying

consumption in India so complex. As a mode of exchange, consumption can sometimes be a fraught process in its attempts to tame unwieldy objects that exceed or surpass their stated qualities. Even things as seemingly simple as breakfast cereal or a medical system are not simply one thing or another, they are cause for social interaction and negotiation.

### **3.8. Conclusion**

This chapter portrayed neoliberalism, middle class, and Ayurveda as formations emerging from historically-contingent circumstances, which are constantly remade as new participants negotiate their place in these projects. Ayurveda is a productive device to examine the breadth of consumption options in the formal market as it invokes – as resolves – a comprehensive range of bodily-based needs from the purchase of daily tonics, the prescription of medicine, clinical visits, and dietary guidelines for oneself or one’s kinfolk. The ethnographic examination of consumption after purchase reveals it to be an intricate meaning-making process which expresses social roles, patterns of exchange, and relationships of caregiving amongst the middle-class. The “pre-purchase” and “post-purchase” lives of pharmacological and therapeutic repertoires of health are elaborated further in my chapters on the household, clinics and public expositions (Ch 6-8).

## 4. Introducing Ayurveda

This chapter traces the emergence of Ayurveda as a medical system in the twentieth century and its ‘on the ground’ practice by practitioners and patients. These historical and anthropological perspectives show how Ayurveda was used as tool for asserting cultural and medical authority and challenges presumptions about what is a medical system.

The many centuries of intellectual interest in Ayurvedic medicines, from scholars such as colonial scientists, indigenous practitioners, historians, philosophers, and social scientists makes it difficult to provide a straightforward overview of this medical practice. The reader is invited to turn to the chapters of a recently edited volume, *Modern and Global Ayurveda: Pluralism and Paradigms* (Wujastyk & Smith, 2008) so they may appreciate the diverse formations that Ayurveda may take and the different scholarly interests it invokes. These chapters are written by authors from diverse disciplines on topics such as, “The evolution of Indian government policy on Ayurveda in the twentieth century” (Wujastyk, 2008), “Ayurveda and the making of the urban middle class in north India, 1900-1945” (Berger, 2008), “Ayurveda and sexuality: sex therapy and the ‘paradox of virility’” (Alter, 2008) and, “Practicing Ayurveda in the western world: a case study from Germany” (Chopra, 2008).

The introductory chapter of this book attempted to distinguish “modern” from “global” Ayurveda, with the former referring to its practice within India from the time of its institutionalisation around independence, in 1947 to the present day, and the latter referring to its practice outside India (Smith & Wujastyk, 2008). The authors acknowledged, however, that the exchange of ideas which had taken place between India and the world via trade, travel, and colonialism over the centuries, prevented salient distinctions between “modern” and “global” Ayurveda being made. The difficulty in parsing out a taxonomy within Ayurveda was shown again in another chapter, “Cultural Loss and Remembrance in Contemporary Ayurvedic Medical Practice” (Tirodkar, 2008),

which began with a discussion of the types of Ayurvedic practice found in Pune, a mid-sized Indian city, as “traditional, modern, commercial, and self-help”, before the author admitted to their significant overlap.

Jean Langford explored the various permutations of Ayurveda by adopting a post-structural perspective and investigated how practitioners reworked medical knowledge in her book, *Fluent Bodies: Ayurvedic Remedies for Postcolonial Imbalance* (2003). She was not concerned to trace how practitioners “deviated” from official renditions of Ayurveda and asserted that institutional medical knowledge was not a stable entity. Certainly Ayurvedic practitioners were experts, but their medical authority was not based on any one authoritative source of knowledge. Even the classic Ayurvedic texts, *Charaka Samhita*, were better understood as compendiums or commentary on health and illness, rather than an exhaustive repository. Moreover, the texts themselves had been reworked to remove all traces of superstition and religion, first by British Orientalist and then Indian medical practitioners in accordance to their ideas of what a medical system should be. As well, official medical colleges offered degrees in Ayurvedic medicine but taught a curriculum which approximated biomedicine, as I will discuss further below. Expertise in Ayurveda was not a self-evident measure. Contemporary practitioners of Ayurveda were in dialogue with India’s legacy of colonial encounters and Langford examined what was at stake as they articulated their claims of “true essence” or culturally distinct qualities of Ayurveda while asserting its relevance for modern times. These practitioners worked in modern institutional settings such as colleges and clinics and thus had a large audience to respond to: local patients, foreign tourists, large-scale manufacturers, and government bodies - and the anthropologist herself.

Structuralist anthropologist Francis Zimmerman best elucidated the spirit of reasoning and cultural relativism that should guide the study of medical systems with his monograph, *The Jungle and Aroma of Meats: an Ecological Theme in Hindu Medicine* (1987). This treatise on the dialectical relationship between humans and the environment illuminated the multi-faceted and integrated reasoning, which is apparent in ancient Ayurvedic texts, but difficult for a novice reader to decipher and interpret. The central theme in his book is landscape, particularly the *jangala*, or jungle. The schema, of the

jangala, connects land, plants, animals and people and reveals probable health conditions amongst its inhabitants, and guidelines for recourse.

Jangala, the free, flat place characterized by sparsely scattered or rare thorny shrubs, a scarcity of water, rains, running water and wells, the heat and harshness of winds... the bodies of its men are thought and dry, disorders of wind and bile predominate. (1987, p.26).

Each living thing possesses pharmacological qualities, oftentimes by virtue of its location. And so herbs, plants, or meat from a drying place such as jangala may be prescribed as an antidote for patients from marshy lands (*anupa*), who suffer from too much phlegm or moisture. Zimmerman mapped the esoteric logic of Ayurveda where all metaphors were therapeutically efficacious. He lamented that scholars were removing the “mythical dimension” in class texts in their quest to legitimise Ayurveda as a modern science (1987, p.209).<sup>22</sup>

#### **4.1. Basic Principles**

“Ayurveda” is of word Sanskrit origins and can be broken down into: *ayus* = life, *vid* = knowledge. It is often translated into “knowledge of life” or more recently, “science of life” (Langford, 2002, p 4). The tenets of Ayurveda are rooted in Hindu philosophy and its workings were first documented in a classic Hindu text entitled *Atharva-Veda* in 1000 BC as a form of magic. The *Mahabharata*, a Hindu epic written around 400 CE, describes Ayurveda as a medical practice (Wujastyk & Smith, 2008). Ayurveda was explicitly elaborated as a form of treatment in 200 BCE in two central texts: the *Charaka Samhita* and *Sushruta Samhita*, which described its eight branches that ranged from general medicine to specialties including *Kaya Chikilsa* (General Medicine); *Shalya* (Surgery); *Shalakya* (Ear, Nose, and Throat and Ophthalmology); *Graha*

<sup>22</sup> In another example, Harish Naraindas (2006) described how the condition ‘*prameha*’, which has 20 different forms and for which there is no biomedical equivalent, is re-worked into “diabetes” in an English translation of this text (p.2668).

(Psychotherapy); *Damshitra* (Toxicology); *Bala* (Pediatrics and Gynecology); *Jara* (Rejuvenation) and *Vrishya* (Aphrodisiacs).<sup>23</sup> These classical texts remain relevant to this day and provide extensive guidance on many aspects of treatment, including the nature of disease and clinical methods of patient examination, diagnosis, and pharmacology, which form part of the curriculum of Ayurvedic colleges in India. Ayurvedic treatment assists in maintaining the balance of *doshas* through dietary guidelines, purification treatments, guidance in lifestyle choices such as exercise, and of course its extensive *materia medica* which encompasses herbs, spices, metals, minerals and more importantly, also food (Dash, 2002). *Charaka Samhita* provides detailed instruction on the harvesting, preparation, and effects of these therapeutic substances for conditions ranging from tumours to abscesses to excessive bleeding.

In Ayurveda, all creation in the world is comprised of five elements: air, water, fire, earth, and ether. People's constitutions were made up of combinations of these elements, known as *doshas*, or "vital forces" (Warrier et al, 2001, p.32). They are made manifest in three forms: *vata* (air), *pitta* (fire), and *kapha* (earth) and influenced the physical and emotional make up of a person and their tendencies towards certain ailments.

Another Ayurvedic text described *doshas* as "invisible forces that can be demonstrated in the body only by inference" (Svoboda, 1992, p. 52).<sup>24</sup> They were associated with a wide variety of physical and mental states that an expert Ayurvedic practitioner could decipher:

Vata's abnormal functions include, but are not limited to, impairment of strength, complexion and well-being; disturbance of the mind and senses; deformation of the foetus; production of fear, grief, stupefaction, depression and delirium; and obstruction of the vital functions. Normal pitta causes digestion, vision, normal body temperature, body luster,

<sup>23</sup> While these categories are based in the classic texts, Naraindas (2006) points out that as these works have been translated in English, they are implicated into biomedical points of reference.

<sup>24</sup> Langford, in her study of the construction of Ayurvedic knowledge in contemporary clinical settings, spent months studying conceptualization of "*doshas*" which were invoked in particular ways according to the clinical setting and practitioner.

courage, intelligence, lucidity and the like, while abnormal pitta results in the opposite of all these. Normal kapha creates compactness, cohesion, firmness, plumpness, strength, virility, knowledge, understanding, forgiveness, fortitude and the like, and abnormal kapha produces their opposites. (Svoboda, 1992, p.56)

In Ayurveda, the body was “composed of fluids, saps, essences, humors, and elements that ebb and flow in a constant process of dynamic interaction” within and around the person (Alter, 1999, p.S46). Zimmerman (1987) stated that Ayurvedic practitioners traditionally could not locally examine a disease within a body, as surgery was not a significant part of its repertoire (despite it being part of one of the eight branches mentioned above). The practitioner instead,

was less concerned to recognize the nature of a disease than to foresee its development, taking into consideration the most general conditions of life: climate, seasons, customs, postures. Ecology was an integral part of this practical context. (p.20)

For instance, a pulse may “slither... under the fingers like a leech or a snake [or]... bounce under the fingers like a hopping sparrow, crow, or frog [or]... swim under the fingers like a swan”, depending on the person’s dosha (Svoboda, 1992, p.179). This diagnostic method helps explain some of the metaphors and patterns of movement in Ayurvedic treatment in relation to the environment.

## **4.2. Nationalist Liberation and the Emergence of India’s Indigenous Medical Systems**

This section reviews the literature on Ayurveda and colonial rule and foregrounds the many complexities involved in the process of rationalizing Ayurveda into a clearly-demarcated medical system by both colonial scientists and, later, indigenous practitioners.

Nineteenth century colonial scientists were interested in Indian systems of medicine and local illnesses so that they could advance their Orientalist scholarship and

also for the more pragmatic reasons of building up knowledge about treatment on local remedies or substitutes for medical substances that could not be sourced from their home countries for the English who would be stationed in India on a long-term basis (Arnold, 1993, p.44). Up until the mid-nineteenth century, many etiological principles were shared between Western medicine and Ayurveda. For instance, they both attributed great importance to the environment and shared the belief that that imbalance of humours influenced health and illness (Arnold 1993). Naraindas' (2006) analysis of an eighteenth century British text on smallpox treatment remarks on this aspect of shared epistemologies: "there is none of the anguish of translatability that comes from any felt notion of incommensurability" (cited in Banerjee, 2009, p.35). A spirit of exchange initially characterized encounters between medical systems.

Arnold remarked that by the 1850s, as the political authority of Western medicine grew, it began to separate itself from the humoral framework that had once served to make easy connections with Indian medical systems possible (1993, p.52-53). The colonial medical administration condemned the principles of indigenous medicine which referred to more invisible and amorphous processes such as humours as not only unscientific but also superstitious, dangerous, and harmful in contrast to the "rationality and clinical objectivity" of Western medicine. This reasoning set the tone for justification of the use of Western medicine on Indian bodies. While colonial physicians consulted the *materia medica* of Ayurveda for research purposes, they considered it valuable only to the extent that it could be submitted to their scientific categories of Western medicine: "in using 'scientific' methods to reorder Indian nature, colonial medicine simultaneously held up the value of Indian botanical material while denigrating the systems that had traditionally organized this knowledge" (Berger, 2008, p.102-103). However, subsequent developments in advancements in Western medicine such as the development of the germ theory and a "scientific pharmacology" shifted the concern away from the collecting of *materia medica* and further undermined the possible contributions that indigenous medicinal systems like Ayurveda could make (Arnold, 2006, p.69).

Ayurveda was included as part of medical training initiated by the *Indian Medical Service* (part of the British military medical service) that established schools in major

colonial cities such as Bombay and Calcutta to create native doctors as British physicians were becoming too costly to maintain.<sup>25</sup> While the curriculum was based on Western medicine, instruction was provided on indigenous medical systems such as Ayurveda and *Unani* with the expectation that this would win over the traditional practitioners to Western medicine – the British expected that its superiority would be made self-evident (Arnold, 2006, p.61-62). The institutions were not successful in their attempts to teach multiple medical systems and closed after a few years. They re-opened in 1835 following recommendations from the Governor General of India, Lord Bentinck, to orient the training of students in line with official needs of the British administration with the exclusive teaching of Western medicine, in English. By the closing decades of the nineteenth century, any acknowledgment of indigenous medicine by medical authorities greatly depended on the degree it could be appropriated into the colonial project of expansion of Western medicine.

Western medicine was held up as the definitive medical option for the nation, which could only be learnt only through specific British-administered channels. Health care increasingly became regulated by colonial rule, as evidenced by the passing of the Indian Medical (Bogus Degree) Bill in 1915, which prevented unqualified practitioners from assuming medical titles of officially recognised institutions and fined anyone falsely claiming to be a Western medical practitioner. Indigenous medicine was not even discussed as a candidate for medical science (Berger, 2008, p.103).

The “cumulative [and successful] effect of state medicine and public health on the major towns and cities” provided biomedicine with added prestige and relevance to the Indians, particularly the elites (Arnold, 1993, p.241). According to Arnold, a medical practice that had “once been the hallmark of an alien presence was fast becoming part of India’s own ideology and leadership” (p.288). By the beginning of the twentieth century, the tenets of indigenous medical practices such as Ayurveda began to be significantly

<sup>25</sup> Bombay and Calcutta were colonial names for the cities which are now Indianized to Mumbai and Kolkata, respectively.

challenged by Indian-trained biomedical doctors whose numbers had been steadily increasing.

Indian nationalists defended and supported Ayurveda as the most suitable medical system for Indian bodies in the early decades of the twentieth century. Ayurvedic practitioners eventually joined this movement of cultural revivalism and began to form national and regional associations and published literature such as monthly journals (Leslie, 1978). They obtained support from the nationalist movement and this helped to establish colleges and hospitals for Ayurveda, *Unani*, and *Siddha* medicine (Leslie, 1976, p.363).

The malleability of Ayurveda was made evident with the many debates it inspired. For much of the twentieth century, the basis of Ayurveda's legitimacy was repeatedly contested as it could be used to invoke both an Indian and "modern" or scientific identity with arguments such as, "native medical science should be re-examined and revised in light of Western science" articulated by one Ayurvedic practitioner (cited in Leslie, 1978).

The Bhore Committee, a group mainly comprised of physicians from British State Medicine set up by Sir Joseph Bhore, a senior government figure in 1943, was influential in creating recommendations for the Indian Public Health System, which undermined the principles of Ayurveda. The committee's pro-biomedicine stance was made clear with their marked bewilderment and disparagement of indigenous medicine: "We realize the hold that these systems exercise not merely over the illiterate masses but over considerable sections of the intelligentsia" (cited in Wujastyk, 2008, p.54). Although indigenous medicine was never heavily valorised in the political sphere, it was not easily disregarded and remained relevant for many citizens. Many proponents for Ayurvedic and *Unani* medicine were urban middle-class practitioners who sought to legitimise and professionalise this medical practice alongside the same parameters as biomedical treatment so that they could be considered doctors and develop their careers (Leslie, 1978). Ayurvedic practitioners, for instance, could be assured of employment as their services were cheaper than biomedical treatment (Berger, 2008). The efforts of such

indigenous practitioners led to the current-day formation of Ayurveda and *Unani* as a medical system integrated with biomedical principles.

The Chopra Report, released five years later, was somewhat more sympathetic to indigenous medicine. It called for the study of the achievements and decline of Ayurveda and *Unani* with the expectation such this would yield a synthesis between indigenous and biomedicine. It also proposed an equal valorisation and recognition of the Ayurveda, *Unani*, and biomedical training. The report was rejected by the Indian government and a number of committees formed in the 1950s to evaluate and re-assess key issues. The Dave Report (1956) and Udupa Report (1959) recommend integrated training for indigenous practitioners whereas the Mudaliar Report (1962) suggested that indigenous medicine be taught according to classical form, in appropriate language (i.e. Sanskrit for Ayurveda, Arabic for *Unani*) and focus on original medical texts. These recommendations proved influential and laid the framework for the Central Council for Research in Indian Medicine and Homeopathy established in 1969 (Wujastyk, 2008).<sup>26</sup>

Brass (1972) traced the relationship between major developments in Ayurveda and the extent to which its practitioners could apply political pressure and mobilise sympathetic figures in the government. For instance, the central government eventually lent support to *shuddha* Ayurveda, a version which does not follow any biomedical points of reference, after having achieved the backing of a few key central ministers which relied on a nationalist sentiment: “Ayurveda is essentially a part of our ancient culture and our rich heritage. It is a way of life” (Vyas cited in Brass, 1972, p.367). However, this was a short-lived victory and official recognition of Ayurveda on a national level by the state would ultimately depend on the extent to which it could be adapted to biomedical parameters (p.364).

In this setting, Ayurveda itself is also a malleable medical practice. And its claims to its legitimacy by the Indian government in the twentieth century have resulted in an

<sup>26</sup> This council was divided into four units in 1978 to form the Central Council for Research in Ayurveda and Siddha (CCRAS), Central Council for Research in Unani (CCRUM), Central Council for Research in Homeopathy (CCRH), and Central Council for Research in Yoga and Naturopathy (CCRYN).

officially-recognised Ayurveda that incorporates biomedical principles. Practitioners who have received training from India's medical colleges graduate with a Bachelor's of Ayurvedic Medicine and Surgery degree (BAMS). Yet, there are also non-officially recognised practitioners who have received apprenticeship-type training from a mentor, likely a family member. They too can lay claim to the title of Ayurvedic practitioner.<sup>27</sup> Prior to the institutionalisation by the state, which began in the 1920s, Ayurveda was not a medical "system" readily distinguishable from other traditional medical repertoires embedded in particular localities (Berger 2008). The national standardisation of Ayurveda and its creation as a medical "system" is a recent phase in its thousand-year-old history. Thus, while a patient can see a practitioner with a BAMS degree, the informal health sector of India is host to practitioners wielding different types of expertise and remains an important resource for health seekers.

India's long history of colonial rule has rendered biomedicine as the most prestigious medical system in India. However, indigenous or alternative medical systems are also recognised by the state as a result of the debates described above. The Ministry for Health and Family Welfare runs the Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy (AYUSH) department, which is responsible for the regulation of officially-recognised indigenous medical systems (AYUSH Background, 2010). I will conclude this section by giving a short overview to the basic concepts of these medical systems.

*Unani* is a medical tradition based on the teachings of Hippocrates, which spread throughout North Africa and the Middle East before it was introduced in India by Arab traders in the 1300s (Leslie, 1976). Its patronage by royalty in South Asia gave it a high profile until it was suppressed by British rule. In the *Unani* worldview, the body is made up of four humours, blood, phlegm, yellow bile, and black bile, which must be kept in balance. Diagnosis takes place via three-fingered examination of a person's pulse and treatment is prescribed according to the humoral constitution of a person (Leslie, 1976).

<sup>27</sup> Prior to state-backed training from medical colleges, Ayurveda was often transmitted down a family lineage. Even today, many professional practitioners come from a family lineage.

*Siddha* medicine is practiced predominantly in South India and shares the same principles of balance as Ayurveda and *Unani*: the body is believed to be made of three humors, *vata*, *pitta*, and *kapha*, which, if imbalanced, can lead to illness. Treatment for many ailments is based on herbal remedies and dietary guidelines (AYUSH Siddha, 2010) as well the consumption of formulations that contain metals such as gold, silver, and mercury.

Yoga is a therapeutic practice made up of postures, mantras, and meditation to bring about balance and harmony, which leads to a healthy mind and body. The AYUSH department places it with Naturopathic sciences with courses that can be taken in medical colleges or universities (AYUSH Education in Naturopathy, 2010).

Naturopathy, like yoga, is a non-drug therapeutic practice which is based on the notion that cure can be found in the five elements of earth, air, fire, water, space. The body, as a product of these elements is potentially capable of healing itself. The exposure to these five elements creates for treatment via hydrotherapy consisting of immersion or exposure to water, mud therapy, sun therapy and dietary changes such as fasting (AYUSH Education in Naturopathy, 2010). Mahatma Gandhi, one of the leaders of India's national liberation movement, was an avid follower of naturopathy, which he considered as a suitable and accessible practice for the Indian population as opposed to biomedicine, which was introduced via colonial rule (Alter, 2000).

Homeopathic medicine originates from Germany and was brought to India in 1839 by a Romanian traveler, Dr. John Martin Honigberger, who learnt it from one of its founders, Dr. Hahnemann (Sarkar, 2008). It operates on the principal of "like cures like" with symptoms of disease induced and expressed to provide cure, rather than being suppressed. If a patient has a cold, for instance, homeopathic treatment can consist of medications, which lead to increased sneezing, throat and nasal discharge to bring about cure. Homeopathy became popular in India following its positive results amongst a selection of high-profile patients. The king of the north western city of Lahore requested homeopathic treatment for his horses and then was so impressed by the results that he used it on himself and it cured paralysis of his vocal cords (Sarkar, 2008). Other members

of royalty and colonial officials utilised homeopathy for cholera, malaria and the plague (Frank & Ecks, 2004). These positive results, along with its low costs, made it popular and homeopathic professional organisations were formed in the city of Kolkata in the 1930s. It acquired official recognition by the Indian government in 1973 (Ecks, 2004).

In addition to these officially-recognised systems, an array of healing practices, such as those related to spirit possession, witchcraft, shamanism, astrology, and herbology form part of India's therapeutic landscape. While these "little traditions" are not officially recognised by the state in contrast to the "big traditions" of Ayurveda and Unani, they form part of the inventory of folk healing practices and intersect with medical systems described above (Halliburton, 2009; Khare, 1996; Lambert, 1992; Langford, 2002, p.16).

Colonialism brought Ayurveda into a politics of modernity as nationalists mobilized Ayurveda as a symbol of cultural revivalism. The terms by which Ayurveda could be legitimized as a medical system were never conclusive. What was at stake here? It seems that the debates were not only about whether Ayurveda should be in accordance to the Sanskrit epistemologies (upon which its texts are based) or biomedical points of reference. They were also over questions of a far more fundamental importance; "What is Ayurveda?" and, underlying this, "What is a medical system?".

### **4.3. Medical Pluralism: Perspectives from 'on the ground'**

In the mid-1970s, social scientists began to examine the practice of South Asian medical systems in a more concerted manner and elaborated the 'on the ground' perspectives from patients and practitioners (Leslie, 1976; Leslie, 1978; Taylor 1976). These empirical studies enabled alternative ways of thinking about health care and society, and helped counter the prevalent notion that a single standardised medical system (i.e. allopathy in America) was the best way to structure treatment for a population. Charles Leslie, the pioneer of medical pluralism studies in South Asia, showed that health care could be effectively carried out in a setting with multiple therapeutic options such as

Ayurveda, Unani, homeopathy and allopathy (1976). Anthropologists pointed out the many ways this diverged from the real-life practice of Ayurveda. One, it ignored the medical exchanges which took place between Ayurveda and Unani practitioners, for instance, which created a *syncretic* medical tradition. Two, these studies did not take into account the significant transformations which had taken place with indigenous medicine as its practitioners struggled to assert them as legitimate medical systems. No less importantly, there was the gamut of informal therapeutic options provided by bone-setters, midwives, and shamans from a locality's popular health culture which health seekers used along with Ayurveda (Leslie, 1976, p.359).

However, South Asia is not the only medically pluralist setting. Around the same time that Charles Leslie was examining medical pluralism in India, Arthur Kleinman (1980) produced an important piece on the patterns of resort amongst health care seekers in Taiwan and United States. This work investigated the health seekers' usage of official medical systems such as Traditional Chinese Medicine and allopathy, and also included an assemblage of unofficial healers such as herbalists, bone-setters, and shamans.

Scholars of Latin America have produced many compelling studies of medical pluralism. Pioneering medical anthropologist George Foster (1987) analysed processes of acculturation in 1949-1950 by investigating the influence of Spanish culture on Latin America. Foster's study of Mexico's health care systems traced the Galenic origins of humoral hot-cold dichotomies amongst the country's mestizo and creole population. This supported his hypothesis of a long history of exchange and diffusion of medical knowledge rather than the notion of multiple origins of humoral medicine (p.358). Libbet Crandon-Malamun (1993) was another Latin American scholar who was interested in medical pluralism. This anthropologist explored the role of medical diagnosis in articulating ethnic identities and class relations amongst different social groups (traditional Aymara peasants, Aymara Methodists, and mestizos) residing in a Bolivian town.

These works provide valuable insight into a community's local worldviews and beliefs, evaluation of therapy and treatment, and patterns of hierarchy and power. Such

processes are configured differently in any given social setting. I thus limit my discussion of Ayurveda as a therapeutic option in India's medically pluralist setting as its contemporary practice is inflected by unique historical circumstances related to centuries of exchange and collaboration between medical practitioners near and far and colonial rule.

So long as humans have travelled and immigrated, they have encountered and integrated new ideas and cultural practices as they see fit. Anthropological works, such as David Mandelbaum's *Society in India* (1970) do portray the exchange of cultural resources and interplay between different systems of meaning from the perspective of its adherents. Mandelbaum explored this type of syncretism by discussing the religious traditions of India's Jewish and Christian inhabitants and their eventual accommodation of India's caste structures over the centuries.<sup>28</sup>

Therapeutic and pharmacological repertoires are one such resource and have been exchanged for many centuries in India. Prior to the emergence of the sub-field of medical pluralism, indigenous practices such as Ayurveda and Unani were studied by historians and Indologists who concentrated on their textual components. Historian A.L. Basham (1976) states that Persian emperor, Khusrau Anusharvan (A.D. 531), brought medical texts back to his country after visiting India, which were then used by physicians who practiced at renowned medical school in Persia. Indian doctors, too, were mobile and were known to settle and practice in Baghdad and Persia around the eight century (p.39). Moreover, the movement of medical resources was not one-sided: Arabic medical traditions, such as Unani, which originated in Greece, were practiced in India following the migration of practitioners and patients. Unani medicine was transformed in this new setting. Its herbal and mineral repertoire had to adjusted to accommodate the resources of

<sup>28</sup> Even an anthropologist such as GM Carstairs, who studied Hindu Rajput masculinity, was only able to access localities free from "modern influence" by deliberately seeking out places which were not near railways and without overly-developed technological infrastructure such as electric lights and factory (1961, p.13).

India. As well, many Unani practitioners opened hospitals, and often had Hindu Ayurvedic doctors as staff who practiced alongside so that upper-caste Hindu patients would visit (p.40).

William Wiser & Charlotte Wiser (2000) wrote a classic account of village life in North India (Karimpur, Uttar Pradesh) and transformations that took place between 1931 and 1961. Their work includes brief discussions of health care practices. In Karimpur, the local healers were called *hakims*, who were informal practitioners of Unani medicine. Allopathy, too, was practiced, as the decades went on. The Wisers remarked on the persistence of *hakims* as patients preferred to consult both allopathic and Unani healers (p.249). Some *hakims* had an interest in allopathy and would observe the Wisers as they dispensed basic medicines and remedies in their clinic. One healer even brought patients to the Wisers and voiced his own ideas for treatment during the visit. The Wisers theorised this interest to be based on the pragmatic reasoning that if “if there are two kinds of treatment, chances of cure must be twice as great” (p.36). As we can see, even before the term “medical pluralism” had been coined by anthropologists, collaboration and exchange of medical knowledge along with assurance of patronage has been a concern for practitioners and patients for many centuries.

Taylor (1976) along with Leslie (1976,1978) observed that distinctions between Ayurveda and allopathy were not so clearly-delineated as one might have presumed from official rhetoric. He participated in health projects in the early 1970s relating to rural medical care and health centre services and found that “indigenous practitioners” rarely used the expected corresponding “indigenous medicine” (p.287): an Ayurvedic practitioner could routinely dispense biomedical injections or antibiotics recommended by pharmacists for common ailments such as fevers or headaches. In other words, there was no guarantee of an Ayurvedic doctor providing Ayurvedic medicines. Medical pluralism scholars demonstrated that the circulation of medical knowledge could be shaped by powerful ideologies such as colonialism and allopathy. However, their empirical analysis also showed that everyday practice of Ayurveda was inflected by local understandings about health, the body, and the world.

The overview of medical pluralism works I provide below show that “the health care system is not a set structure to be used, but a dynamic that is negotiated and mediated by all the actors: patients, practitioners, and officials alike” (Nichter & Nordstrom, 1988, p. 488). This assertion resonates with my conceptualisation of the medical marketplace as a system of interactions of the formal and informal sectors conducted by networks of practitioners, entrepreneurs, and consumers. The work on medical pluralism in India took seriously the spectrum of experts who enact Ayurveda such as professionally-trained *vaid*s along with folk healers. More importantly, it did not denigrate informal practitioners as ‘quacks’ and so on. Rather, these studies acknowledged how legitimacy and trust were established for informal practitioners as “locally situated [and accountable] social actors... [who are] entwined in binding relationships” (Cross & Macgregor, 2010, p.1596).

The medical pluralism literature did not portray Ayurveda as “an applied science” based on “logically-formulated [and] linguistically-encoded knowledge” (Pfaffenberger, 1992, p.508). Rather its scholars showed the interactions which took place in the clinic and depicted Ayurveda as a sociotechnical system: “as a domain of purposive, goal-oriented action in which knowledge and behaviour are reciprocally constituted by social, individual, and material phenomena” (Pfaffenberger, 1992, p.508). In this framework, patients are not passively receiving treatment, rather they navigate the medical marketplace and create assemblages of “health-making” practices. This carries significant implications for thinking about *medical expertise* as the practitioner and patient engage in a creative and meaning-making dialogue.

Margaret Trawick examined how worldviews and epistemological frameworks created Ayurveda as a useful platform for health practices. She investigated the healing practices of an Ayurvedic practitioner, Mahadeva Iyer, in South India to illustrate the open-ended and flexible nature of Ayurvedic cosmology that characterises phenomenon as a unified whole, with eventual disintegration taking place through the passage of time (1987, p.1036). This framework allowed him to encompass contemporary diseases such as cancer into his treatment. Such a disease was not considered contradictory to the principles of Ayurveda, rather its etiology and symptoms were assimilated into

Ayurvedic theories of imbalance and excess within the body. Trawick used this study to respond against an influential essay by Robin Horton, “African Traditional Thought and Western Science” (1967) who argued that traditional systems of thought are inherently closed or conservative because they were oriented to the past compared to scientific thought in the modern world, which is oriented to the future. For the Ayurvedic practitioner Mahadeva Iyer, “seemingly unconnected phenomena that one has apprehended in the present could be seen to be converge upon a single source if one traced them far enough” (p.1036).<sup>29</sup> The past-oriented nature of Ayurvedic thought allowed practitioners to encompass a wide variety of non-native phenomenon, such as cancer.

Lorna Rhodes (1980) examined patient trajectories carried out in the medically pluralist settings of Sri Lanka to argue that the presence of heterogeneous medical systems did not necessarily make for a competitive health care arena (see also Khare, 1996). Rhodes provided an account of Kusuma, a young female patient with a long health trajectory that included visits to an Ayurvedic practitioner, a psychiatrist, and an exorcist in search for resolution of her ailment. Various practitioners related the idiosyncrasies of the patient’s personal conditions and generalised them to a widely understandable “public idiom of cultural symbols” (p.72). The resulting aetiologies included cosmological, moral, humoral components which were “held simultaneously and without apparent discomfort” (p.81-82) by patients and practitioners. For Kusuma, each medical intervention built on the previous and made for a cumulative experience of health care. The diagnoses were “minimised and juxtaposed with the others so that [they] [took] a place in a system of multiple explanations” (p. 85). The diagnoses were not simple taxonomies that the patient matched to her symptoms, rather they produced networks of meanings, which dynamically interact and overlap. “The patient collecting these ‘puzzle pieces’ finds them useful...because they provide a number of ... interconnected... perspectives” (p. 89). Health seekers in India could easily integrate or reconcile ways of knowing that might otherwise be considered contradictory or competitive.

<sup>29</sup> In Ayurvedic thought, the universe tends towards disintegration as time goes on (Trawick 1987).

Analysts have stressed that local understandings create the body as a coalescence of an array of material, spiritual, environmental influences with no one medical intervention considered sufficient enough to address all these dimensions (Nordstrom 1988). Rhodes (1980), in her article, “Movement Among Healers in Sri Lanka: A Case Study of Sinhalese Patient,” emphasises the importance of shared, yet open-ended, cultural symbols that resonate across different medical settings in a particular locale. The concept of “excess”, for instance, holds great significance in Sri Lankan Buddhist society as it refers to certain moral and spiritual sensibilities and can be invoked across both the social and the medical spectrum from Ayurvedic practitioners and hospital wards to explain certain illnesses.

Nichter and Nordstrom (1988) argued that the explanations offered by, say, Ayurvedic medical systems provide therapeutic value because they were multi-dimensional and related to different facets of a patient’s lived-experience and were also open-ended enough so that patients could provide their stance to the diagnosis. The medical pluralist setting and the ambiguity of diagnoses were productive mechanisms for patients: “Multiplicity of interpretive systems increases ambiguity. Ambiguity may be preferable in the face of an uncertain and uncontrollable world; diversity may give strength” (Kundstadter cited in Nichter & Nordstrom, 1989, p.384). What may look like an incoherent health practice to an outsider can be an important resource for its patients.

Halliburton’s (2009) ethnography, *Mudpacks & Prozac: Experiencing Ayurvedic, Biomedical, & Religious Healing*, discussed patient’s experiences with Ayurvedic treatment for psychiatric issues in a medically pluralist setting. He acknowledged that Ayurveda was transmuting to a more gentle therapy so that its practitioners could differentiate themselves from allopathic treatment, reputed as being more invasive, with its injections and electroconvulsive therapy (p.34-35).

This work extended on how scholars theorised on embodiment by investigating how patients engaged with the aesthetic or sensorial components of Ayurvedic care. Treatment took place in formal settings such as clinics where patients receive weeks of *panchakarma treatment* that was comprised of “purgatives, enemas and nasally-

administrated medicines while on a special vegetarian diet”, which is followed by *talapodichil*, or a “cooling mudpack” treatment to the patients, an aesthetically pleasing and therapeutically efficacious process (p.173). Halliburton also investigated informal therapeutic milieus such as temples, mosques, and churches where patients could “sing, pray, dance... act out compulsive behaviours amidst music, pleasant smells, and scenic outdoor settings” (p.35) as a form of treatment.<sup>30</sup> Halliburton echoed Joseph Alter’s (1999) claim that health in Ayurveda needs to be re-thought as it refers to much more than remedial aims or the absence of disease, and indicates a general state of well-being that can be cultivated and continually enhanced. Health can be accessed by physically placing oneself in pleasant surroundings, such as temple gardens, and through religious or spiritual devotion, which offers the adherent a sense of integration, resolution, and totalisation.

Lambert (1992) remarked that the fixation of social scientists with codified medical practices likely had more to do with how this concept resonated with their idea of what medicine should be like rather than what was actually taking place ‘on the ground’. She maintained that there were health resources other than formalised medical practices which are compelling and relevant for people in a given setting and asserted, “the interpenetration of folk healing and the textually based (Brahmanic) medical and religious traditions” (p. 1070) needed to be considered.

