Religious Discourses, the State and Medicine: A Study of Health Behaviour among Muslims in Kerala

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DECLARATION

I Declare that this thesis entitled **'Religious Discourses, the State and Medicine: A Study of Health Behaviour among Muslims in Kerala'** submitted by me in the partial fulfillment of the requirements for the award of the degree of **Doctor of Philosophy** of Jawaharlal Nehru University is my own work. The thesis has not been submitted for any other degree of this university or any other university.

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CERTIFICATE

We recommend that this thesis be placed before the examiners for evaluation.

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Contents

Chapter 1

Introduction

Problem, Setting, and Method

Background of Study

The religious life of Muslim societies has gained considerable attention especially in the last quarter of the twentieth century owing to the academic endeavours on the new theoretical and empirical developments in the sociology and anthropology of religion. These enquiries have addressed the theoretical questions as well as provided empirical data on Muslim societies. The recent engagements with Islam as 'signifier' and the study of the social life of Muslims have inspired diverse strands of thinking and writing and generated several questions and debates on various grounds: theoretical, methodological, and empirical.

Despite their limits and ambiguities, these theoretical and methodological reorientations have opened new possibilities in understanding the complex realities in the context of Muslim societies. Clifford Geertz's (1968) study has provided a very significant theoretical framework in anthropology to the study of Islamic society. As Eickeleman (1982) observes, Geertz's oeuvre that spans in decades has a pervasive influence on scholars of many disciplines. In contrast to E. E Evans-Pritchard's (1949) and Ernest Gellner's (1968, 1981) British social-structural model to study Muslim society, Geertz proposed a cultural anthropological reading of meaning in Muslim contexts. He studied Islam as a cultural system, as a text to be interpreted in specific local contexts which provided its adherents particular system of meaning through religious symbols. However, he excluded the Islamic scriptures and texts from the study of Muslims' religious life in the Far East and saw 'scripturalism' as a crisis to the lived religious symbols which were to undergo transformation. Geertz pointed out that it is the ritual, and not the canonical text, that was the sacred symbol sustaining the religious worldview. He argues the universal Islamic tradition of scripture and the local culture that he considers as 'syncretic', 'classic' and 'mainline tradition' are oppositional binaries that have to be set

apart while approaching Islam. In other words, he understood religious change as change in the local tradition against the Islamic scholasticism, or the *ideologization* of Islam.

The writings of Talal Asad (1986; and 1993) marked a major theoretical shift in the sociology of religion, particularly Islam and Muslim societies. Asad studied religion by tracing the genealogy of the very concept of 'religion' and 'ritual' as western categories and showed the dangers in employing them while studying non-western religious communities like Muslims. Calling for a rethinking of the given anthropological consideration of religion, he took a very influential definition of religion, that of Clifford Geertz's, and enquired into the genesis of that conception which had the epistemic leverage of Christianity than that of colonialism and modern west. In contrast to Geertz's symbols, Asad's explorations exposed the history of the role of power in the production of religious truth, religious worldview, meaning, and knowledge. The notion of the *authorizing discourse* is the prominent theme that comes out in his critique of Geertz's definition of religion, and how power operates through it. Asad argued that doctrines, laws and sanctions, authorization process and discourses, apart from symbols, produce meaning for the religious communities. He showed how the discourses and the disciplining authorities defined and redefined the religious practices as true or false from time to time. He hence suggested that social science has to focus not only on the symbolic aspects of the rituals and performances, but also on the institutions and disciplinary discourses and the very production of religious knowledge. He studied the institutional powers inherent in rituals by which the truth is attained and the religious subjectivity is formed.

El-Zein (1977), criticizing Geertz's presumption of a universal Islam, argued to see multiple versions of local Islams in the process of meaning making. He did not see Islam outside the minds of subjects. Responding to the theoretical debate, Dale F Eickelman (1982) argued for a middle ground, approaching Muslim rituals through the interconnection between textual tradition and ethnography of diverse socio-cultural contexts. Mark R Woodward (1988) suggested a complex typology of text and practice to study local practices. Both these authors questioned the dichotomous understanding of Muslim rituals as text versus practice and universal versus local, and folk versus elite Islamic traditions.

