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Introduction

Yoga and meditation have been increasingly promoted as healthcare interventions by the Indian government. In 2014, a department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (AYUSH) was raised to the level of an independent ministry, unambiguously positioning the Indian government as supporting a collection of ‘indigenous’ traditions as medical interventions. However, this event is predicated on a much longer, but inconsistent history of support for indigenous medical traditions from the government of India, various regional and municipal governments, princely states and ascetic orders.

This chapter is organised into three main sections: the first explains the contemporary structural positioning of yoga and meditation as interventions for health by the Indian government. The second section explores some of the historical entanglements between yogic and meditative traditions as healthcare provision within the subcontinent. The third section will provide insight into contemporary popular experiences of yoga and meditation as health and wellbeing practices.

Yoga and meditation in AYUSH

During the colonial period and in post-Independence India, government sponsorship of indigenous forms of healthcare in the Indian subcontinent has been inconsistent, with many regional variations (Barois, Newcombe and Wujastyk forthcoming; Brass 1972; Priya 2005). The twenty-first century has seen India’s central government more consistently present an ambition for uniting yogic and ayurvedic interventions as well as attempting to achieve more national conformity of content and standards. As Abraham has described, recent developments show that the promotion of Indian indigenous systems of medicine is ‘increasingly being driven by narrow political interests and by the dictates of global markets ... reflected in the focus on the export’ of a few products (Abraham 2005: 211). Attempts to get a grip on the contemporary positioning of yoga as a health intervention in India can quickly become overwhelmed with facts and figures of numbers of institutions, beds and exports (e.g. GOI 2005; Priya 2005). This emphasis on the quantitative in official publications masks the great diversity of provision and experience of healthcare with interventions in this broad area.

Yoga was officially recognised as a component of indigenous medicine in the formation of the Central Council of Research for Yoga and Naturopathy in 1978 (a pairing that will be

discussed further below). In 2003, the Ministry of Health recognised a unified Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (AYUSH). With this department being raised to the level of independent ministry in 2014, yoga and ayurveda have become ever-more institutionally intertwined. Contemporary Indian university syllabi for the Bachelors in Ayurvedic Medicine and Surgery (BAMS) require undergraduate syllabuses and graduate programmes to cover a basic understanding of Patañjali's formulation of yoga as well as of therapeutic applications of asana and pranayama (CCIM 2014).² This incorporation of asana and pranayama as ayurvedic interventions in government-approved training syllabuses is a contemporary innovation. The change appears to be largely a direct response to global market trends rather than being a natural extension of a historically complex dialogue between yoga and ayurveda. Although there have been many areas of overlap, in general, ayurvedic, siddha and yogic systems of treating bodily suffering offer distinct ontological frameworks and practical techniques. While there is much more consistency within ayurveda and siddha than yogic systems per se, it is extremely important to note that all of these traditions are best understood as being internally plural and diverse (Lambert 2018; Sujatha 2020).

From the nineteenth century, yogis and ascetics have been tested with biomedical tools measuring pulse rates, blood pressure, respiration and more recently with various brain-imaging technologies. Early attempts were an attempt to explore and verify claims of yogic 'attainments' (*siddhis*) and yogic 'cures' by biomedical criteria (early examples include Paul 1851 and Thamoathamphilly 1897). Biomedically-framed measurements of yogic health claims were applied more consistently from the 1920s onwards. This was particularly evident in *Yōga Mīmāṃsā*, the first and longest-running periodical of this nature, which has been published out of Kuvalayananda's Kaivalyadhama Institute in Maharashtra since 1924. For many years this was the primary place in India for biomedical research on the effects of yoga, and the journal had wide circulation among English speakers across the globe (Alter 2004: 73–108; Goldberg 2016: 97–99).