The above accounts take Lambert’s points into account and trouble presumptions about ‘medicine’ or ‘health’ as much of the treatment described responded to broader ideas of the integration of a person in their body and social, physical and cosmological environment. Patients were not merely purchasing treatment from the clinic: they were also accessing cultural tools to interpret and act on the myriad of relationships taking place within and around their bodies.

Waldawsky-Berger (2012) claimed that sociotechnical systems were essentially people-oriented activities because they were designed, built, and managed by humans.

<sup>30</sup> Halliburton’s (2009) field research takes place in Kerala, a south Indian state which has a strong Ayurveda tradition and is also a religiously-pluralist setting.

The overview of the medical pluralism literature above corroborates this point by showing Ayurveda to be much more than a goods-based practice. Rather it is a dynamic exchange whereby patients purchase treatment, and also receive cultural tools such as symbols, parables, stories so that they can make meaning and move towards health. In these accounts, consumption of healthcare is portrayed as a process that precedes and follows monetary exchange: patients *consume* medical treatment from a practitioner, and then *produce* meaning about their condition.

#### **4.4. Conclusion**

As a long-established medical practice, Ayurveda can be enacted by a variety of experts to assert cultural or nationalist resilience and therapeutic efficacy. During the swadeshi movement, this medical practice was mobilized as a political and cultural tool when proponents declared Ayurveda as a traditional Indian practice. The ethnographic investigation of local medical practices depicted how official and informal practitioners integrated medical, bodily, and spiritual knowledge into their clinical practice.

The anthropological literature on Ayurveda and medical pluralism challenges conventionally-held notions about the boundaries of a medical system and expertise by discussing the diverse ways that medical authority may be showcased. The role of the patient is put to question as well as the ever-changing and unpredictable conditions of the body compel health-seekers to “shop around” for treatment. In such scenario, what is the role of patient-as-consumer in the medical marketplace? Patients, too, negotiated Ayurvedic treatment as a meaning-making practice to assemble health.

These questions regarding the basis of expertise, exchange, and consumption, show that there are a variety of producers and consumers who engage in health care practices and set the stage for my ethnographic study of Ayurveda in contemporary Delhi.

## **5. Translocal Enactments of Ayurveda in Delhi and Kerala**

This chapter introduces the different roles played by range of actors, such as patients, consumers, practitioners, and enterprises in enacting a certain configuration of health care practices, namely Kerala-based Ayurveda. The state of Kerala is the renowned birthplace of Ayurveda with much of its herbal repertoire and treatment protocols developing here.

Ayurveda may be considered India's definitive indigenous medical tradition, however, its usage varies regionally, and it exists alongside a variety of indigenous medical systems (for instance, Unani is more often resorted to in cities such as Delhi, Lucknow and Hyderabad with large Muslim populations, while homeopathy is a commonly used treatment in Kolkata). Ayurveda, too, is more popular in some regions than others, and the southern state of Kerala is reputed as its birthplace. Kerala is a tourist-friendly state, described as "God's own Country". In 2010, the state attracted 7.5 million domestic and almost 600 000 international visitors (The Hindu, para 1, 2010). Many of these visitors to Kerala engage in nature-oriented activities such as houseboat tours on its network of rivers, beaches along the Arabian sea, and hill stations with forests, tea, and spice plantations.

**Figure 5.1. Kerala, India**



*Note.* Wikipedia Commons, June 17, 2012.

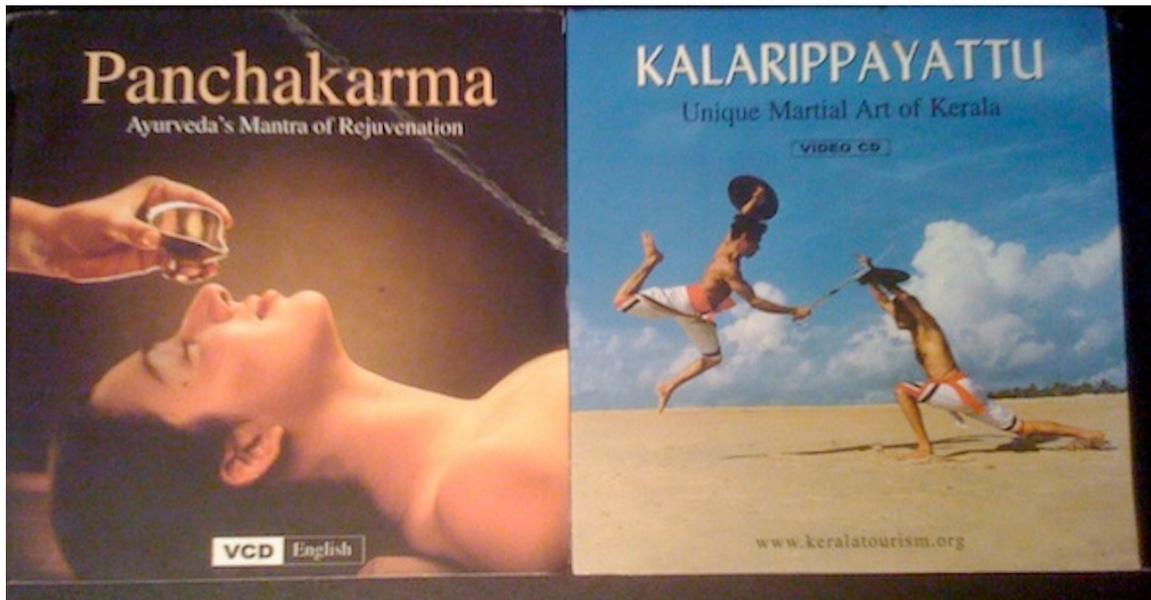
The advertisement below by India’s tourism board places Ayurveda in such an assemblage of nature-based activities,

Kerala's equable climate, natural abundance of forests (with a wealth of herbs and medicinal plants), and the cool monsoon season (June - November) are best suited for Ayurveda's curative and restorative packages. Kerala is the only State in India, which practises this system of medicine with absolute dedication. (Incredible India, para 3, 2009)

Kerala-based Ayurveda may be understood as an intensification of the processes of marketisation which propel the making of the “traditional medicine” industry today, in India and around the world. The extent to which Ayurveda was embedded into the more

commercial activities of Kerala was made clear during my visit to the Kerala Tourist Information office (in Delhi), towards the end of my fieldwork. I met with a tourism officer who provided helpful information and maps, and I was given a selection of promotional DVDs which depicted various cultural activities at the end of my visit. I walked away, imagining what a short holiday visit would be like as I sifted through the video compact discs on boat racing, martial arts, cooking - and Ayurveda.

**Figure 5.2.** *Kerala Tourism CDs*



*Note.* Invis Multimedia, 2002; with permission

This type of advertising is well positioned to capture the fantasies of both the India's urban middle-class who could imagine Kerala as a natural respite from their hurried lives, and of foreigners who could imagine it as an exotic cultural destination.

Kerala's reputation as the origins of Ayurveda is amplified in tourist materials by presentation of images of its verdant landscape, presumably replete with herbs, and of its Ayurvedic healers, who provide beneficial treatments. Marketers position this medical practice as a perfect antidote to the trials and tribulations of a fast-paced lifestyle. During my fieldwork, my Delhi informants would often ask why I was not doing my research in Kerala. This inquiry eventually led me to wonder whether Delhi was thought to host a

second-best, or muted, practice of Ayurveda. I eventually began to understand that the popularity of Kerala-based Ayurveda stemmed from its potential as a translocal practice, rather than its primordial origins: its reputation as a timeless and natural getaway was sustained via technologically-mediated means of production such as advertising.

One did not have to be in Kerala to partake in its medical legacy: Delhi, as India's capital and most prosperous city, is an exemplary site of convergence of medical professionals, entrepreneurs, and residents of Kerala. Ayurvedic practitioners from Kerala congregate in health care centres of India's major cities. Some work as general Ayurvedic practitioners (such as Dr. Nayar from Chapter 7) and others treated patients as in larger clinics as *panchakarma* specialists.<sup>31</sup> The fact that I did not have to be in Kerala in order to learn about it or to even access Keralites and their experiences of health care is indicative of the mobility and movement which characterizes the workings of the Indian economy its consumer health care culture. In India's neoliberal economy, Kerala is placed at the forefront of Ayurveda's production, through increased availability of services such as treatment, education, and tourism, which connects Ayurveda to cosmopolitan middle-class lifestyles.

## 5.1. Delhi as a Site of Convergence

Communications scholar Arun Saldhana has remarked, "through the mechanisms of colonialism, Third World cities were 'postmodern' and 'multicultural' long before migrations to the First World brought forth similar cultural differences there" (2010, p.338). Saldhana investigated how Indian youth translated tradition and created their

<sup>31</sup> Panchakarma is a specialised oil-based purification or rejuvenating treatment meaning "five actions" and is "divided into two sorts, according to whether it depletes the system (emesis, purgation, evacuative enema, evacuative nasal medication, blood-letting) or nourishes it (oily enema, nourishing nasal drops...)" (Svoboda, 1993, p.204). Panchakarma could assist with a range of health issues ranging from mental disorders to arthritis and paralysis (Halliburton, 2009). In Delhi, some Ayurvedic clinics were solely dedicated to panchakarma while larger Ayurvedic clinics or hospitals may have had a panchakarma unit on their premises. This treatment originated in Kerala and as my informant, Ramesh pointed out further along this chapter, while panchakarma was efficacious, it was also a rather demanding and gruelling treatment (June 2, 2006).

identities as global citizens through leisure practices such as going out to socialize and listening to music. His research took place in Bangalore, India's information technology hub, nicknamed Silicon Valley. However, as his quotation points out, Bangalore is not the only Indian city suited for the investigation of hybridity.

Delhi has been significantly transformed by the colonial presence of British rule, which established the city as the capital in 1911 and developed what is now considered the central Delhi area with government buildings, residences, and colonial-style shopping arcades (Favero, 2003). Since 1995, many major Indian cities began to undo some of the vestiges of colonial rule by reverting back to their non-Anglicized names: Delhi is now *Dilli*, Bombay is *Mumbai*, Calcutta is *Kolkata*, and Bangalore is *Bengaluru*. Nonetheless, prominent landmarks such as the Gateway of India which was built in Mumbai harbour to commemorate the visit of King George in 1911 or the British-styled city planning that features roundabouts leading to shopping districts named Connaught Place remain as quotidian reminders of the colonial empire (Dalrymple, 1994).

However, Delhi was a node for foreign influence long before British colonialism. This city was originally founded as a settlement in 300 BCE, and ruled by North Indian empires until around the 11<sup>th</sup> century. From that point onward, it acted as the capital for various Turkic, Central Asian, and Afghan emperors (most notably the Moghuls) until it became the capital of British India in 1911. The northern part of the city is known as Old Delhi and renowned for its forts and mosques which serve as reminders to its palimpsest of past emperors (Dalrymple, 1994).

Following India's independence in 1947, the southern part of Delhi was settled by a major wave of refugees from the newly-formed state of Pakistan following the Partition of India. Many of the city's residents in this area continue to be those who arrived because of Partition. The next major wave of migration took place after India's transition to neoliberalism with the expansion of Delhi's economy. More than half of the multinationals which have entered India have set up their head offices in Delhi. Moreover, the city is now India's most affluent market and enjoys "the fastest rate of job creation in India" (Favero, 2003, p.559)

Delhi is essentially a city of migrants, with a population is about 14 million - seventy percent of the population were born outside the city (Favero, 2003). The economy of Delhi attracts a variety of workers ranging from manual labourers for the informal sector (domestic workers, taxi drivers, construction workers) to Indian middle-class workers who work for media, business, or governmental organizations.<sup>32</sup> Moreover, Delhi's status as a capital city attracts a host of people from abroad who come to work in transnational settings such as embassies, aid organizations, and multinationals. Clearly, the establishment of the neoliberal economy has dramatically transformed the organization of urban centers such as Delhi. Yet, this transition is not an entirely new process, rather it is one that has long been inflected by processes of imperialism and colonialism.

## **5.2. *Panchakarma and Ayurvedic Clinics***

Delhi can thus rightfully be considered "the epicentre of India's economic modernization" (Favero, 2003, p.559). The confluence of diverse inhabitants from India and beyond makes this city both a culturally and medically pluralist setting. Its growing consumer base makes it an ideal location from which to consider rapidly expanding medical practices, such as Kerala Ayurveda. I begin this section by describing how my fieldwork encounters pushed me to reconsider my conceptualisation of Ayurveda as primarily an object-oriented medical system.

This began early onto my arrival to this city when I met with a local contact, an academic named Rahul, who lived in Delhi with his wife and children and generously assisted in my search for potential informants. I shared my interest in speaking with those in the advertising industry about the marketing of Ayurvedic medicine for Indian

<sup>32</sup> If one keeps this population makeup in mind, the assumption of a "local" informant is greatly destabilized and expanded: many of Delhi's citizens are relative newcomers rather than long-established inhabitants. This is discussed in my other thesis chapters such as the one on household which features domestic workers who are migrants.

consumers. Rahul excitedly brought up the newfound popularity of Kerala Ayurveda clinics. As a newcomer to both India and Delhi, it was the first I heard of this.

In Delhi's medical marketplace, Kerala Ayurveda is generally made manifest through clinics and therapeutic treatments, many which are centred on panchakarma. This treatment has been appropriated as part of a general repertoire of spa-oriented treatments such as massage, which accounts for its proliferation, to some degree (Zimmerman 1992).<sup>33</sup> Yet, it also circulates as a distinctly therapeutic option in medical settings (Halliburton 2009; Langford 2002).

<sup>33</sup> One health care centre, Arya Vaidya Sala originated from Kerala but had two branches in Delhi: a clinic with a medical dispensary and out-patient clinic and the other was a hospital for in-patients requiring longer stays of multiple days or week. Arya Vaidya Sala was a charitable trust and involved in many facets of Ayurveda which included the manufacture of medicines, publication of magazines and books, and out-patient and in-patient care (Bode, 2008).

**Figure 5.3.** *Typical example of a place that might be designated as providing Kerala-based Ayurveda*



*Note.* Photo by Vinay Kamat October 28, 2010; with permission

Francis Zimmerman (1992) observed that, with the marketization of Ayurveda in India and beyond, panchkarma is presented as a relaxing oil-based massage. In such a scenario, central concepts of panchakarma were reworked to refer to more gentle measures such as bathing or massages rather than, say, vomiting or enemas. Both were ostensibly purifying, however the “[v]iolence of catharsis is transformed with the nonviolence of oil bath” (p.216). Zimmerman pointed out that in traditional Ayurveda, gentler detoxification techniques like massage were one of the many stages of panchakarma. However they were now given prominence while the more unpalatable evacuation processes were disregarded so that panchakarma could more effectively appeal to the burgeoning medical tourism and complementary and alternative medicine (CAM) market. Here, the

cachet of panchakarma rested in its possibilities to be enacted as a gentler and more holistic alternative to biomedicine. A quotation from an Ayurvedic doctor from a newspaper editorial discussed related misunderstandings which resulted from the newfound commercial appeal of Ayurvedic treatment.

In fact massage is the wrong word for them — they are really oil applications. A doctor determines what are the right oils you need, and they are then applied systematically over a period of time. The benefit of the treatment comes from the oil, not from the rubbing. (Tharoor, 2002)

A massage therapy was often understood to be manipulation of tissue amongst lay consumers. Yet in Ayurveda, the purpose of massage is to enable the skin to absorb the oil. According to certain medical professionals such as the doctor above, massage was not only inappropriately foregrounded but also misconstrued. However erroneous, this rendered panchkarma as a more alluring service for emerging consumers such as medical tourists.

An emphasis on massage allowed Ayurveda to more easily circulate outside of clinics to the lucrative settings of spas and hotel fitness centers as per the requirements of India's burgeoning tourism, leisure, and hospitality industry. My first ethnographic encounter with such a spa-based Ayurveda occurred precisely in this more commercialized context when I met Malvika, an executive from an advertising agency one Friday afternoon (November 13, 2004). Malvika and her three colleagues (including one who worked in accounting and another who was a copywriter) chatted with me about the middle-class and their consumption of Ayurveda as they winded down before their lunch break. Malvika was most involved with Ayurveda as she had recently completed an account for a spa that offered Ayurvedic massage amongst other services such as facials, hair care, pedicures, and related beauty treatments. The massage was not offered as a panchkarma treatment; rather it was enfolded into the repertoire of spa services.

Malvika traced the complexities of Ayurveda by explaining its many other properties. While Malvika opened our conversation by portraying Ayurveda as a beauty remedy with her recent client, a Delhi-based spa opened by a foreign entrepreneur, she

also had experience with other forms of Ayurveda. For one, she had a long-standing relationship to this medical practice, which preceded her professional involvement. She recounted that she had suffered from skin complexion problems as a child, which were treated through home remedies containing kitchen ingredients such as fruit, herbs, and honey.<sup>34</sup>

She suggested that I get in touch with a Keralite Ayurvedic practitioner, Dr. Vidya, who ran a clinic in Delhi.<sup>35</sup> Dr. Vidya had first opened her clinic near Malvika's neighbourhood over a decade back and she had seen her for a few weeks to treat her skin issues. The account manager asked Malvika if her skin issues had been resolved and she stated that they had not. However, this did not make her any less enthusiastic about the Dr. Vidya's clinic. Malvika recounted a story of a woman who suffered injuries from a ski accident and entered the clinic in a wheelchair. Dr Vidya prescribed one month of massage and told the patient, "After the third day, you'll feel cold." This prediction was made in 46 Celsius Delhi heat. This patient did indeed feel cold, and she was eventually cured from her injuries, three years later.

I left the interview musing on the multiple facets to Ayurveda and panchakarma. This practice could be lucratively commoditized as an expensive beauty treatment to pass the afternoon hours and as efficacious intervention requiring a long-term commitment when there was almost no hope for cure. Kerala offered both idyllic pastimes and very specialized expertise. Perhaps these diverging dimensions helped establish Kerala as a place of such medical magical repute.

Ayurveda was intrinsically connected to the Kerala landscape and seemed a conduit for engaging with its environment. Zimmerman argued that the synergistic relationship of a natural "green" state, such as Kerala, with natural "green" medicine, such as Ayurveda held great sway for middle-class consumers.

<sup>34</sup> As an aside, consider this as another way in which Ayurveda may invite engagement from from the professional and personal sides of informants such as Malvika.

<sup>35</sup> 'Keralite' refers to those from Kerala.

### 5.3. Kerala-based Patients of Ayurveda in Delhi

In Delhi, a Kerala-based invocation of Ayurveda was not exclusively invoked by enterprises like clinics and techniques like panchakarma. In fact, as I searched for health seekers, I met two middle-class residents of Delhi, Sunil and Ramesh, who were from Kerala, and articulated patient perspectives on Ayurvedic medicine. At first, I wondered if they could be treated as part of Delhi's middle-class. However, considering that almost half of this city's residents come from outside of the city, Sunil and Ramesh are arguably a representative stratum of "locals".

Sunil was a journalist was in his late twenties who moved to Delhi with his wife, Evelyn, an ex-patriate who Sunil met when she carried out an internship in Kerala.<sup>36</sup> I interviewed the couple in their home one springtime Saturday evening in May. We met at a chain coffee chain shop near their home and caffeinated ourselves in the brightly-lit and clamorous environs -- a much-needed lift in a day of heavy rain -- before commencing with the interview. The couple lived in a nearby apartment only a few minutes away and we conducted the interview in their living room. Sunil and I sat on the couch, around a coffee table and Evelyn busied herself with her computer at her desk in the same room and occasionally added comments over her shoulder as Sunil and I spoke.

Sunil's discussion of his interactions with Ayurveda in Kerala depicted health seekers as mobile agents who negotiated therapeutic options in accordance to their needs at the time. While renowned for Ayurveda, Kerala is actually a medically pluralist setting (Halliburton, 2009), which was made clear when Sunil narrated his encounter with Ayurveda, following an unfortunate case of food poisoning.

Sunil: It goes back to a very bad period of my life when I couldn't eat anything. It happened in college. We were 350 students... After lunch one day, I developed a rash all over my body. I freaked out and went to the [allopathic] doctor [he was nearby, at a clinic]. He said that he could give me something, but that it would only

<sup>36</sup> I met Evelyn at a martial arts class, and she introduced me to Sunil.

suppress the problem. So, he referred me to an Ayurvedic doctor, who was also a priest.<sup>37</sup>

This Ayurvedic doctor told me that this rash probably due to poisoning – spider poisoning. There are many spiders in Kerala... He asked me what I ate and thought that a spider must have fallen into the rice, melted, and died in the heat.

The priest said not to scratch with my hands because the nails may have some kind of poison. Instead, he gave me fibrous root to use for itching. He also gave me a thick oil which I had to drink four times a day – no, no, no... I was supposed to heat up the oil, dissolve the pill in lukewarm oil and apply all over my body. I had to let the oil sit for 30 minutes and drink medicine every six hours. (May 24, 2006)

Sunil's ultimate treatment for his spider bites was not entirely pre-mediated. His healthcare network directed him to the most suitable therapeutic intervention - and this happened to be Ayurvedic treatment. Additionally, this was likely an informal practitioner as he was referred to as a priest.<sup>38</sup>

Ramesh was another Keralite, a man in his forties, who had relocated to Delhi for work purposes. He had undergone long-term panchakarma treatment for back problems which involved an approximately month-long stay in an Ayurvedic hospital. He agreed to meet with me one weekday at a café, in the early evening and share his experiences of Ayurveda for Kerala. He, too, portrayed Kerala as a medically-pluralist setting with access to Ayurveda being mediated by the same concerns as anywhere else in India such as cost, social network, and efficacy.

Ramesh: See, there was a survey carried out for the population, what they found was... the average person could consume three branches, three types, of health care. There is western medicine which is predominantly the preferred one -

Mandip: Is this an Indian survey – or a Kerala survey?

<sup>37</sup> It is unclear whether this priest is a professional or informal Ayurvedic practitioner. In an Indian healthcare setting, it could be either.

<sup>38</sup> Approximately 20% of the population in Kerala is Christian.

- Ramesh: This is a Kerala survey. It's predominantly Western medicine, preferred more for acute conditions. For more chronic, you know, conditions, Ayurveda is preferred. But for children, homeopathy is preferred. So, the same person can consume all this – the branches – depending on what the preferred branch is for a certain condition.
- Mandip: What are the price ranges for all these?
- Ramesh: For the chronic conditions, on average Ayurveda, is more expensive. But if you are going for a surgery, of course then Western medicine becomes more expensive. But for a normal, you know, acute condition, Western medicine would be cheaper. The cheapest would be homeopathy.
- Mandip: So for the average person, middle-class, or lower middle-class [what do they do?]...
- Ramesh: This [a middle-class consumer] is a generally informed person. So what you look at is "What is my condition? Where am I going to get relief". Generally, people immediately go to Western medicine. And uh, many self-medicate also. (June 2, 2006)

My fieldwork in the clinics revealed that patients often resorted to Ayurveda for chronic ailments, such as digestive troubles and arthritis. Others may have used Ayurveda following a long period of unsuccessful attempts with other medical systems such as allopathy.<sup>39</sup> Sunil recounted the story of his mother, Arshi, who had previously undergone spinal surgery for an advanced stage of arthritis in her knee and spine. She had turned to allopathic practitioners for treatment, but had met with little success. Sunil recounted that his mother decided to go to an Ayurvedic hospital for a month-long treatment after being becoming frustrated by visiting allopathic practitioners who told her that she would require yet another operation.<sup>40</sup> Surgery is the forté of allopathy, but patients such as Arshi may be reluctant to undergo such methods and may pursue other

<sup>39</sup> I elaborate on these motivations to Ayurveda in my chapter on the clinic.

<sup>40</sup> Sunil described the hospital as "modern", it had X-rays.

treatment modalities, perhaps for reason of cost or preference for a less-invasive treatment.<sup>41</sup>

Ayurvedic treatment is reputed to cure health problems from their root causes without the need for invasive measures such as surgery. When Arshi checked into an Ayurvedic hospital, she was recommended to undergo detoxification and to lose weight by undergoing *panchakarma* treatment, which consisted of purification remedies consisting of doses of milk and castor oil along with oil and steam baths. Sunil recalled that his mother also followed a strict diet, which was “frugal, with no spices”. After the treatment, she looked healthy. Sunil and Evelyn opined that the month-long treatment, per se, did not cure arthritis, but it did help her lose weight and keep it off. This provided significant relief for Arshi’s back and joints which had become so weak that any extra weight posed a problem.

Ramesh, too, underwent a month-long treatment in an Ayurvedic hospital, described some of his daily routines,

Ramesh: You would finish your morning ablutions and everything and start... around seven. In fact before that, they [clinical staff] have to start because they have to get the oils ready, it takes time... so 7.30 you reach there and they strip you down. You are near-naked. And, uh. In fact, actually you *are* naked. And then they start... They do it with two people on either side and they massage you...

Mandip: How about seeing the doctor?

Ramesh: The doctor comes and looks at you one once in three days or something...He examines you. He takes your history, looks at your X-rays, a lot of it has to do with the feel of his palms. The hands. And then he decides.

Mandip: “Feel of the palm”? On the problem area?

<sup>41</sup> Also, many middle-class Indians opt for private medical treatment – and surgery is a very expensive option.

Ramesh: Yeah. It's not a very diagnostic-oriented medicine. It's not very specific [at this clinic]... it's for the whole body. It doesn't matter where you actually have that problem... the whole back gets taken care of. But unlike a diagnostic-oriented Western medicine surgery where you'd want to very specifically locate it to an MRI... and then your intervention will focus exactly on that area, because it's invasive [i.e. surgery]. But [Ayurveda]... is not invasive.

Halliburton (2009) similarly observed that a patient with, say, stomach cramps and headache “will not necessarily be identified as having a particular disease indicated by these symptoms” (p.48). Rather, the patient was treated for the symptoms that resulted, and the imbalanced *doshas*, which were understood as the root to such health issues.

Sunil and Ramesh depicted Ayurveda as a relatively harmless and non-invasive therapeutic option. Yet, patients must exercise some commitment to endure through some of its difficult stages, which included sitting still while drenched in oil and painful treatment).<sup>42</sup> Their narratives emphasized that Ayurvedic treatment requires time, occasional discomfort, and dedication to build up the body to health.

The trope of Kerala as the motherland or ultimate source of Ayurveda obfuscates rather than reveals what takes place on the ground for local health seekers. Khare, who writes about multiform Indian cultural reasoning for health care, states that people judge Ayurveda, biomedicine, or any other medical system according to the same reasoning: "Does it work, or has it worked, for me/us?" (1996, p. 839). These Kerala-based users depict the wide range of treatment which can involve a consultation with a priest for food poisoning or month-long admission into a hospital for the relief of chronic ailments such as arthritis. In Kerala and Delhi, the workings and trustworthiness of any medical system are constantly evaluated in the medically pluralist setting by its users.

Yet, Sunil stated at the beginning of our interview, that in Kerala, “You are almost [forced] to consult an Ayurvedic doctor” (May 24, 2006). Keralites were well-

<sup>42</sup> This is in some contradiction to Halliburton's observation that psychiatric health patients in Kerala seek Ayurveda precisely because it offers a “pleasant” means of healing (2009).

aware of Ayurveda as a long-established medical tradition in their state and could not help but notice the marketisation of Ayurveda. Their reading of Kerala's therapeutic landscape showcased its geographical, economic, and cultural (martial arts, religion?) attributes.

Sunil and Ramesh straddle perspectives as local patients and as professionals groomed with middle-class sensibilities, likely targeted by the marketing efforts of Kerala-based Ayurveda. Such local perspectives can be considered one of the many voices which articulate the therapeutic landscape (Gesler, 1994) and show how Kerala's reputation as the motherland or source of Ayurveda is an outcome of its very many interconnections.

Mandip: Is there something about Kerala's political organization which makes it support Ayurveda?

Sunil: The Kerala government [puts in money for Ayurveda'. There is an Ayurveda directorate, and colleges. Now, a high profile to Ayurveda is given because of money from the tourism sector. So, the government treats it well.

Kerala is a translocal space with close networks to the tourism and service economy. Tourism generated about 45 billion rupees in revenue in 2001 and increased to 173 billion rupees, almost a decade later, in 2010 (Government of Kerala, 2011).<sup>43</sup> Medical tourism is a thriving market in India, particularly for allopathic services such as surgeries and fertility treatments, which are of good standard and relatively affordable with short wait times for tourists from abroad. The medical tourism sector in Kerala serves its diaspora who work in Gulf economies and visit burgeoning corporate allopathic health chains, such as Fortis Escorts which have mushroomed over the past decade for Kerala's middle-class consumers (Wilson, 2010). Other types of tourists come for complementary alternative medical (CAM) treatment, such as Ayurveda.

<sup>43</sup> \$1.00 Canadian dollar equals 54 Indian rupees.

Sunil pointed out that Ayurveda's promise for health also attracted the attention of other global actors such as pharmaceutical manufacturers seeking to profit from the desires of complementary and alternative medicine (CAM) market.

- Sunil: There is an article in Frontline on the "wonder drug" of Ayurveda. The title is "Ayurveda goes global", with no byline. [Evelyn, who is nearby on her computer, brings up the page for us to look at.]
- [Sunil reading from the screen]. This plant grows only in certain parts of Kerala, around the mountain. It is used by tribals, who eat it. It's kind of heart-shaped, like a *paan* leaf.<sup>44</sup>
- Arogya Bhagya broke down the leaves and discovered its chemical compound. But now there are battles between tribes over benefits from global interest.<sup>45</sup>

Evelyn mused at one point to my inquiry on the linkage between Kerala and Ayurveda and responded, "The origins of Ayurveda, I don't know... it makes sense if it is in Kerala, because so much *grows* there". Sunil elaborated his perspective on this as he sketched out a geography of the state,

- Sunil: There are no villages in Kerala. It's a semi-urban sprawl for 600 kilometers. Kerala is a long state and densely populated. But also very green – from the plane, it looks like a green carpet. Everything grows there, [a lot of] rain, moisture and heat.
- ...Kerala has a lot of Ayurveda but with this, there are also a lot of... [turns to his partner] What is that word, Evelyn? "Fakes"?
- Mandip: "Quacks"?
- Sunil: Yes, quacks for Ayurvedic massage treatment... But there have been no deaths... Ayurvedic medicine does not kill you.

Even with its inevitable quacks, Ayurveda is still considered a source for harmless care. This sentiment was echoed by Ramesh, who stated that he did not understand why he was

<sup>44</sup> *Paan* can be chewed as a digestive and breath freshener after meals.

<sup>45</sup> Arogya Bhagya is a national research/regulatory body.

taking drugs, but “the advantage of Ayurveda is that there are no side-effects, so it didn’t matter” (June 2, 2006).

Moreover, in Kerala, the therapeutic efficacy of Ayurveda is not only contained in clinics or in specific herbs but extends to include the surrounding environment. Ramesh stated certain times of the year were more therapeutically efficacious,

Ramesh: Yeah... the best results come during the monsoon... I think the temperature goes down and maybe then the hot oil is welcome (chuckles). Monsoon... it’s a hot place. The only time the temperature drops is during the monsoon. Otherwise it remains in the thirties.

Mandip: Okay... So all these once-in-a-year treatments, they *all* take place then.

Ramesh: Yeah, that’s the preferred season... they are just not advised to have it during, you know, the hot period. Which immediately precedes the monsoon.

Treatment does not simply refer to the localized-to-the-body repertoire of pills or medicated oils, it may also be based on placing oneself in ideal climactic conditions, when environment and the treated body are in a complementary equilibrium with one another.

Such is the image invoked by the advertisement which opened this chapter. However, Ramesh stated that panchakarma treatment could be quite long and last anywhere from 30 to 45 days - and require return visits every year. Most tourists instead pursued what Ramesh called a “cosmetic” treatment, offering relaxation akin to spa services, but little in the way of therapeutic benefit. He stated to me, chuckling, “You can tell your people: people who come here for medical tourism and Ayurveda are getting ripped off!”<sup>46</sup> The therapeutic landscape of Kerala worked both on a symbolic level for the imaginations of consumers such as tourists seeking an idyllic getaway and also represented an untapped medical resource, which drew in producers such as pharmaceutical companies.

<sup>46</sup> This is the most commercial invocation of Ayurveda, but the diaspora could engage in another type of medical tourism, stay longer in Kerala to undertake month-long hospital stays.

The popularity of Ayurveda in Kerala was not only based in its capacity to be marketised. Sunil and Evelyn pointed out that it was a long-established practice which was integrated into Kerala's cultural life. The distinction between medical and non-medical are not obvious in Ayurveda, a repertoire of knowledge which interrelated "bodily conditions to humours, environmental and climactic factors, psychological dispositions, and moral and spiritual states" (Khare, 1996, p.838). Sunil brought up the practice of Ayurveda outside of clinical settings and brought up Ayurvedic scriptures written in ancient Malayalam (language spoken in Kerala). This can be held up as proof to its long establishment in Kerala. As well, Ayurveda is connected to other local body-oriented traditions:

Sunil: There is also Kalaripayattu, a martial art. Have you ever heard of it? It is thought to be the mother of all martial arts. Ayurvedic treatment started along with this. In Kerala, many of the martial art centers offer Ayurvedic medicine alongside massages and such.

Kalaripayattu is a 3 000 year old martial art which required years of rigorous training and, in return, lent great strength, agility and flexibility to its practitioners (Mullaratt, 2002).<sup>47</sup> As Sunil pointed out, training centers often included Ayurvedic treatment alongside to help students recover from their sessions – and to prepare them for further training, which can be seen in the example below,

Revival-"Thapa Abhyakaranam"-7 day treatment [sic]. The treatment includes restoration of the smooth flow of energy and identifies the disproportion of Tridoshas in the human body. (Indian School of Martial Arts, para 10, 2007)

Students could follow a fourteen-day detoxifying treatment or twenty-one day balancing and meditation treatment. The links to Ayurveda were signified with the term, *tridoshas*, which referred to humoral substances: *vata* (air), *pitta* (fire), and *kaph* (earth).

<sup>47</sup> Many of its proponents consider it to be predecessor to kung fu.

Ayurveda is a complex and multifaceted cultural practice in Kerala and perhaps this prevents it from being wholly placed on commodity circuits in the “green-washed” manner described by Zimmerman (1992). Sunil and Evelyn’s account emphasized the connection of Ayurveda to other dimensions of Kerala’s cultural framework. Halliburton’s ethnography on Ayurvedic treatment for psychiatric disorders in the same state similarly argued that health was not simply a remedial condition which could be measured by clinical outcomes, it also related to more holistic concerns such as physical and spiritual development.

In a country as large and culturally-diverse as India, each state is renowned for its particular language, culinary specialities, or landscape. This lends Kerala Ayurveda much attention. Sunil remarks on the distinctions of other Indian localities by referring to their naturalistic attributes: “You have Amritsari fish. What’s in Rajasthan?... The camel. And Kerala has the backwaters and Ayurveda.” One can argue that in a neoliberal setting, “capitalism works not so much by cancelling out historical difference as by proliferating and converting differences into sets of preferences, of taste” (Chakrabarty cited in Mazzarella, 2003, p. 19). Perhaps Kerala Ayurveda becomes emblematic of Kerala for the tourist gaze.

Medicine and culture in Kerala seem to be conflated with one another as the intensification of India’s neoliberal economic transition expands this state’s tourist industry. In such a setting, to what extent can martial arts such as Kalarippayattu and health traditions such as Ayurveda be valorized as multi-faceted vehicles of cultural expression? They may be reworked as folk or cultural practices as the tourist industry seeks to translate them into economically-viable practices which are placed together on an assemblage (such as CD collections) for show and tell.

