Unani refers to the Graeco-Arab system of medicine as it has developed in the Indian subcontinent since the 12th century. Unani responded to the western medical absolutism of the colonial period and the communal machinations of the post-colonial period also by essentialising the body. This is true for Unani’s representation of the human body as for its body of knowledge. This was in part ‘tactical’ in the face of a perceived threat of extermination, domination and denigration by the structures of power; and also to critically foreground the constitutive elements of Unani medicine distinct from other forms of medicine, which acquired specific connotations in the given situation. The body became tension ridden. Unani-Muslim, canonical-local, elite-subaltern, colonialism-nationalism-communism, Ayurveda-Unani-western medicine, are some of the oppositions that formed the constitutive elements. These categories were manipulated in the process of defining the human body and the body of Unani knowledge.

Neshat Quaiser
The past is constantly referred to in a critique of Unani’s present colonial period to Unani vs. Ayurveda in the post-colonial state. In contending parties – from Unani vs. western medicine in the age of complaints are strikingly similar. However, with a change in and challenge from western medicine.

In post-colonial India, colonial and post-colonial time zones were declared irrational, unscientific, and inauthentic. The obvious rationale is that if Unani is accepted as a Muslim category and quacks, and all were accepted as daktar. But this did not suggest any ontological distinction between daktar and biomedicine – what they practiced was still western medicine. Vernacular forms of the word ‘doctor’, such as daktar, docter, and doktori, angrezzi dawa (English medicine), etc., did not make it local or native. The miseducation Bengal daktar constructed his identity in the image of a western doctor, with all the visible signs of authority, and also through the ways in which people, including uneducated ones, imagined doctors and biomedicine, which was certainly not like any other local medicine, but decidedly English medicine. And if daktar had a fluid identity as Projet argues, so too did the dhamki [Unani practitioners]. Along with trained dhamki there were large numbers of Unani practitioners without any formal training and without a license, such as d’tarr [apothecary] and pansar [grocer].

When in need, people consider all sorts of medicine and healing practices that are accessible and affordable. Biomedicine was used because it was politicised and made accessible. After all, like the Permanent Settlement, Fort William College, English Education, babus, sahibs, mems, new judiciary, or Indians in the army and the police, western medicine became a reality to them. Yet there was almost no scope for reciprocal sharing. Local, traditional medical knowledge and healing practices were declared irrational, unscientific, and inauthentic. Heterogeneity of healing practices was to be replaced by western medicine’s absolutism. The process of the absorption of western medicine in Indian society was tied to the colonial ideological state apparatus where knowledge was intrinsically linked with power.

But to argue that there existed a neatly drawn bipartisanship between western medicine and Indian forms of medicine, would not be true. For instance, in the case of Unani we find a ‘similarity of function’ with the evidence of continuities and certainly propelled issues such as what counts as quackery, and the controversy over medical registration and medical reform. This constituted a complex whole fuelled by the spread of challenge from western medicine.

Essentialising Unani post-colonially

Unani in the post-colonial situation is intrinsically linked with its colonial contexts. With the defining event of India’s first struggle for independence in 1857, colonial India’s various social spheres were increasingly communalised, and medicine too did remain untouched, resulting in Ayurveda and Unani being projected, respectively, as the markers of Hindu and Muslim socio-economic organisations. This radically altered the social lives of the Muslim high caste elite who later emerged as the visible propagators of Unani. Efforts to bring Unani and Ayurveda together on an anti-colonial platform collapsed soon after the partition of India in 1947.

In post-colonial India, colonial and post-colonial time zones collapsed into one. In both periods the nature and manner of complaints are strikingly similar. However, with a change in contesting parties – from Unani vs. western medicine in the colonial period to Unani vs. Ayurveda in the post-colonial state. The past is constantly referred to in a critique of Unani’s present situation. In the post-colonial period Ayurveda was projected as indigenous and as the only Indian medicine representing the spirit of India, whilst Unani became an outsider, inextricably linked with Muslims who constituted the sacred body of mother India (see Hardiman on indigenity and global market). However, in addition to communal politics, several other dimensions such as economy, market and new identity came into play in the post-colonial situation.