More recently, the Swami Vivekananda Yoga Anusandhana Samsthana (S-VYASA) – the first nationally accredited 'Yoga University' in India (founded in 1986) – has been publishing the results of its research into the efficacy of yoga as therapy in its in-house, open-access journal, the *International Journal of Yoga* (2008–). S-VYASA's journal explores yoga in the paradigm of the 'life sciences', focusing in particular on the mechanisms of yoga, physiological changes and therapeutic benefits (S-VYAS 2020). However, research studies on the efficacy of yoga have been conducted throughout India by many different institutions doing active research into AYUSH. Throughout the history of the Indian state, Abraham notes, government funding has largely gone into institutions and individuals that have an agenda of either: (1) creating more 'scientifically' verified articulations of indigenous systems of medicine (ISM); or (2) rhetorically 'reasserting its traditional roots' (Abraham 2005: 211).

A pivotal figure to capitalise on an international interest in yoga as a health intervention at a global scale was the Maharishi Mahesh Yogi (1918–2008). The Maharishi achieved unheard-of popularity after attracting the attention of the world-famous band The Beatles for a short period in 1967–1968. The Maharishi's teachings in the 1960s were focused on a mantra-based meditation given to initiates in a private 'Vedic' ceremony. Trademarked as 'Transcendental Meditation' or 'TM', these teachings were presented as scientific in promotional materials (Maharishi 1968) and quickly became very popular in the United States, Europe and across the globe (Bainbridge 1997: 188–189). The place of meditation as a central component within the Maharishi's greater revival of 'Vedic' arts was markedly influential – in addition to his unprecedented global success at promoting meditation, yoga and commercial products. The Maharishi's organisations³ poured significant sums of money into researching and promoting the universal

benefits of ‘Vedic Science’ – which first and foremost rested on the practice of Transcendental Meditation. Research studies, many of which have been conducted and funded by Maharishi-affiliated organisations, have shown Transcendental Meditation practices to have effects on lowering blood pressure, assisting with the management of diabetes and reducing insomnia and feelings of anxiety, among other specific measures (e.g. Forem 1974; Maharishi 1968; Chalmers 1991; Maharishi International University 1998; Balaji, Varne and Ali 2012).

In the United States and Europe, medical attention initially went into exploring the healing potential of meditative techniques. In particular, Herbert Benson and Miriam Klipper’s seminal book *The Relaxation Response* (1975) showed how generic meditation and relaxation techniques yielded measurable improvements in lowering blood pressure and reducing feelings of stress. This research was a direct response to the TM-funded research specifically promoting the Maharishi’s organisation and established a broader, untrademarked basis of the medical benefits of meditation-based, relaxation interventions.⁴ In the United States, this finding resulted in a secondary wave of meditation-focused health interventions, especially in the eventual creation of the highly influential Mindfulness-Based Cognitive Therapy (MBCT). In the next few decades, the majority of biomedical research in the United States on the health effects of meditation shifted interventions from the ‘TM/Hindu’ intervention to more secular-Buddhist-based interventions.⁵ The 1977 US Supreme Court decision that TM was a religious technique which could not be taught in publicly-funded schools firmly established this as a religious, rather than secular biomedical intervention (*Malnak v. Yogi* 1977). This limited the organisations’ global expansion, particularly in more overtly secular contexts.

However, the exploration of meditation as a technique for health and healing took on a different focus within the Indian subcontinent. In India, the Maharishi’s intervention significantly (re)established ‘mental techniques’ as the lost heart of ‘Vedic Science’ – and an essential component of the ‘true sense and value’ of Indian ayurvedic traditions (Jeannotat 2008: 289). Through the figure of the Maharishi (who was previously a disciple of Śāntānanda Sarasvatī (d. 1997), the Śāṅkarācārya of Jyotirmath) the image of the yogi was transformed in the Indian imagination: he represented an India that was simultaneously modern and traditional, scientific and spiritual. The Maharishi attracted international and celebrity interest. Following this trend, in India, meditation has not been framed as an independent healthcare intervention. Rather, from the 1970s onwards, meditation is included by the Indian government as a part of scientific, ‘yogic’ interventions. This is evident from the headline status given to the work of the Maharishi, Aurobindo and Dharendra Brahmachari at the 1975 conference on ‘Yoga, Science and Man’ sponsored by the Indian Government in New Delhi (Kothari 1975).