## **5.4. Conclusion**

This chapter introduces many different readings of the therapeutic landscape, otherwise known as Kerala. Its most prominent invocation refers to an assemblage of

highly-lucrative bodily-based economic services such as medical care, beauty and spa treatment, and tourism. The stories from Sunil and Ramesh show a different picture of what takes place in Kerala and the medically pluralist nature of its medical marketplace. Ayurveda is not the only phenomenon which is deterritorialized in India, its middle class inhabitants are highly mobile actors as well, who can speak of multiple intimate engagements with Ayurveda – both as witnesses and patients. This positioning shows one outcome of analyzing a consumption practice which is locally-created and produced for a deterritorialized audience. The first-hand narration of Ayurvedic practices in Kerala is invaluable in articulating the “practical reasoning, knowledge, action strategies, and cultural sense and sensibility” guides the practice of health (Khare, 2002, p. 838) .

Yet, just as in Delhi, Ayurveda in Kerala continues to thrive in the informal and formal economic strata which includes local informal healers such as Sunil’s Catholic priest, well-reputed hospitals, a burgeoning tourism industry, quacks, global actors such as pharmaceutical manufactures. Kerala is not the primordial motherland of Ayurveda: it is a buzzing medical marketplace.

## **6. Informal Therapeutic Options: Generating a Household Practice of Ayurveda**

This chapter examines the significance of the household in the health seeking strategies of the middle-class and emphasises exchanges that take place in the informal economy, which emanate from one's domestic network. The material culture and medical knowledge which sustains the practice of Ayurveda in the home is portrayed through my discussion of the activities of two home-based users of Ayurveda, Raj and Bina. The remainder of the chapter explicates how familial and household relationships of care and dependency broker access to health care resources of informal medical marketplace and encompasses people such as domestic workers, herbal vendors, and religious guides or *gurus* in the medical marketplace. The concluding section traces the pathways of a herb, *jatamaansi*, which is used by an elderly lady, Mrs. Simar, for blood pressure problems. This makes explicit the role of various human actors (from family members to informal practitioner) and their labour in transforming a herb to a therapeutic substance. The sociality which drives consumption practices is a recurring theme in this chapter.

My interest in how Delhi's middle-class integrated the consumption of Ayurveda in their everyday lives led me to interview those who stated they practiced Ayurveda, on their own, without going to a clinic. Pharmaceutical anthropologists had emphasised that drugs were not necessarily exclusively exchanged between doctor and patient in clinics: so-called "prescription" drugs circulated freely and could be purchased from pharmacies and shops even without a prescription (Van der Geest & Whyte, 1988; Whyte et al., 2002). Laypeople obtained information from about these drugs through consultations with pharmacists or inferred workings from these drugs in light of their previous experiences with them (Kamat & Nichter, 1997; Das & Das, 2008).

India's transition to a neoliberal setting had resulted in the increased production of over-the-counter Ayurvedic drugs to consumers such as *brahmi*, a drug for enhanced memory, and *shilajit* for youthfulness and vigour, whose advertisements I saw regularly on billboards the city and villages of India. I anticipated that a home-based production of Ayurveda would be object-oriented and based on goods which were therapeutic resources such as food, herbal remedies, and packaged drugs.

I learned the household brokered access to numerous informal medical resources: therapeutic resources such as herbs were not controlled substances and so were available to the public. However, these substances were not beneficial in of themselves, one had to know about their existence and how to use them effectively. The household mediated access to sources of knowledge, such as informal practitioners who had some kind of medical competency, even if they were employed as domestic workers for middle-class homes, or *gurus* (authoritative spiritual guides) of yoga and philosophy. These human experts were the sources of medical information – more so than inanimate objects like books and magazines. Ayurvedic medicine in the household was a people-centred practice.

### **6.1. Self-Care in a Domestic Setting: Conversations with Raj and Bina**

I was introduced to Raj, a follower of Ayurveda who was in his mid-sixties, by Amar, an Indo-Canadian friend who had grown up in India and moved to Canada when he was sixteen. Raj was a close family friend of Amar's parents, and so was treated as an uncle. Raj declared himself as a user of Ayurvedic medicine, however during our interview, he revealed that he incorporated yoga, naturopathy, and Unani medicine into his repertoire of health-making practices.<sup>48</sup>

<sup>48</sup> "Ayurveda" or what came to mind as Ayurveda when my informants spoke to me. Ayurveda medicine in the household can form part of an assemblage of *desi* (country, folk) medicine or home remedies.

This man's interest in indigenous medicine was spurred from his neighbourhood past times as a child. Raj explained that his interest in indigenous medicine began when he moved to Delhi as a child, after his family was displaced from Pakistan during Partition in 1947. They relocated to a refugee settlement in Old Delhi when he was seven years old. A few years later, at age eleven, Raj began to visit a yoga ashram located near his neighbourhood for early morning yoga classes. This class socialized him into principles of indigenous medicine, including Ayurveda. He enjoyed these classes and their physical benefits, recalling that people began to comment on his muscular build. On the weekends, the attendees practiced yogic massage by rubbing oil into their limbs, against the hair growth so that the skin could absorb the therapeutic qualities of the oil (students bathed before class to ensure against impurities). Afterwards, the students relaxed into a yoga pose, called *shivasana* (corpse).

Raj gradually became interested other forms of non-allopathic healing, such as naturopathy, Ayurveda and Unani. He stated that all of these alleviated some of his long-standing health problems. Raj had suffered from sinus problems for many years and demonstrated how he treated it by sketching a small kettle with a long snout in my notebook, explaining that this was a *neti* pot. One could tip the snout into each nostril and flood the nasal cavity with warm salted water. This technique was called nasal irrigation and was useful for health ailments such as colds and sinus problems.

Raj learned about naturopathy, which was known as a “drugless” system of healing.<sup>49</sup> Therapeutic interventions were based on the five elements of earth, water, fire, air, and ether.<sup>50</sup> Naturopathic treatment required one to adjust daily routines, so the body

<sup>49</sup> Both yoga and naturopathy are “drugless” systems of healing, and medical colleges offer a five year training program leading to a Bachelor of Naturopathy and Yogic Sciences.

<sup>50</sup> I had opportunity to visit a naturopathic hospital a few months after my interview with Raj and witnessed how its treatment could be carried out in an institutional setting. I was shown the premises by a hospital attendant who took me to a large room which was the in-patient unit. Here, a female patient sat upright in her hospital bed with a hot water bottle to her stomach, to receive the healing properties of heat. The tiled bathrooms nearby had steam chambers and showers, both for hydrotherapy (water therapy). The hospital's small kitchen likely prepared food not only for nurturance but also for its therapeutic value since diet therapy and fasting therapy are integral components of naturopathic healing (AYUSH, 2008).

could maintain a balance between the five elements. For instance, Raj explained that a headache was caused by inadequate consumption of water, lack of sleep, and improper “evacuation” (defecation). One could become healthy by adjusting these routines. Raj had successfully taken up a long fast with salted water years ago for weight loss issues. He stated that naturopathy provided the “best balance” because it was based on *panchbhuta*, the five elements of earth, water, fire, air, and ether.

Raj’s familiarity with five elements from naturopathy overlapped with his foundational knowledge of Ayurveda that understood disease to result from an imbalance of *doshas*, namely *kapha* (earth), *pitta* (fire), and *vata* (air). In such a schematic, arthritis was understood as a *vata* affliction and sufferers could obtain relief by avoiding common foods such as a type of lentils called *urad dahl*, rice, and yogurt, which were gaseous, and therefore aggravating to *vata* constitutions. In Ayurveda, therapeutic strategies were oriented towards a person’s bodily constitution (i.e. whether they were *vata*) rather than being uniform across the board. Accordingly, most culinary substances such as spices were not intrinsically beneficial; rather, they could benefit or aggravate a specific person’s *dosha*. Raj pointed out that in allopathy, diet was not differentiated in this way - it simply referred to calories.

At the onset of the interview, Raj brought me his collection of packaged medicines and displayed them on the coffee table. The products were from major manufacturers such as Himalaya. As I noted their names, Raj described the conditions for which he needed them. The medication with the label *Tankan Bhasma* and *Talisadi Choorna* was useful for sinus congestion and Raj related this to the imbalance of Ayurvedic *doshas*: phlegm, for example, was related to an excess of *kapha*. In Ayurveda/ Ayurvedic thought, any substance from food to packaged medicines to the weather influences the *doshas*. He also had a few hardcover books taken out from the library, in English, on naturopathy.

Raj stated that he would rather suffer pain than take allopathy if possible and relied on an assemblage of yoga, naturopathy, Ayurveda, and Unani resources for treatment. Even if these medical practices seemed eclectic, they helped create balance in

the body in relation to the environment. The latter was his main concern rather than affiliating to a particular medical system.

I interviewed Bina, an artist in her late fifties who had been a follower of Ayurveda since she was in her late twenties.<sup>51</sup> We met in a coffee shop one weekday afternoon and Bina began the interview by recounting her struggle with fibroids in her twenties which left her with symptoms such as heavy menstruation and a “hard stomach”. She had seen allopathic doctors who wanted to cure her fibroids by removing her uterus. Bina was against this course of treatment as it seemed too much of an intrusive procedure for a benign condition and so she opted instead to explore other methods despite looking pregnant with her large belly. She consulted with three Ayurvedic vaidas and while they could not immediately help with her condition, they were able to stop it from getting worse. When I asked Bina what kind of Ayurvedic medicine she had taken for her fibroids, she replied that she did not want to intervene with her body, and instead followed procedures such as steaming [to reduce hardness and swelling], in contrast to surgery.

Bina’s next encounter with Ayurveda took place when her partner, whom she described as a serious man, brought home the *Caraka Samhita*, which they both studied at home. Over the past twenty years, she has been taking between eight and ten herbs which include remedies to rejuvenate the body, and others to beautify the skin and hair. Perhaps in anticipation to my possible questions regarding Ayurveda’s efficacy, she added that she did not know if they worked - but it did not matter to her because she felt better after taking them. She believed that the herbal beauty mixtures helped to keep her hair smooth and soft and invited me to touch her strands and see. Her hair was indeed soft.

These herbs were purchased from an Ayurveda pharmacy in bulk and powdered form, which Bina then prepared at home. Bina also recalled other more informal sources for acquiring herbs, mentioning a gardener that she and her partner once employed. The

<sup>51</sup> Bina was an exceptional case in that she was one of the few people I met who used Ayurveda almost exclusively for her health needs

gardener was also an informal herbalist and supplied them with quantities of herbs. Bina's preference is for unsynthesised therapeutic substances. She acknowledges that the quality of "crude" (bulk) and "sterilised" (packaged) medicines is different, yet she remains unconvinced about the superiority of sterilised products.

Raj and Bina were not concerned about the distinction between Ayurveda, herbal medicine and home remedies. Raj preferred to use as few drugs as possible and enjoyed physical or "hands-on" interventions such as massage and nasal irrigation. Bina distanced herself from therapeutic options which seemed synthesized, processed, or invasive: she favoured medical techniques, such as steaming, which did not intervene intensely on the body, and favoured therapeutic resources which had not been too processed or synthesized, such as bulk herbs.

The use of Ayurvedic treatment outside of clinical settings may involve mass-produced and packaged medicines, however it is not restricted to this. Ayurveda may also encompass a range of additional health resources such as loose herbs, food, and texts. The therapeutic qualities of these objects are not automatically known, and so Bina and Raj turn to a variety of informal sources of knowledge, located in close proximity to them, near their homes or neighbourhoods. (In turn, Bina propagated this circuit of informal medical knowledge by stating that she could provide me with the names of the herbs and remedies she had learnt from her grandmother to help me with my research.)

The household is a source of on-going knowledge-production with associated regimes of care that remain characteristic of Ayurvedic practice and of other informal medical practices. Historians Elaine Leong and Sara Pennell (2007) analysed the exchange of lay medical advice and relationships of trust in early modern England in the domestic sphere. They observed that the interest in keeping good health through self-care and daily routines was quite common and argued that the domestic sphere had been under acknowledged as an important health care resource, perhaps considered as nothing more than a site for mundane tasks (p.133). This may be because the health care activities of the household were invisible: recipes from the kitchen functioned as prescriptions; cordials were therapeutic drinks which were cooked up in ordinary pots and pans (p.134-

5). Raj and Bina's accounts, too, show how these processes may be invisible, with yoga classes that provide both muscular training and health care techniques, a gardener who acts occasionally as an herbalist, and a cup of tea which is therapeutic, at times.

## **6.2. A Delhi Household and its Permeable Boundaries**

Compared to a suburban Canadian household, a middle-class Delhi household is less of a self-contained space as its functioning relies on the work of many human labourers who enter and leave the premises throughout the day. This section describes the permeable boundaries between the household and neighbourhood, outlining the types of traffic that connect the home to neighbourhood and to spaces beyond. The household is a nexus connecting social networks of family, domestic staff, and neighbourhood entrepreneurs, any of whom enact Ayurveda.

Delhi's middle-class neighbourhoods consist of between 100-1000 households that are demarcated by fences, gates, and security guards. Before entering a household in such an area, one passes a gate usually staffed by security guards who are privately hired (perhaps by the neighbourhood association or by households who have hired additional security guards for their residences). The surveillance of the boundaries of the neighbourhood is part of the everyday experience of a middle-class resident.

During the years I visited, between 2004-2007, the look of these middle-class residential enclaves was changing in other ways as a result of the increased purchasing power of the population in this area. My time in Delhi was punctuated by constant construction as houses were renovated or given extensions which could be rented out as separate units (I lived in one such place). The construction was not mechanized or machine-driven, rather it relied on manual human labour: men stood on bamboo scaffolding to work on the upper stories and women carried bricks to and fro from one part of the construction site to another while their children sat by. The security guards, manual labourers, and domestic staff came from less-affluent states and moved to Delhi so they could benefit from its prosperous economy. Itinerant vendors came from outside

the enclaves at certain times and sold fruits and vegetables or household essentials (such as brooms, buckets, and baskets) from their carts. These enclaves buzzed with the activities of the neighbourhood economy which serviced household needs and provided security, chauffeurs, construction, renovation, and ironing.

Within the household itself, domestic labour was central to its proper functioning. While some workers lived in the household to cook and clean for a family, others visited daily to perform particularly menial tasks such as cleaning the toilet, washing the floor, or collecting the garbage. Mornings were often punctuated by the sound of the doorbell ringing from these visitors and others who delivered newspapers, over the counter medicines ordered from the pharmacy, or perhaps freshly-ironed clothing by the neighbourhood *presswallah* (ironer). A middle class family could even enlist a trusted domestic worker to drop off bill payments to the bank. The household thus is not a closed space restricted to family, but a nodule, which is a part of a system in constant motion.

### **6.3. Accessing Health Care Networks from Domestic Relationships: Informal Practitioners**

As I conducted additional interviews amongst Delhi's middle-class on household practices of Ayurveda, I learnt of health resources that were not immediately obvious to an outsider but which nonetheless played a crucial role in healing outside of clinical settings. Informal practitioners were one such therapeutic option and while they were not officially recognized as experts, they were nonetheless a trustworthy resource for health seekers. Prior to entering the field, I had assumed that "Ayurvedic *healers* referred to official *practitioners* who had attained a Bachelor in Ayurvedic Medicine and Surgery (BAMS).

However, the middle class drew upon a spectrum of experts who encompassed informal practitioners in their health care strategies. Vishal, for instance, was a successful entrepreneur who spent some time living abroad, in England, but later returned to India. He ran a successful business in Delhi, a fitness centre geared towards needs of the middle

class, who were increasingly exposed to cosmopolitan lifestyles and were ready to spend as consumers in the burgeoning health and self-care scene (recall Mr. Bedi's comments in Chapter 3). When I discussed my research, one Saturday afternoon over coffee, Vishal declared he used Ayurvedic medicine and recounted its helpfulness for his long struggle with an illness. Vishal was a man in his late thirties who had acquired jaundice about fifteen years ago and had sought help from various allopathic practitioners to no avail. He was beginning to conclude that there was no solution for him until his maid suggested a healer for him to visit. Vishal's older brother took him to the recommended healer who cured him from jaundice after a few visits. This was the private health care arena, however, the healer did not profit from his work. Instead, Vishal was instructed to make an offering of 12 rupees and a coconut at a nearby Hindu temple to ensure that he would never have jaundice again.<sup>52</sup>

In India's informal health care setting, the middle class may resort to a variety of informal practitioners who are not officially trained, but are endowed with skills, perhaps learnt via apprenticeships. The healer discussed above made his full-time living in a different sector of employment: "This guy was a sweeper!", Vishal had exclaimed to me. "Sweeper" is the name for domestic labourers, usually of lower-caste, employed to remove human and other waste from many Indian middle-class households. Normally, a great social distance is maintained between the middle-class and these labourers, who perform especially defiling tasks. This is in contrast to other categories of domestic labourers such as cooks (or the maid that Vishal referred to), who may often live on the premises and interact more intimately with their employers. The vulnerable physical condition of a middle class sufferer may lead them to having unanticipated interactions with groups of people who were otherwise kept at a distance.

An ethnographic examination of the private health care arena showcases the diversity of experts invoked by the contemporary practice of Ayurveda: "practitioners" is thus not a stable category. It also illuminates the spectrum of monetised and non-

<sup>52</sup> A coconut, considered the fruit of god, is a common offering made by Hindus for a variety of occasions: weddings, festivals, celebrations, temple visits.

monetised exchanges which propagate treatment – Vishal’s obligation to the healer was to make a religious offering, not a commercial transaction.

My interview with, Geet served as another critical turning point which dismantled my initial conceptualisations of lay users, practitioners, and experts. This middle-aged man described his family as followers of Ayurveda when he heard about my research and invited me for an interview. Geet looked after rental units located on his property consisting of a few small apartments rented to temporary residents of Delhi. I had initially met him when I was house hunting at the beginning of my arrival. Geet lived in an affluent South Delhi neighbourhood with his mother, wife, and daughter in her early twenties who was a university student.

I met with Geet and his mother on an oppressively sunny weekday afternoon at the onset of Delhi’s scorching summer. Geet greeted me at the door when the sun was at its zenith and jokingly remarked on my wise choice to be a vegetarian. This dietary preference of mine was interesting to him because I was not Hindu, from Canada, and not raised a vegetarian. Geet explained that avoiding meat would help me adjust to the heat of Delhi by keeping me cool (I hoped the same for myself since I felt sickly rather than comfortable during my first summer of temperatures which were above 40 Celsius).<sup>53</sup> Stepping into the dimly-lit living room, I was invited to join Geet and his elderly mother on the couch which faced a loud “cooler” (a device which is between a fan and air conditioner) that blasted air in my direction. The curtains were drawn to keep away the sunlight. Geet’s cook, Manoj, served us cold juice and I turned to my set of questions to commence the interview. Geet brought up the importance of domestic workers, too, during our conversation on the therapeutic options available to Delhi households,

Geet:                So, as I said, what you call the “informal knowledge” of Ayurveda ... is far more than anywhere else in the world. Not only with Ayurveda, you know, but some of the other [medical practices] as well. Ayurveda is typically Indian. But here, people, the class of people also have

<sup>53</sup> In the north Indian culinary humoral framework, meat is a heating substance.

[knowledge]. For example, Joona, she knows about [remedies] for women's problems and all that...<sup>54</sup>

Mandip: So she would know where to go and get something for...

Geet: No, here she would not know, but she would know where in her village. So she knows what grows locally. So if you are having a problem like diarrhoea, then she would know that you go to that particular tree, or that particular field, and you get that particular thing from there.

Maurice Bloch, an anthropologist who specialized in cognitive knowledge described how this type of learning occurred amongst the Malagasy of Madagascar to identify arable land,

This Malagasy is going through the forest with a friend who says to him, 'Look over there at that bit of forest, that would make good swidden'. What happens then is that, after a rapid conceptualization of the bit of forest, the model of 'the good swidden' is mentally matched with the conceptualized area of forest, and then a new but related model, 'this particular place as a potential swidden', is established and stored in the long-term memory. (cited in Pfaffenberger, 1992, p.508)

Domestic workers such the sweeper mentioned by Vishal, and Joona, were seen as having access to zones containing healing potential, including villages, fields, and parts of the city unknown to the middle-class. Their competency or expertise was based on their familiarity with these zones, and of knowledge that was acquired via experiential means, perhaps by visual observation. The term "informal practitioners" itself is a diverse category which could refer to domestic labourers or those with more exalted statuses such as a guru, the latter which I will discuss in the following section.

<sup>54</sup> Joona is their domestic worker.

#### **6.4. From Herbal Commodity to Therapeutic Remedy: The Transformation of *Jatamaansi***

Like many other middle-class Delhi residents, Geet's family did not exclusively affiliate themselves to any one medical practice. They practiced yoga, used indigenous medicine such as homeopathy and Ayurveda when possible, and allopathy when necessary. Mrs. Simar had suffered from high blood pressure for the past decade and had initially treated herself with Ayurvedic remedies.

Geet: For a long time... Mama [Mrs. Simar] has been taking Ayurvedic medicine known as *jatamaansi*, you can write that down... it is a root. You boil it like tea, keep it over night and in the morning, first thing - empty stomach, you have it with a little bit of honey, half a teaspoon of honey.

Mrs. Simar: It's very good for high blood pressure

Geet: That is a kind of tonic for the body as well as antidote for high BP. And she has been taking that.

Mrs. Simar: [echoing] Yes. I take that.

*Jatamaansi* was prepared as a tea and was part of Mrs. Simar's daily routine. I wondered what pharmacological and therapeutic pathways this herbal remedy was a culmination of.

My inquiry was inspired by the analytic concerns of Kopytoff (1986) in which medicines were constructed as objects with biographies that moved through phases: at times they were unique and singular, other times they were mass-produced as commodities (Whyte et al., 2002). I asked the Simars how they obtained this herb and Geet described the long distances and obstacles he traversed:

Geet: From Old Delhi - Chandni Chowk. That is the Khaori Baoli market. [This] is the place which is the source for all the, you know, Ayurvedic and Unani medicine.

Mandip: [Knowing that this market is about an hour long commute from the household and assuming that someone was hired to do carry out this errand]: Does somebody go there [for you] ?

Geet: Somebody goes there yes. There was a man who was working for my father... he'd go there once [every] two or three months... You have to find the right herb. You know once we got *jatamaansi* but not from the same

place. It turns out it was not the right [herb], it was a fake.

Geet: But recently... I have sourced it from a place nearby, that is Kotla Mubarakpur. It is quite near our house. There I have discovered a chap who is also dealing with Ayurvedic medicine – he sources it from Chandni Chowk or from wherever.

Mandip: [Inquiring about “a place” in Kotla Mubarakpur] Is it an Ayurvedic pharmacy?

Geet: It is not an Ayurveda pharmacy, but his father or grandfather was practicing Ayurveda. So he kind of knows [the basics] and he sells jatamaansi and ancillary herbs...<sup>55</sup>

Many herbs and spices, which are part of Ayurvedic treatment, are not controlled substances and could be easily found in places such as Khaori Baoli, known as the world’s largest spice market.<sup>56</sup> Jatamaansi was widely available but its quality could not always be assured as the Simars purchased it in raw or bulk form. Consequently, a consumer like Geet “shopped” by negotiating issues of access, distance, and trust (in the integrity of the product and its vendor). Jatamaansi reached its intended consumer, Mrs. Simar, only after such a trial and error process.

The reader may note that Geet did not obtain jatamaansi from an official Ayurvedic practitioner or even a pharmacy. I was struck by the important role of informal experts with intermittent presences, such as “the chap”, in manifesting the practice of Ayurveda in Delhi. Jatamaansi was a relatively accessible and powerful therapeutic agent, but its origins and integrity were not always known or guaranteed. The fact that this product could be adulterated or impure caused concern, specifically because it would be imbibed by the body, while in a vulnerable state of illness. Yet this herb could be re-cast as a safe substance once it circulated as a socially-embedded object in the medical marketplace, by being affiliated with a trustworthy medical vendor along its journey.

<sup>55</sup> Medical knowledge is experientially-acquired (from this family lineage) for this vendor as well.

<sup>56</sup> Small pharmacies could also be found in Khaori Baoli and sold over the counter medicines. Although prescription drugs were formally controlled substances, they could be accessed without a doctor’s prescription (Kamat & Nichter, 1998).

Jatamaansi is not a therapeutic agent in itself. One must know that it exists and how to use in order as a benefit from it: jatamaansi is an outcome of a medical knowledge which is acquired from the informal health care arena. I elaborate below on how Geet and Mrs. Simar learnt about the healing properties of jatamaansi in the first place.

Mrs. Simar: I'll tell you, [it was from] my guru, he is... very good.

Geet: He is 110 yrs old, and he is still living.

Mandip: [to Geet] You also go to him, right?

Geet: Yes.

Mrs. Simar: ... He doesn't practice anything but if you want any help, he can give it.

Geet: He is the person who recommended, and introduced, Mama [Mrs. Simar] to jatamaansi

Mrs. Simar: *Hanh*. [Agrees]. And it helped. Actually when I was having that, I solved my blood pressure. It became alright.

Mrs. Simar had been seeing her guru, Swami Ji, when Geet was a child. Geet, too, followed in his mother's footsteps and began seeing him at the age of 21 once he became a student of yoga.<sup>57</sup> Geet's relationship to Swami Ji become stronger as Mrs. Simar had difficulty travelling to see him. Geet visited Swami Ji a few times a year, in the neighbouring province of Uttar Pradesh and obtained guidance on a number of issues, including health matters for himself and his family.

Jatamaansi was an artefact embedded in this long-established repertoire of health-making practices. To visually map how this process culminated in a cup of herbal tea for Mrs. Simar, one could follow two pathways. The first commenced from the Simar household to Khaori Bhaoli market and then finally to the herbal supplier, Ajay, in the nearby market of Kotla Mubarakpur for the herb. The second pathway started from the Simar household and then led to the neighbouring province, Uttar Pradesh, to the Swami Ji's ashram so that the Simar family could procure the knowledge, instruction, and technique which informed them to the existence of jatamaansi. They also learnt how to

<sup>57</sup> The Simars never mentioned the name of the guru, and so I use the term "Swami Ji" , a general honorific term for such figures.

transform this object into an efficacious remedy. The pathways then converged again back at the household, in the kitchen for Mrs. Simar. Jatamaansi became an important actor in Mrs. Simar's story once it was suitably located on circuits of exchange that are propelled by trustworthy human actors, such as Geet and the part-time herbal supplier, and so on. This trajectory revealed the sociality which drove the process of consumption (Appadurai, 1986). Acknowledging these diverse pathways (or "provisioning" as Narotzky [2005] puts it) is helpful in illuminating the processes of consumption and production which follow financial purchase.

Going back to Appadurai's question articulated in *The Social Life of Things: Commodities in Cultural Perspective* (1986), what are the salient distinctions between a commodity and a gift? This question is especially pertinent for health care in Delhi which can follow non-market pathways along,

communal or kin-oriented provisioning along complex paths that are affected by things like domestic or local networks, cultural patterns of mutual responsibility and the position in the production system of network members. (Narotzky, 2005, p.89)

Jatamaansi was sort of a commodity, sort of a gift. This herb was purchased from the medical marketplace, but its usage as a therapeutic resource was sustained by relationships of caring, dependency and mentoring between Mrs. Simar, Geet, and Swami Ji.

## **6.5. Informal Practitioners and the Basis of their Medical Authority**

Ayurveda converges diverse forms of expertise in spheres ranging from herbology (personified by the vendor of jatamaansi and Bina's gardener) and religion and spirituality from figures such as gurus, who derived their authority in fields broadly related to Ayurveda, such as Hindu Vedic philosophy. Swami Ji was a healer who had renounced the world and lived in an ashram with no affiliation to any institutional setting.

How was he able to express medical authority? He was not explicitly a medical practitioner, but his authority in religious matters segued into his authority on health. This brought to mind the assertions by some scholars about the non-remedial conceptions of health so that one could live out a full life and achieve the four goals (*purusharthas*): desire, *artha* [material prosperity], *dharma* [social and cosmological harmony], and deliverance (Alter, 1999; Halliburton, 2009; especially Zimmerman, 1987, p.205).

Some health care researchers denigrated practitioners who lacked official qualifications as *quacks* who posed a danger to patients (Nandraj, 1994; Sheehan, 2009). Certainly, it is true that unqualified practitioners could be a risky therapeutic recourse, however, social scientists consider their function in a local setting before dismissing them as such. Sarah Pinto (2004) observed that informal practitioners may compensate for the gaps or “lacunae” of institutional structures in India exemplified by government hospitals with absent doctors and overloaded waiting rooms, and prohibitively expensive private hospitals (p.239). Fernandes (2006) stated the middle class of Mumbai frequently recounted negative experiences regarding treatment in private hospitals or else relayed stories of corruption featuring particular doctors who demanded bribes (p.134). Patrons of both government and private institutions often had doubts that their needs can be met in fair manner. Trustworthiness was not a given, however the middle class could elicit the services of a particular doctor who had a good reputation.

Pinto (2004) observed that informal practitioners were an important resource for marginalized patients. For instance, the services provided by a gynaecologist or “lady’s doctor”, named Mishrein, were based on informal training she acquired from her husband, a highly regarded allopathic doctor. This “lady’s doctor” made house calls and helped women give birth, provided injections, and treated related gynaecological medical procedures. Most significantly, she was called upon for controversial procedures that women would be reluctant or unable to undergo in the hospital, such as abortions. Practitioners such Mishrein derived their expertise and legitimacy via professional or kinship-based networks and filled pressing medical needs in their community (2004).

Pinto problematized the divide between local and institutional authority by investigating how local politics and village hierarchies intersected so that certain actors could successfully claim a self-made medical authority. For instance, a powerful landowner, Babu-ji, was a village authority and also entrusted to handle disputes, legal problems, and other local issues. He learned about allopathic medicine on the side and assisted in the well-being of the village inhabitants by providing injections and prescriptions (Pinto, 2004, p. 345). Babu-ji's practice of medicine relied on his village authority rather than any official degree.

This research took place in rural North India where biomedical institutions prevail and are frequently resorted to by patients for health care (Pinto, 2004). This made for two types of practitioners: those who were officially recognized and those who mimicked the former to dispense pharmaceuticals or injections, for instance. The patient populace was habituated to biomedicine, and this is why informal biomedical practitioners were the salient alternative to officially recognized ones.

This chapter extends Pinto's theorising of how local authority can be re-cast into a medical authority. Geet, for instance, brought up the work of a non-officially trained medical practitioner,

Geet: A lot of people are practicing homeopathy, *even though they do not have a formal degree... they have a degree of experience*. There are quite a lot of these people. I would not say that they are uncommon. To give you an example – you've been there - Sanyas Ashram... earlier on, Dr. Lal looked after their homeopathic division. You know, he would give a clinic in the morning organized by the ashram. But he had no formal experience or a degree in homeopathy. He was a retired general manager... then he became a homeopath at Sanyas Ashram, and he was very good. It was only the *experience* of homeopathy [that he had]. [italics mine]

Dr. Lal did not have any official training and so did not practice in institutionalized settings, such as hospitals. However, his long association with Sanyas Ashram as a devotee provided him the opportunity to carry out homeopathic practice as a non-

professional (i.e. volunteer). A practitioner must be trustworthy, but one did not necessarily require a formal degree to be considered as such.

India's informal health care economy, which is not officially regulated, is disparaged as "unregulated" (Nandraj, 1994) or the "unorganised sector" (WIEGO, 2012). Yet, informal economies may offer their own means of control and safety that are based on relationships of trust and "first-hand knowledge of the nature and origin of the goods or service and of the person distributing it at each stage" (Narotzky, 2005, p.89). Moreover, they illuminate other types of transactions that take place in the health care arena, such as non-monetised exchange.

## **6.6. Conclusion**

In the households of Delhi, the home-based production of Ayurveda consists not only of objects or goods, such as medications, but also includes other therapeutic resources, namely informal practitioners such as gurus and especially domestic labourers. The relationships of care and dependency, which take place between various members of the household, connect the household to therapeutic options in the informal medical marketplace.

The stories told by Vishal and Geet reveal how the domestic world intertwines with the bazaar in a mode of labour, trial and error, and intermittent consultations between family members and a spectrum of experts. The process is an unstable one in which the legitimacy and efficacy of Ayurvedic knowledge is opened to questioning. The presence of many networks (for instance through household, friends, religious gatherings) could generate competition, but also provides a ground for accessing and testing different approaches

A spectrum of experts who have experiential knowledge rather than formal training enact this medical practice and expands our understanding of "medical practitioners". These informal healers need not practice in the clinic nor base their livelihood on their therapeutic work.

How might one understand those who receive this expertise? Raj, Bina, Geet, and Mrs. Simar may be considered “consumers” if this practice is understood as a transformative process of purchasing (products) to creating (remedies) which need not take place in the formal economy. In the household, being a practitioner or consumer of Ayurveda is based on affective and commercial exchange of medical knowledge.

Health care practices from the household may be invisible to outsiders, and even what is called Ayurveda is embedded in an assemblage of local or indigenous health care options. A closer examination reveals the intricate configurations of expertise and relationships which sustain this practice.

## **7. Enactments of Ayurvedic Knowledge in the Clinic**

Medical anthropologists frame clinical interactions as patient-healer relationships. The marketization of Ayurveda and the persistence of informal transmission of medical knowledge gives one opportunity to inquire, What does it mean to be a consumer in the Ayurvedic clinic for patients and practitioners? What kind of activities does this involve inside and outside the clinic?

As Ayurveda becomes more prominent in the private health care arena and associated with cosmopolitan lifestyles, it attracts a new class of emerging consumers, such as India's urban middle-class. The popularity of Ayurveda outside of India, in the alternative medicine industry, shapes its practice in the capital city of Delhi, as clinics fashion themselves as appealing sites for consumption.

I portray clinics as sites which coalesce the many ways of being a consumer and an expert of Ayurveda. In a service-based economy, this health care practice is exchanged as a therapeutic and educational entity. For instance, visitors from abroad may be interested in Ayurveda as potential practitioners, rather than patients. Similarly, local medical practitioners act as promoters and regularly go abroad to disseminate Ayurvedic knowledge to emerging alternative markets in North America, Europe, and East Asia.

I examine the role of the patient-as-consumer in such a setting and emphasize the attentiveness to daily health care regimens required by them before and after the clinical visit. Here, consumption of health care is highlighted as process which continues beyond the moment of financial transaction. Clinics are thus host to different types of consumers, which includes both patients and practitioners from India and abroad.

Clinics are not self-enclosed sites. They reproduce the values and medical norms of the cultural context they are located in. In India's medically pluralist setting, clinics condense diverse types of medical frameworks which includes Ayurveda and allopathy,

and formal and informal repertoires of knowledge. Even in the formal space of the clinic, informal repertoires of Ayurvedic knowledge may be exchanged amongst medical practitioners for aims of professional development and service for the community.

## 7.1. Ayurvedic Clinics in India's Service-Based Economy

India's adoption of neoliberal market policies in the 1990s coincided with the World Trade Organization's (WTO) implementation of the General Agreement on Tariffs and Trade and Services (GATTs) in 1995.<sup>58</sup> The exchange of *goods* had traditionally been the focus of trade regulations, but advancements in information and communications technology, such as the Internet and broadcast media, enabled more cost-effective and therefore greater circulation of *services* (Harvey 2005). The GATTs regulated the international trade of emerging services such as telecommunications, education, and banking.

India's health care industry figures prominently in the global service-based economy because it is of low cost but of high quality. The great number of educated and English-speaking health care professionals and scientists makes India an increasingly popular destination for medical tourism from both the diaspora and foreigners. GATT's four modes of service supply benefit health care:

- cross border supply:  
(i.e. telemedicine or remote health care transmitted through communications technology such as telephone or video or medical transcription services [Wilson, 2010])

<sup>58</sup> Cross-border supply is defined to cover services flows from the territory of one Member into the territory of another Member (e.g. banking or architectural services transmitted via telecommunications or mail); Consumption abroad refers to situations where a service consumer (e.g. tourist or patient) moves into another Member's territory to obtain a service; Commercial presence implies that a service supplier of one Member establishes a territorial presence, including through ownership or lease of premises, in another Member's territory to provide a service (e.g. domestic subsidiaries of foreign insurance companies or hotel chains); and Presence of natural persons consists of persons of one Member entering the territory of another Member to supply a service (e.g. accountants, doctors or teachers). The Annex on Movement of Natural Persons specifies, however, that Members remain free to operate measures regarding citizenship, residence or access to the employment market on a permanent basis. (GATS Additional Mode of Supply, 2011)

- consumption abroad:  
(i.e. medical tourism as undertaken by patients)
- commercial presence:  
(i.e. opening medical establishments in other Member countries)
- presence of natural persons:  
(i.e. movement of health practitioners to other countries)

Health care can become a very deterritorialized and mobile enterprise in its various service-based permutations (i.e. as a treatment in hospitals, in India and abroad).