There have been attempts to see Muslims as distinct from other religious communities in view of their specific worldview. In this regard, anthropologists like Akbar S. Ahmad

(1984; 1987; and 1988) and Richard Tapper (1995) argued for 'Islamic anthropology' by *Islamizing* anthropology and placing Muslim societies within the framework of one universal Islam in diverse social situations. This is different from Asad's theoretical framework of 'Anthropology of Islam' (1986) which seeks for a new anthropological perspective to study Islam without Islamizing it per se.

Sociologists and anthropologists tried to study Muslims in India through the oppositional binaries of universal versus local and text versus practice by assuming their social practices as 'syncretism of Hinduism-Islam' (cf. Ahmad 1981; Burman1996). Imtiaz Ahmad's (1981) approach appears to be similar to Clifford Geertz as he argues sociology should look into the actual religious beliefs and practices of Indian Muslims, which are syncretic and indigenous, varied from place to place. He also calls for excluding the formal doctrines and scriptures that are universal because Islamic belief in India has acquired an indigenous form.

Imtiaz Ahmad (1981) suggests that in various sociological approaches it has been accepted that the local is the domain of symbolic meaning and syncretism. The implication here is that the scriptures understood to be universal have to be kept apart while studying the practices on the ground. Another axis for studying Muslims and their practices was the dichotomies of 'traditional,' 'modern', or 'counter-traditional' and orthodox or heterodox. Even if some authors like Woodward and Eickeleman challenged the text-practice dichotomy, a comprehensive method to understand the complex process of the authorization and legitimization of practices through the harmonious interpretation of text and context is not easy to find. Some authors like El-Zein and Ahmad neglected the role of orthodox tradition, and their approach misses aspects of change, revival, reform and the intra-Islamic dialogue, that are perhaps the most interesting and pertinent questions with regard to contemporary Muslim society.

Responding to these questions, Talal Asad (1986) provided a better alternative framework for the study of Islam. He criticized most of the earlier anthropological conceptualization of Islam, because they tend to imagine Islam as a religion in the modern western notion of the word. He stated that Islam should be approached as a discursive tradition that includes and relates to its foundational texts, not as types of Islam according to the types of societies, as Geertz saw them. He argued that as a tradition, Islam consisted of the

discourses to instruct the practitioners to follow the correct form. The arguments and conflicts over a practice have to be understood as natural and necessary part of Islamic tradition not as the crisis for local cultures as Geertz has conceptualized them. Therefore, the sociologist who wants to study Muslim societies has to focus on the religious discourses within the specific historical situation. In short, the discussion is to view Islam as knowledge tradition.

Inspired by Asad's discursive tradition, several scholars like John R. Bowen (1993; 2012),Saba Mahmood (2005), and Charles Hirschkind (2001a; 2001b; and 2006) dealt with the social life of religious discourses in the formation of subjects. They recommended the discourse centred approach in the study of religion and ritual among Muslims. Ethnographic approach was encouraged to understand the everyday life of Muslims. These post-colonial theoretical trends have tried to study Islam through a discursive method, through the ways in which it has been debated and articulated by the actors or participants in the discourse.

Islamic Religious Discourses on Classification of Healing Practices

It was against this existing theoretical background of sociology and social anthropology that we tried to understand the religious discourses and classification of healing practices among Muslims in Kerala. We found that certain practices always tended to be the objects of discourse. Among these controversial practices, we selected the healing practices purposefully, because, in Islamic though they were the fountainhead of several foundational debates on truth and validity of the world, cosmos and beings. Our aim was to add to Asad's notion of centrality of discourse (1986; 1993) in the formation of religious subjectivity.