From the late 1970s, the Maharishi began researching ayurveda and ayurvedic pharmaceuticals and established ‘Ayur-Vedic’ branded products around 1984 (Jeannotat 2008). From this period onwards, there has been a ‘mushrooming of ayurvedic luxury resorts, spas and retreats across many of India’s tourist destinations’ which offer ‘expensive “relaxation” and “rejuvenation” therapy, yoga and meditation sessions, lifestyle advice, as well as beauty treatments, to affluent clients, mostly (though not exclusively) from overseas’ (Warrier 2011: 86; see also Zimmermann 1992; Zysk 2001). The Maharishi’s commercial and ideological initiatives, promoting the revival of many arms of ‘Vedic Science’ under the trademarked ‘Maharishi’ name, associated yoga and ayurveda with international fame and fortune for Indians.

With the Bharatiya Janata Party’s rise to power in 2014, the government’s enthusiastic promotion of yoga and ayurveda has created an explicit political association of yoga and AYUSH therapies with ‘Hindutva’ (or ‘Hindu-ness’) – a term with charged political currency. India is a very diverse nation and yet, far from all the population legally defined as Hindu under Indian family law, identifies as Hindu (Hindu Marriage Act 1955). Meanwhile many Indians who are

happy to identify as Hindu might have a complex relationship with the BJP's understanding of Hinduism. This situation creates a politically charged undercurrent to the promotion of yoga and meditation for health and wellbeing, despite unifying and reassuring official rhetoric surrounding these practices. Contemporary AYUSH definitions of yoga combine spirituality and science in a united quest for mind-body unity and transcendent health that incorporates meditation (AYUSH 2017: 5).

This constellation of (biomedical) science, meditation, yoga (or yogis) and Ayurveda, which was largely pioneered by the Maharishi, continues under current AYUSH initiatives. For example, the guru Sri Sri Ravi Shankar (b. 1956) (who was a student of the Maharishi) markets a specific pranayama (Surdarshan Kriya™), a programme of yoga asana as well as a Sri Sri-branded line of ayurvedic remedies. Meditation is subsumed under yogic interventions for health, e.g. Sri Sri Yoga is described as offering:

a holistic way of life that integrates all elements of ancient knowledge of Yoga, to make a prayerful discipline uniting the body, mind and soul. Along with the series of simple yet effective yoga postures and breathing techniques, a greater emphasis is placed on the inner experience of meditation, for the well-being of mind. The programs quickly restore balance by helping to strengthen the body, calm the mind, regain focus and improve self-confidence.

(artofliving.org 2015)

Politically, subsuming the category of meditation-based interventions into state approved 'yogic' ones creates a particular narrative in a charged environment of a very diverse nation. This framing helps to support a vision of (Hindu) national unity and yoga as a promotable export in the healthcare context. In addition to a wide variety of unregulated ingenious health interventions available on the private market, AYUSH-approved forms of yoga may operate as part of an informal fee-based economy, run charitable outreach projects, offer interventions in government-funded hospitals and be subsidised by some private insurance companies within India (PTI 2018).

Within India, yogic therapeutic interventions are typically described as 'Patañjali' or 'Hatha' with a vague idea that all kinds of yoga are 'one'. However, these generic terms might be used to promote specific teachings from a variety of different lineages (both the more 'traditional' and more innovative). Within the broad collection of practices associated with 'yoga' and 'meditation', some techniques will have very different aims and effects than others. This diversity is often in the presentation of yogic interventions in the healthcare context where 'mind-body' integration (however obtained) is often presented as a remedy for pain if not a panacea for all 'dis-ease'.

There are also methodological problems in judging yoga, meditation and other AYUSH traditions as biomedically effective. Considering yoga in particular, there is a lack of standardisation of what exactly a 'yogic intervention' entails as well as a lack of standardisation of 'dose' (how much and how often 'yoga' is prescribed) and a lack of systematic control for 'confounds' or other factors that may be responsible for positive statistical associations suggesting efficacy (Elwy et al. 2014; Jeter et al. 2015; Patwardhan 2016). In the context of indigenous systems of medicine like ayurveda and siddha, any interventions prescribing meditation, asana or pranayama techniques as part of a treatment is likely to also include dietary advice, herbal compounds and perhaps other therapeutic measures such as massages, emetics, steam or oil treatments. As Sujatha and Abraham argue, 'the laboratory is not suitable for evaluating multimodal therapies of indigenous systems of medicine' (2012: 29). Therefore, the emphasis on biomedical 'gold standards' in determining the

efficacy of therapies and devising training systems for therapists has led to a distortion of indigenous systems of medicine towards standardised products and services.