Biomedical services in India had undergone the most dramatic transformation following the implementation of GATT. Yet, Ayurveda, as an ancient herbal medical tradition, also had great appeal in the marketplace for both domestic and international consumers as its production became marketised for a service-based economy.

Historically speaking, health care has long been underfunded by the Indian government and much of India's middle class resorted to the large private health care sector comprised of informal and formal practitioners located in variety of settings ranging from small neighbourhood clinics to large hospitals. In sum, before neoliberal reforms, private health care was conducted on principles of "economicism" whereby the goal was to "to achieve a stated end [i.e. health], using the least resources or means as possible" (Wilson, 2010, p. 37). These facilities were quite as the circulation of medical technologies were restricted up until the early 1990s due to licensing and trade restrictions (Baru, 2002). As well, many patients were reluctant to spend money on health care, as consumption was not yet an ideology promoted by the state, and perhaps also because health care facilities did not entice consumers sufficiently.

The goal of "functional" health services transformed with the advent of neoliberal transitions and the marketisation of health care. As I stated in Chapter 1, marketisation refers,

to the ways in which the provision of health care is being shaped by the globalisation of trade in health services, the commercialisation of the health care industry, the local context of a competitive marketplace, the fashioning of health care as a commodity, and the aspirations of the middle classes for social mobility. (Wilson, 2010, p.38)

In this setting, health care was carried out as an enterprise and its activities were oriented to gaining a greater share of the consumer market more so than responding to public health needs. In this context, values such as competition and entrepreneurship, reduction of risk (i.e. through increased medical testing) configured health care activities (p.37-39). Accordingly, clinics and hospitals established themselves in the medical marketplace by transforming their organization and management; integrating emerging technologies and services; cultivating positive customer relationships, and so on. In this way, both hospitals and customers could align themselves with cosmopolitan practices of health care. One advertising executive, Jayesh, I interviewed opined on the newfound importance of services by remarking, “A good clinic is like a hotel... with an A/C room, a welcome drink, pleasant doctor, magazines, the finest needle --- and no horrible smells” (Jayesh, December 4, 2004).

As health care becomes “an important and growing activity” in the medical marketplace, advertising and marketing becomes a crucial means of assuring continued business (Kearns & Barnett, 1997, p.179). Marketing strategies may be *implicit* with medical buildings such as hospitals attracting consumers due to their great stature and visibility, or by their location in retail zones such as shopping districts where health care can be found alongside brand-name clothing, athletic sneakers, and fast food (Kearns & Barnett, 1997). Consumers, in turn, cultivate and express their middle-classness by frequenting such spaces (Liechty, 2002; Srivastava, 2007). My quest for a clinic to conduct fieldwork brought me to a wide range of private Ayurvedic clinics, some of which had fashioned themselves as appealing sites following India’s economic transition. The section below describes how such spaces captured the attention of consumers as much as it depicts the ‘journey of the ethnographer’.

More importantly, my interaction with these clinics as an ethnographer revealed the myriad of ways one could be positioned as a consumer of Ayurveda in Delhi’s medical marketplace. Certainly clinics relied on patients to ensure their functioning and success in the medical marketplace. However, clinics also addressed – and cultivated – new consumer desires, such as medical education for aspiring practitioners. My interest in Ayurveda often led me to be positioned in this way. Looking back, the terms of my

integration into most Ayurvedic clinics related to the role I could play in expanding the enterprise or being proof of its global interconnections in my role as a foreign researcher. I was positioned as various types of consumers: patient, potential practitioner, and even a promoter of sorts, as the reader shall see below.

One of the first clinics I visited had been recommended to me by Manali, an advertising executive who had previously worked on an account for a spa which marketed Ayurvedic beauty treatment. This woman had been personally involved with Ayurveda from the time she was a teenager for recurrent skin problems and had visited Dr. Vidya for the latter issue several years ago when she moved to Delhi from Kerala and opened up a clinic. Manali recommended that I visit this practitioner to help with my research (November 4, 2004).

In fact, I not only heard of Dr. Vidya's clinic via word of mouth from Manali but also came across its advertisement in one of Delhi's English-language newspapers. Clearly, there was something about this clinic, which the middle-class enjoyed. I was not sure if it was the practitioner, her Kerala-style of Ayurveda, or perhaps just Ayurveda in general. I called the receptionist and made an appointment. I visited the clinic several days after setting an appointment with the receptionist. Upon entering the clinic, one was presented with a small waiting room and counter with a receptionist. This area was quiet and reminiscent of a living room. There was no evidence of tired staff and frenetic medical activity taking place. Instead, a handful of patients sat in plush seats around a coffee table with English language newspapers and magazines such as *Times of India* and *Frontline* (p.178).

The clinic seemed to cater exclusively to a middle-class affluent clientele of various ages, most of whom were sporting Western attire. Patients were let in one at a time to a closed office, and two clinicians (Dr. Vidya and her assistant), lent their undivided attention to patients. I was eventually called into Dr. Vidya's office, and sat across a large desk, opposite an empty chair that Dr. Vidya would eventually occupy. Seated next to me was a young woman with clipboard in hand, who was an assistant. We introduced ourselves and made small chat for a while (she asked where my family was

from). When Dr. Vidya stepped in and sat behind her desk, I introduced myself and explained that I had learnt about her clinic from one of her former patients, Malvika. I was able to speak to her for a few minutes as I asked some opening questions about the relevance of Ayurveda in contemporary Delhi, before she cut in to conclude the conversation by requesting that I move on (meaning, exit) so that she could attend to her other patients.

The opportunity cost of speaking with an ethnographer was too high for this busy practitioner and so thwarted the possibilities for long-term fieldwork. As a foreign researcher with an interest in Ayurveda, I was perhaps an embodiment of the global marketplace, and this provided a means to capture some of the time from Dr. Vidya, however provisional. Yet, I did not occupy any overly productive role in this clinical setting. In fact, I impinged on the needs of the practitioner and patients, which prevented any further interaction from taking place.

In my efforts to obtain a birds-eye view of the number of Ayurveda clinics located in Delhi, I used telephone directories as a resource. However, telephone books were not widely consulted in Delhi. In fact, I purchased this item from a bookstall, a likely indication that this was not an exhaustive resource for information for Delhi residents. I did find a few clinics listed - perhaps the fact that these two clinics were listed at all reveals something about their acumen in marketing themselves towards clients with middle-class sensibilities (those who had travelled abroad who would know what a telephone directory once offered) and increasing their invisibility.

In any case, I visited Akash Ayurveda, a clinic that I successfully “cold called” from the directory, and conversed with owner, Dr. Chabra who happened to be present at this location. Akash Ayurveda was part of a chain with headquarters in the outskirts of Delhi. Where Dr. Chabra spent most of his time. During my visit, he allowed me to sit in as he received a patient, a thin school-age girl who had been suffering from allergies. She was accompanied by her mother, and an aunt or family friend.

However, Dr. Chabra had already established the terms by which I could participate in his enterprise. After the family left, he let me introduce myself and my

research project. He then spoke about some general Ayurvedic principles and provided me with contact information for a colleague, a former classmate of his, who worked in a large government hospital as a possible site for my fieldwork on clinics. Dr. Chabra did not provide regular access to his clinics, however he invited me to join in on a series of upcoming workshops he provided for students of Ayurveda who came from all over the world. In fact, there was an orientation taking place the following week. I was uncertain about the workshop since I was not an aspiring practitioner and the fee, which amounted to hundreds of Canadian dollars, was prohibitive. Nonetheless, I planned to attend the orientation session to acquire some exposure to Ayurveda and its practitioners. Dr. Chabra gave me the phone number of a Belgian student who would be attending and suggested that I arrange a ride with her as the orientation would be taking place in his headquarters, located in the new townships which had developed in the outskirts of the city. Rana Dasgupta, an award-winning British-Indian novelist, writes about the striking transformation which has taken place in townships such as Noida (acronym for New Okhla Industrial Development Authority) and Gurgaon following India's transition to neoliberal reform,

The quaint community markets built in the socialist era were entirely inadequate for exhibiting the products of the new consumer economy. So when Gurgaon opened its doors, proclaiming a 'new Singapore' of glass office blocks, gated communities, golf courses and shopping, it did not take long for the corporate classes to respond. Flush with boom cash, India's banks handed out loans to anyone who asked, and house prices were rising so fast that it made sense for everyone to put their savings into property. Microsoft and its ilk built their Indian headquarters in the thrilling emptiness of the Haryana countryside, and Gurgaon quickly became the largest private township in Asia, a dusty, booming expanse of hypertrophic apartment complexes, skyscrapers and malls. (Dasgupta, para 35, 2009)

**Figure 7.1. Gurgaon and Other New Townships Outside of Delhi**



Note. October 10, 2012; © Google

Dr. Chabra’s Ayurvedic clinic was located in the heart of Delhi’s new business district. Unfortunately, I became ill the night before the orientation and so was unable to attend. Yet, this almost-entry spoke volumes about how Ayurveda was reworked into a global enterprise with workshops offered for foreign students and a location in an area expanded by transnational corporations.

The following week, I called up another Ayurvedic clinic listed in the phone directory, *Sattva Ayurveda* and spoke with a woman named Dr. Sharma on the phone. She was employed to work in the clinic, however the owner, whose name was listed, was frequently off-site and establishing other Ayurvedic clinics as part of this chain. I made an appointment to visit the facilities, which were located in walking distance from an upmarket shopping locale, consisting of brand-name shops and eating establishments. This could perhaps be understood as a strategic entrepreneurial move to draw in traffic consisting of a well-off clientele who were prepared to spend (Kearns & Barnett, 1997, p.175).

Upon entering the clinic, the dimly-lit waiting room contrasted with the hot, bright afternoon outside. The sound of generators, loud as lawn mowers, could be heard from the back. These devices were providing power to compensate for electrical surges which were common in Delhi, especially in the summer when frequent use of air conditioning resulted in many blackouts. On the coffee table lay a selection of Hindi and English-language publications for patients to browse. Across from this seating area was a long reception counter and the dispensary with a selection of medicines lining the walls behind.

Dr. Sharma's office was down a short hallway, a few feet away, behind a closed door. I spoke about my research project in her office as she sat behind a large desk. Afterwards, she gave me a tour of the facilities. Next to her office, there was a small darkened room with a long wooden table where *panchkarma* took place. Panchkarma referred to a treatment whereby patients could receive oil massages or steaming for detoxification, stiffness, pain, and other issues. There was also a large bathroom with toilet, tub, and shower for patients to use before and after treatment. Once our introductions and tour had been taken care of, Dr. Sharma suggested that I take a course at the clinic as a means of learning more about Ayurveda. She explained that she had formerly taught small groups of foreign students from Europe and could accommodate me with one-on-one with teachings based on an Ayurvedic book. My interest in why and how health-seekers used Ayurveda, was interpreted as a desire to want to learn more about Ayurveda and I was positioned as a student or possibly aspiring practitioner who might purchase Ayurvedic knowledge. To be fair, many non-academics, including practitioners, understood the research interests of medical anthropologists in this way. In any case, I agreed to this arrangement as the fee was affordable, the service seemed flexible to my research needs, and the clinic was easier to reach.

I visited Dr. Sharma several times, making appointments for discussions based on the chapters from the book and learned about central Ayurvedic concepts such as *doshas* [substance or force in the body which must be kept in balance]; dietary guidelines, and the ten-fold examination which is based on assessments of the patient's tongue, skin, nails, body weight, and general demeanour (Feb. 04, 2006). Moreover, I witnessed

clinical interactions which coincided with our tutorial session and enabled me see the teachings put into practice.

On one occasion, as I was waiting for my appointment, Dr. Sharma introduced me to two female patients who were exiting the clinic. These patients were foreigners: two European flight attendants who frequently had stopovers in Delhi and so became regular visitors to the clinic. Both had oil glistening in their hair from the panchkarma treatment, One woman headed to the shoe rack by the door to remove her slippers and put on her shoes while the other explained how she became a client of this clinic during her struggle for hepatitis, a condition she had not been able to successfully to treat in her home country.

How did European flight attendants and a North American medical anthropologist such as myself converge as consumers in this clinic? The expansion and commercialization of Ayurveda as a health care service for consumers is contemporaneous with India's more general transitions towards neoliberalism. As the country's borders become more permeable to the movement of people, technology, and businesses, corporate cosmopolitan workers such as airline workers and foreign researchers can be encompassed into its clinical services. Some of these visitors, such as the airline workers, engaged with Ayurveda as patients, while others, with more of an intellectual interest, were invited to purchase medical knowledge as students. The business of foreign consumers is not necessary -- Ayurvedic clinics are lucrative enterprises appealing to Delhi's middle-class -- but it does epitomize the extent to which Ayurvedic services are fashioned as relevant therapeutic option for consumers.

The three clinics I described above asserted themselves in the burgeoning health care market through advertising, and increasing their visibility to capture the attention of consumers who may be 'browsing' retail or media environments such as shopping districts, newspapers, or telephone books. Yet, my ethnographic encounters as an ethnographer revealed that clinics could be embedded in the global market for Ayurveda, even if they did not explicitly market themselves.

I realised this after accompanying a family friend, Neena, to her appointment with Dr. Arora (her Ayurvedic practitioner) one evening so she could resolve a recurring issue of low grade chronic pain in her legs.<sup>59</sup> Neena explained that Dr. Arora came from a lineage of practitioners and that her family had been consulting him for at least two generations. Neena declared that her grandfather used to visit Dr. Arora's father for his ailments, and he that lived a long life. Ayurveda was, in this case, a family tradition inherited by both practitioners and patients.

I lived en route to the clinic and Neena picked me up on her way. My intention was to accompany her with the hopes of asking Dr. Arora some questions, and investigating possibilities for future fieldwork. Neena may have walked to Dr. Arora's clinic when she lived in the neighbourhood as a child, but was now a longer distance away and required her to drive in traffic. She remarked that it was increasingly worse over the years as Delhi's roads filled up with more people who had automobiles. We spent about 15 minutes in Delhi's long rush hour (which started around 6 PM and could go on past 8 PM) amidst other buses, cars, auto rickshaws, motorcycles, and scooters as people made their way home from work.<sup>60</sup> Traffic clustered in certain intersections and drivers beeped their horns frequently with a casual exasperation and boredom. Neena drove a large vehicle that was quite high off the road and resembled a 4 x 4 and gave her power to navigate Delhi's aggressive streets as a female driver.

Once we cleared the clog of traffic, we exited the main road and continued along a series of quieter side streets which had no street signs but were expertly navigated by Neena's decades of local knowledge about her parent's neighbourhood. Suddenly ours was the only vehicle on a dark road. To my right, was a concrete building with benches inside, and a crowd of people in an interior illuminated by fluorescent lights. This utilitarian setting, along with the open door, which left its attendants in full view, led me to believe that we were passing a very public place – perhaps a train station? “This is it”,

<sup>59</sup> Neena used Ayurveda but also resorted to many different therapeutic repertoires in the medically pluralist setting of Delhi: homeopathy was used for certain issues, and allopathy, in accordance to the needs of her family.

<sup>60</sup> An auto rickshaw is a small three-wheeled vehicle used for transport around Delhi.

said Neena as she parked the vehicle. It was actually the clinic. The fact that this was an Ayurvedic clinic quickly became undeniable as the smell of herbs hit our noses as we walked in through the doors.

Dr. Arora's clinic was a busy space with people presenting a variety of ailments for treatment. The patients consisted mainly of middle-aged women and men who held tickets with a number on them. As in thousands of waiting rooms the world over, there was a digital LED display on the wall corresponding to patients' ticket numbers. People stood in line just outside an enclosed area where the practitioner was seated. Those who had seen Dr. Arora already had sheets with prescription numbers written in a column and waited in line at the dispensary. I followed my aunt, who made her way through the crowd quite easily. The practitioner's office was simple with a few benches for patients, his desk, and two posters on the wall: one with an encouraging message in English which read something like "Don't give up until you have the right answer". The other was a colourful depiction of the elephant-headed deity, Ganesh, the remover of obstacles and a favourite god of many Hindus.

The practitioner, Dr. Arora, was in his fifties and dressed in white, and this lent him a very distinct look from his patients. He wore a *kurta pajama* outfit and was slightly balding, with black hair.<sup>61</sup> He carried a steady serious expression. We, as a group of about a dozen waiting patients, watched his treatment. Each consultation took a few minutes and began with him putting his hands on the patient's wrist to measure their pulse, and then making a list of numbers: a code which referred to the prescription. When it was my aunt's turn, her role in the clinic switched from bystander to patient as she sat at the side of his desk surrounded by a half-circle of patients. She hitched up the bottom of her *salwaar kameez* and showed her calf which had been bothering her since her trip to

<sup>61</sup> A *kurta* is a long tunic button-up top which is usually matched to the same material and colour of the baggy drawstring pyjamas.

Canada over a year ago.<sup>62</sup> Neena had a soft voice and Dr. Arora also spoke quietly which lent some degree of aural privacy to an otherwise publicly-witnessed interaction. Like most of the others in the clinic, they conversed in Hindi. After her consultation, she introduced me. It was now my turn to sit in the patient's chair (except that I was not a patient). I tried to speak loud enough so that my voice was heard above the sounds of herbs being grinded at the dispensary. I explained that I was a graduate student from Canada with an interest in the contemporary uses of Ayurvedic medicine. After he agreed to be interviewed, I began with my questions and took notes in my book.

From my interview, I learnt that Dr. Arora's father has been practicing Ayurveda for 65 years and Dr. Arora himself had been practicing for 30 years. This clinic's operations depended on the help of six employees: four who made medicine, a dispenser, and a cashier. Dr. Arora was educated at a well-known Ayurvedic medical college which provided training in both Ayurveda and biomedicine.<sup>63</sup> When I asked about the relevance of Ayurveda in India today, Dr. Arora did not discuss the preferences of consumers. Instead, he brought up the mass-production and wide circulation of medicines, stating that "It is now practiced everywhere... North America, Mexico, Switzerland, and Germany ... the quality and standard has gotten better". I wondered what could influence someone to use – or overlook – Ayurveda as a therapeutic resources and inquired about the cost of Ayurvedic medicine. Dr. Arora stated that "Ayurveda is cheaper than allopathy. It is more cost effective." I asked about the significance of Ayurveda in a medically pluralist setting his opinion on combining medical systems. He replied,

<sup>62</sup> A *salwaar kameez* is an outfit worn by women in the north of India consisting of a long tunic and drawstring pyjamas which are traditionally baggy but can be worn tight sometimes depending on fashion trends (and their followers). There is also a scarf or *dupatta* which women drape around their shoulders or cover their head with if they are devout Sikhs in public view.

<sup>63</sup> As stated earlier, all state Ayurvedic colleges provide training in allopathy, but some emphasize this component more.

Some people combine Ayurveda with other medical practices or allopathy [biomedicine]. Sometimes a combination is needed. If there is surgery, allopathic medicine is needed for that. Allopathy is also needed to treat tuberculosis.<sup>64</sup>

Dr. Arora had a pragmatic attitude and did not seem concerned that Ayurveda be the sole medical option for his patients. He asserted this pragmatic attitude towards our interview by requesting that I unseat myself from the chair at the side of his desk (reserved for patients) and that I shift to a bench further from his desk. After asking a few more questions from the bench, I closed the interview by inquiring about the kinds of illnesses Ayurveda was considered efficacious for. He responded that Ayurveda could treat many chronic diseases and even included serious ones such as cancer, AIDS, and arthritis (November 18, 2004).

As Neena and I made our way out of the clinic, my attention was drawn to a window at the entrance of the clinic which opened to its dispensary. A cluster of hundred rupee notes flashed as the attendant handled a cash transaction from a man and a woman, perhaps a couple, who then picked up their purchases and walked to their nearby vehicle.<sup>65</sup> They loaded the trunk with approximately ten bags of bottles and packages of light-coloured powdered herbs (perhaps the ones which were grinded as I spoke to Dr. Arora) in plastic bags, which were then packed together in paper bags. I commented on this massive purchase to Neena who remarked, “They are probably from abroad” to explain their bulk purchase.

We paid a quick visit to Neena’s parent’s home, located nearby, and sat around the table drinking warm milk and tea. Neena announced to her parents that I had interviewed Dr. Arora. She also commented that he spoke very good English. This news did not surprise them and Neena’s father commented, “He goes all over the world”. So, Dr. Arora had first-hand knowledge about the practice of Ayurveda outside of India.

<sup>64</sup> “Allopathy” or “Angrezi” medicine (English medicine) is commonly used in Indian English to refer to biomedicine.

<sup>65</sup> \$1.00 Canadian Dollar = 46 Rupees.

My visit to Dr. Arora's clinic destabilised certain presumptions I had about how Ayurveda was integrated into the global medical marketplace. I initially conceptualized (perhaps romanticized) Dr. Arora's Ayurvedic clinic as a small, perhaps quaint, neighbourhood establishment after learning that Neena's family had been patients for a few generations. However, Dr. Arora's clinical practice seemed to function on principles of "economicism" as articulated by Wilson (2010) with its minimal and functional ambience (spare décor, hard seating, no waiting room) which was in contrast to the clinics such as Akash Ayurveda and Sattva Ayurveda which were more marketised. Yet, Dr. Arora's clinic was still part of the global enterprise of Ayurveda with diasporic visitors from abroad, and a practitioner who travelled to Europe as a consultant.

The three professionals, Dr. Arora in his traditional kurta pyjama attire, Dr. Vidya in her white doctor's coat, and Malvika in her pants-shirt business work attire all propagated Ayurveda for Delhi's middle-class. Perhaps the contemporary practice of Ayurveda shows that the distinction between local and global enactments are impossible to parse. Clinics can be junctures for long-established neighbourhood health care practices and for emergent consumer practices of Ayurveda. Clearly, I was dealing with a busy enterprise, not a dying cultural tradition. My interest in this medical practice as an anthropologist was not enough to entice its practitioners, who already had many enthusiasts, into participating in my research.

## **7.2. The Ethnographer's Entry into Ayurveda Clinics**

As it turned out, I ultimately did not need to be a consumer for my long-term entry into a clinic. Instead I was integrated into a clinical setting as a visiting researcher at SK Memorial Hospital, a private and predominantly biomedical institution with an Ayurvedic department. I conducted research under the supervision of Dr. Gupta, an Ayurvedic practitioner who treated out-patients (i.e. day patients) and in-patients (i.e. those who were ill enough to require overnight hospital stays). I learned about this hospital from an aid worker named Gillian, she had an American friend who had conducted research in this hospital, however in another department with Dr. Bains. I was

able to arrange a meeting with Dr. Bains one weekday morning and this person took me to the Ayurvedic wing of the hospital after I introduced my research and myself. I was presented to Dr. Gupta as he was at work, receiving patients in his clinic. This doctor graciously invited to take a seat across his desk and I was able to start clinical observation from that point on.

In Ayurveda, transactional and more personified relationships intersect rather than oppose one another in institutional settings such as the hospital (Langford, 2002, Svoboda, 2008). Perhaps my placement in Dr. Bain's research network (however serendipitously) legitimized my presence in Dr. Gupta's specialized clinical setting. Yet, the functioning of a clinic is based on formally-mediated transactional relationships between actors with roles such as patient, consumer, and clinician. A medical anthropologist also needed to be appropriately integrated into this workflow. In terms of access, the clinic presents itself as quite a specialized setting with entry which is restricted to experts, such as medical professionals (i.e. practitioners, nurses, and various medical assistants) or those in need of them, such as patients. The inclusion of the ethnographer, whose intellectual concerns and temporary presence rarely enable them to be completely integrated into social milieus is remarkably challenged in such a setting (Wind, 2008).<sup>66</sup>

One basic and important activity of anthropologists, "participant-observation", can be understood as a productive means of capturing the insider-and-outsider dynamic that underlies fieldwork as ethnographers immerse themselves into the social lives of their participants and yet also step back to reflect on what took place (Mason, 2002). In a clinical setting, to what extent can a social scientist with no background in medicine conduct participant-observation? Wind (2008), a qualitative researcher who was once a nurse, admitted that her activities of observing and speaking with nurses and patients in the hospitals could not be suitably classified as "participant—observation". She preferred the term "negotiated interactive observation" because she could not claim to fully

<sup>66</sup> To be fair, not all fieldworkers are transient visitors, some are permanent members of their ethnographic sites.

understand the perspectives of patient nor practitioner (p.83). My interest in Ayurveda and enrolment in a graduate studies program classified me as a student or trainee of Ayurveda. I, too, was, located on the observation end of the participant-observation spectrum and thus found it more appropriate to frame my interactions as *clinical observation*.

A variety of research activities configured Dr. Gupta's clinic as a transnational space. Dr. Gupta, too, participated in the international propagation of Ayurvedic knowledge and regularly went abroad to Europe and East Asia to teach in Ayurvedic clinics. In turn, medical interns from these establishments visited his clinic to observe him in practice. These students were often present during my visits and, in fact, Dr. Gupta treated me in the same manner as them. The medical interns and I sat across Dr. Gupta's desk and observed his activities as he attended to his mostly Hindi-speaking patients. From time to time, he would occasionally provided us explanations, in English. My clinical observation sessions took place an average of twice a week and were approximately three hours long. Patients presented common illnesses ranging from colds and coughs to digestive problems such as gas and acidity, skin problems such as eczema, weight problems, mental illnesses, sexually transmitted diseases, along with many arthritic conditions.<sup>67</sup>

I was incorporated into the everyday workings of the clinic, which allowed me to witness a variety of interactions between patients and clinicians as I was sat on a chair

<sup>67</sup> The frequency of the latter could be due to the timing of my clinical observation, the bulk of which took place in the winter months from November onwards, a time when arthritis-related conditions peaked.<sup>67</sup>

across from Dr. Gupta, with pen in hand, furiously writing notes.<sup>68</sup> Most of my time was spent listening to patient's verbal accounts as they spoke to Dr. Gupta.<sup>69</sup>

Exactly what does 'consumption' involve? Ayurveda is clearly purchased as patients pay for treatment in this private clinic. Patients consume Ayurvedic treatment as a means to an end, which, in this case, is health. I examined how patients integrated these clinical sessions into their everyday lives beyond the visit by listening to their verbal narratives as Dr. Gupta inquired into their daily routines.

For my analysis of patient-practitioner interactions, I rely on Cheryl Mattingly's (1994) understanding of clinical encounters as opportunities for healers to "plot" therapeutic actions or interpretations, which help create a story towards recovery for patients. Mattingly is an anthropologist who has written extensively on narrative and cultural construction of healing *in situ* in clinical spaces. She argued that clinical interactions featured narratives of illness which were unfolding in real time or "contemporaneous" (p.811). This is different from the "retrospective" accounts provided by Sunil and Ramesh in Chapter 5, which referred to stories of illness recounted after the fact, from the "the other end" of an illness episode, usually recovery. In Dr. Gupta's clinic, patients were situated in a liminal stage and sought resolution to their suffering. In such interactions, "the movement towards recovery dominates the experience of time" (p.813). My empirical description of Dr. Gupta's workday below shows how the routines

<sup>68</sup> When the clinic was not busy, I was sometimes introduced to different staff or activities which provided an additional layer of understanding to the complex workings and research activities which propagated Ayurvedic treatment in this hospital. For instance, one day, I was introduced to Dr. Gupta's research assistant, Megna, in the hospital and ushered to her temporary office. Here, she showed me paperwork related to her research project, which translated Ayurvedic bodily conditions, doshas, into concepts that could be measured by evidence-based medical (EBM) practice. Part of her task was to enlist Dr. Gupta's patients as research participants following their visit and then conduct a brief interview based on a close-ended questionnaire. This project was supported by the Central Council for Research in Ayurvedic Sciences Council. EBM can be thought of the lingua franca of clinical research enabling Ayurveda to be communicated and understood by a wide scientific community. Although this clinic was a physical bricks-and-mortar entity in Delhi, it was a conduit for the global flows of Ayurveda.

<sup>69</sup> Most of the discussions took place in Hindi. Dr. Gupta took notes in English and spoke to me and the visiting researchers in English too.

of the clinic structure the flow of verbal and non-verbal activities of practitioner and patient.

As the reader shall see, a multitude of social (human) and non-social (non-human) actors conspire to enact Ayurvedic treatment in the clinic. Pfaffenberger explained sociotechnical systems to be animated by,

complex social structures, nonverbal activity system, advanced linguistic communication, the ritual coordination of labor, advanced artefact manufacture, the linkage of phenomenally diverse social and non-social actors, and the social use of diverse artifacts (2002, p.513).

Dr. Gupta is considered an Ayurvedic practitioner, but his placement in a modern, allopathic hospital and usage of tools like the stethoscope, blood pressure monitor, referrals for extra tests such as MRIs, scans and other “biomedical fetishes” (Naraindas, 2006, p. 2667) blurs the distinction between allopathy and biomedicine.

The accounts below are a selection of cases which took place over a typical day in the out-patient department from Dr. Gupta’s clinic. The consultations rarely lasted more than a few minutes as Dr. Gupta treated a high volume of patients. Most of the conversation in the clinic took place in Hindi, but Dr. Gupta recorded his notes in English and used the terminology exactly as I have italicized (i.e. some words in Hindi, others in English). The patients tended to be returnees and so the names and details of their ailments were not always explicitly articulated.

Firstly, the patient’s interaction with clinicians commenced before they saw Dr. Gupta. They received their folder upon checking in with the unit clerk and then sat in the large waiting room on plastic seats affixed in rows. The sweet pleasant smell of warm oil and herbs permeated the air. These herbs were used in the panchkarma treatment unit, located further down a short corridor. The waiting room was frequently full and the Dr. Gupta often worked past his official closing time to accommodate the influx of patients. An assistant summoned a patient from the waiting area when their turn with Dr. Gupta approached. This assistant weighed the patient on a nearby weight scale by the doorway of Dr. Gupta’s clinic and recorded this information in their folder.

Patients then waited around the doorway for their turn. Although they could see the patient Dr. Gupta was treating, about ten feet away, they could not hear the details of the conversation. When it was their turn, the patients would then sit to the side of Dr. Gupta's desk so that he could test their blood pressure. He would also do *nadi parakshaan* (Ayurvedic method of pulse-checking) by encircling three of his fingers around the wrist so that the pads of his fingers were on the inside of the patient's wrists (the right wrist for men, on the left wrist for women). Following this, Dr. Gupta affixed a cuff to the patient's upper arm to read their blood pressure. He then placed his stethoscope inside the cuff to hear the heartbeat. Finally, Dr. Gupta would then ask patients, "How are you?" and this gave the patient opportunity to articulate their ailments. As Dr. Gupta examined the pulse of the patients and so on, he posed a routine set of questions related to daily activities to his patients:

- How is your sleep?
- How is your urination?
- How is your elimination?<sup>70</sup>
- How is your diet?

Patients responded to these questions and they could elaborate on their answer if necessary.

On this particular weekday, Dr. Gupta's first patient was a woman wearing a sari and stated that she was experiencing more pain at night. Dr. Gupta asked how her days were and she replied that when she worked, she did not feel too much pain. He asked if her digestion was well: "*Pet saaf hai?*". He asked if she was able to sleep. She confirmed that yes, she could sleep, but that she was waking up early in the morning, at five-o'clock. She described the pain in her lower back. He wrote in the patient folder, "lumber spondylitis", and instructed her to get an X-ray. He explained to me the cause of her visit:

<sup>70</sup> This question refers to bowel movement, a more specific way of inquiring about digestion.

“Pain in lower back and radiation to lower left limb”. At one point during this session, Dr Gupta, had told me over his desk, in English, that that he had “seen thousands of cases [and that] proper history makes for proper diagnosis”. He continued, “In the USA they wait till MRI report comes. But if the patient talks and confirms the pattern, this correct approach is better than an MRI.” Although Dr. Gupta is recommending testing, narrative remains crucial for diagnosis.

A long-time patient of Dr. Gupta then seats himself. He had previously suffered from *hypertension*, but was now visiting to continue his treatment for *diabetes mellitus* and problems with his knee joints. As Dr. Gupta affixes the blood pressure cuff on the patient, he informs me that this patient had *osteopenia*, and explains (after spelling it out) that this is a precursor to *osteopathy*. He takes note of the blood pressure and asks the patient about his blood sugar count. Dr. Gupta prescribes medicine that is specifically beneficial for arthritis in diabetic patients.

After this patient a frail-looking man comes who is bundled up in a sweater-vest and a pair of light pyjamas under his slacks. Dr. Gupta explained to me that he had an advanced case of *osteoarthritis* and elaborated that inflammation in the joints leads to muscles becoming very weak and emaciated. This man, who was an electrical worker, had problems in multiple joints, and stated that if he did not take medicines, he would experience pain all over his body.

Dr. Gupta asked if he still had his X-rays and the patient affirmed that he did. The practitioner then asked him to demonstrate range of motion by straightening his knee, which was very difficult for the patient. He had very severe pain in the right knee and slightly less severe pain in the left knee. Dr. Gupta wrote him a prescription and he limped out of the clinic.

As the man was leaving, a female patient took a seat. Dr. Gupta checked her pulse and asked if she was having any problems with urination, and she answered no. He then asked about her sleep as he checked her blood pressure. She responded to this and brought up chest problems and congestion that she experienced while in Mumbai. Dr. Gupta then inquired about her medical reports, which she described as normal. He

finished measuring her blood pressure and assured her that it was normal, too. This patient requested pain medicines for a condition that she had been afflicted with for two or three years. She requested treatment for the day after tomorrow and mentioned that she had a month-long supply of medicine. The patient also requested cough medicine for her throat.

At some point, as Dr. Gupta was seeing his patients, a business card of a Ayurvedic medicine manufacturer, named Ayur Herbal, was visible at the centre of his desk.<sup>71</sup> Perhaps a nurse or medical assistant had placed it there on behalf of someone.

After Dr. Gupta had seen his last patient, a medical sales representative who was affiliated with the business card came in, holding a folder bearing the same logo as the card. He held his folder upright, in front of him, so that he could display the text and graphics on the page: he sort of became a human Power Point presentation and provided a brief overview of Ayurvedic medications. This pharmaceutical representative spoke quickly and in what seemed to be rehearsed manner – it seems that he must have recited these presentations dozens of times. Each product featured had its own page. The first page featured a medicine for menstrual problems, the next for *bronchitis*, and another for *cholesterol* and the last one was a remedy for *stress*. Dr. Gupta nodded and listened politely to the pitch. He, too, was a consumer in this clinic who decided between brands and medicines. On the desk was a mini-calendar with the brand name of another Ayurveda manufacturer, perhaps with its own pharmaceutical sales representative who visited.

Anthropologists have discussed the strategies of pharmaceutical sales representatives from all over the world and consider the relationships these agents establish with health care providers, and their powerful influence on prescribing practices through advertising and gifting of samples and other perks (Van der Geest et al., 1996; Oldani, 2004; Kamat & Nichter, 2007). Many social scientists were unable to speak from this insider perspective, but Michael Oldani's work on this subject is particularly

<sup>71</sup> Alias.

illuminating as he was once a pharmaceutical sales representative, a status which lent him in-depth access to this world. Oldani (2004) applies the classical anthropology concept of the “gift economy” to understand how relationships between sales representatives and clinicians were forged and propelled the intense promotion of pharmaceuticals.