For the post-colonial health and medicine related state policies the Chopra committee, formed towards the end of colonial rule to address the problems of Indigenous Systems of Medicine, became an important benchmark. State policy in the initial years after 1947 was influenced by the recommendations made by this committee’s report (1948), particularly by what it had to say on integration or synthesis of the three systems of medicine – Unani, Ayurveda and western. The Chopra Committee was followed by the C. G. Pandit and D.T. Dave Committees. However, most of their recommendations were concerned with Ayurveda, not so much with Unani. These recommendations were opposed by Unani practitioners as they were seen as a way to ultimately destroy Unani. They were also seen as a testimony of discrimination against Unani in the community hostile post-colonial atmosphere where the Indian state appeared to be favouring Ayurveda. Once more Unani’s independent identity was negated and essentialising Unani became necessary.

In 1969, systematic research in indigenous systems of medicine began with the establishment of the Central Council for Research in Indian Medicine and Homeopathy (CCRUM) by the Government of India, but in 1979 the Central Council for Research in Unani Medicine (CCRUM) came into existence because vistas of Unani felt submerged within the CCRUMH structure. In 2009 the CCRUM consisted of twenty-three research centres across thirteen Indian states. Now there are forty-one recognised Unani colleges, spread over twelve states, including the National Institute of Unani Medicine in Bangalore. Unfortunately, compared to India’s Ayurvedic infrastructure, the number of Unani institutions is still miniscule.

Essentialising Unani in response to the market

In the given atmosphere of statist and non-statist medical communalism Unani manufacturers complained that the manufacturing and marketing of Unani products became adversely affected causing serious impediments to the survival of its medicine and manufacturing has declined and weakened due to the policies and attitude of the people who hold power”, and “ayurveda is making steady progress under the patronage of government” (Quaiser, 2012c).

Notwithstanding, Unani has in recent years made vigorous endeavours, beyond the mode of complaining, and has of Unani as a distinct system of medical knowledge. The Indian state was accused of discriminating against Unani as the following quotes illustrate: “After 1947 unani, its medicine and manufacturing has declined and weakened due to the policies and attitude of the people who hold power” and “ayurveda is making steady progress under the patronage of government” (Quaiser, 2012c).

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Essentialising Unani’s identity

Medical communalism in post-colonial India resulted in a crucial need to essentialise the body of Unani’s self in terms of a new Muslim Unani identity vis-à-vis the ‘other’, represented by Ayurveda and the Indian state. Essentialising the body of Unani became a battlefront, which produced an exclusive when the adversary could not be combated. In the face of communal prejudices, seemingly strange arguments were marshalled in the process of essentialising the body of Unani. Take for example the ‘establishment’ of links between religious affiliations and the incidence of certain diseases. At one moment it was argued with every news item in the press, that if Hindus practised Unani medicine and curving ways of life they would not be afflicted with stomach and gastric cancer. In the same vein are arguments such as ‘prohibition of [practicing Unani] [...] is not just a method of treatment but can become divine worship’, and “Christian missionaries all over the world propagate Christianity through schools and hospitals” (Quaiser, 2012h). Now that Unani has been linked with Islam and Muslims, Unani practitioners and the public at large are also forced to accept this reality at least tactically. The obvious rationales in this case are that the medical knowledge system then it could be saved and developed in the age of ‘competitive electoral politics’ and ‘assured safeguards for minorities’. Therefore the survival strategy and the ways in which it is linked to economy. Local and global senses of victimhood have also become involved. Thus, references to Christian missionaries take on a meaning in the context of local-global (real or perceived) prejudices against Muslims. Myths, metaphors and symbols are produced out of everyday experiences as palpable mechanisms to essentialise the post-colonial Unani body.