Historical entanglements of yoga, meditation and health

South Asian traditions that promote physical health and liberation (*mokṣa*) have often been in dialogue. Relatively early in the history of Buddhism, the Buddha became associated with the title of ‘the great physician’, suggesting that his escape from *saṃsāra* was the ultimate cure for both mental and physical suffering. Some of the earliest extant records of medical treatment in the subcontinent were associated with early centres of Buddhist and Jain monasticism; Zysk argues that the early development of what would be systematised in the foundational texts of ayurveda – *Carakasamhitā* (first century CE) and the *Suśrutasamhitā* (third century CE) – were nascent in and influenced by these early Buddhist and Jain monastic traditions (Zysk 2000/1991: 38–49). This monastic interest in health was both ideological and practical. In both Jainism and Buddhism, there is a moral imperative to avoid and reduce the suffering of other sentient beings. Additionally, when the body is seen as a tool for liberation, it may need to be maintained at a certain standard of health in order to master the meditation techniques necessary for liberation.

Within the Indian subcontinent, ayurveda has historically been the most dominant tradition of knowledge about health and healing. Ayurveda has both preventative and prescriptive aspects; it addresses general practice, surgery, toxicology and paediatrics and also provides guidelines for creating life-prolonging elixirs, virility enhancers and treatment for those possessed by supernatural beings. Strictly speaking, the ayurvedic tradition can be understood as holding a particular canon of Sanskrit texts as authoritative, some of the most important being the *Carakasamhitā*, the *Suśrutasamhitā* and the *Aṣṭāṅgahr̥dyasamhitā* (seventh century CE), the latter of which attempts to combine the *Carakasamhitā* and the *Suśrutasamhitā* into a single coherent text (Wujastyk 2011: 31–42). Although these texts are considered central, it is also important to understand that ayurveda is and always has been a living tradition that makes adaptations to local contexts and new technologies and has included the recognition of new disease categories over time. Additionally, family lineages continue to adapt their own traditional remedies in both oral and manuscript forms.

The *Carakasamhitā* contains a chapter on ‘The Embodied Person’, which describes yoga ‘as both spiritual liberation and the means of attaining it’, describing various supernatural powers (*siddhis*) that may arise along this path to liberation (Wujastyk 2011: 34). Yet although ayurveda considers mental balance as important to maintaining health, its focus is on the health and healing of the physical body and not on soteriological matters. In ayurveda, disease is usually explained as being caused by an imbalance of the constituent elements of the body: *doṣa* (substances that circulate within the body), *dhātu* (substances whose quality and relationship to each other shape the physical body) and *mala* (substances which leave the body). Most popular presentations of ayurveda speak primarily of the three-dosha theory (*tridoṣa-upadeśaḥ*), namely *vāta*, *pitta* and *kapha*, often glossed into English as air, fire and earth (Benner 2005: 3852–3858). There is a distinct absence of physical postures (*āsana*), breathing exercises (*prāṇāyāma*) or meditation as explicit therapeutic interventions in ayurvedic literature until the modern period (Birch 2018: 1–3). However, mental disturbances such as loss or ‘shock’ are acknowledged to manifest as illness (Wujastyk 2003: 244–251).

There are other important distinctions between the salubrious ayurvedic tradition and the soteriological yogic system – most notably in their elucidation of distinct models of the body. Early mentions of yoga and yogis are more likely to be associated with the practice of austerities

and bodily mortification specifically aimed at liberation and not at all intended to promote health and healing. However, the literature associated with the *haṭhayoga* corpus certainly demonstrates an interest in maintaining health and in curing specific diseases. The ‘yogic’ body is more generally characterised by networks of energetic channels (*nāḍīs*) and their ‘knots’ or ‘centres’ (*granthis*, *cakras* and/or *padmas*), circulating winds (*vāyus* and/or *prāṇas*) and the movement of ‘seed/ semen’ (*bindu*). In the modern period, yogic traditions also describe increasingly subtle ‘bodies’ (*kośa*) (Mallinson and Singleton 2017: 171–184; in this volume Borkatakya-Varma Chapter 25). It appears that conceptual overlap between yoga and ayurveda becomes more common in the textual evidence from the sixteenth century onwards and the role siddha practitioners played in this dialogue is as yet unexplored (Birch 2018: 5; Mallinson and Singleton 2017: 187n2).