Visits by pharmaceutical sales representatives were an established routine in health care spaces as doctors are powerful disseminators of a trusted product: they can prescribe a medication to hundreds of patients, or over many years. Ecks (2010) discusses Pfizer’s promotion of antidepressants and its attendant disease categories, depression and anxiety, to Indian general practitioners. Pfizer’s rationale is endorsed by authoritative international bodies such as the World Health Organization, which states that less developed nations need to catch up with developed nations in terms of their protocol for mental health issues (p.155). Pharmaceuticals are part of a billion-dollar industry and can assert themselves as powerful symbols of healing with the backing of a medical authority, such as Dr. Gupta.

Apart from pharmaceuticals, the clinic featured other medical technologies, including various artefacts such as X rays and laboratory results, brought in by the patients. These artefacts were embossed or printed with logos of speciality or corporate health care centres such as Fortis Escorts Heart Institute or Apollo Hospitals, which have been mushrooming in the major cities following neoliberal economic reforms. In Delhi’s medically pluralist setting, patients continued to resort to Ayurveda alongside the offerings of the above-mentioned super speciality biomedical hospitals. These health care centres measure and manage lifestyle diseases such as obesity, hypertension and diabetes which have increased in India following changes in diet and decrease in physical activity levels among the middle-class (Patwa, 2011). The appearance of such disease categories and related artefacts contribute to the shifting permutations of activity, which are designated as “Ayurveda” in the clinic.

India is a medically pluralist society, but the activities of the Ayurvedic clinic seem to be configured by the workings of allopathy with the proliferation of machinery and testing apparatuses promoted for consumers in the private health care arena, and the

attendant diagnostic categories such as “high cholesterol”. This was vividly portrayed in one case I witnessed which involved a woman who returned to Dr. Gupta a few minutes after her appointment to request a medical test. Dr. Gupta, in his role as a clinician, articulated a rationale of procedure and protocol by responding that she was above the age limit, which made her ineligible for the test. She tried to convince him otherwise, however feebly. This patient understood Dr. Gupta as a gatekeeper to coveted technological apparatuses of health care, such as specialized medical testing.

In India, interactions in institutional settings can be motivated by personal favours, personified relationships, or preferential treatment, which depends on. Such a social modality continues to influence access to desired but scarce opportunities such as admission into competitive schools, or job offers. This reliance on benefactors who may bend rules or create loopholes, occasionally culminates in charges of corruption, but often continues unabated.<sup>72</sup> Perhaps this patient was in hope that Dr. Gupta might use his position to make an exception for her. He instead asserted himself in line with the rules of the hospital conduct and re-state: the matter was not in his hands; she was over 50 years of age and not diagnosed with rheumatoid arthritis which prohibited her from having the test. The female patient tried one last plea: “Who knows, I might have it, I’m always in pain”. Dr. Gupta looked down at his desk and shook his head no. This woman was stranded in narrative time as a sick person or “the place of desire where one is not where one wants to be, *where one longs to be elsewhere*” (Mattingly, 1994, p.813, italics mine). This woman wanted to be “elsewhere” or healthy, with the help of technological apparatuses.

Harish Naraindas (2006) argued that patients and practitioners of Ayurveda were socialized into an allopathic epistemology and that the intensification of neoliberal reforms was exacerbating this tendency. Certainly, patients may be attracted to Ayurveda because they have concerns about the harmful side effects of allopathy or because they

<sup>72</sup> A prominent Indian activist, Anna Hazare has been making the news since leading anti-corruption protests in India since spring 2011. He has since enlisted high-profile supporters to form “Team Ann”<sup>a</sup> to demand more accountability and transparency from the Indian government (The Indian Express, 2012).

believe Ayurvedic treatment is ineffective for their illness. Indeed, many patients who visited Dr. Gupta had suffered side effects from conventional allopathic treatment for arthritis, characterized by repeated dosages of cortisone (an anti-inflammatory and pain reliever).

Naraindas (2006) used the example of a quite atypical Ayurvedic practitioner, Therese, as a case study in his article, “Of Spineless Babies and Folic Acid: Evidence and Efficacy in Biomedicine and Ayurvedic Medicine” to discuss epistemological clashes which took place with her patients: she refused to subscribe to biomedical categories such as “arthritis” or “cancer”. Naraindas pointed out that even as patients pursued alternative treatment, such as Ayurveda, they became uneasy if biomedical measures of “cure” cannot be provided since their diagnosis, for example, “high blood pressure” may be framed in a biomedical medical (p.2660). As well, these patients may be under pressure to provide biomedically-based measures for their workplace. This was the case with a pilot who successfully obtained relief from Ayurvedic medicine for symptoms of high blood pressure, but he was unable to clear his medical examination because his blood pressure rate was too high.

Ayurvedic practitioners such as Therese were also under intense pressure as they attempted to abide by Ayurvedic aetiologies regarding serious medical issues that are categorized in biomedicine as “cancer”. Accordingly Therese demanded a commitment from her patients to pursue Ayurvedic treatment exclusively. She recounted to Naraindas the stress she faced when treating a patient with cancer:

I was really scared. She would constantly shuttle between me and a series of biomedical doctors and would come back and regale me with the possibilities of what could happen if the tumour turned out to be malignant. While I was busy reassuring her that she would be fine, I was going through my own private hell, as I knew what the score was. I had to treat that lump strictly according to concepts and categories native to my system. I knew if I didn't I would be lost. That is the promise I had made myself when I began my practice. (cited in Naraindas, 2006, p. 2665)

Therese and many of her patients seemed to be debating which kind of sociotechnical system Ayurveda should be. The patients preferred that it approximate biomedicine while Therese thought otherwise. The institutionalized version of Ayurveda which has its roots in British colonial systems continued to carry sway for much of the population. Therese resisted this hegemonic rendition of Ayurveda and tried to submit her practice to a different meaning system, one that did not entertain biomedicine as any point of reference. Therese's patients were thus required to be "rehabilitated into a new cognitive and therapeutic universe", but they were unwilling to be stranded in these incredibly charged negotiations between biomedicine and Ayurveda (p.2668). Naraindas concluded that in these fraught negotiations, biomedicine occupied a privileged status (as it has since colonial rule) and Ayurvedic practitioners bore the burden of coaching patients through alternative worldviews of the relationship between cause and effect, medicine and the body understandings of Ayurveda – if they could find any patients who were receptive.

As I stated earlier, a sociotechnical system needs to be upheld or corroborated with homologous social, political, and economic infrastructures to maintain itself. Therese's making of Ayurveda is estranged, as its worldview is not mirrored by the world at large, outside the clinic. Many of the Ayurvedic clinics I visited were not as purist as Therese's. However, I am not certain they were completely dominated by biomedical tenets.

### **7.3. Interactions in the Clinic: Accommodating and Appropriating Biomedicine**

India's colonial history has lent biomedicine a privileged position and the allure and authority of this medical system remain compelling in today's post-colonial setting. Yet, patients and practitioners of Ayurveda interpret biomedical concepts in a variety of ways, in accordance to local worldviews. Perhaps, just as "social information is... crudely encoded in artifacts", so too can epistemological assumptions be crudely encoded in

medical concepts (Pfaffenberger, 1992, p.510). Below I show how ethnographers portray the flexible use of biomedicine for therapeutic aims by Indian patients and practitioners. Following this, I return to Dr. Gupta's clinic to examine how Ayurvedic modalities emerge from patient-practitioner interactions even as biomedical signifiers circulate in the setting.

Judy Pugh (1993), an anthropologist who studied the intersection between South Asian systems of healing and cosmology, showed that biomedical disease categories conditions could overlap with locally-conceptualized illnesses. For instance, an Ayurvedic practitioner's use of the term "arthritis" did not necessarily indicate an adherence to biomedical reasoning as this term was found in classic texts, such as the *Caraka Samhita*. In this text, an assemblage of ailments including "pain and stiffness in the hands, neck, back, waist, calf, ankle, and foot, along with two types of sciatica and two types of gout" were classified as "wind in the joints" -- or arthritis (*Caraka* cited in Pugh, 1993, p.419). Pugh pointed out that Unani medical texts also outlined treatment for arthritis and sciatica.<sup>73</sup> Both of these systems considered "wind" and "coolness" as factors that could trigger arthritis. Patients were generally familiar with these humoral concepts and understood that modulating daily routines by, for instance, avoiding exposure to damp weather and foods that were considered "cooling" could minimize aggravation and provide relief.<sup>74</sup>

Some characteristics between arthritis and "wind" were shared or mutually comprehensible between biomedicine and these indigenous medical practices, even as their etiology was different. In this scenario, biomedical concepts resonated (to some extent) with the healing frameworks of indigenous medical practitioners rather than dominating them.

<sup>73</sup> Unani is a Greco-Arabic medical system that is officially recognized as one of India's indigenous medical systems.

<sup>74</sup> Foods that are "cooling" or "heating" according to a humoral, not temperature, framework and learnt through the course of everyday life.

Other Ayurvedic practitioners also creatively assimilated biomedical concepts into their practice, in their own way. Langford (2003) for instance, described one practitioner's translation of *doshas* as "terms of thermal energy and Ph values", whereas others understood doshas as biochemical principles of "movement" (*vata*), "metabolism, or conversion" (*pitta*), or "material composition" (*kapha*). Still, other practitioners argued *doshas* could not be envisioned in such a way (2002, p.153-154). The author concludes, "if clinical gazes move quickly from dosa to dhatu to disease and back again, they also move flexibly among the many possibilities for imagining their object" (p.172). In the Ayurvedic clinic, biomedical concepts are used, but not uniformly. Rather, they may be selectively and provisionally encompassed into practice. Langford asserted that these practitioners were not drawing upon a unitary ethnomedical paradigm as they re-work biomedical concepts into their practice. These re-workings were an outcome of a series of post-colonial encounters.

Patients, too, negotiated biomedical reasoning in India's medically pluralist setting. Sachs (1989) showed how patients re-interpreted their allopathic diagnosis and prescriptions into an Ayurveda-based reasoning. In her study, patients approached their doctor with a particular understanding of their ailment and selected which aspects they would foreground as mutually intelligible articulations. For instance, a patient who experienced a "cough that results in dry phlegm [and] burning feeling in chest and back" would abbreviate their malady to "cough" as a term to supply to the doctor. When patients received a diagnosis, such as "bronchitis", they engaged in Ayurveda-based etiology and articulated explanations such as "got too hot sitting in front of fire, heat enters the body when sitting by the fire, gets too much *pitta*" (p.342). This explanation likely diverged from the diagnosis provided by the doctor.

Here, the medical worldview of patients was temporarily disrupted as they presented their illnesses to the allopathic practitioner, but these divergent aetiologies were eventually reconciled. Sachs argued that both the patient and practitioner shared a "mutual confidence" in the power of the medicines which kept the therapeutic encounter coherent (p. 345). Even as one invoked biomedical terminology and its objects, it did not signify an adherence to the worldview.

Much of the literature and many of my fieldwork encounters show that actors in the clinic deftly accommodated different medical modalities. Both patients and practitioners are active agents who collaborate in knowledge-making and health care: it is not exactly a case of a medical expert and a passive patient.

What are the implications for understanding the processes of consumption in the clinic? Certainly patients are “consuming” Ayurveda by deciding to visit at a particular clinic and paying for treatment and medications. Although the visit to the clinic takes place once every few weeks or so, the patient’s relationship to Ayurvedic treatment extends into their everyday lives, beyond the clinic as they configure their routines and cultivate an attitude of attentive-ness.

As patients form a relationship with their treatment regimen, their narratives become attuned to the concerns of the Ayurvedic practitioner, with whom they share the same worldview. Judith Farquhar (2002) depicted patients as “microtechnicians” of self in her study of Chinese medicine and the clinic: however inattentive a patient may have been to his or her bodily state prior to seeking traditional medical treatment, once having entered into this therapeutic process he or she cultivated an attentiveness to symptoms and a willingness to report subtle changes. Patients living with chronic illness such as asthma, arthritis, coronary heart disease, or migraines became microtechnicians of cause and effect: they noted the timing of the appearance of symptoms in relation to daily demands, frustrations, and pleasures (2002, p.74). In Dr. Gupta’s clinic, this attentivity to and articulate of certain sensations from patients were interlaced with biomedically-based measures such as pulse rate, blood pressure, and various medical reports.

As I stated earlier, Dr. Gupta posed questions to his patients which included queries about sleep, appetite, urination and elimination. Patients thus needed to be attentive to their daily routines so they could effectively inform Dr. Gupta, and progress away from illness and towards recovery.

“You must listen very carefully to the patient”, Dr. Gupta commented to me following a particularly nuanced narration by a middle-aged woman who came in to the

clinic, dressed in a pastel-coloured *salwaar kameez*.<sup>75</sup> She described symptoms which included: pain (*dardh*) after eating. Dr. Gupta stated that she had acidity and indigestion as he examined her tongue. She commented that her feet felt a bit strange, as if there was something on them. Dr Gupta attributed this itchiness to digestion too. He then went to check her blood pressure. This patient had lab results in her hands for him to consult and remarked that she would feel heavy under the eyes when she awoke in the morning as she handed over the file. She answered the doctor's routine questions on processes of elimination and stated that her digestion is clear: she defecates twice a day. She added that time "seems to drag on", *badha lagta hai*.

I was initially struck by how a seemingly disparate array of sensations and discomforts such as heaviness under the eyes and time passing slowly, were articulated as noteworthy points for Dr. Gupta to assess. In Ayurveda, signs and symptoms are recognized in their own right - not because they build up to a biomedical diagnosis: itchiness, for instance, can refer to an imbalance of doshas (Narandas, 2006, p.2661, Halliburton, 2009) rather than a symptom of say, an allergy.

A second woman came in wearing a green sari. She began by describing issues with her breathing, which was sometimes blocked from throat irritation. This patient also had pain in her knuckles. Dr. Gupta asked her to close and open her hands by making a fist and then splaying out her fingers. He then asked if she felt any *kamjori* (weakness). She responded that she had weakness in the right arm and also that she had pain in her chest. If she reduced her medicine, the pain started. She continued elaborating her emotional conditions stating that if she sat quietly, anger would rise up in her. He documented "hyperacidity" as part of his notes and remarked that her blood pressure was higher in the winter season. Dr. Gupta provided the patient with dietary guidelines and suggested that she reduce her salt intake. With this patient, Dr. Gupta drew on biomedical

<sup>75</sup> "Salwaar" refers to trousers that are often loose and tied around the waist with a drawstring and "kameez" refers to a long tunic worn over. It is worn all over Punjab (in contrast to the sari). In Delhi, many Indian women wore this.

and Ayurvedic frameworks to respond to a range of mental, emotional and physical concerns to resolve different sorts of health issues simultaneously.

For instance, the importance of food cannot be underestimated in Ayurveda as this substance greatly influenced the making of the body (Svoboda, 2008). Although Dr. Gupta diagnosed the patient's issue as "hyperacidity", he then went on to recite foods such as *makkan* (butter), *ghee* (clarified butter), and *ladoo* (a dessert) to the patient. He utilized an Ayurvedic framework to explain that these type of foods contained too much *tamas* and *raja* which led to imbalances in the physical body. Tamas referred to the quality of being too fixed or too lethargic whereas rajas referred to the condition of being too active or too ungrounded (Svoboda, 2008, p.61). In Ayurveda, *sattvic* foods are preferred as they create equilibrium and clarity. Dr. Gupta's patient insisted that she ate only a certain kind of *roti* (a flatbread) and a bit of milk (which is very sattvic-inducing). Whether this was true or not, the patient did concede to Dr. Gupta's reasoning. She requested medicines for two months, but Dr. Gupta responded that he would give her medicine only for one month, which would oblige her to return to him for a follow-up if she wanted to continue.

Dr. Gupta then greets a female patient who was experiencing pain in her hands and shoulders, which became more pronounced in the evening. Dr. Gupta explained to me that she was suffering from *osteopathy*, which has been brought on by *menopause*. Her blood pressure reading was also high and Dr. Gupta recommended that she take less salt and less butter. This woman was experiencing stomach acidity, and she was instructed to avoid sour foods.<sup>76</sup> Dr. Gupta remarked that her body weight was excessive and that the fat needed to be *liquefied*. Dr. Gupta told her he would prescribe medication to help with this, and also give her some medicine to bring some *aram*, or relief, presumably from her pain. As he wrote out the prescription, he told to me: "These

<sup>76</sup> In Ayurveda, the taste qualities of foods (i.e. sour, sweet, bitter) carry their own beneficial or harmful qualities. For instance, a classic Ayurvedic text, *Vagbhata's Heart of Medicine*, describes sour savour (flavour) as, good for the heart, digestion, and appetite. It causes phlegm, cholera, and blood, and corrects the flow of sluggish wind... If it is used too much, it makes the body slack, and causes blindness, giddiness, itching, pallor, spreading rashes, swellings, spots, thirst and fever (cited in Wujastyk, 1998, p.273)

[problems] are *psychosomatic*. If you are happy, then you won't have any disease: physical problems cause mental problems and mental problems cause physical problems”.

While writing the prescription, Dr. Gupta asked the patient if she had any oil for massage. She was limping and had difficulty switching positions with her female companion, who was experiencing pain in her knees and was also recommended to lose weight, so there would be less of a toll on her joints. The two women engaged in self-care and therapeutic care as a duo: they walked together for exercise, and came as a pair to the clinic for treatment. “All of this is from an improper lifestyle... from seasonal, mental, SES problems”, Dr Gupta surmised. He then asked me, “Do you know about SES problems?”. I thought about the term he was referring to, socioeconomic status, and offered, “Standard of living? Environmental problems?” He responded that it was about behaviours that take place in the office, in the house. “There is anxiety and tension [associated] with these roles and responsibilities.” With these two patients, Dr. Gupta intervened on a variety of health conditions, which included: high blood pressure, osteopathy, menopause, psychosomatic problems, and excess weight. Dr. Gupta also offered me a variety of explanations which encompassed diet, age, household, and work roles and responsibilities.

These patients consume Ayurveda as part of their journey towards health and so are expected to take up quite involved roles. Their progression towards health is made known as they collaborate with Dr. Gupta: both of these actors have a role to play in gathering and assembling knowledge from a myriad of signs and symptoms. Such continuous attentive-ness helps information emerge. Actors such as patients and especially healers such as Dr. Gupta “plots” (Mattingly, 1994) these disparate elements into a meaningful narrative of events.

Mattingly (1994) investigated how occupational therapists rendered coherence from the signs and symptoms expressed by their patients to help them attain health. Dr. Gupta is trained in both biomedicine and Ayurveda. What does this fluency mean for how he carried out his clinical interactions? He is required to read evidence in accordance

to both biomedical and Ayurvedic frameworks to assist patients towards recovery. Dr. Gupta's clientele, or patients, are required to converge information from disparate times and spaces (such as mealtime, household, workplace) when they present themselves to the clinic and respond to questions about their daily routines. Practitioners and patients are compelled to converge various frameworks of knowledge for the pragmatic aims of attaining health. Health care is a meaning-making process and this makes it difficult to simply classify certain modalities of knowledge such as biomedicine and Ayurveda, or formal and informal medicine as "dominating". However, consensus between patient and practitioner is not so easy to establish, which is discussed in the following section.

#### **7.4. Interactions in the Clinic: Debating the Signifiers of Ayurveda**

I have been differentiating the health care options so far on the basis of type (Ayurveda and biomedicine). However, Kalpana Ram (2010), an anthropologist who studies class, gender, and experiences of the body, points out that patients' access to therapeutic options in India are not only decided by *types* of medical practices which are available. One's navigation of a medically pluralist setting is strongly influenced by their class position and their access also depends on their cost. This argument counters the more common tendencies in the medical pluralism literature to conceptualize patients as practical and pragmatic agents of health care (Khare, 1996). Ram acknowledges that this emphasis is important as it lends agency to health-seekers who may otherwise be considered passive recipients of medical care (see especially Leslie, 1976).<sup>77</sup>

Ram (2010) argues that the class position of less well-off users' not only affects their physical entry into certain clinics (i.e. can they afford to go?) but also shapes their interactions in the clinic. Ram contrasts patient encounters in rural Tamil Nadu among biomedical doctors from the high and low ends of the economic spectrum. She finds middle-class patients to be outfitted with a level of comfort and familiarity or 'habitus'

<sup>77</sup> See my literature review on medical pluralism in Chapter 4.

with medical spaces which allows them to have a more active role. Accordingly, they can ask many questions, share their thoughts, and voice their needs.

This ability to negotiate treatment is in great contrast to the experiences of poorer patients (or their caretakers, such as parent) who are not habituated to voicing their concerns in the same way. Moreover, they are regularly reprimanded by didactic medical professionals with what Ram terms as the “scolding lecture” (p. 206).<sup>78</sup> Such patients have limited ability to discuss their illness with a medical authority who is frequently condescending. Ram analyzes encounters between doctors and patients where the class difference is narrower and finds that while the doctor acts authoritarian, patients nonetheless can voice their concerns.

Ram emphasizes the continuity between the clinic and other social spaces in which class-differentiated power negotiations take place. The clinic is not a neutral space: patients come here with their scope for negotiation already decided by their class position and this determines the type of treatment they will receive.

However, Ram’s study is limited to biomedical practitioners and my ethnographic study on Ayurvedic clinics reveals that patients are more involved as collaborators in attending to their illness via narration and attentiveness based on shared cultural sensibilities. Also, Ayurveda is not *the* privileged medical system. In India, it is second to biomedicine. Perhaps this makes Ayurvedic practitioners more inclined to collaborate and cooperate with their patients to ensure their livelihood.

That said, middle-class patients who could afford to pay more for treatment were encompassed into clinical settings differently compared to non-middle class patients. The overview I provided at the beginning of this chapter of the architecture, physical layout,

<sup>78</sup> This demand which is shouted from a doctor in the hospital hallway is an example of such a lecture, “We need blood for your daughter! Who is going to give it?! We have already put in two bottles. We need another one — fast! — or she will go!” (Ram, 2007, p.206).

and ambience of a range of Ayurveda clinics I tried to access for research provides a good idea of what the different types of patient interactions which may take place.<sup>79</sup>

Dr. Gupta also worked in a clinic which catered exclusively to well-off consumers and I was able to sit in on a few sessions. However, after a few sessions, Dr. Gupta requested that I refrain from observing as he was concerned about privacy issues that his patients might have. The integrity of the clinic as an insulated and exclusive space had to be maintained, which prevented any further fieldwork from taking place.

However, I had opportunity to accompany an educated, middle class friend, Anil, to a private Ayurvedic clinic. He had chosen this clinic because his uncle regularly purchased medicine from its dispensary (one could buy over-the-counter medicines without having to see a practitioner). Anil sought treatment for his constant cough and for what he called his high biometabolic rate. We met beforehand at our regular meeting spot, a café called Barista, a coffee chain, which had been becoming very popular all over India. We walked to the nearby clinic together. Anil had a laboratory report in hand. Upon entering the clinic, we passed the waiting room area with its rows of hard plastic chairs, to the dispensary counter which was also where reception took place. Anil inquired to the male attendant about the price of a consultation and was surprised to learn that it was free. He then asked how long the waiting period was. The attendant said it would take about ten or fifteen minutes.

We then sat in the sparsely populated waiting room, Anil was slim, but mimed himself with big muscles on his arms. “I need to get fit”, he said, referring again to his high biometabolic rate and aspirations for a different type of body, likely the well-muscled ones, which were increasingly displayed by Bollywood heroes (Govender, 2012). In such a scenario, Ayurveda could potentially be cast as a means to achieving a variety of middle-class aspirations, including body image, (as discussed in Chapter 3).

<sup>79</sup> As my introduction shows, even private Ayurvedic clinics are a heterogeneous grouping and invite different types of interactions. Compare Dr. Arora’s or Dr. Gupta’s clinic to that of Dr. Vidya or Dr. Sharma’s.

I looked around and asked Anil if he thought the clientele was middle class and he responded that they seemed lower middle class. Anil had a token in his hand, a piece of cardboard with the number “36” written in pen, and looked to the LED display. It beeped as the number changed. “Oh, I hope this goes quickly”, he said. I noted that he was next, but he was not thinking about the wait time. Rather, he was anticipating his encounter with the practitioner: “Yes, but we have to exchange views and discuss”.

Anil was heading into the clinical situation with a clear idea about his goals. Ram’s (2010) argument that this expectation may be borne from the conduct of middle-class clientele in other medical and non-medical scenarios, which they regularly traverse, seems to ring true. And Anil was probably a pronounced exemplification of such an inclination: he was a sociable and extremely talkative young man. Moreover, he worked in marketing, and so he was quite accustomed to utilizing his oratory skills to manoeuvre his way around the professional world. How would this play out in the clinic?

A family exited the practitioner’s office and we went in once the LED display showed our number. Dr. Nayar was a young practitioner, in his 30s, with dark curly hair and glasses who sat the desk. Unlike most of the clinical encounters, this verbal exchange was carried out in English, most likely because Anil spoke it well and because Dr. Nayar is from Kerala, a state in the south where Malayalam, rather than Hindi, is spoken.

Anil began by reporting on his cough, which had been bothering him for a week: he stated that whenever he lay horizontally, he coughed repeatedly. Anil stood as he spoke, and the practitioner instructed him to sit on the stool next to his desk. Anil took a seat and continued, saying that this cough was only one part of his problem. At some point during the session, Dr. Nayar took his pulse, which allowed him to learn about which Anil’s *dosha* and its imbalances. Anil described himself as being troubled by what he called “anxiety attacks”. He went on to explain how he would sometime walk or go up some stairs and feel choked from his breathing – for several seconds. Dr. Nayar attributed this to stress. He inquired about Anil’s age and assured him that he was still young at age 27 and could get over his health problems quickly.

Anil then stated that he had not slept properly in years. He explained that he would fall asleep, and wake up, and feel like he had never slept at all. He then approached his final health issue, and reported his biometabolic rate. Anil elaborated that he had a large appetite but that he did not know where the food went. He gave Dr. Nayar the lab report brought with him, saying that he saw a nutritionist who diagnosed him with a high biometabolic rate. Dr. Nayar quickly glanced at the lab report and put a paperweight on it so that it would not be blown away from the ceiling fan whirring above. Anil had articulated variety of troublesome ailments for Dr. Nayar. Yet, the practitioner assured Anil that he did not really have any major problems.

Dr. Nayar did not agree that with Anil's assessment about being underweight. Instead, he reasoned that he might be at normal weight for his body type (in Ayurveda, this is likely related to one's dosha). Meanwhile, Anil was fixated on his desired body type, that of a heavier, more muscular one and insisted on his need to gain weight. To support his point, Anil went to the scale in the corner of the office and stated his current weight, which was already four kilograms below his average. To further his claim about his biometabolic rate, Anil mentioned that his energy levels were sometimes very high for a few hours and then dropped to a low.

Dr. Nayar had a different understanding of what was taking place. He agreed that was Anil was suffering from various deficiencies and excesses. Anil was stressed, with *too many thoughts* keeping him up at night.<sup>80</sup> His *doshas* were imbalanced with *too much kapha*, which refers to a combination of water and earth. Dr. Nayar stated that Anil was not deficient in anything - not even pounds.

This is the approach of one Ayurvedic practitioner, and may not resemble the diagnosis of, say, Dr. Arora. Langford similarly states that Ayurvedic doctors have different approaches to resolving ailments and recounts how one practitioner prescribed six different medicines for throat inflammation and another whose approach was very similar to Dr. Nayar and prescribed one medicine for eczema, migraines, and fatigue and

<sup>80</sup> I italicize the excesses and deficiencies that Dr. Nayar was concerned with.

declared: “For me there is no difference in your problems... Basically you have excess pitta in your body” (2002, p. 172).

As per Ram’s observations, as an educated middle-class patient, Anil certainly did “make his case” in Dr. Nayar’s clinic: he verbalized all his concerns, brought some test results, and walked himself over to the scale to show his weight when he disagreed with Dr. Nayar’s diagnosis concerning his weight. Dr. Nayar sat back and gave Anil space to articulate his concerns without interrupting or being condescending to him. However, Dr. Nayar insisted on grounding his assessments in an Ayurvedic framework. Both these speakers are concerned about *amounts*, but of different substances. Anil described himself lacking weight and sleep and with an excess of metabolism, anxiety (and coughs). Some of these claims were quantitatively evidenced with lab reports and numbers from the scale. Dr. Nayar understood Anil to be suffering from an excess of the more amorphous qualities of stress and kapha.

Even as their reasoning was based in different paradigms, both Dr. Nayar and Anil did converge in that they shared an interest in resolving the problem. Dr. Nayar inquired if Anil lived in the city and then gave him a prescription for two weeks. Anil was expected to return for a follow up and continue treatment for four or five months. The duration of such treatment is to be expected. Earlier on in the waiting room, Anil told me that in Ayurveda and homeopathy, “faith is the main ingredient”, and explained that faith in the whole system of medicine is needed because it takes a long time to be cured. He explains that with allopathy, the focus is on disease and medication. However, if someone commits to Ayurvedic treatment, the disease is completely removed. “With allopathy, you know that you’ll get cured for sure [in the short-term], but it also might just bring it back again”. But Anil was not going to exercise his faith at that point in time. While Dr. Nayar recommended that Anil return in two weeks, he never did.

Anil mentioned to Dr. Nayar that at the end of the session that he came to this clinic because his uncle regularly purchased medicines from here. We went to the dispensary counter and Anil purchased the prescribed medications which consisted of a

syrup and two types of tablets to take on an empty stomach before meals. Along with this, he requested Chyawanprash, a daily tonic, to bring back home for his uncle.

Who had the last word here? Dr. Nayar and Anil debated about his health condition and its treatment. Was it Dr. Nayar who had the final say by proclaiming that Anil had an imbalanced dosha (kapha) – a quality that Anil was unable to quantify, measure, or debate? These questions reveal the extent to which people, such as patients, and objects, such as food and medicines, are multidimensional entities, with qualities that become visible under different medical frameworks.

In treatment, patients and practitioners negotiate various types of medical frameworks: “if we merely envision different knowledge systems bumping into each other, or supplanting one another, we risk oversimplifying the already syncretic, hybrid, polyglot conditions with which most people contend” (Pigg, 2001, p.483). The quest for health motivates these syntheses of Ayurvedic and biomedical, informal and formal repertoires of knowledge.

## **7.5. Interactions in the Clinic: The Informal Exchange of Ayurvedic Knowledge**

In this final section I discuss how two middle-class practitioners acquire and produce Ayurvedic knowledge for Delhi’s medical marketplace. Here, knowledge is exchanged via an affective mode and helps enact informal expertise in the clinic. This knowledge may be informal, it does not mean that is marginal from the aspirations of the middle-class. In fact, this informal expertise assists homeopath, Dr. Sharma, in her professional and entrepreneurial ambitions in the formal medical marketplace. It also assists Mr. Verma, a retired bookkeeper in his aspirations to provide voluntary community service, or *seva*.

My analysis of informal knowledge evokes Ayurveda as a sociotechnical practice by showing how practitioners may disseminate knowledge via affective relationships or non-formalized parameters to novices such as aspiring practitioners and researchers. In

Chapter 6, we witnessed how Geet and his mother learned about Ayurveda via informal means from their guru, which enabled them to practice at home, amongst their family members. Such apprenticeship-based knowledge comes up again, as I elaborate on how Dr. Anand and Mr. Verma practice Ayurveda.

Dr. Anand was a homeopath with a private clinic adjoined to her home and I met her while accompanying a Neena's teenaged daughter (who lived in the neighbourhood) for an appointment one cold December evening, several days after my arrival in Delhi. Following this, I began to see Dr. Anand as patient whenever I suffered from the various (thankfully minor) ailments, which resulted from fieldwork in India. After passing the security guard who was hired to stand at the foot of her driveway, I would descend a short flight of stairs at the side of the house. Dr. Anand's clinic was kept in a very pristine condition clinic with shiny tiles on the floor of the waiting room and office and uncluttered décor – a few cushioned chairs to seat a handful of people and a small coffee table with reading material. A counter flanked the waiting area which was attended to by Dr. Anand's assistant or dispensary, a young man who updated the homeopath to any visitors. A Bachelor's of Homeopathic Medicine and Surgery (BHMS) diploma was displayed in the office. She now spent most of her time working from her private clinic, but had would occasionally provided voluntary service in other therapeutic milieus.

This homeopath's training had provided her fluency in biomedical principles which was not surprising as her program followed the same template of *integrated learning* as other indigenous medical practitioners, such as those who had a Bachelor's in Ayurvedic Medicine and Surgery (BAMS). Over the course of my visits as a patient, I was prescribed many well-known homeopathic remedies with names such as Bella Donna and Pulsatilla, dosages of little round white pills carefully hand-wrapped into small squares of wax paper by her dispensary assistant. However, Dr. Anand also inquired into my hemoglobin and iron levels and sent me a (biomedical) laboratory for testing if I did not know these counts. In the medically pluralist setting of Delhi, the movements of a patient such as myself were not restricted to Dr. Anand's clinic.

Dr. Anand posed questions about my personal life and daily routines as part of her homeopath diagnosis, and occasionally ask how my research was going. During the beginning my fieldwork, I recalled one conversation, in which I stated I was looking to enter clinics to investigate patients' use of Ayurveda first-hand. I elaborated that I hoped to learn about the relevance of Ayurveda in Delhi today by listening to patients and practitioners talk about health and illness in the clinic.

Dr. Anand asked why I thought patients needed to speak about their illness. I wondered how a practitioner could know of a patient's condition. She then revealed her own interest in learning Ayurveda and stated she visited a practitioner located on the outskirts of Delhi. Here, she learned of his healing techniques by observing him in practice. Patients did not verbalize their ailments to the practitioner. In fact, he was so skilled in the pulse-diagnosis, or *nadi parikshaan* that it precluded other forms of diagnosis.<sup>81</sup> Although Dr. Anand was not officially an Ayurvedic practitioner, she was intrigued by this technique, as it seemed a very efficient way of assessing the health of a patient.

How was this practitioner able to interlace homeopathic and Ayurvedic diagnoses in the institutional setting of the clinic? To be clear, practitioners with the institutionally-derived signifiers of competence, such as a Bachelor's degree remained the most widely-legitimized and trustworthy source for healthcare. However, as I stated in Chapter 4, Ayurveda was only transmitted in a curriculum-based manner relatively recently in its history, in the twentieth century (Brass, 1972; Naraindas, 2006). Beforehand, this 2 000 year old medical practice was propagated by an apprenticeship-style of learning, for instance within the family lineage, a child (usually the son) could learn it from their parent (usually the father). From the fifth to twelfth century, the renowned localities of higher learning, such as Nalanda and Takshashila, hosted students who lived here for

<sup>81</sup> The pulse is more an art than science which and needs to be experienced and interpreted in a subjective manner and one-on-one training is likely more helpful in learning to read the different types of pulses described as such: "the pulse of someone with a *vata* constitution is described as "usually irregular, weak, fast, empty, cold and changeable; it slithers under the fingers like a leech or snake" (Svoboda, 1992, p.179).

several years with their guru.<sup>82</sup> The students immersed themselves as apprentices by living with their guru, studying ancient scriptures, gathering and preparing medicines, and observing and assisting in treatment of patients for a period of five to seven years (Langford, 2002, p.101-103).

[Guruparampara] was the ancient “system”... in which there was a close bond [yog] between the guru and disciple. These days instruction follows the modern method, which is a business transaction [hisab] in which the student has less faith... in the guru and so is not able to grasp the knowledge in its true form. In ancient times knowledge was acquired through the absorption... in the guru. (Vd. Shastri cited in Langford, 2002, p.106).

While the institutionalized Ayurveda was considered as the most legitimized formation, it was not the “gold standard” per se. For Vaid Shastri, the guruparampara modes of teaching were based on an experiential connection which was crucial in helping students imbibe knowledge. This is why guruparampara modes of learning remained compelling modalities of learning for contemporary middle-class users of Ayurveda.<sup>83</sup>

Svoboda, an Ayurvedic practitioner, who was one of the few non-Indian students to train in an Indian medical college observed that “in India, blood is substantially thicker than water, any vaid [Ayurvedic practitioner] would tend, when considering to whom to pass on propriety practices and preparations, to limit the list of recipients to kin alone” (2008, p.119). In these relationships, “the salient subject positions are those of kinfolk, patrons, and friends” rather than “public employees and citizens”. Among the former, “gifts and favors are expected to float freely” and there is little concern for abstract bureaucratic measures such as academic qualifications (Langford, 2002, p.134). Although these relationships need not take place amongst biological kin, they are based on a close

<sup>82</sup> The Indian royalty funded their education and living costs. As well, smaller centres of learning were also established in other localities with several students to a few gurus (Langford, 2002, p. 101).

<sup>83</sup> This long-established tradition of apprenticeship or *guruparampara* type of learning is not restricted to Ayurveda, it is utilized more generally to propagate knowledge in the complex arts such as musical training, martial arts, yoga, and philosophy.

and personalized connection (in contrast to the more depersonalized or instrumental relationships between, students and a professor in a classroom, for instance).

The relatively accelerated transformation in the transmission of Ayurveda from patronage relationships such as guruparampara to institutionalized training in medical colleges in the twentieth century made for many sudden “misalignments” and subsequent contradictions between these two spheres of learning (Langford, 2002, p.134). Langford pointed out that many of the controversies or misgivings which emerge in the teaching of Ayurveda in institutional contexts such as complaints by students of receiving only rudimentary knowledge about pulse-reading techniques (*nadi parikshaan*) or examinations that well-connected but non-diligent students invariably pass, stem from India’s long history of patronage alliances. These patron-client subjectivities persist in institutional settings and culminate in scenarios whereby Ayurvedic college students suspect that they miss out on complete training as they lack the social capital which provides access to affective relationships, such as guruparampara.<sup>84</sup>

The “kinlike relationships” of guruparampara have not been completely displaced by the “transactional relationships of modern colleges” that assume autonomous and generic individual subjects (Langford, 2002, p.108). Dr. Anand did not consider her learning of *nadi parikshaan* as a threat to her identity as a homeopath. In fact learning this enhanced her skills as a healthcare professional. As a private and self-employed practitioner whose livelihood depends on her ability to attract and maintain patients, Dr. Anand was also motivated as “medical entrepreneur” (Kearns and Barnett, 1997, p.172). Her informal learning of *nadi paraakshaan* was an example of how one could harness the creative opportunities provided by expansion of the health care market in Delhi to assemble a unique and innovative medical practice. My previous chapter had informal practitioners personified by domestic labourers and itinerant medical consultants. Dr. Anand is a professional health care provider, but she, too, engages in apprenticeship-style

<sup>84</sup> As Jayesh notes, an Ayurvedic practitioner can claim authority “either from having lots of degrees or being the man with the red *tikka*” (December, 2, 2004). *Tikkas* are red marks applied with an upward stroke and worn by religious Hindus. Jayesh’s comment states that Ayurvedic expertise can result from academic training or from specialized experiential knowledge.

medical training and is a therapeutic resource in a middle-class neighbourhood. Such informal renditions of Ayurveda were important for health care providers like Dr. Anand who wished to cater to their middle-class clientele by providing efficacious services. In Delhi's medically pluralist marketplace, Dr. Anand asserts her place by having formal homeopathic knowledge inflected by informal Ayurvedic training.

Mr. Verma's practice of Ayurveda not only allows us to think about the nature of expertise, but also about the exchange of medical knowledge in a non-monetised sphere as he provided Ayurvedic treatment as a voluntary service. I was introduced to Mr. Verma by an acquaintance, Geet (the same man from Chapter 6).<sup>85</sup> These two men had met when they were students of a morning yoga class. I was instructed to meet with Mr. Verma one weekday morning at a Hindu *mandir* (temple) located in an unfamiliar and sprawling neighbourhood about a twenty-minute auto rickshaw ride away from my house. I made my way there one winter weekday morning and disembarked from the auto-rickshaw when I spotted a cluster of buildings, presumably signalling a commercial or public district in a residential area. I walked along a series of small meandering roads with little vehicular traffic. Instead, there were small stalls selling pirated DVDs and barbers offering hair-cuts for pedestrians. The road led towards the temple which stood higher than the other buildings which were one or two stories tall.

The temple was located in a complex with a school and a fenced-in court-yard filled with 5-year-olds shouting and enjoying their recess. I asked the school teacher where I could find Mr. Verma and she motioned towards one of the doors. Knocking on the door and stepping in, I introduced myself to the man who sat behind a desk who welcomed me in.

I took in the surroundings, as I made my way to a seat he offered. I did not see any patients; calendars or notepads embossed with logos of pharmaceutical companies; or any other signifiers which I had learned to associate with Ayurvedic clinics. Yet, there was a small table to the left of the door and books of assorted sizes (hardcover to small-

<sup>85</sup> Geet and his mother are featured in my chapter on Ayurveda and the household, lay users of Ayurveda.

press booklets written in Hindi about Ayurveda and Vedic philosophy, which he would consult and show me in subsequent visits). Behind his desk was a small table with containers of herbs was near this desk. The furnishings and objects suggested that Mr. Verma had some authority with Ayurveda, but I was not sure which kind. I nodded towards the books and asked if he was a professor of Ayurveda.

He explained that he learned about Ayurveda about thirty years ago from his guru upon the birth of his first child. During this time, he practiced Ayurveda as a father and husband, as means of providing domestic care. Mr. Verma probably never anticipated that he would be sitting in on a clinic when he first became interested in Ayurveda as he was not a professional practitioner of medicine, but had made his living as an accountant and recently retired from this profession. Now he had more time to practice Ayurveda as a part-time hobby in this temple where he provided basic treatment to neighbourhood residents as a volunteer. I visited Mr. Verma several times over the following weeks and witnessed a few patients, often elderly and not middle-class, who came in for ailments such as colds and stiff joints. They were not obliged to pay, but did offer some money. However, most of my time was spent listening to Mr. Verma expounding on cosmological principles of Ayurveda. This began moments after my arrival, after I introduced myself.

I was invited to take a seat across from the desk and take notes as he referred to a book and explicated the four *ashramas* or life-cycles of a person. The first stage, *Brahmachari* took place from time of birth to age 25 when one prepared for life by dedicating oneself to intense study and practicing celibacy. The second stage, *Grihasthasrama*, from the age of 25 to 50, refers to a householder role where one married, had children, and worked to feed family and other people in need. The third stage, *Vanaprastha* happens from the age of 50 to 75 and refers to a stage of retirement from the profane and material world so that one could provide guidance and service to others. The last stage was *Sanyasa* (renunciation) a period in which one retreated away from civilization to the jungle or ashram to wholly dedicate themselves to spiritual undertakings.

I wondered how this overview of the ashrams related to Ayurveda. Perhaps it related to our interview as Mr. Verma located himself in the Vanaprastha stage placing me, as the student, a Brahmachari. Otherwise, this did not seem to relate much to contemporary empirical enactments of Ayurveda, or even medicine. I tried to steer our meeting “on track” to this concern by stating that I was interested in why people used Ayurveda in the medically-pluralist setting of Delhi. I thought I could learn this by inquiring about what kinds of diseases Ayurveda was beneficial for.

However, Mr. Verma insisted on a different outlook: “We treat a patient to keep him healthy. Ayurveda is a science of how a person can be healthy, not just a science of treatment”. My assumption that the main aim of Ayurveda was to treat disease was brought into question (as was my implicit equation of “health” with “lack of disease”). Joseph Alter brings into question this tendency amongst anthropologists who are undertake relativist and comparative analysis of medicine and healing but remain uncritical regarding their assumptions of health. Anthropologists end up adopting a “remedial” approach and understand health to be a involve some kind of intervention on illness (1999, p.S43). Alter asked if anthropologists could study medicinal practice outside of this pathological-based conceptualization of health. My encounter with Mr. Verma was an opportunity to take up this suggestion.

Mr. Verma highlighted the therapeutic guidelines of Ayurveda which are embedded in the everyday life, such as “natural diet control”:

Indians take extra herbs, salt, *kali mirch* [black pepper], *kala namak* [black salt]. Medicine of Ayurveda is part of the diet. We take [a] diet which keeps us healthy... Digested food, *raas*, goes into the blood and in the blood. Oxygen combines with raas to create energy and carbon dioxide. Diet control and *pranayam* [yogic breathing exercises]: they are medicines to keep mind peaceful, without worry or anger.

One did not have to rely on the ingestion of pharmaceuticals or clinical treatment to achieve health, rather this state could also be cultivated from culinary habits and exposure to natural elements such as oxygen. The benefits of these substances depend not so much on their intrinsic properties but on how they were coordinated with other substances (i.e. other components of the meal, time of the day to eat or perform pranayam). The classical

Ayurvedic canons such as *Caraka-Samhita* included rules for *dinacharya* (daily routine) so that one can know when to wake up, defecate, eat, pray, bathe, sleep, take walks, and so on (Alter, 1999, S51). If one followed the prescribed daily routines and respected circadian rhythms, the body and environment could be harmonized with one another. Mr. Verma elaborated,

All of our living organism have two parts: the five elements and energy or the soul. As per our mythology, the five elements are satya (truth).<sup>86</sup> They are:

Sun: firey  
Earth: earthy  
Water: sea  
Air: as you see  
Space: akashthryia [ether]

In a healthy human being, the five elements are in fixed proportions. If the proportions change, then body of the person is diseased.

Mr. Verma articulated cosmological conceptions of medicine and therapy, which encompassed ordinary daily activities such as diet and meditation. Here, the sacred and profane intersected in simple gestures such as a hand movement. Mr. Verma elaborated on these ideas in a lecture-type monologue that took place in English and Hindi,

As I am working, I am moving my hand, as per our mythology, I move my hands with the order of my brain, and my nervous system. The nervous system is controlled by an energy called the *atma* [eternal energy]. I have a certain energy in my body - it rises to certain levels, it does a job at certain levels.

The aim of life [is] to increase energy levels to eternal at every level – [we can create] such a life with diet control, yoga and meditation, so that we may do a lot of work in life. The more energy you have, the further you can go. As per our mythology: when we die, our *atma* [leaves the] body and goes to other bodies. *Karma* decides where it goes.

The results of all energy in our body are called *atma*. It means if my thoughts are positive, if my energy in the body is positive, my *atma* becomes positive. If my *atma* is more energetic...I can do more work and I can enjoy *anand* [bliss]. If I think wrongly, do wrongly, I will be in sorrow [and] anger - I cannot enjoy bliss.

<sup>86</sup> Translation: The five elements are a given, indubitable.

[The] basic aim of Ayurveda is to have a natural diet control ...as per season (winter, spring, summer, monsoon, pre-winter). There is a separate diet for each season. If we take diet and medicine according to season and do yoga and meditation, we can keep our body, mind, spirit, [and] nervous system healthy... We will have eternal energy and can enjoy bliss of life. This is the aim of Ayurveda. Ayurveda is our lifestyle...not only a treatment...we have to lead according to lifestyle. With energy we can achieve anything - you need positive energy. Health [comes from] balance and a high amount of energy.

These ideas encompass far more than a remedial intervention that characterized treatment in many formal private Ayurvedic clinics. Mr. Verma's approach collapsed boundaries between the individual and environment, and physical, mental and spiritual realms. While his philosophy was different from other Ayurvedic practitioners, it is not entirely idiosyncratic, Alter cites another well-known written account of Ayurveda which resonates with Mr. Verma's description,

Ayurveda is not just a system of medicine but a science of health promotion designed to increase our well-being and happiness in all aspects. It shows us not only how to treat disease but how to live in such a way as to arrive at optimum health and the maximum utilization of our faculties, which according to Yoga and Ayurveda are almost un- limited'' (Ranade cited in Alter, 1999, p. S50).

Mr. Verma's explanations were not simply abstract philosophical discourses, this was Ayurveda in practice. In Mr. Verma's clinic, I learned about Ayurveda even though he was not a professor, and he treated sick people even if he was not an official practitioner. These activities were an execution of the many types of expertise that propagate this medical practice in contemporary Delhi. In the middle-class marketplace of Delhi, Ayurvedic knowledge is not necessarily enclaved to a certain authority. This allows for an ethnographical investigation to the shifting demarcations among ways of ways of being a practitioner and of being a patient.

## **7.6. Conclusion**

In a setting in which different types of expertise and different types of consumption are enacted, what does it mean to be a practitioner and patient of Ayurveda? This medical practice is inflected by the processes of marketisation and by the exchange of informal medical knowledge in the clinic. Medical practitioners may sometimes be positioned as ‘handmaidens’ of consumer desires by acting as consultants for practitioners of alternative medicine abroad or disseminating the latest pharmaceutical products. At the same time, these practitioners may engage in non-monetised exchange of medical knowledge in their clinical practice.

Ayurvedic patients may be invited to engage in new practices of attentiveness outside of the clinical visit and understand their daily routines in medical frameworks that they may not be accustomed to. These modalities of consumption and knowledge diverge and converge in local clinical practices.

## **8. Expositions: The Marketing Ayurveda in Public Spaces**

As the neoliberal economy relies on the movement of people, images, ideas, and capital for its expansion, it connects more facets of everyday life across greater spatial distances. Such configurations condense in major urban centers around the world, including Delhi. In Chapter 5, I showed how Delhi converged the mobility of patients, experts, and enterprises which enacted Kerala Ayurveda. As the ethnographer follows the terrain of the medical marketplace by inquiring into the consumption patterns of users ‘on the ground’, she is led to a myriad of sites, where Ayurveda is formally and informally enacted, and this includes households and clinics. Chapter 6 discussed how Ayurvedic medicine was integrated into household routines and domestic relationships. Chapter 7 examined how Ayurvedic knowledge was co-constituted amongst human and non-human actors in the clinic. Thus far, I have portrayed the variety of informal and formal experts who coordinate the material (i.e. herbs) and non-material (i.e. knowledge, treatment) repertoire of Ayurveda in Delhi’s dispersed medical marketplace.

In this chapter, I shift from the private and exclusive spaces of the household and clinic, respectively, to explore the production of health care in more public settings: I investigate the role of expositions in producing Ayurveda for consumers. Expositions are large-scale and temporary exhibitions which showcase manufactured products and provide leisure pastimes for the general public. As I will explain further on, expositions began as temporary events in the nineteenth century which displayed humankind’s latest technological and cultural achievements for the general public. The Chicago World Fair (1883) and London’s Great Exhibition (1851) are two such examples.

My fieldwork brought me two types of expositions, those which showcase goods and the other which showcases bodily practices. The first section of this chapter will

discuss how herbal products and medical goods and goods are presented to viewers and the second section will examine communal health-making practices as mediated by the body from audience members who participate in *yog shivirs* or yoga camps.

I will show how exhibitions and yoga camps motivate the consumption of indigenous medicine – such as Ayurveda - by locating themselves at the forefront of the “shifting ideologies of health, health care and the economy, as strengthening transnational linkages have developed to evolve the model of global capitalism over the last thirty years” (Wilson, 2010, p.63).<sup>87</sup> Accordingly, I treat expositions as sites that condense marketing processes (more than health-making practices).

The contemporary industrialisation and mass-production of Ayurveda has been studied by two scholars, pharmaceutical anthropologist Maarten Bode (2008) and political scientist Madhulika Banerjee (2009). Bode (2008) focused on how India’s major manufacturers market Ayurvedic medicines in the neoliberal setting by positioning them paradoxically as traditional yet modern. Here, manufacturers emphasised the culturally distinct qualities of indigenous medicines to succeed in the marketplace for indigenous medicine. For instance, the label of a Unani tonic evoked the glorious days of the Muslim Moghul empire and a best-selling Ayurvedic health tonic, *Chyawanprash*, featured a cross-legged yogi on the label. At the same time, these medicines emulated the appealing qualities of allopathic medicine by being attractively-packaged in plastic containers and easily-ingestible forms as pills and capsules in contrast to typical loose powders and herbs that characterised Ayurvedic treatment.

Banerjee (2009) has examined how Ayurvedic knowledge was submitted to hegemonic biomedical discourses so that it can circulate as a legitimate therapeutic option in the contemporary Indian and global market. The author remarked that this process was nothing new, it was facilitated by the processes of standardisation and pharmaceuticalisation which has been taking place over the past hundred years in India.

<sup>87</sup> I use the term ‘exhibitions’ when specifically speaking about events in which goods are showcased and otherwise use the term ‘expositions’.

which now undermines Ayurvedic epistemology and threatens the dissemination of its worldview.

These scholars provided useful findings pertaining to the contemporary manufacture and valorisation of Ayurveda from the perspective of manufacturers and regulatory bodies, who are powerful players in the medical marketplace. However, their analysis is limited to the actual medications and related products (i.e. food supplements and toiletries). There remain, therefore, important questions about Ayurveda for consumers who interact with it both as an object and also a repertoire of knowledge.

Manufacturers and marketers are certainly powerful players in the marketplace, but their success does depend on the extent they can win over consumers and cultivate new desires within them. The exposition can thus be conceived as a commercial arena in which producers vie for the attention of consumers. I build upon the analyses of Bode (2008) and Banerjee (2009) by considering how those who on the receiving side of Ayurvedic marketing strategies (i.e. consumers) are invited to engage with mass-produced formation of this medical practice in communal public settings such as expositions and yoga camps. I show that expositions are cultural apparatuses which strive to re-make medical practices and configure consumer interactions so that they are in line with the requirements of the neoliberal economy. In the previous chapters, I showed how Ayurveda was constituted as a sociotechnical system by various strata of producers (i.e. from an informal part-time practitioner found in the neighbourhood to an officially-trained full-trained practitioner of the clinic). The exposition is backed by significant state and private industry resources and can therefore put forth a much powerful vision of what Ayurveda should be.

Delhi has a dearth of truly public spaces aside from parks, and less of an established form of public etiquette compared to other Indian cities such as Mumbai and Kolkata (Delhi is often reputed to be a “collection of villages” in terms of its citizens’ conduct). However, the expositions, especially the yoga camps, were one of the few sites where people voluntarily and cooperatively grouped together over an extended period of time. The success of expositions actually depended on their capacity to attract multitudes

of people in their midst and transform them into a “voluntarily, self-regulatory citizenry” (Bennett, 1988, p.76) who would then become captive audiences. Such an image might come as a surprise to readers who are familiar with India’s population of over one billion and 250 million strong middle class, because as Subramaniam (2002),

Certainly crowds, whether cast as the teeming millions of a growing population, as the citizens of the largest democracy, the violent mobs stoked to communal hatred, or even as a source of annoying fascination for the tourist, occupy centre stage in any account of India. (p.8)

Counter to these outsider’s stereotypes, it is instructive to analyse the communality of group events. Expositions aim to transmute these crowds and entice them as consumers by impressing upon them the delights of the latest consumer developments related to traditional Indian medical systems such as Ayurveda. The expositions provide ample opportunities to reflect on traditional medical modalities, such as Ayurveda, and emergent consumer practices, such as the mass-consumption of indigenous medicine.

Any attempts to theorise on this collective consumer experience with binaries such as *tradition* and *modern* or *Indian* and *foreign* are futile because the framing of cultural practices as traditional is in itself a modernist stance (Pigg, 1996). As stated in Chapter 4, Ayurveda has been subject to processes of “auto-orientalism” for over a century as it was made to stand for principles of self-sufficiency and swadeshi by Indian nationalists. This chapter articulates how concepts of authenticity and nation now invoked to encourage mass-consumption. How then to speak about this configuration without becoming ensnared in the above-mentioned binaries?

Arjun Appadurai and Caroline Breckenridge, in their edited volume, *Consuming Modernity: Public Culture in a South Asian World* (1995) called for the adoption of the term *public culture* to investigate recent socioeconomic transformations associated with “cities, media and consumption, and the cultural flows that draw cities, societies and states into larger transnational relationships and global political economies” (1988, p.7). They explain,

The term public is not a neutral or arbitrary substitute for all these existing alternatives. Nevertheless, it appears to be less embedded in such highly specific Western dichotomies and debates as high versus low culture; mass versus elite culture; and popular or folk versus classical culture. With the term public culture we wish to escape these by now conventional hierarchies and generate an approach which is open to the cultural nuances of cosmopolitanism and of the modern in India. (p.6)

Many scholars who previously studied the making of public and nationhood in India followed Benedict Anderson's theorising on the "imagined communities" of nation and therefore studied print culture, a sphere which played an important role in creating sentiments of nationhood. Analysts from the field of visual studies (who came from a variety of disciplinary backgrounds ranging from anthropology, history, to art history) investigated more image-based media such as calendar art, cinema, and television and embraced the term *public culture* because it allowed for a compelling analysis of the everyday life shared by a non-elite culture (Dwyer & Pinney, 2001).

Public culture scholars also took the scholarly study of urban India seriously in contrast to earlier anthropological and sociological studies which positioned the village as the locus of authentic India (Rao, 2005). This was partly due to the legacy of nationalist leaders, such as Gandhi, who revered the village as the site where Indian citizens could live as liberated and dignified human beings.

[the] city occupies an ambivalent place in the Indian nationalist imagination. Most nationalist leaders hailed from towns and cities; and Calcutta, Bombay and Madras were chief centres of nationalist activity. Yet, the urban experience seldom received any concentrated attention. (Prakash, 2002, p.3)

The nationalists considered the village as the ultimate signifier of India. Sandria Freitag took a different approach in her study of communal interactions and public performances in the city of Benares, an important Hindu pilgrimage site, and emphasised the significance of activities in public spaces for studying urban social experiences and group identity formation (1989). Considering that expositions are both very public and visual experiences, this chapter incorporates the theoretical contributions from public culture

and visual studies scholars such as Freitag to illuminate how South Asian audiences, in particular, are invited to engage with this phenomenon.

## 8.1. Chapter Outline

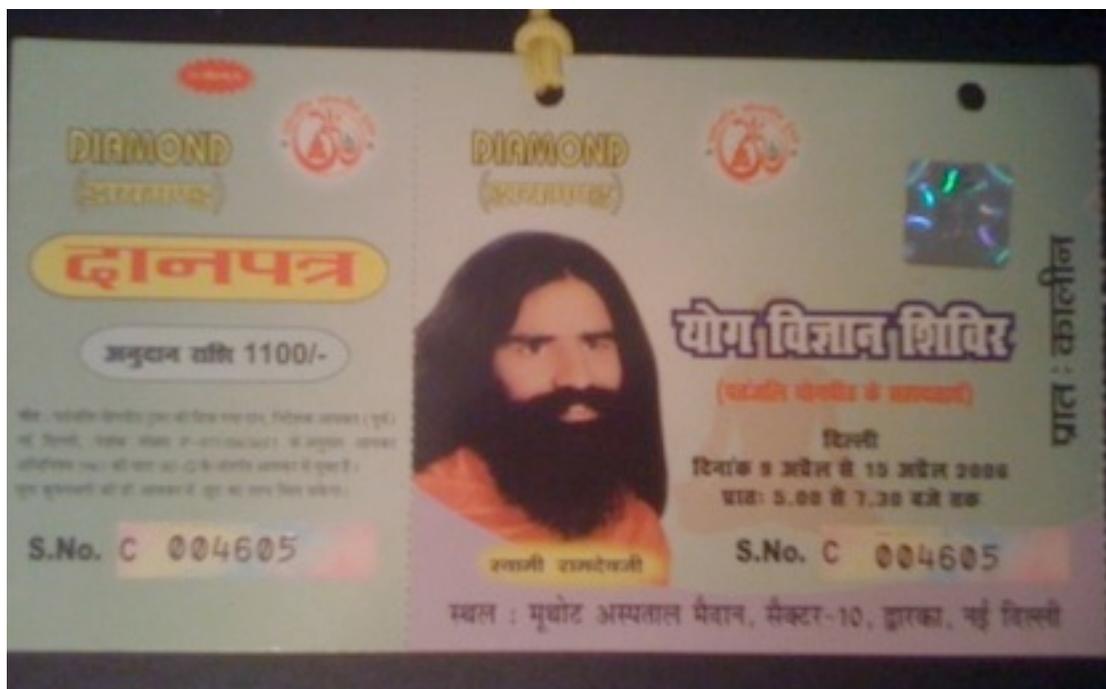
In the first section I show how the physical layout of the exposition, and arrangement of objects and people, structures exhibitions as “vehicles for inscribing and broadcasting messages of power” which, in this case, refers to prevailing economic ideologies (Bennett, 1998, p.74). Delhi hosts many kinds of exhibitions throughout the year, such as the widely-attended Indian International Trade Fair (IITF) which brought in 7 000 exhibitors and was attended by one million general visitors in 2011 (IITF, 2012).

I examine two health exhibitions (which were much smaller events compared to the IITF) and took place over a few days (they usually include a Friday and the weekend) to showcased the latest products and developments for professionals and the general public. Here, products such as medicines, herbs, therapeutic oils, magazines, were showcased in stalls for visitors to peruse. Visitors could participate in a myriad of activities and acquaint themselves with Unani medicine by seeing an on-site practitioner, attending a free presentation, picking up a pamphlet containing information on the facilities available from a new Yoga and Lifestyle Clinic located in a super specialty hospital (see image), or peruse the offerings of a stall by major manufacturers such as Dabur. Attendees were free to walk around, peruse, sample, and shop.

In the second section, I focus on yoga camps featuring corporal activities such as breathing exercises and postures that were interspersed with health care advice derived from Ayurvedic principles. These week-long yoga camps were attended by thousands of people and witnessed by millions more who watched the televised versions from their living rooms. The sessions were led by Ramdev, a renowned yoga teacher or *guru* who claimed that practicing yoga and Ayurveda were necessary antidotes to allopathy, fast food, and other trials and tribulations of modern life which undermined India as a nation and Indians as a collective. For Ramdev, “the malaise of the human body is a reflection

of the malaise of the national body in a globalising era” (Charkaborty, 2006, p.388). While this sentiment at first seems critical of neoliberal economic principles, Ramdev profits greatly from the burgeoning alternative care market and the yoga camps which he leads over many Indian cities and towns (Charkaborty, 2006).<sup>88</sup> I was fortunate enough to be in Delhi when he passed through in the Spring of 2006 on one of his tours, and will discuss this experience further below. In this exposition, the experience of the attendee was based on communal corporpothetic participation through yoga.

**Figure 8.1. Ticket for Ramdev’s Yoga Camp**



*Note.* Photo by author, May 15, 2007

Both of these events rely on a high volume of attendees for their success and so construct themselves as entertaining pastimes to draw in audiences. The significance of such promotion cannot be overlooked in India’s health care setting where health seekers are

<sup>88</sup> Now, he tours internationally to areas where there is a significant South Asian diaspora, such as Europe and North America.

increasingly expected to negotiate health care via their pocketbook. This chapter concludes by recounting the thoughts of Indian consumers on mass-produced Ayurvedic medicine promoted by these exhibitions.

## **8.2. Expositions I: Consumer Exhibitions**

In this section, I describe my visits to two expositions as a participant-observer and interviewer I engaged in conversations with stall attendees, and one interview with an exhibition organiser. The first exhibition I attended was entitled the Herbal Expo (December 26, 2005) and the second was called Swasthi Fair (September 28, 2006). Both exhibitions featured a variety of goods and services related to herbs and indigenous medicine. The structure and layout of these exhibitions configured interactions between objects and attendees so that the potential of the objects as consumable goods could be assimilated by everyone.

Sociologist Bennett described expositions such as museums, world fairs, shopping arcades, and carnivals, which became popular in nineteenth century Europe as the “exhibitionary complex”. He traced the complementary role of the exhibitionary complex and institutions (such as the prison, hospital, and asylum) in reinforcing prevailing ideologies and ways of knowing (1988, p.73). Prisons and hospitals were powerful institutions for this type of socialisation, but their status as enclaved settings kept them inaccessible to the public. In contrast to these institutions, the exhibitionary complex attracted a larger general public which enabled them to exercise a more extensive influence. Yet, the exhibitionary complex paralleled institutions because they too used “objects and bodies [as] vehicles for inscribing and broadcasting the message of power... throughout society” (p.74). While each of these apparatuses worked differently, both were concerned with order and surveillance.

Institutional settings were regulated by what Foucault terms the *panoptican*, whereby one’s activities were submitted to surveillance by an authority (cited from Bennet, 1988). Bennett argued that the public settings of the exhibitionary complex

exercised a practice of seeing, too, except here it was more subtle and taken up by attendees themselves who arrived as strollers or viewers and interacted with an assemblage of objects which “organize and co-ordinate an order of things and... produce a place for the people in relation to that order” (p.80).

To illustrate what I think Bennett is trying to get at, I will show how one particular ideological aim was enacted by one of the most spectacular expositions of nineteenth-century Britain, the Great Exhibition. This event provided visitors with an a view of the world via encyclopaedic types of display which charted the development of different nations on a linear progression -- culminating with Britain's position as the global leader in cultural development and technology (Kishlansky et al., 2006). This central message was echoed in other displays throughout the exposition featuring technological marvels and such (Bennet, 1988).

This exposition attracted a large general public, including the working class, who were educated on comportment: for instance they were provided instruction booklets on how to dress themselves for such a leisure outing (p. 85). The structure and layout of the exhibitionary complex configures interactions between objects and attendees so that the logic and rationale of the displays could be assimilated by everyone present. Also, the public could view themselves as a mass, undifferentiated by class divisions (Grame cited in Bennett, 1988, p.78). The expositions I examined featured displays of “culturally-familiar” content such as indigenous medicine but their mass-production required audiences to conceptualise them in new ways, one amenable to the requirements of the neoliberal economy, which I will explain below.

### **8.2.1.     *The Herbal Expo***

I attended my first consumer exhibition, called the Herbal Expo held over three, sunny winter weekend days. I entered the exhibition grounds in the mid-afternoon when temperatures rose to 15C, more comfortable for strolling outdoors. The event was set up on a park with green Astroturf over the open grassy grounds and a temporary fence-like barrier around the perimeter. The crowd consisted of many men but it was not unusual to

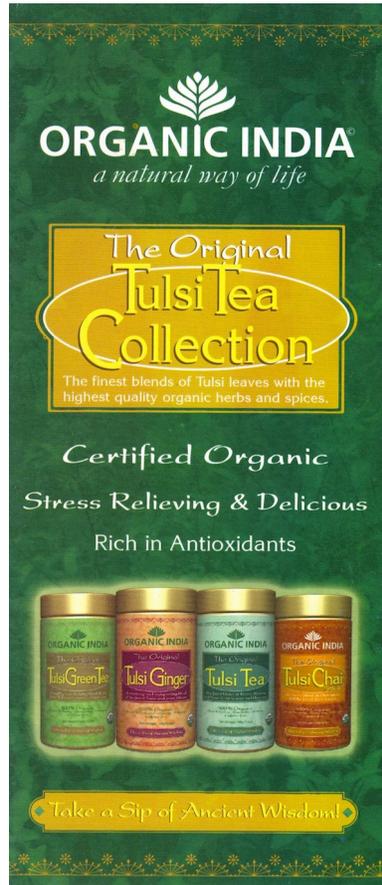
see women or family milling about. Most of those in attendance seemed to be from their mid-30s to early 40s. I would estimate there were over two hundred people present including the promoters and medical practitioners. Attendees could stroll comfortably through the three rows of widely-spaced stalls. They were free to walk, peruse a stall display from near or far, speak with those behind the stall, and purchase. At the entrance was a sign leftover from a previous event, a handloom fair. The coincidence of herbal products and handloom goods were interesting themes for exhibitions: both evoked the aspirations of the *swadeshi* movement and could lay claim as quintessentially Indian products.

A wide array of goods were showcased, namely herbal products, and were laid out in neat rows in stalls with vendors minding their wares. Their careful presentation evoked the concern manufacturers had with packaging as discussed in Bode's (2008) book, *Taking Traditional Knowledge to the Market: The Modern Image of the Ayurvedic and Unani Industry, 1980-2000*. And this was true at the Herbal Expo: *aachar* (pickled vegetables) was labelled as *organic* were sold in jars; spices, pulses, and dried beans in rectangular plastic packets— a great many stalls offered these along with other wares which included: aloe vera as cream and gel for the skin; aloe vera in papadums (a crispy appetizer, like a potato chip) for snacking on but also “sold” as potentially therapeutic; herbal tea; honey; various jars of balms (including tiger balm); anti-mosquito products; skin care products (creams, lotions, masks); essential oils; an Ayurvedic tonic Chyawanprash; Herbs for diabetes; and a “brain drug” as an antidote mental stress. All of the items were packaged with labels with the exception of the spices and dried legumes which were uniformly packed in rectangular bags but with no manufacturer label.

As the reader may deduce, the array of products ranged from relatively unprocessed edibles such as spices, pulses, and honey which were simply packed into plastic bags to highly processed toiletries such as face cream with labels. Most of these products, such as pickled vegetables and spices were likely familiar to the audience, yet they were objectified in a packaged form.

One stall in particular enticed me with its attention to packaging and presentation which culminated in samples of tea of different flavours in plastic cups. The tea was made of *tulsi*, or holy basil, a renowned Indian herb with many therapeutic properties which I had never seen in tea form. I sipped one flavour and read the box which which proclaimed that it was organic and came in the flavours of Tulsi Chai. Tulsi Green, Tulsi Original, and Tulsi Orange. This was one of the few displays in English, most of the others were in Hindi. I remarked to vendors on the sophisticated packaging, which resembled something I would spot in a Canadian health food store (especially since herbal tea had not really yet become mass-produced as a salient beverage option when I was in India (the sweet and milky black tea prevailed). The stall-minders responded that this tea was packaged similarly all over the world and followed design standards set up in the Netherlands.

**Figure 8.2. Pamphlet**



*Note.* Photo by author May 17, 2007; with permission

Many of the herbal products themselves were of local or Indian origins, but the emphasis was on the extent to which they could be processed, packaged, and distributed for mass consumption. This attention to display echoed the manner in which “rhetoric of power” made manifest in nineteenth century expositions which reconfigured “displays of machinery and industrial processes, of finished products and *objets d’art*, into material signifiers of progress – but of progress as a collective national achievement with capital as the great co-ordinator” (Bennett, 1988, p.80). Similarly, the Herbal Expo featured a great variety of objects, which were all in the same form: labelled or packaged commodities. The revered tulsi or ‘holy basil’, too, sublimated into mass-produced packaging for worldwide consumption. In this case, the cosmological aspects of tulsi were disregarded and its capacity to be a mass-produced tea or health beverage was

foregrounded. In the exposition, and in other consumer environments, tulsi is crafted to assert its existence as a retail rather than ritual object.

The Herbal Expo featured a stage with invited speakers who discussed *jaari-booti* (herbs) in Hindi. Attendees could sit on the chairs in the open and sunny area and take a break from their strolling and perusing. We listened to a speaker who echoed the messages of the tulsi tea stall attendants, stating that standardised products automatically carried higher value which made them more beneficial for the Indian farmer. Bennett (1988, p.93) stated that the transitory nature of expositions, in contrast to more enduring structures such as museums, enabled them to communicate messages pertaining to more “immediate ideological and political exigencies of the moment”. Accordingly, secondary discourses such as educational messages and lectures were made to reinforce the message of the state. At the Herbal Expo stage, this speaker discussed the potential of herbs in relation to the economic health of India as a nation, rather than the physical health of its citizens. Of course, I half-expected (actually, half-hoped) to hear about the health benefits of jari-booti, based on my research project, but I had not yet understood that I was witnessing a microcosm of market processes, not herbal medicine. Moreover, the stall area was dotted with non-indigenous herbs such as rosemary and thyme in terra cotta pots with their Latin names written alongside, as if to further reinforce India’s position as a supplier of herbal products (of all sorts, even culinary Italian ones) for the global market.

While the exhibition was a temporary structure, the myriad of activities it offered drew in a great number of people. Its location in a park near a commercial district and inviting and safe grounds provided easy access and free entry for those who had planned to come – and for those who just happened to be walking by.