Despite these important distinctions, for an individual seeking alleviation from physical pain, there is likely to have always been some overlap between yogic and ayurvedic forms of healing (e.g. Kakar 1982). Nineteenth-century European travelogues suggest that ascetics were sometimes present in the courts of princely states, offering medical advice (e.g. Honigberger 1852: 92–95, 116). It is likely that in Tamil and Telegu-speaking areas from the medieval period until perhaps even the contemporary period, *siddhars* (wandering religious heretics of these regions), acted as roving physicians among the rural population, supplementing settled individuals with medical expertise (Sujatha 2012: 83–84, 2003).

In nineteenth-century Punjab, institutions of learning associated with ascetic orders – including those associated with the Dadupanthi, Nath Yogi and Jain as well as Udasi and Nirmala lineages – were known to teach indigenous medical knowledge in their institutions (Sivaramakrishnan 2006). As in contemporary India, individual *sādhus* probably gained reputations as being able to heal both mental and physical problems through yogic techniques. For example, it appears that a kind of ‘sick bay’ evolved at the guru Madhavdasji’s ashram in Malsar, Gujarat by the beginning of the twentieth century (Rodrigues 2008: 43–44, 47). Further research is needed to determine to what extent ascetic institutions and wandering *sādhus* served as repositories of medical knowledge in other areas of India throughout the Mughal period and into the colonial one (Sujatha 2012, 2020; Narayan 1989; Newcombe 2017b, forthcoming a).

The Usman Report, commissioned in 1923 by the government of Madras, offers an unusual snapshot of ayurveda, unani and siddha practitioners’ responses to a set of questions about their practices throughout the subcontinent. The unani medical tradition is associated with Muslim communities and key source texts in Persian and Arabic. Siddha medicine is particularly found in the southern areas of the Indian subcontinent and its key texts are in Tamil and Telegu. Siddha medical knowledge is explicitly connected to yogis and believed to be an ‘offshoot of the siddha yogi’s experiments in yoga and alchemy towards the achievement of an uninterrupted lifespan and an imputrescible body in this world’ (Sujatha 2012: 82). One of the central texts of siddha medicine, the c. twelfth-century *Tirumantiram* (*Sacred Mantra*), is a Śaiva mystico-religious work that combines yoga, medicine and alchemy in an encrypted, poetic language (Kędzia 2017; Weiss 2009).⁶ The conception of the body in siddha traditions is distinct from both those of *haṭhayoga* and ayurveda, emphasising both *prāṇa* channels and increasingly subtle bodies (*udampu/kośa*) (Sujatha 2012: 86–87). Contemporary siddha practitioners in Tamil and Telegu-speaking areas of south India continue the traditional medical treatments attributed to the yogic *siddhars* – which have both distinctive characteristics and many overlaps with ayurvedic practice – although not all siddha practitioners are ‘yogis’ or wandering medicants (Sujatha 2003, 2012). Yet despite this connection between siddha medicine and yogis, what we now associate with ‘yogic’ treatment methods (e.g. asana and pranayama) does not appear to be a significant element of the medical practice for any indigenous medical practitioner in the early twentieth century (Barois, Newcombe and Wujastyk forthcoming; Usman 1923).

However, yogic treatment methods that employed asana and pranayama were starting to be institutionalised during the early twentieth century (Newcombe 2017). In 1924, Swami Kuvalayananda founded a research centre that offered yoga techniques both for general improvement of health and as therapeutic intervention for specific conditions (Alter 2004). Kuvalayananda's therapeutic ashram in Lonavala – easily accessible from Mumbai (Bombay) – was able to attract substantial private investment, expanding into a thirty-six bed 'Yogi Hospital' in 1962 (Newcombe 2017: 16). As mentioned previously, Kuvalayananda's guru Madhavdasji offered health cures at an ashram in Malsar at the beginning of the twentieth century. Madhavdasji trained both the young Kuvalayananda and Yogendra, whose Yoga Institute in Santa Cruz (now a suburb of Mumbai) was a pioneer in offering curative yoga therapy to middle-class patrons during the twentieth century (Alter 2014; Singleton 2010: 116–122; Goldberg 2016: 116–122).

The first half of the twentieth century was a dynamic period during which what was understood as yoga – particularly yoga as a health-promoting activity – was rapidly changing. Important figures in this reframing were Bishnu Charan Ghosh (1903–1970) at the Ghosh College of Yoga and Physical Culture in Calcutta (established in 1923), Swami Sivananda (1887–1963) in Rishikesh (from 1936) and Tirumalai Krishnamacharya (1888–1989) who operated a *yogaśāla* in Mysore (1933–1950) and Chennai (Madras) from 1952. The early publications of Swami Sivananda, who was trained as a biomedical doctor, showed interest in health and healing and he opened an Ayurvedic Pharmacy in 1945 (Divine Life Society 2011). Academic studies have noted the innovations and influence of each of these figures in the establishment of what is now understood as 'Modern Yoga', a family of practices shaped by globalised ideas of biomedicine, physical culture, New Thought, esotericism and psychology (among other factors) (Alter 2004; Armstrong 2018; De Michelis 2004; Singleton 2010; Strauss 2005).

But perhaps most influential in the context of yoga as a nationally-supported intervention for promoting health and healing were the interventions of Mohandas Karamchand Gandhi (1869–1948), often called Mahatma or 'great soul'. Gandhi's anti-colonial conception of *swadeshi* (Indian self-sufficiency) included an ideological critique of western medicine, doctors and hospitals, whom he viewed as agents of colonial oppression. Gandhi was also critical of ayurvedic *vaidyas* whom he also saw as largely being part of and serving a metropolitan elite. In a pragmatic and nationalistic response to what he saw as the inability of either ayurveda or western medicine to provide for the majority of the Indian population, Gandhi promoted naturopathy (nature cure) as well as yogic breathing and strengthening and cleansing exercises, in addition to other forms of Indian physical culture (Alter 2000; Priya 2012: 119–120; Sheldon 2020). He emphasised techniques that could be done by poor individuals themselves, without needing to pay for expensive herbal or medicinal compounds (Gandhi 2012 [1948]). He advocated self-discipline and self-help which could build the physical and moral strength needed for an independent India. Because of this strong Gandhian legacy, in early post-independence India, yoga was often paired with naturopathy (and not ayurveda) for promotion by the Ministry of Health (Alter 2018; Brass 1972: 342–371).

However, in other instances, cures conducted by yogis were more specifically associated with ayurveda, as in the well-publicised rejuvenation treatment of the Indian nationalist Madan Mohan Malaviya at the hands of a yogi (an Udasi *sādhu*) in 1938, which received global newspaper syndication (Newcombe 2017b). In line with Gandhi's utilitarian interests for healthcare, the Independent Indian government has been largely focused on being able to improve the health and longevity of the majority of India's citizens: the rural poor (Alter 2000, 2004; Tidrick 2006: 213).

After independence, the Indian government reports show evidence of conflict between wanting to promote indigenous forms of health and healing (especially ayurveda) and a reliance

on the demonstrable efficacy and dominance of biomedical models of measuring health and healing. While biomedicine was the dominant force in state-sponsored medical initiatives (Brass 1972; Priya 2012), considerable pluralism in medical care continued among the general population (Sujatha and Abraham 2012: 13–14). Meanwhile, from the 1960s onwards in Europe and the Americas, the dominance of biomedicine was slowly challenged by growing counter-cultural and feminist movements, which were increasingly identifying limitations and power imbalances (Newcombe 2012).