The logic which guides the configuration of objects in the Herbal Expo may be more appreciated if one contrasts this with other venues in which herbal substances circulate. I will now temporarily depart from the Herbal Expo and describe Delhi’s Khaori Baoli bazaar, a large market for wholesalers and general consumers where herbs, spices, nuts, and dried fruit are sold – but in a far less-contained manner.

*Indian society is a panorama of piles, stacks, bunches, bundles, baskets, bags among which people appear, as laborers, as shopkeepers, as vendors, as housewives, and as pedestrians, making their way through an endless landscape of things, ranging from the most precious to the most ugly and filthy.*

(Appadurai, 2006, p.17)

Khaori Baoli is located in the old city part of Delhi and considered as the world's largest spice market. This market is nestled amongst other markets that sell a wide variety of goods including stationary, books, tools, flowers, and electric light fixtures, each with their own name (Chawri Bazaar, Fatehpuri Bazaar). In contrast to the wide boulevards of south Delhi (where I resided and conducted most my fieldwork), here the roads were too narrow for cars, but remained busy with activity as bicycle rickshaws and scooters transported people and delivered wares to the shops. Traffic consisted of suppliers, deliverymen, vendors, and shoppers, each of whom seemed to enact one stage of a commodity's biography from production to consumption.

The exuberant setting of Khaori Baoli seemed a perfect spot from which to begin a conversation about the intersections between herbal medicine, such as Ayurveda, and the world of consumption. Many of the goods were sold in bulk, or in "piles" as Appadurai puts it, and included dried fruit (such as raisins and dates); nuts (such as almonds and cashews); and a variety of spices, seeds, herbs, and loose teas. My fieldwork in clinics and discussions with patients and practitioners of Ayurveda had made clear the importance of diet in this medical practice (i.e. the use of spices for their cooling or heating humoral properties, or herbs to be mixed with milk or water for their therapeutic effects). A few pharmacies sold packaged Ayurvedic and herbal medicines such as Gold Capsules, Fat Loss Pills, Sexual Enhancers, along with bottles of almond oil and energy supplements. This familiar sight echoed the advertisements found on billboards throughout the city and television. Khaori Baoli, the famous market for spices and herbs, also had mass-produced medicines for sale. While romanticised as a centuries-old market, it was also a highly-commercialised zone in modern-day India.

On this Saturday afternoon in mid-May I was visiting Khaori Baoli market with a friend, Naresh, who was in the mood to browse and shop in our search for Ayurvedic medicines and conversations with vendors. He rifled through a selection of snacks on a counter and picked out a small plastic packet of dried mango slices which had no recognisable brand name – instead, there was a graphic of Mickey Mouse. Naresh laughed and joked to the vendors, “This is probably not licensed by Disney!”. Maybe the dried fruit had been packaged to catch the attention of busy parents who would purchase it for their children and perhaps the addition of a famous icon was the next logical step that set the dried mango slices onto the thrust of mass consumption. This bazaar was indubitably becoming interpellated into the circulation of global brands.

In Khaori Baoli, vendors sold more or less a similar array of goods in one area. New customers likely could not discriminate between the wares and repeat customers likely would return to a favoured vendor. This entrepreneur of the dried mango slices fashioned his goods so they would be appealing and literally graspable by consumers who might be inclined to purchase from impulse instead going through the steps of having their pre-planned bulk purchases measured out on a scale. This particular vendor attempted to stand out against the proliferation of people and objects engaging in his own market strategy to attract customers: by offering packaging with the face of Mickey Mouse.

Naresh and I went looking for Ayurvedic medicine and did not expect to see Mickey Mouse at *Khaori Baoli*. However, it cannot be doubted that long-established markets become translocal spaces as vendors seek to appeal to consumer’s desires - and their pocketbooks. The neoliberal transitions have granted the middle class increased opportunities for work and disposable income and local vendors are exposed to marketing strategies which they may emulate.

Mickey Mouse, a well-known icon who is almost a century old, can be considered an archetype of a global image. He is a potent symbol which speaks to the global circulation of people, objects, ideas, and mass mediated images which propel the neoliberal economy. His appearance on the package of dried mango un-does any firm

linkage between a locality and particular mode of life. Likewise, in Khaori Baoli, one can find cardamom, a seed which helps in digestion, a staple in North Indian cooking, and popular ingredient in *chai* – a globally-circulating referent which signifies India as much as Mickey Mouse signifies America.

Mickey Mouse circulates under different conditions in India compared to America. For one, his image is not licensed: this Disney character is not enclaved and has moved beyond the intended arenas of television and upmarket shopping malls to arrive at the spice market and is now enfolded into a local vendor's entrepreneurial aspirations. Certainly, Disney did not own Mickey Mouse, just as a food stall I frequently passed during my time in Delhi called *harichutney.com* did not claim this website. Both, however, are laying claim to meaningful signifiers of contemporary times.

Appadurai's observation that the proliferation of objects is taking place in India is of course true (2006). This is after all market capitalism at work. India is not only host to a proliferation of objects, but also to a proliferation of mimetic forms of packaging, labels, and brands.

Generally speaking, the Herbal Expo contained and ordered its commodities in a much more deliberate and systematic manner compared to the Khaori Baoli market. The exposition aimed to win over consumers while Khaori Baoli provided more of a 'backstage' look at the exchange of herbs. Yet, as the actions of the vendor who sells dried mango indicates, similar marketing processes may motivate aspirations and exchange in both spaces.

### **8.2.2. *Returning to the Herbal Exposition***

My overview of the Herbal Expo (and Khaori Baoli) provided one look at how the consumption of herbs, spices, and dried fruit were transforming in line with neoliberal market processes. I conclude this section by explaining how Ayurveda was incorporated into the Herbal Expo. As the reader may deduce, "herbal products" were an extensive category which could not be necessarily equated with indigenous medicine. Nonetheless Ayurveda was not completely invisible in this setting as, it too, was a herbal product.

Ayurveda also has a comprehensive herbal repertoire encompassing hundreds of herbs (Dabur Therapeutic Index, 2003). Moreover, one herb could be employed for a range of medicinal, culinary, and cosmetic issues. Turmeric (*haldi*) for instance, is used in cooking and can also be applied to the face as a skin-brightening agent. (More recently, curcumin, an active agent of turmeric has been demonstrated to kill cancer cells [Ravindran, 2009]). Ayurveda is invoked for these varied purposes via increasingly industrialised rather than home-based and hand-crafted means.

Banerjee (2009) explains that unlike other Ayurvedic substances (such as medications), cosmetics and supplements do not require extensive testing by international regulatory bodies to be mass-consumed. As I stated in Chapter 3, cosmetics such as skin and hair care products are prominent signifiers of Ayurveda in India's contemporary market setting. Indeed, the top four products sold by Dabur, one of the major manufacturers of Ayurvedic products, cannot be considered *drugs* per se. Bode reports that Dabur earned 70% of its sales from four products (2008, p.82):

- Dabur Amla Hair Oil, US 40\$ million
- Dabur Chyawanprash, US 30\$ million
- Laal Dant Manjan (a tooth cleaning powder), US 27\$ million
- Hajmola (digestive tablets), US 15\$ million. )

The Herbal Expo had many stalls which displayed containers of Chyawanprash, an energising tonic for daily use. Chyawanprash was marketed to Ayurvedic and Unani practitioners and “lay consumers” up until the end of 1940s. This traditional remedy could nourish dhatus (body tissue), restore vigor and was useful for,

memory, intelligence, appearance, the functions of the organs and digestive powers; confers longevity by preventing a number of maladies such as emaciation, hoarseness, weak heart, dropsy, abnormal thirst, neuralgia, urinary disease, spermatorrhoea, etc. (Dabur cited, in Bode, 2008, p.98)

This tonic is made from a variety of Indian herbs namely *amla* (gooseberries), *dashmool* (ten roots) and *ashwagandha* (Indian ginseng) (Dabur cited in Banerjee, 2009, p. 176).

It is a popular product with made by approximately 7 500 Ayurvedic manufacturers and four “mega-manufacturers” (Dabur, Himalaya, Zandu, and Arya Vaidya Sala) in India (Bode, 2008, p.76). At the Herbal Expo, Chyawanprash was promoted both by local companies and Indian-based multinational manufacturers.

Other popular Ayurvedic products included anti-diabetes remedies and supplements for memory and intelligence. The face of Ramdev which I had seen so often on television and would later see in real life, a few months later, appeared on a stall placard. Ramdev was the founder of Divya Yog Trust, a manufacturer of Ayurvedic medicines and clinics and its stall was quite popular with a crowd milling about, perusing its medicines.

The Herbal Expo excelled in showcasing the recent technological developments related to herbal products, which culminated in their pharmaceuticalisation or packaging. As I stated earlier, while these medicines were subject to industrialised manufacturing processes, this intermediate phase was not highlighted for the attendees. Bennett recalls that the major expositions in the nineteenth century offered this “technical education” by showing visitors manufacturing processes and products, amongst other commodities and curiosities, such as new foods, amusements parks, and musical performances. However, London’s Great Exhibition (1851) foregrounded *products* over *processes*. This is because expositions mirror and propagate economic processes at large. Many expositions thereafter became “places of pilgrimage... to the Fetish Commodity” (Benjamin cited in Bennett, 1988, p.94). Visitors could locate themselves at the threshold of more promising things to come by transforming themselves into consumers upon their repeated exposure to these commodities (p.95).

Timothy Mitchell (1989) studied the intersection of representation, power, and colonialism, and provided a complementary perspective to Bennett’s work in his article, “The World as Exhibition” which discussed the power of gaze in ordering the world and asserting prevailing ideologies, such as colonialism. He argued that exhibitions were borne out of and perpetuated particular practices of seeing as, say, a flaneur strolled down a city boulevard to take in a view – or travels to a foreign destination and attempts to

visually compose the surroundings into a scene, one that evokes a pre-established idea of what an exotic place such as, say, Egypt should look like. This practice of seeing and objectifying is most clear with Mitchell's elaboration on the experiences of Egyptian scholars who travelled to places such as France and Sweden. These Egyptians were actually Orientalists who visited Europe to conduct research and were received as living encyclopedic specimens, "*bona fide* Orientals" by their European colleagues at an academic conference—rather than the Orientalists they were (1989, p.218).

Mitchell foregrounded the experience of being an audience member at the exhibition to show these events worked to inculcate modes of being which served the requirements of society beyond the exhibition. For instance, Mitchell recounted the experience of the same Egyptian visitors attending the Paris Exhibition (1867) and their startled reaction at level of commerce which supported the exhibition: one paid for donkey rides in the exhibition just as one would pay such an amusement outside of the exhibition. The distinction between exhibitions and the Commercial Machinery of the non-exhibition world was irrevocably blurred (Mitchell, 1989).<sup>89</sup>

Bennett notes that along with the replication of financial transactions, the experience of exhibition began to resemble the world outside with the increased visibility of spaces, such as factories, the mint and courts, that were once closed to gaze of the general public. The expansion of this show-and-tell modality interaction emphasised the power of vision in making things knowable and made citizenry feel familiar with (and complicit to) the mechanism and inner workings of society. (p. 78, Bennett). Going back to my fieldwork setting, the presentation of pharmaceutical products seemed as a logical continuation of the tours I had taken of two factories which produced indigenous medicines, Ayurveda and Unani. The exhibitions presented the pharmaceuticals in their complete, packaged form while the factories tour showed how medicines went from their loose, grinded, form to pharmaceutical form.<sup>90</sup>

<sup>89</sup> The term *Commercial Machinery* is from Mitchell (1988, p.224), but I added the capitalization.

<sup>90</sup> One factory was quite well-established, the other received an on-site evaluation for certification by AYUSH (Dept. of Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy).

What might be the implications for Ayurveda at it is mass produced in this way, as pharmaceuticals? During my interview with advertising executive Jayesh, more than a year earlier on the consumption of Ayurveda amongst the middle-class, he remarked on the displacement of authority and expertise which may result from the industrial mass-production of Ayurveda.

Jayesh:           A *vaid* [Ayurvedic practitioner] will prepare it all for you in a steel bowl, with elaborate rituals. [He can] win over people by doing a difficult ritual: such as special *tulsi* leaves, dark on one side, light on the other. The upper sector has never seen [this form of] Ayurveda...

Now the R & D [Research and Development] replaces the *vaid*.

The lure of Ayurveda once rested in its intricate and elaborate process of preparation – ideally grinded and mixed by hand for *one* patient and this has been forgotten by the middle-class or “upper sector”. Jayesh’s account likely romanticises what took place as Ayurvedic medicine, has been mass-produced for over a century, even if it not marketed in the same way as it now (Bode, 2008). Nonetheless, this image of herbs being grinded by hand is a stunning contrast to how products are showcased and valourised in the exhibition - as technological marvels or an “assemblage of glamorous commodities” for consumer subjects (Bennett, 1988; p.78). Jayesh is correct in observing that in this scenario, it is the Research and Development team who can best address the needs of an

ever-expanding consumer base, rather than the *vaid*, his two hands, and bowl.<sup>91</sup> Certainly this manifestation of Ayurveda dislocates it from the more private spaces such as the home or fields (where herbs like tulsi may grow) and locates onto the commodity circuits spaces such as expositions, shopping complexes, and pharmacies.

The Herbal Expo reveals the interlinkages between pleasure, leisure and inculcation as visitors are evoked to adopt practices of seeing to imbibe the logic of the “glamorous commodities” encountered (Mitchell, 1989, p.78). The packaging and presentation of culturally-familiar herbal products, including Ayurvedic medicine, transforms/generalises them to be interchangeable with the gamut of other retail products (i.e. brand name clothing, electronics) available on the market, in homologous spaces such as shopping malls and entertainment complexes. The attendees are well-poised for continued consumption beyond the exhibition following their visit.

The remaining two expositions I analyse also rely on physical arrangement to entice attendees into consumers, but their engagement is cast in a trope of tradition to create captive audiences.

The Swasthi Fair exhibition was an event of a much larger scale than the Herbal Expo and was held on very large open grounds adjacent to a busy major Delhi road. I arrived in the afternoon and garlands of Christmas-type lights were strung up, but not yet switched on. I will later elaborate on how the Swasthi Fair constructs itself as a

<sup>91</sup> However, this substitution of practitioner with medications also makes Ayurveda more appealing for consumers, especially with regards to taboo or embarrassing health ailments such as sexual dysfunction or menstruation. Jayesh had mentioned the latter as he elaborated on the plans behind an proposed advertising campaign which would feature an Ayurvedic product to relieve menstrual pains. Jayesh explained, that menstruation, as a natural and cyclical part of life, was congruent with the similar Ayurvedic principles. And it was considered an especially safe and natural therapeutic option in comparison to allopathy. Menstruation is a taboo subject for many Indians and so young females may be reluctant to see a medical professional for issues such as premenstrual syndrome or pains. Also, readers may recall Ram’s (2010) article about condescending medical treatment doled out for some patients, such as the “scolding lecture” which some patients can experience, especially those who are not educated and middle-class. Interestingly, Ram’s article focused on female patients visiting *obstetrics and gynaecology* clinics – sites where patients are especially vulnerable and discomfited and would likely rather avoid. Jayesh states that the availability of such a remedy for menstrual pains in a retail environment appropriates treatment from the “hand of the male gynaecologist” and is an alternative that relocates remedy the safer space of the home rather than clinic, following purchase from the marketplace (December, 2, 2004).

traditional *mela* or “fair” which explains the festive atmosphere made evident by the lights and, in the distance, a small Ferris wheel which seemed to act as a temporary landmark for this event. The auto rickshaw driver who had dropped me off was similarly entranced by the scene and paused for a few seconds to take in the scene before driving off and merging back into the traffic on the noisy and congested road.

The entrance had a temporary water dispenser (free and safe drinking water was an uncommon site in Delhi), in the form of a large rectangular steel sink and a man drank from it. A photographer (possibly a journalist as he had a large single-lens reflex camera) snapped a photo of this scene: this public exposition carried great potential to become even more publicised. A group of school children between the ages of 10-13, who were dressed in uniforms and presumably on a field trip, stood by the gate. The corporate presence of the event was made evident as I purchased my own version of drinkable water – bottled water from a Coca Cola kiosk with a placard with a picture of a Bollywood actor.

Going inside, one could stroll the grounds and browse the stalls of the multitude of players who were participating in this exhibition. This included state representatives such as AYUSH from the Ministry of Health and Family Welfare who manned stalls featuring information about India’s indigenous medical systems: homeopathy, Unani, Ayurveda, yoga and naturopathy. Private industry players such as hospitals and clinics were also present. As well, there were more small-scale vendors who sold modestly priced booklets with titles such as *Yoga: Yoga and Pranayama for Health* for 30 rupees. The central hub of the exhibition featured a stage, stalls by AYUSH, and stalls by large private industry players such as major hospitals and clinics. As one walked further away from this area, spectrum of commodities encompassed products such as booklets, accessories such as key rings and plastic jewellery and trinkets for the home. Finally at the edge of the exhibition, attendees could visit the small fair grounds hosting several mechanised rides.

The AYUSH stalls exhibited each of India’s officially-recognised medical systems and provided information about their colleges and their hospitals for interested

patients or students. As well, practitioners of other Indian medical traditions (which were not officially-recognised but well-known in Delhi, such as Tibetan medicine) were present too. The practitioners conducted mini-diagnosis for any interested attendees. A Unani *hakim* (practitioner) checked my pulse and then gave me a computer-generated hand-out reading of my pulse. He then asked me about my dietary habits and recommended me to eat more certain foods (such as dairy, for its protein). AYUSH also exhibited informational displays of their research projects to capture the attention of viewers passing by. Many of these displays were centered on the processes of standardising *materia medica* and thus making it comprehensible to global technocratic parameters such as clinical trials. However, one stall caught my eye as it featured an almost museological display: a tank of wriggling leeches. Expositions are reputed as presenting both commodities and curiosities: I had seen plenty of the former but very little of the latter. The text beside the tank explained the therapeutic properties of leeches stating that they were used for bloodletting. This was not packaging, but great care was lent to *presentation*. This display scientised indigenous medicine by presenting leeches as therapeutic specimens, safely contained in an aquarium, and easily viewable on a table, with explanatory text alongside.

Despite these attempts to tame or contain, they these were still wriggly leeches, a rather menacing sight compared to the inanimate displays of standardised medicines uniformly packaged and glossy pamphlets. I couldn't help blurting out, "Isn't this [bloodletting] controversial?" to a medical student who was arranging the tank and putting finishing touches on the stall and while nodding towards the leeches. He looked at his nearby colleague, and laughed it off, shrugging, "What isn't?". Perhaps he had been asked this numerous times already. Or maybe the attitude of the student was borne of the fact that indigenous medical systems have always had precarious claims to legitimacy and never quite won over huge audiences. Or, as this chapter will eventually discuss with the controversy over the integrity of Ramdev's medicines, perhaps every therapeutic option is debated and open to question in India's medical marketplace.

I had learned about this event from an AYUSH representative and she had provided me contact information for the organiser of the event, Mr. Datt, several days

earlier. I assumed he would be at the temporary trailer-type structure which housed the office headquarters of the exhibition, very close to the entrance gate and Coca Cola stall. A security guard who protected the entry to the office let me enter after I asked to speak with Mr. Datt. I went inside and waited on an upholstered bench. Across from me, on the wall, a poster described the Ayurveda *panchkarma* purification therapy and recommended steam baths and the ingestion of *sat-isobagal*, or psyllium husk, at night. At a nearby counter, event employees worked from a row of computers. Swasthi Fair was clearly a large undertaking required significant labour and coordination. A woman walked around and passed out bags of chips to everyone, likely from a corporate sponsor of the event.

The bag of chips was a puzzling contrast to the poster advocating for regular consumption of psyllium husk, a decidedly tasteless fibrous substance consumed solely for digestive purposes. This juxtaposition reminded me of the free-running drinking water and Coca Cola stall. Surely these objects which were situated in close proximity to one another, must have shared something in common? Even if they were not unified from their health-giving properties, they were all appealing to consumers. Medicine, food, and remedies: all of these reverberated together as mass-produced substances accessible through the act of monetary and physical consumption.

I called Mr. Datt from my mobile phone and he showed up a few minutes later, with the phone affixed to his ear, engaged in another conversation. After he terminated his call, we introduced ourselves. I specified my interest in the health care practices for consumers of Ayurveda. I motioned to the poster on panchkarma and psyllium-husk and remarked that the exhibition seemed like a good site to investigate how the benefits of health and Ayurveda were communicated to audiences.

Mr. Datt then elaborated on his role in this exhibition. Mr. Datt stated that he was an event planner and specialised in providing “exhibition solutions”. I mistakenly assumed he was a doctor as I had been introduced to him from an AYUSH representative. In fact, he was another type of health care professional needed for this exhibition, one concerned with promoting health more so than treating it. He outlined the main goals of

this particular health fair, which interlaced education, public health, and commercial aims. The organisers of this event educated the general public about basic practices regarding work and health safety. Indeed, public health information signs had been put up around the event in Hindi and English bearing messages such as “You cannot get AIDS from sharing food”, “Have one partner only” and “Smoking is bad for you”. Attendees could easily imbibe these messages as they browsed the stalls of commercial health care providers (i.e. clinics and drug manufacturers), shopped for health books or even trinkets, or tried out the free yoga classes. All these social activities happened simultaneously to a more general strolling, commenting, socialising, and hanging out with the group consisting of family, friends, or classmates.

Here, the public was not forced to direct their activities in any one way, but their attendance in this space rendered them captive audiences for the exposition’s messages. Indeed, the power of expositions to inculcate their messages rested in its capacity to win “hearts and minds as well as the disciplining and training of bodies” (Bennett, 1988, p.76). Mr. Datt’s explanation of the exhibition’s aims bring to life the theorising of Bennett (1988) and Mitchell (1989) on expositions as new configurations which converge the spheres of commerce, knowledge, and pleasure in a newly-emergent consumer society. Yet, in India there is a different kind of experience of being a public compared to Bennett and Mitchell’s nineteenth-century Europeans.

Mr. Datt explained that concept behind the Swasthi Fair was based on a very Indian form of gathering and asked if I knew what a *mela* was. A *mela*, could be translated into fair or perhaps *bazaar*, is a temporary gathering that takes place urban and rural settings of India to mark harvests, seasonal celebrations, and religious festivals. One well-known example is the Hindu festival, Kumbh Mela, reputed as the “biggest show on earth” is India’s most famous gathering and is attended by at least 30 million pilgrims every twelve years at the confluence of two holy rivers, the Ganges and Yamuna (Prasannarajan cited from Maclean, 2003; However, more localised commercial activities, such as the Kharwa Mela in the state of Rajasthan for cattle trading are also referred to as melas. This malleable quality has captivated scholars who study cultural transformation. Economic historian, Anand Yang studied various marketplaces or melas

in the state of Bihar and argued they served as nodes of intersections between colonial, economic and social transitions from late eighteenth century until India's independence in 1947. These events that would alter the rhythms of everyday life by drawing people into new spatialised arenas and introducing them to new activities and goods (1998, p.146-147). Events like the mela can thus mobilise an experience of public space particular to India and yet also mediate cultural transformations such as the emergence of the mercantile, colonial and the market economy (Freitag, 2001; Maclean, 2003; Yang, 1998).

As Mr. Datt pointed out, melas traditionally hosted a multitude of activities. In the case of the health fair, this included stage performances, contests to engage the audience, consumption of health care-related products and even yoga classes. Attendees could be exposed to or participate in health care activities as viewers and readers, or as patients. Certainly, Mr. Datt is not the first to capitalise on the mela's capacity to attract the general public with the hopes of creating a manageable citizenry for the state. For instance, in the 1950s, a cholera outbreak were successfully controlled by the interception of millions of pilgrims en route to religious gatherings who were provided anti-cholera inoculations before continuing through the infected areas (Rogers, 1954). And, fifty years later, cholera outbreaks are controlled during the Kumbh Mela via digital health care work stations (also known as telemedicine) staffed by medical practitioners and coordinated with established hospitals in the area (Ayyagari et al, 2003). Examining these types of health care practices in the melas provides an opportunity to reflect on the tension between voluntarily becoming complicit rather than dominated to the requirements of the state (Bennett 1988).<sup>92</sup>

Melas are malleable formations which are host to a variety of consuming experiences. This is illustrated by the ad copy (below), which describes both its traditional origins and contemporary offerings,

<sup>92</sup> Of course, the appearance of students mentioned earlier who were attending the Swasthi Mela as a class fieldtrip provides another such opportunity.

Gwalior Mela has evolved as a trade fair from a simple rural fair of a century ago when the Mela would turn into a big "haat" (village market) of farm cattle -- oxen, horses, camels, etc. as well as village products and handicrafts... Major cut down [discount] on important commodities is another attraction of Gwalior Trade Fair. This is especially a great gift for the middle class consumers who have a modest budget for costly dreams. Scooter, Motorcycle, TV., Washing Machine, Camera, Music System, Juicer & Grinder, Molded Furniture, Kitchen Machine, Microwave Oven, Refrigerator, Cooler, Wooden furniture, and what not! (Mishra, 2006)

Gwalior mela had transformed from an informal village fair to a wholesale market, from selling animals to appliances and yet it was still able to designate itself as a mela. And now, indigenous medical systems such as Ayurveda, once overlooked, or else produced by grinding herbs by hand in a steel bowl are also placed on this circuit of mass-produced goods via expositions, such Herbal Expo and Swasthi Mela

Mr. Datt's 'glocal' conceptualisation of Swasthi Fair as an Indian mela which tries to inculcate its visitors with rationality in line with the requirements of national public health and consumption demonstrates one way that evoking tradition is a powerful means for mobilising consumption in India's neoliberal economy. Moreover, tradition need not be exclusively invoked by elite cultural products such as ancient texts, particularly in a country with a high illiteracy rate and more than twenty official languages (Pinney, 2001). The general public can access tradition from a more visual and affective register by taking in the sights provided by nostalgic formations like the mela.

In other words, though Swasthi Fair focused on the consumption of health and wellness, its way of going about presenting information and products relating to these practices referred to familiar modes of public gathering. In my ethnographic setting, the visual showcasing in the exhibitionary complex was in line with the requirements of Delhi's economic setting. Visitors were invited to establish continuities between how to engage with health care resources in the exposition in relation to other newly-established retail environments such as shopping malls and cinema entertainment complexes (Mitchell 1989). The line between consumption, recreation, and entertainment was already extremely blurry in expositions. An attendee's experience of the exposition as a

mela made the distinction between new and established modalities of consumption blurry too.

The configurations of these exhibitions exercise a “technology of vision” (Bennett, 1988, p. 97) with a certain encompassing homogeneity and interchangeability which is made evident to the eyes with spices ground up and gathered uniformly in bags, or products placed on tables which are part of a stall with a placard on top, beside others of the same dimensions, in rows. This layout physically structures people’s interactions – attendees promenade down rows and can gaze at a myriad of objects ranging from medications to booklets to trinkets - all which are amenable to consumption.

In sum, expositions are culturalising apparatus which work on many levels by transmuting crowds into disciplined consumers, reifying herbs and spices into uniform, neatly-packaged commodities, and differentiating indigenous medical systems as separable, codified, and formalised entities. Although Bennett (1988) and Mitchell (1989) do not explicitly designate expositions as sociotechnical systems, they are a powerful example of how a myriad of actors, activities, and discourses can mutually reinforce each other and constitute a desired version of indigenous medicine and establish the terms by which it should circulate for the collective population. The stalls by AYUSH and manufacturers legitimise Ayurveda as a standardised medical system which can be mass-produced irrespective of context. Ayurveda is sometimes singularised as a medical system (made evident by the AYUSH stalls, a different one for each indigenous medical system) and other times it is enfolded into the gamut of herbal medicine (made evident in the Herbal Expo).

In the following section, I will continue to analyse expositions as socialising apparatuses by incorporating insights from public culture scholars in my analysis.<sup>93</sup> I shift from looking at the stable configuration of objects and move on to consider the orchestrated movement of bodies and communal health practices in Ramdev’s yoga camps.

<sup>93</sup> I understand public culture and visual studies scholars as interchangeable categories.

### 8.3. Expositions II: Communal Bodily Practices

I now turn to a discussion of Ramdev's yoga camps provide a markedly unprecedented reach – much more extensive than what Bennett (1988) and Mitchell (1989) and the visual studies scholars have discussed thus far (Freitag, 2001; Pinney, 2001). Here, I will argue that Ramdev's success in mobilising the consumption habits of middle-class consumers lies in his strategy of locating his health regimen at the intersection of a new public culture, one that is increasingly mediated by various technological advancements (i.e. the mass production of Ayurveda, television) and a trope of Indianness and tradition mediated by the body.

Ramdev is a guru who has been studying yoga since he was a teenager in *gurukuls* and eventually renounced worldly life to fully dedicate himself to yoga.<sup>94</sup> He was initiated as a *swami* (one who has self-mastery, a monk) in 1995.<sup>95</sup> Although he generally carries a great authority, his age is not certain - he is rumoured by some to be an old man who looks much younger as a result of his health care regimen, others claim he is in his mid-forties.

When I arrived in Delhi in December 2005, Ramdev had become a renowned guru and toured India to lead yoga camps for his many thousands of followers. These yoga camps were televised and watched by millions more from their homes. He had no formal training in Ayurveda, but these health practices shared similar principles and his religious authority enabled him to act as a spokesperson.

Ramdev associated himself most concretely as the founder of Divya Yog Madir, a health care organisation with headquarters in Haridwar (Uttanchal), a pilgrimage city for Hindus in the foothills of the Himalayas. On its premises was a hospital providing services such as panchkarma, surgery, ophthalmology and yoga and medical manufacturing facilities were located here, along with a large ashram for the public

<sup>94</sup> A gurukul is a residential place where disciples (students) can learn from a guru by living with him as an apprentice over an extended period of time.

<sup>95</sup> Swami refers to one who has been initiated into a monastic religious order.

(Divya Yog, 2012). Divya Yog Ayurvedic clinics could be found in major cities, such as Delhi. Here, one could obtain treatment or purchase therapeutic resources such as medicines, or more more immaterial resources such as DVDs and Divya Yog's magazine, *Yog Sandesh* (published in several Indian languages).

Ramdev adopts a *swadeshi*-inspired discourse in which adopts yoga and Ayurveda as necessary antidotes to allopathy, fast food, and other tribulations of modern life that threaten the health of India and Indians. At the same time, one cannot deny Ramdev's aspirations to capitalise from the indigenous health care market – this is made clear from his extensive promotion via television, tours, and Divya Yog (Chakraborty, 2006).

Ramdev was best known for his yoga regimen which was comprised of light aerobics, breathing exercises, and sitting and standing postures for the audience to follow. These are portrayed as easy and convenient practices that Indian citizens could take up to improve their health. The physical movements are interspersed with verbal interaction from the audience as Ramdev engages them with questions about their progress. His victory against the general ravages of aging and disease is symbolised by his lustrous and pitch-black hair which represents youth and vigor in India. His triumph against particular adversities is verified by the slight paralysis on one side of his face which stands as testament to what an individual is capable of attaining from their personal efforts, for viewers to draw inspiration from.

I learned about Ramdev, quite early on, during my first few weeks in Delhi (December 2005) while staying with family friends as I was apartment-hunting. Neena and her parents were followers of his health regimen and she introduced me to his program when I described my research project.<sup>96</sup> Neena went to her bedroom and brought me his DVD and book to look at. Later, that evening, she clicked to his channel when the evening run of his program started, around 8 PM. Ramdev presented himself as a powerful image on the airwaves: he sat cross-legged on a stage in a saffron robe with a

<sup>96</sup> I initially actually saw more of him on the news when he was embroiled in a controversy surrounding the contamination of Ayurvedic medicine manufactured by his company.

pitch-black beard dominating his face which was matched by equally black hair tied back on his head.

Multitudes of people who watched his program and they became familiar with basic and small routines such as *pranayama* (alternate nostril breathing) abdominal breathing exercises to keep the body in balance, which Neena did while huddling under a warm blanket in the mornings as she waited for her son to get ready for school. Ramdev's popularity extended to all socio-economic classes of India, as this National Geographic article on a life in a Mumbai slum illustrates:

Mornings at Rajendra Prasad Chawl are equally hectic. With the eight furniture makers to whom she rents part of her apartment gone for the day, Meera Singh combs the hair of her grandchildren: Atul, 7, Kanchan, 10, and Jyoti, 12. Soon the apartment, home to 15, is empty, save for Meera and her twentysomething son, Amit... A couple of years ago, the Singh family, like everyone else in Dharavi, sat in front of the television to see local singer Abhijit Sawant win the first Indian Idol contest. But now Meera is watching her favorite TV personality, the orange-robed yoga master, Baba Ramdev, who demonstrates an antiaging technique: rubbing your fingernails against each other at a rapid pace.

"Why listen to this fool?" dismisses Amit.

"You know nothing," Meera shoots back. "His hair is black, and he is more than 80 years old."

"Eighty? He's no more than 40. Don't fall for these cheating tricks."  
(Jacobson, 2007, para 7)

As this passage suggests, Ramdev was a controversial figure, too, and I elaborate on this further along in the chapter. The extent of Ramdev's influence never ceased to surprise me during my time in Delhi. For instance, one winter evening, almost a year after my arrival to India, I accompanied Neena for her drive to the airport so that she could pick up an international guest arriving after midnight on an international flight. We drove down the relatively quiet streets and waited for a traffic light to change to green at one intersection. We chatted idly and Neena suddenly looked over my window (her SUV-type vehicle type gave her a great height off the roads) laughed and exclaimed "Look!". I

looked down my passenger window and in the car below, a chauffeur sat alone and bided his time at the red light by taking advantage of the few spare minutes to rub his fingernails together: this was one of Ramdev's most popular anti-aging technique which could presumably stop hair from turning grey. Such exercises could be easily enfolded into people's daily routines, whether they were leisurely relaxing at home, or on the road, like this driver, as his enthusiasts continued to participate in his health regimen on their own, apart from the television broadcast.

This moment provides an opportunity to think about the power of expositions. Ramdev's yoga camps were certainly well-attended, and their influence was amplified to an even greater audience because they were televised daily. This enables Ramdev's lessons to reverberate in unprecedented times and spaces – such as the midnight traffic light.

### **8.3.1. *The Collapse of the Televisual and the Actual***

*Please remember when you get inside the gates you are part of the show.*

*'Short Sermon to Sightseers'*

*1901 Pan-American Exposition*<sup>97</sup>

I had the opportunity to participate in Ramdev's yoga camp in April 2006 when his nation-wide tour passed through Delhi. These week-long tours featured morning yoga classes which started at 5 AM and ended at 7 AM. Attendees could purchase tickets in advance (from the Divya Yog Ayurvedic clinics) in seating categories ranging from diamond (the most expensive and closest to the stage), gold, silver, and bronze.

This event took place in one of the newly-constructed satellite cities adjacent to Delhi. All of the signs of Delhi's potential as a hyper-modern city were visible. Recently-

<sup>97</sup> Cited in Bennett, 1988, p.81

built high rise apartment buildings flanked one side of the grassy area that the yoga camps would take place, approximately the size of a football field. On the right side, metro cars silently zipped by on the above-ground track for Delhi's newly-constructed subway. The airport was located nearby and so one could witness airplanes making their diagonal ascent or descent in the background during Ramdev's yoga session. Freitag writes that public performances such as "street theatre, popular musical performances, textual exegesis, and wrestling" (also considered as melas) became an increasingly popular mode of "urban visual communication" which took place in a range of public areas such as "bazaars, street corners, [and] open fields" (2001, p. 43). The placement of Ramdev's event is not incongruous in relation to other melas. What ideological message was being communicated in this event? Just as Ramdev's yoga and Ayurveda regimen directed attendees towards the apex of good health via consumption, perhaps the hyper-modern backdrop of his yoga camp reinforced Ramdev's messages and positioned citizens at the brink of new urban lifestyles.