Responsive to global trends, the Indian government slowly but regularly increased funding and official promotion of both ayurveda and yoga as therapy. In 1970, ayurveda was officially recognised as a national system of medicine by the Indian government, which then set up a council for regulating its practice as well as creating and monitoring standards for ayurvedic education (Leslie 1998). Funding and interest in indigenous or Indian systems of medicine (ISM) began to increase from the 1970s onwards. However, the total amount of support is still at paltry levels when compared to state investment in biomedicine provision for the Indian population (e.g. indigenous medical traditions received only 2.7 percent of health and family welfare spending in 2007–2012) (Priya 2012: 124–125).

Contemporary experiences of yogic health interventions in India

Perhaps no one embodies the contemporary Indian understanding of yoga for health more than Swami Ramdev. Ramdev shot to national fame in 2003 having purchased airtime on one of India's cable television channels (Pathak–Narain 2017: 56–59). His programmes are simple and accessible for many Indians who were experiencing a poverty of money, time and health. His positive messages, free yoga sessions and relatively affordable products inspired millions of Indians to take up yoga *āsan*, *prāṇāyām* and turn to 'Patañjali products' as a truly Indian form of health and healing (he uses the Hindi versions of the Sanskrit terms). Venera Khalikova (2018) emphasises how Ramdev's rhetoric is well aligned with Hindu nationalist narrative. But Ramdev's vision goes beyond India, and, as Stuart Sarbacker explains, offers yoga as a wish-fulfilling tree that might ultimately answer all the needs of humanity (2014: 369). Using ayurvedic terminology, Ramdev proposes that human beings are essentially the same, composed of the same *doṣas* and *guṇas* (using the ayurvedic model of the body), all suffering from the impressions of past lives; therefore the same balancing programmes of *āsan* and *prāṇāyām* are efficacious for all (Ramdev, 2009: 32). Typically, Ramdev claims numerous specific biomedical benefits attributable to each exercise (Bālakṛiṣṇa 2015; Balkrishna 2007; Ramdev 2009; Poddar 2010).

Ramdev's superlative rhetorical use of scientific language in claims for his methods' results, which do not always hold up to the weight of scientific scrutiny, has been strongly criticised by Meera Nanda in particular (2005 and 2009). Ramdev has been known to make the highly controversial claims that his programmes of yoga and ayurvedic products can cure cancer and homosexuality. However, the extent to which these claims are New-Thought-influenced hyperbole rather than meant to be taken as literal, scientific 'truths' is ambiguous (Newcombe forthcoming b). Rhetorical positivity is paired with the establishment of extensive Ramdev's Patañjali Yogpeeth-funded research institutions in order to prove the biomedical efficacy of his treatment plans.

Perhaps because of – rather than despite – Ramdev's rhetorical exaggerations of yogic and ayurvedic cures, many people experience his interventions as healing and empowering. He is often described as a 'household name' and is very popular among the diasporic Indian population globally, many of whom watch his programmes on satellite television. Ramdev is now one

of the most influential promoters of ‘*swadeshi*’ Patañjali Yogpeeth-branded yoga and ayurvedic products throughout India. In 2017, the Patañjali group of companies had the second largest turnover of Fast-Moving Consumer Goods (FMCG) companies in India (Pathak-Narain 2017: 189).⁷

Ramdev has located himself as championing Indian culture and interests in the face of aggressive ‘western’ multinationals, which selectively exploit and steal from Indian culture, simultaneously stripping Indians of their own powers of self-healing and self-respect. Ramdev and other successful gurus such as Sri Sri Ravi Shankar and Jaggi Vasudev (‘Sadhguru’ of Isha Inner Engineering) have positioned themselves as revivalists to heal Indian bodies, minds and self-images by using traditionally Indian technologies of health and healing. This language of *swadeshi* nationalism is also associated with the modernisation and pharmaceuticalisation of the production of ayurvedic remedies (Banerjee 2008; Berger 2013; Bode 2008; Zimmerman 2016). Herbal prescriptions, which were once produced personally by the *vaidya* (doctor) or close associates are now mass-produced in factories and bought over the counter in shops.

To some extent, this ‘commodification’ is in contrast to what many who turn to yoga and meditation as ‘therapy’ expect from these interventions. Maarten Bode has explained that in the case of what he terms an ‘authentic ayurvedic approach’ in contemporary India, it ‘looks upon the patient as a conscious being who lives his or her disease and gives meaning to treatment by the way he or she responds to it’ (2012: 75). This description is echoed by Sujatha’s depictions of siddha and tribal medicines in Tamil Nadu (2012 and 2003) as well as by first-hand accounts of many who turn to yoga and meditation as healing interventions globally. These accounts emphasise the subjective transformations of pain and suffering as being at least as important as a biomedically measurable ‘cure’. However, those who testify to the power of Ramdev’s techniques also emphasise a powerful experience of healing (Newcombe forthcoming a, forthcoming b). As Andrea Jain (2014) has argued for the case of commodified yoga traditions which also represent deeply meaningful, spiritual approaches to life, any apparent contradiction between neoliberal commodification and accessible healing is often not experienced as such by those seeking its benefits.

Conclusion

Yoga and meditation form growing and dynamic areas of health intervention in contemporary India, enjoying considerable support from both governmental and private initiatives. With the unanimous acceptance of Prime Minister Narendra Modi’s proposal for an annual International Yoga Day by the United Nations in 2014, yoga (including meditative practices) is being presented by the Indian government as a potential global panacea for health, wellbeing, world peace and even environmental regeneration. The rhetoric proclaims these practices as simultaneously suitable for everyone, but also rooted in authentic, ancient Indian traditions (United Nations 2014; Modi 2019; McCartney 2019). Contemporary Indian state support for yogic and meditation-based health interventions comes with a particular political agenda. But at the same time millions of Indians are finding their personal experiences of yoga salubrious and empowering.

Significantly, today’s world – including India – is characterised by medical pluralism (Lambert 2018). ‘Yogic’ and meditative healthcare interventions are one of several possible approaches that an individual may try in hopes of alleviating a particular health issue. Patterns of engagement with this diversity of healthcare providers vary in distinctive ways between groups with particular cultures, caste, social class and income levels (Priya 2005, 2012; Sujatha 2020). But despite these structure differences in access and engagement, yoga and meditation interventions are

now part of the menu from which individuals may choose in seeking to improve their health and wellbeing. The layers of interaction with and between the specific techniques associated with yogic interventions (including meditation) and the multiplicity of indigenous systems of medicine in India is a fertile area for more in-depth research, as other authors have argued (Sujatha and Abraham 2012). The complexities of practices and identities in contemporary India that relate to yoga, meditation and indigenous medicine cannot be subsumed into the dominant narratives of authentically revived tradition and biomedical efficacy.

Notes

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- 2 There are suggestions that some early ayurvedic institutions might have included Patañjali in their syllabuses for *vaidyas*. For example, the Mumbai-based Prabhuram Ayurvedic College (established in 1896 as the Aryan Medical College), claims to have been teaching this from the late nineteenth century (Ayurved Sadhana 2018).
- 3 The Maharishi's organisations are vast and varied – at the time of his death he was worth an estimated £2 billion (Webster 2012). Most associated organisations are prefaced by the title 'Maharishi' and or 'Vedic' and or with 'TM/Transcendental Meditation' but there are some notable exceptions, e.g. The Natural Law Party (a political party est. 1992), the Global Financial Capital of New York (established 2007) and the Global Country of World Peace (established in 2000, which currently has physical locations in the USA, Ireland and The Netherlands).
- 4 For a richer history of relaxation interventions in the biomedical context, which has a much longer genealogy, see Nathoo 2016.
- 5 For more on the development of MBCT see Chapters 3 (Husgafvel) and 18 (Rahmani) in this volume; for a summary of current physiological and cognitive science research on yogic and meditation interventions see Chapters 30 (Schmalzl et al.) and 31 (Federman) in this volume.
- 6 This dating is much contested, but I am following Kędzia 2017: 124n16 who follows Goodall 1998 and 2000 in the dating. It is more rhetorically associated with the Siddha medical tradition rather than offering recipes or practical prescriptions.
- 7 Priyanka Pathak-Narain (2017) has detailed many allegations of illegal practices associated with Ramdev's rise to power that have not been subject to legal proceedings.

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