The yoga camp commenced at 5 AM and we attendees showed up to the site approximately half an hour beforehand. We set ourselves up on an open grassy area, roughly the size of a football field. The audience members consisted mostly of middle-aged people with more men than women.<sup>98</sup> Everyone unfolded blankets that they had brought with them, took off their shoes before sitting on the blanket, positioned their water bottles and/or notebooks to a convenient corner and then huddled underneath another blanket or shawl against the pre-dawn chill while awaiting the start time. Despite its size, it was the largest – and quietest – public gathering I had ever participated in Delhi. Unlike other public settings with people in close quarters, no cell phones rang and people spoke quietly when necessary.

<sup>98</sup> Public space is quite gendered in India (I would frequently see men everywhere, not many women in public spaces) with the understanding that sexes should not have to mix, for example, with separate queues for women not uncommon and , trains could be segregated for ladies (official term?) and also the option to choose seating placement in the more upmarket movie theatres to ensure a comfortable experience in public spaces.

For me, as a participant-observer, it was generally not difficult to blend in so long as one participated in the same warm up and yoga activities as everyone else. I wore cotton *salwaar kameez* (baggy trousers and long tunic) like the other women present and resembled everyone in terms of appearance even if I was likely the only Canadian graduate student there.

Pink (2008), reflects on the principle of “attuning” oneself with the research participants by engaging in deep participant-observation to understand how one’s experiential involvement with people and aspects of the environment generates a sense of place. Pink shows how place is produced from social interaction rather than a self-evident physical location. She conducts her study with participants of context urban walking tours and states, “it was by walking and eating with others, sharing their gazes, rhythms, sounds, smells and more and by attuning my imagination to their own imaginings for the future material, social and sensory environment” (p. 193). Our experiences in the expositions, especially Ramdev’s yoga camp which required its attendees to conform in their behavior, relied on similar processes of attunement over for a short period of time. Freitag (1989) remarks that collective activities in public spaces were the heart of shared urban experiences. These events revealed intersections between concerns of the individual and larger cultural processes. Moreover, like expositions and mela, collective activities and public performances brought people of different backgrounds together and expressed a collective identity.

Pink remarks that this type of connection may be provisional and difficult to replicate: attunement can quickly unravel when one departs from the scene, and result in destabilisation and disorientation. Perhaps this unravelling was less of an issue in Ramdev’s yoga camp as attendees could maintain continuity with the experience of being at the yoga camp by watching it on television.

The attunement between ethnographer and research participants who carry out a corporally-mediated practice foregrounded a variety of social alliances in the yoga camp: as participants in an event taking place in a city that was still sleeping, we were conjoined with Ramdev. Other times, we as the audience would be differentiated from Ramdev,

who was the obvious leader in this event with his position up high and away from the audience on a stage. Yet, there was also another “we”, the virtual audience.

The conception of “place” becomes very compelling as his yoga camps can be experienced both from television and in a real-life setting. How can *place* be reconceptualised when it sustains interactions that are not necessarily physically-delineated? Attending this yoga camp was a mildly destabilising experience because it had taken place virtually – it had already been rendered familiar by repeated viewings on television.

This technological mediation also created for a slightly surreal subgenre of participant-observation on a communal experience. Even audience members who were seated relatively close to Ramdev’s stage, of the Diamond or Gold category were still at a distance which required a microphone, speakers, and additional screens. Certainly, attending this event as a “real-life” participant allowed for more of a sensory engagement in contrast to the television viewers. Yet, the distance between Ramdev and the audience, the uniformity of activities, the amplification of sight and sound via video screens and speakers cohered the space and made it viscerally-similar to the televised version. Furthermore, the video screens showed the audiences. Perhaps this is why I could not help imagining myself being broadcast into the homes of the television viewers, watching me as much as I had once watched them.

Ramdev came to the stage at 4.57am and the audience respectfully stood up to acknowledge his arrival. His yoga session was based on breathing exercises, *pranayam*, which consisted of exercises such as alternate breathing between nostrils or expunging air from the belly with forceful exhalations. These techniques were understood to alleviate and possibly even cure a host of problems ranging from blood pressure to headaches. Other physical exercises ranged from yoga postures where we remained relatively still and then more aerobic ones where we lay down on our back and spun our legs in a circle, in a motion similar to riding a bicycle. “The cycle is broken! The cycle is broken!”, Ramdev humorously commented to us as many lacked the endurance to maintain this movement for very long.

Ramdev regularly solicited participation from the audience to confirm the workings of his program. At one point he asked, “Who has stopped using their eyeglasses after doing pranayam (breathing exercises)?” Between 10 and 15 people raised their hands. One man walked towards the microphone near the stage and stated that he had been able to stop using his eyeglasses about six months back following a year of doing yoga. Ramdev later asked who was attending because they had a particular illness, a woman near me with white patches on her skin (who presumably suffered from vitiligo), raised her hand as did a teenage boy who sat near me who had similar white patches on the back of his ears.<sup>99</sup>

Along with these questions, he offered guidelines which were veiled with a slight criticism not against anyone in particular but as a commentary against fast-paced contemporary lifestyles. After asking the audience: “Who eats yogurt at night?”, he explained to us, “People in cities eat yogurt at night. If you eat yogurt, at night you will most certainly become sick with bronchitis, arthritis”.

Ramdev’s yoga camps are not only a fitness session, of sorts, but also acts as a blueprint or template for interactions one should carry out in daily life in India’s rapidly transforming socioeconomic setting. He was not simply offering guidelines, opinions, and instructions, he was also articulating a discourse which was a means of “ordering up the world” within and beyond the body and exposition (Mitchell, 1989, p.218). For instance, Ramdev spoke Hindi, but articulated the problematic words (those which were a threat to the health of India as a nation, and to the health of Indian citizens) in English which included: multinational; cold drink (soft drinks, such as Coca Cola); diabetes; obesity; and BP (blood pressure). Foreign products and their concomitant foreign diseases had to be mitigated by Ramdev’s health regimen. An Indian citizen could very well regularly ingest a *cold drink*, and could be met with illness, such as *diabetes* as a result. One could stay up and enjoy the nightlife of a city, but needed to pay heed to humoral sensibilities when ingesting certain kinds of food at that time. The

<sup>99</sup> Vitiligo is an autoimmune disease, and therefore not easily treatable by allopathy. However, the Council of Unani Medicine dedicates itself to conducting research on this disease and its remedies.

contemporary setting offered access to plenty of temptations and their physical consumption had to be tempered with the sensibilities of indigenous health care practices such as yoga and Ayurveda.

Ramdev's yoga camp involved many different types of activities ranging from sitting to yoga to clapping to speaking and singing, and carried out collectively to unite individuals to audience and to Ramdev. The two hour session ended around 7 AM with the singing of religious and patriotic songs and Ramdev informing the audience on his topic of lecture for the next day. This execution of activities which encapsulate entertainment, religious and political concerns were typical of large-scale gatherings in India.

In contrast to the health care exhibitions discussed earlier, Ramdev's yoga camp featured bodies (and many of them) rather than objects. The yoga camp attendees could certainly see themselves as part of a spectacle much like the attendees at the health exhibitions. Yet, for the former, their exposition experience was mediated by the body, as they collectively undertook a set of routines.

Ramdev's yoga camp elicits this mode of interaction in a public space as he delivers a corporal, verbal, and musical performance and solicits audience participation. This event is reminiscent of established forms of public gathering as pointed out by Freitag (2001). However, these yoga camps provide a markedly unprecedented reach – much more extensive than what Bennett (1988) and Mitchell (1989) and the visual studies scholars have discussed thus far (Freitag, 2001; Pinney, 2001). Ramdev's success in mobilising the consumption habits of middle-class consumers lies in his strategy of locating his health regimen at the intersection of a new public culture, one that is increasingly mediated by various technological advancements (i.e. mass production of Ayurveda, television) and a trope of tradition mediated by the body. To show how I came to this conclusion, I will go over the works of other public culture scholars who discuss the co-constitution of South Asian visual culture, the middle-class, and religious nationalism. Having covered this, one can then ask, what does this collapse between virtual and actual realities, mean for the politics of consuming culture in India?

This chapter so far makes clear that Ramdev was certainly well-known to many Indian citizens ranging from a chauffeur to the middle-class followers who purchased “Diamond” seating for the yoga camp. How did Ramdev manage to cut across class boundaries in such a manner? As stated earlier, in a country such as India with over 20 official languages and a high rate of illiteracy, images are a particularly potent vehicle for expression. In the opening chapter of, *Pleasure and the Nation: The History, Politics and Consumption of Public Culture in India*, visual anthropologist, Christopher Pinney (2001) writes of the paradoxical nature of India in how it is both deeply divided through caste, class, languages and yet converges on persistent “shared cultural idioms”, usually visual. Indeed only certain sectors of the Indian population can appreciate pastimes such as novels written by Shoba De, the Jackie Collins of India, but a common ground does converge on shared visual phenomena such as Bollywood films, sports such as cricket, or public performances.

The establishment of television across the nation in the 1980s was remarkable in providing a “single visual regime” (Rajagopal, 1998, p. 15) with a reach that was both far-reaching and yet intimate (i.e. inside people’s living rooms). Visual scholars Purinima Mankekar (1999) and Arvind Rajagopal (2001) have undertaken exemplary studies on the intersection of television and India’s neoliberal socioeconomic and argue that television played a critical role in promulgating consumer culture by embedding into a Hindu Indian nationalism, especially in the mid-1980s during the onset of neoliberal reforms.<sup>100</sup>

The amalgamation of religion and mass-broadcast allowed proponents of the free market, such as the Bharatiya Janata Party (BJP), which promoted Hindu nationalism, cultural conservatism, and military might to articulate swadeshi principles. Swadeshi, which once signified self-sufficiency, was reconceptualised as pro-globalisation and pro-Indian without being anti-foreign (p.11). Mazzarella remarks that many pro-globalisation advocates (such as those in advertising) did not consider the idea of India joining the free

<sup>100</sup> Mankekar is an anthropologist and Rajagopal is a communications studies scholar.

market to indicate homogenisation or loss of cultural distinction, in fact this transition was claimed as the mark of any self-confident nation (2003, p. 9).

The perceived failure of the state to protect Hindu culture was of a piece with its failure to liberate market forces. The repressed energy of society, which was Hinduism, was equated with the repressed energy of entrepreneurial forces under the Nehruvian state. (D'Monte, 2000, para 14)

This new modality of consumption was championed as a democratising force which could introduce newcomers to the infinite powers of self-transformation via consumption (Mazzarella, 2003, p. 89).

Rajagopal is most well-known for his study of an incredibly popular television program which aired during the 1980s in India, a religious epic called *Ramayan*. Rajagopal demonstrates how the Ramanayan became an impetus to the intersection between mass media, public and political culture in India.

The mythological stories featured in the show were made out to be commensurate with the BJP right-of-center ideology as the program was worked into

a kind of parable about the nation state, projected back into the distant past. India was seen as always having pro-development rulers who were uplifting the lower castes, women in distress and so on. It endorsed the idealised view of Ram Rajya. Vedic sacrifices and rituals were shown as scientific research and experiments undertaken for national defense. The rishis' weapons were described as nuclear missiles used for the benefit of the nation state. Many ideas about the modern national security state were carried back in time. (Rajagopal as cited in D'Monte, 2000, para 18)

This interlinkage between mass media, consumerism, and Hindu nationalism was not intended, but the popularity of the show, along with the intensification of neoliberal reform and the BJP's willingness to engage with mass media resulted in such an

outcome.<sup>101</sup> Ramayan's viewers were a captive audience since there were not many other channels for India's citizenry to watch: Mankekar recounts that shops and markets would be closed and activity came to a standstill when the show aired (1999, p.188). A large viewing audience was thus made receptive to the idea of a "Hindu civilization which could be readied for a modern age [and come] to inhabit the intimate spaces of daily life" (Rajagopal as cited in D'Monte, 2000, para 19).

As we can see, the distinct national identity that Ramdev articulates is not only evoked from a trope of refusing foreign influences. It was also based on a very exclusionary Hindu manifestation of an Indian identity which is indexed on Ramdev via his saffron robe, the aum symbol, and speeches and songs that invoke deities from the Hindu pantheon such as Ram and Sita.<sup>102</sup> Chakraborty (2006) observes that these symbols are interlaced with tales of national heroes such as freedom fighters: "the strategic mixing of mortal and divine heroes serve as visual reminders of Hindu masculine and martial prowess of the past" (p. 388).

The yoga camps share a similar ethos to that of "akharas" (wrestling) and Rashtriya Swayamsevak Sangh (otherwise known as RSS – a militant Hindu organization affiliated with the BJP) *shakas* (sports camps which instill discipline and militancy). All of these "provide the foundation for the construction of a somatic nationalist bond through shared bodily performances" (Chakraborty, p.389). Ramdev's program is a reminiscent of this, some fifteen years after neoliberal reform as the Indian citizenry is

<sup>101</sup> Why did this so effectively capture the attention of the Indian populace? Mazzarella theorizes that in the secular Nehruvian era from Independence in 1947 to the mid-1980s denied citizens any capacity to bring a "corporal, affective density to public life" (2005, p.9).

<sup>102</sup> Even the channel which broadcasts his program affiliate themselves to a national Indian identity to capture their market and serves as a clear example of the intersection between a non-secular modernity and economic expansion.

We recognize and respect the fact that spirituality is integral to the very essence and fiber of the South Asian culture and AASTHA will fill those social and spiritual needs... AASTHA will provide a link to India's cultural roots, customs and society to the more than two million South Asians living in the United States." (Aaron McNally).

The AASTHA lineup features spiritual discourses, socio-spiritual-cultural ceremonies and events, meditation techniques and devotional music. It charts the holy places of pilgrimage, elucidates on traditional festivals and focuses on Indian vedic sciences like ayurveda, yoga, astrology, crystal therapy and aroma therapy (AASTHA, 2010).

access satellite television and becomes willing to spend on Ayurveda and yoga to express a middle-class authenticity.

India's contemporary urban landscape features the expected signifiers of a free market economy such as shopping malls and flyovers. My ethnographic examination of India's public culture through Ramdev's yoga camps shows how that India's consumer culture is enfolded in a non-secular modernity, and a "retail Hindu identity" in particular (Rajagopal, 1998, p. 28). Kajri Jain, an art historian of Indian popular culture describes its impact on the post-neoliberalisation cityscape which is:

increasingly dominated by the visually distinct – albeit ideologically and experientially complementary – forces of Hindutva and "globalized" consumerism, unfolding through an intense and creative use of every medium available: not just prints and cinema, but also television, billboards, vehicles, spectacular events, public spaces, monumental structures. (Jain, 2007, p. 368)

If we review this chapter we can trace Ramdev's avatar appearing in many of the formations Jain mentions: his face appeared on a billboard of the Divya Yog stall at Herbal Expo, Neena introduced me to him via television, and I attended his yoga camp, a "spectacular event" in a public space, and received the complimentary copy of Yog Sandesh, with his face on the cover. The rise of technology in India results in an abundance or multiplicity of images, rather than any kind of Big Brother surveillance. As specific renditions of nation enter people's lives as an ordinary point of reference, citizens are coaxed to relate themselves to mass-mediated phenomena while sublimating their desires in a manner amenable to consumption as Indian citizens.

#### **8.4. Before and After the Expositions: The Response of Consumers**

I conclude this chapter by considering the possible response people might have to the consumer sensibilities promoted by these expositions. I wonder, DO they sublimate themselves and become docile consumers? These expositions are not unique for

promoting mass-produced medicines or bodily practice. Such offerings are found in Delhi's other sites of consumption, from television to shops. Knowing that, the response of consumers which I consider below refers to their encounters with mass-produced medicines in general, not so particularly from the exposition.

Chakraborty (2006) observes the contradiction in how Ramdev exploits the communications technology borne from the free market while protesting its other outcomes such as mass-produced food in his quest to profit from the surge in popularity of indigenous medicine. The availability of satellite television, DVDs, Internet and magazines broadens the immaterial "sphere of exchange" in the consumer economy, which Ramdev capitalises on. Meanwhile, he reconciles this contradiction by adopting a Hindutva nationalist stance and echoing principles of swadeshi.

During my fieldwork, I noticed that the debates about mass-produced Ayurveda by consumers were not centred on notions of authenticity, traditional Indian identities, or medical philosophy. If consumers had any concerns, it was centred on the purity of substances about to be ultimately ingested by the body.

When Neena introduced me to Ramdev's program early on my arrival to Delhi, I was presented with his yoga program as it was broadcast by the AASTHA channel. Later that week, we also witnessed his image on the Indian news channel with the text running at the bottom of the television screen announcing, "Breaking news: Baba ko jandu!" ("Ramdev's magic!") underneath Ramdev's terse face as he spoke to reporters: Ramdev was accused of producing tainted Ayurvedic medicines. The Department of AYUSH had found questionable substances in the Ayurvedic drugs produced by Divya Yog and that the laboratory report stated that some of the medicines contained ingredients such as "testicles of animals, and bone and skull powder" (Patranobis, p. P1, 2005). These ingredients violated labeling and licensing laws as they were not listed on the packages of the medicines.

"Impurity" was articulated on two different registers with these findings. The first related to lack of transparency between the label and contents of medicine. The other layer of impurity was denoted by the class of ingredients - animal parts for a product

promoted by a Hindu guru, a strict vegetarian who advocated for purity of the nation and bodies.

What was most striking to me was how the findings were debated and not taken at face value by its viewers. Were they not afraid of ingesting skull powder? Neena was nonplussed when learning about the controversy on the news channel and scoffed: “The multinationals are jealous”. The spectre of corruption which is always just beneath the surface in India, implicated Ramdev this time, but perhaps it could have incriminated AYUSH at another instance: perhaps AYUSH was affiliated with Brinda Karat of the Communist Party politician who had originally called for investigation into the Divya Yog manufacturing facilities. Karat had been concerned about the labour conditions of the workers and it was this inquiry which had led to the breaking news about the ingredients of Ramdev’s medicines. Middle-class consumers not only negotiate different medical systems, their efficacy, and cost, but they also decide what counts as truth in India’s medical setting.

As we can see, as Ayurveda becomes more prominent in India’s medical marketplace, so too have threats to its integrity. Daily newspapers would occasionally carry small reports about dangerous ingredients such as mercury or lead found in Ayurvedic medicine which had been shipped abroad. Such ingredients were well established in ancient Ayurvedic pharmacopeia (with their harmful effects being cancelled out as they were mixed with other substances) but powerful medical authorities such as those who contribute to the well-reputed *Journal of the American Medical Association* remained skeptical. One researcher reported, “it is difficult to understand scientifically how the lead could be truly detoxified. It’s something that warrants more examination”. Banerjee lamented that Ayurvedic pharmacologists were denigrated as unscientific “medieval alchemists” as a result (2009, p.266). The safety and integrity of Ayurvedic medicines were frequently often called to question over these particular ingredients.

Indian consumers emulate the same reservations about Ayurvedic medicine as it becomes transformed into a consumer-friendly product. My introductory chapter included

a description of a middle-class consumer, Rohit who admitted to being won over by the packaging of Himalaya Drug Company, despite the foul taste of the medicine: “even if they had rat’s poop, I’d have to have it” (April 4, 2007). Later in the conversation, he went on to voice his suspicion about the contents of medicines by the same company below,

- Rohit: Himalaya has become this fancy household name for Ayurvedic products, but if you actually read insider reports, they are not Ayurveda, they are not fully Ayurvedic, there’s a big conspiracy, there are lots of chemicals in it.
- Mandip: It’s tainted?
- Rohit: ...My uncle, he’s an engineer, he was actually doing some research on the products and it had some elements of mercury, some elements of metal in some of the products. I cannot really put a finger on it and say ‘This is really true’, but I’ve heard reports from people that this cannot be purely Ayurvedic.

Lead and mercury are part of the Ayurveda pharmacopeia but are construed as contaminants in Rohit’s account. As Ayurvedic medicine acquires prominence in the medical marketplace, different types of experts from *JAMA* contributors to engineers stake a claim to its workings. Their power comes from the technocratic fields they are situated in, rather than any deep knowledge of Ayurveda (Banerjee, 2009).

Going back the issue of mass-produced Ayurvedic products, Rohit is not only concerned with harmful ingredients. Earlier, he admits to being won over by the packaging and appearance with Ayurvedic medicine acquires a more prominent place in retail environments such as pharmacies (chemists), and consumer health exhibitions such as the expositions discussed in this chapter. Yet the emphasis on appearance also leads him to cast doubts about the efficacy of Ayurvedic medicine.

- Rohit: Because the way it functions is so like cosmetics, that it’s hard to believe that it’s purely Ayurvedic, know what I mean? But it sells well because they’ve packaged it well and they’re marketing it really well. And it’s suddenly become a rage amongst the urban society. Suddenly the Ayurvedic pills for liver and for kidney or for migraines - they (consumers) used to actually purchase it from these small Ayurveda dispensaries

around the city. They [the pills] looked ugly, they were bitter – they were just not appealing. Now suddenly you have this brand that packages it really well, markets it really well, has this fancy bottle for it. And people say, “Oh my god! There’s a face wash, there’s a face mask, conditioner for my hair - it’s Ayurvedic.” I don’t believe it. Honestly? This is my view. (April 4, 2007)

Rohit wonders if well-packaged and nice-looking Ayurvedic medicine can carry in contrast to earlier times when people more willingly suffered through bitter tastes to become well. It seems that the mass-production and marketisation of Ayurvedic medicine either causes it to be harmful - or full of fluff.

This issue with the integrity of mass-produced goods is not restricted to Ayurvedic medicine. Rohit may not be stating anything about Ayurveda’s clumsy attempt to enter the market and move on from its former incarnation an indigenous home-made cultural remedy. This lack of belief and questioning of claims and truths seems to be evoked by any mass-produced or anonymously-prepared commodity for physical ingestion. Recall the Coca Cola placard that I mentioned earlier in this chapter upon my entry to the Swasthi Fair (on p.28). Coca Cola’s brand ambassador, Aamir Khan, was a Bollywood star whose image was featured on the placard. And, actually alongside his image was a text saying that Coca Cola is “safe to drink”. What could this mean?

This advertisement was borne of a controversy a few months earlier regarding the ingredients of Coca Cola. A private British research company had tested some samples in India concluded that no pesticides were present. However, the samples were not randomly selected from the market, they were provided from Coca Cola. A Delhi-based environmental group took matters into their own hands and tested random samples from the domestic market. Their findings reported that high levels of pesticides were indeed present. By August 2006, two months before the Swasthi Fair, several Indian states had “partially banned” Coca Cola, and Kerala had prohibited the production and sale of Coca Cola. (Gentlemen, 2006, para 8). Coca Cola responded by putting out statements and advertisements such as the one I saw in response to the controversy (ibid). There seems to be no stable truth in India about purity of substances in mass-produced items. Just as

Ramdev criticises the purity of Coca Cola in his discourses, so too are Ramdev's products criticised by other players, such as Brinda Karat.

The debates about mass-produced Ayurveda by consumers are not centred exclusively on notions of authenticity or traditional Indian identities, or medical philosophy. Rather it is centred on the purity of substances about to be ultimately ingested by the body. Thus it is not only Geet who has to worry about the quality of herbs purchased in bulk form for his mother as discussed in Chapter 4, but also consumers of packaged Ayurvedic products. Are these negotiations so different? Perhaps these disputes over truth explain the persistence of the informal practice of Ayurveda.

## **8.5. Conclusion**

This chapter depicts how in the contemporary neoliberal setting, Ayurveda is increasingly implicated into the marketisation of objects and bodily practices. Nowhere is this more clearly articulated than in expositions which aim to inscribe objects and experiences with a consumer ideology (Bennett, 1988). The first exposition I analysed (Herbal Exposition) presented an array of herbal products, including medications, in a packaged manner which made them homologous to other mass-produced retail goods that circulate for consumption for middle-class consumers. The second exposition, Swasthi Fair, had similar aims but was much deliberate in its conceptualisation of space. Its layout was planned to invoke established forms of gatherings, such as the *mela*, to capture the attentions of attendees and make them receptive to the educational and consumer aims of the expositions. My examination of Ramdev yoga camps showcases another genre of exposition, taking place two decades after neoliberal reform with India's deepening integration into the global market and unparalleled advancements in information and communications technology. Ramdev's exposition is the most lucrative one of all the I

have described and is based on communal bodily practices and a rhetoric of swadeshi-style resistance to incite consumption.<sup>103</sup>

The exposition inscribes neoliberal ideologies regarding health and consumption onto the therapeutic repertoires of Ayurveda to enact it as a sociotechnical system. In Pfaffenberger's schematic, the showcasing of objects and people can be understood as taking place through aspects such as "complex social structures", "ritual coordination of labour" and "non verbal activity" systems which showcase "advanced artifact manufacture" (p.513). All of these aspects are present in the three expositions I described even if their enactments (or content?) varies. All of these expositions invite and cultivate linkage between health and retail, and between exposition and shopping, between spending and leisure, to ensure Ayurveda's livelihood in the medical marketplace. The consumer responses reveal that expositions, even with their modernist or 'Machine Age' aesthetic and ideology (Herbal Exposition) or communal millenarian ethos (Ramdev) do not provide definitive renditions of sociotechnical systems nor Ayurveda.

<sup>103</sup> Ramdev regularly takes hunger-strikes to protest against the corrupt workings of the Indian government. He also holds great political sway amongst the voting population in North India (Tripathy, 2011).

## 9. Conclusion

Health is a mutable and subjectively felt condition. The malleability of health makes it an infinite terrain for the expansion of consumer desires for oneself or one's kinfolk. Delhi's booming economy made it a promising site of study for the production and consumption of Ayurveda amongst its urban middle-class.

My examination of an indigenously produced medical practice emphasises that studying consumption is not just about the circulation of products such as Coca Cola and cell phones. One need not study the entry of foreign-produced objects to speak about emergent consumer practices. Rather, it is the ways of relating to such mass-produced entities, including Ayurveda, which is of anthropological interest.

Amongst the middle-class of Delhi, Ayurveda is not in any danger of dying out because it was a traditional medicine. In fact, it continues to be widely sought by health seekers. Ayurveda is an economically viable entity in the marketplace, in part because it can motivate a range of consumer behaviour to resolve health issues ranging from the mundane to the exceptional, and resonate with different degrees of desire and urgency: tourists could occupy their leisure time and relax by receiving Ayurvedic massage from a spa, young professionals could purchase Chyawanprash as a daily tonic, and middle-aged patient could visit an Ayurvedic clinic to help with chronic illnesses. These diverse therapeutic options circulated in the formal economy.

This study builds on the findings of Bode (2008) and Banerjee (2009) on the mass manufacture of Ayurvedic medicines by acknowledging the important, efficacious, and immaterial facets of Ayurveda as a health care practice which drive its production and consumption as a good and service in both the formal and informal economic spheres. My examination of Ayurveda took place from various sites around Delhi, which included the household, clinic, and expositions. These spaces can be thought of generating

particular manifestations of Ayurveda: the household spotlighted informal practices, the clinic foregrounded its standardized institutional aspects, and the expositions emphasized the commercial dimensions of Ayurveda. They are sociotechnical spaces with particular kinds of structure, social roles, expertise, and knowledge which enact Ayurveda. As well, these spaces are not self-enclosed units, they are points of *convergence*, which configure particular objects and relationships to generate health practices.

I portrayed Delhi as a node of confluence for health care and consumption practices through my examination of Kerala-based Ayurveda. My examination suggested that the popularity of Kerala-based Ayurveda was due to the potential of Ayurveda as a translocal practice, connected to wider economic networks. The mobility of people and enterprises positioned Sunil and Ramesh as Keralite patients located in their local medical marketplace and other times as possible consumers for the complementary and alternative health care market as they witnessed the commercial efforts dedicated to launching Kerala into the larger medical marketplace for global consumers. Sunil and Ramesh exemplify emerging consumer subjectivities as local medical or cultural practices are translated into economically viable practices.

The household was a site of intersection, too, one which featured non-market or informal exchange of medical material culture and knowledge. Medical knowledge was exercised in the household as health seekers by Raj and Bina who employed artifacts, such as *neti* pots and herbal medications, for their regimes of domestic self-care and health. The household also mediated access to informal repertoires of knowledge provided by part-time and unofficial practitioners such as domestic labourers and gurus.

The clinic, a formalised and hierarchical space animated by the activities of professionals who attend to many patients, is a dense site of interaction. Clinics were inflected by the processes of marketisation so they could assert themselves as powerful players in the medical marketplace. This was demonstrated by the expansion of clinics (i.e. greater numbers of private enterprises) and expansion of services (i.e. medical testing and medical education). Dr. Gupta's clinic was a busy node of therapeutic activity. I emphasised the process of interaction and feedback between bodies, objects, and ideas

that constituted Ayurvedic treatment. Here, therapeutic knowledge was not communicated one-way via expert doctor and passive patient. Instead, it emerged from their exchange, and patients were expected to remain vigilant to their daily routines of healthcare.

My interviews with middle-class practitioners such as Dr. Anand and Mr. Verma revealed the different kinds of expertise that could be mobilised from the informal transmission of Ayurvedic knowledge even in formal spaces such as the clinic. This chapter invited one to reconsider assumptions of expertise, practitioner, medical knowledge, and health

The very public and temporary space of the exposition delineated interactions which were oriented to viewing and consuming. These expositions shaped and reflected the requirements of the formal medical marketplace. The first genre of expositions I examined were exhibitions, which focused on the presentation of herbal and therapeutic resources available to the public. The second genre of expositions involved communal bodily-practices at Ramdev's yoga camp.

These expositions invited two different types of visual interaction. In contrast to the first genre of expositions, the attendees of Ramdev's yoga camps did not explicitly engage in any visual and bodily interaction reminiscent of shopping – no strolling, people-watching, window-shopping, or perusing. The visual and bodily engagement was directed to conducting communal yoga activities. Yet, Ramdev's exposition was likely the most powerful means of disseminating indigenous medical traditions such as Ayurveda for the medical marketplace. His practice engaged audiences in a comprehensive consumption of health care: one that was mediated by the body and mediated by the televisual field. In turn, this could lead to other types of consumption – perhaps herbal medicinal products and clinical treatment from his company, Divya Yog.<sup>104</sup>

<sup>104</sup> According to the Divya Yog website, Delhi now has 36 such clinics. (<http://www.divyayoga.com/list-of-patanjali-chikitsalya.html>)

The sociality of consumption in the exposition is made evident in how Ramdev asserted a series of relationships between bodies and the nation which evoked a *swadeshi*-style of rhetoric of self-sufficiency with a “be Indian, buy Indian” ethos. He advocated for resistance against the invasive forces of globalisation, even as he exemplified how one profited from the burgeoning health care market.

What kind of sociotechnical system should Ayurveda be? This seems to up for debate in India as more processes of daily life are implicated into the neoliberal paradigm. As the Indian economy becomes more deeply embedded into the international marketplace, the parameters by which Ayurvedic medicine circulates shifts to adapt to the burgeoning health care market. Perhaps health care practices will accommodate the requirements of powerful global agents such as pharmaceutical manufacturers, who can produce and market drugs effectively to large audiences. In Langford’s (2002, p.263) study, students and practitioners of a medical college opined that the livelihood of Ayurveda depended on the extent to which it was deemed acceptable by the “West”. The Department of AYUSH dedicates its research efforts to developing regulations for standardisation of plant material and drugs so that Ayurveda can circulate for global consumption. They also maintain a repository of indigenous health care practices, such as the Traditional Digital Knowledge Library, to prevent bio-piracy and keep the intellectual property of long-established healing practices such as herbal remedies and yoga poses in the public domain (AYUSH, 2010b).

The extent to which Ayurveda medicine will be implicated or not to the processes of commodification remains to be seen. The expressive dimensions of sociotechnical systems and their ability to express more than the sum of their parts maintain them as locally relevant cultural tools. This dissertation has shown some of the ways in which aspects of Ayurvedic treatment overlap with other relationships such as caregiving and spiritual mentoring thereby preventing it from being fully commensurable in the sphere of formal economic exchange.

The institutionalisation and mass-production of Ayurveda has constantly been inflected by contradictions and contestation about its workings. When its proponents

sought to develop it as a medical system in the mid-twentieth century, the process were marked by debate rather than consensus. As well, medical colleges gave students legitimacy to practice Ayurveda, yet some used their licence to practice allopathy while others felt short charged about the quality of training they had received (Langford, 2002; Svoboda, 2008).

Those on the receiving end, such as middle class consumers, are accustomed to negotiating and debating medical knowledge to assemble an efficacious health practice. This is due, in part, to the unpredictable nature of health and healing which may compel one to draw upon the multiple resources of Delhi's medically pluralist setting. Additionally, health seekers are not convinced their needs are met by official health care institutions (private or government), as they are often rumoured as being corrupt or extending favours clients who could pay extra for bribes and so on (Pinto, 2004; Fernandes, 2006). As well, the controversies with Ramdev's Ayurvedic medicine indicate that lack of transparency from manufacturers, too, is a recurring problem in India. This is especially a cause for concern when it comes to substances which are to be literally consumed, or physically ingested.

Zimmerman's (1987) food chain whereby plants are eaten by animals, and then by humans explained the logic of Ayurvedic medicine in classical treatises, like the Charaka Samhita. The contemporary practice of Ayurveda may be more appropriately described with the metaphor of a "dog eat dog" world where debates about the efficacy and quality of medicine constantly take place amongst its consumers and in the public sphere of mass media. Health seekers negotiate their medical practices in a myriad of ways as there is no "coherent local counterideology that resists modernity" (Pigg, 1996, p.192). The debates and re-working of health care practices are indicative of consumption as a complex process of meaning-making, rather than an invocation of authentic cultural essence (Langford, 2002). My research of Ayurveda in the formal economic sphere troubled binaries such as local-global and traditional-modern as I examined how a classic remedy, Chyawanprash, was both mass-produced and positioned as an antidote to the tribulations of modern life; how a traditional cultural event such as the *mela* promoted messages about consumption and social marketing for public health; or the popularity of

Ramdev's exposition, a technologically-mediated production which espoused a rhetoric of exclusionary Indian-ness.

My investigation of Ayurveda in the informal medical marketplace challenged the binary nature assumed in relationships such as practitioner-patient and producer-consumer. The spectrum of medical expertise is showcased in informal sites of health care, such as the household along with the more formal spaces of the clinic. There is thus not one type of "practitioner", nor even one type of "informal practitioner" who may provide Ayurvedic treatment. My examination of Ayurveda from the clinic shows the wide range of consumers who are drawn into this practice, ranging from widely-travelled professionals, middle-class patients, and aspiring practitioners. Consumption is also a process of meaning-making, especially when it comes to physically-ingestible substances that are taken in by those seeking health. Mrs. Simar's tale of *jatamaansi* was particularly evocative as it depicted a multiplicity of producers and consumers who showed up at various intervals. Swami Ji and Mrs. Simar could be thought of producers for *jatamaansi* at different stages of its journey as a therapeutic and pharmacological substance.

India's health care system continues to rely on a lively informal strata. How to relate this to Wladawsky-Berger's observation about the marketplace for sociotechnical systems? He claims that it is "truly the research lab for innovation in services, the place where new service ideas have to developed, prototyped, and tested" (para 14, 2012). The medical pluralism literature indicated that such innovation been taking place for quite some time amongst practitioners and patients. My dissertation shows that it continues to take place from vendors in Khaori Baoli who appropriate Mickey Mouse to sell dried goods or Dr. Anand the homeopath who travels outside the city to learn about *nadi-parikshaan* (pulse technique) from a reputed Ayurvedic practitioner. Delhi as the nation's capital and economic powerhouse is a particularly amenable site for the ethnographic exploration of the various permutations of the medical marketplace. The informal health care economy, invisible and misunderstood from afar, illuminates the complexities of economic and non-economic exchange and spectrum of expertise when examined up close.

## 10. References

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