We wanted to look at a specific domain of discourse in micro-level analysis of individual experiences and explore the possibility of diverse ways in which religious practices can be understood. Hence, we focused on healing practices. Healing practices are related to health and survival that consist greater creativity, negotiation, and resistance on the part of social actors towards authority and authorizing discourses. As Dipankar Gupta (1988) pointed out, health and illness are aspects of human suffering that always attract pluralistic behaviour in order to alleviate pain and discomfort at the earliest possible duration of time.

The healing practices of *urukku* (tying amulet) and *mantram* (whispering the prescribed healing words) among Muslims of Kerala are based on the believed relationship between the elements of nature[1], metals[2], Arabic alphabets and numbers[3], and the extra-terrestrial planetary bodies[4], zodiac signs[5], and calling the superhuman beings such as *jinns* and angels. In this framework, the illness is classified into physical, and spiritual like the illnesses caused by the evil eye, for instance. In addition, it is believed that superhuman beings can help by assisting the healer and harm by causing illnesses for human beings. Such beliefs and practices, even if they include particular religious symbols such as Quranic verses and chanting words, are understood by some as 'controversial' in Islam and as deviations from the foundational texts. The cosmology and the interconnections between the terrestrial and extra-terrestrial domains of universe as reflected in the textual corpuses of the healing tradition are interpreted differently by various sectarian groups among the Muslims which allege the other group as 'un-Islamic'.

In contrast to Asad's (1993) theory, the field studies on Islamic healing sites such as that of Kakar (1981), Rasanayagam (2006), Fluickiger (2006) and Bowen (1996) indicate the incongruence between the textual norms and actual practices, flexibility and negotiation on the part of actors even if they lived in the context of authorization discourses. At the same time, the actors such as the healers and patients never perceived their practice as 'syncretic' or 'local' tradition (as Geertz and Ahmad said); rather, they placed them within the religion of Islam. Ethnographic accounts of healing practices of Muslims in Kerala (cf. Miller 1976) have shown that *urukku* and *mantram* were practiced in mainstream religious

[1]According to the healing texts like *Mujarrabathu Dairabi*, *Manbau Usoolil Hikam*, and the locally circulated healing guides like *Al-Husban*, our living nature has four *anasir* (elements), namely, water, fire, wind, and soil.

[2]Healing for good purposes such as fulfilling the desire is prescribed to be performed using the good metal, namely gold or silver while for the bad purposes such as parting ways between two companions, bad metals like iron are used.

[3] Healing tradition says each Arabic alphabet carries a particular numerical value, which brings particular results. Numerical values of the alphabets in the name of the seeker and his or her mother are added and the diagnoses and prescription are made accordingly.

[4]It is a debated topic among the Muslims that whether the events on earth and what happens in individuals' life have a connection with the movements of planets and stars. When the Islamic reformists like Mujahids in Kerala argue that such beliefs are baseless and they are infiltration of beliefs from Galanistic and Hindu tradition, the contemporary Muslim healers and the texts they rely on confirm that there is a connection that happens according to the will of Allah, the Creator.

[5] Zodiac signs are the stars each individual carries based on the time of one's birth. The healing guides like *Al-Husban* give the signs in Malayalm like *Medam*, *Bharani*, *Karthika*, *Rohini*, *Makaram*, *Thiruvathira*, and *Pooyam* (cf. *Al-Husban* authored by Baqawi and published in 2010).

centres like mosques, and religious men like mollaka provided the services[6]. Thus, we find that not all healing practices are located in the periphery and that believers do negotiate with the mainstream authorization discourses on every day basis. They were not set apart as a separate category of 'practical religion', antithetical to the scriptural Islam as Ahmad (1981) argued. Healers in the ethnographic studies as cited above also classified healing into 'white' practices (accepted and Islamic) and the 'black' practices (rejected and un-Islamic), revealing the moral basis of their classificatory scheme.

In the process of negotiation with the mainstream or orthodox discourses, some specific beliefs, rites, and rituals related to healing tended to become a subject of intense debate between the contending denominations of Islamic organisations and they become 'controversial.' The links between terrestrial and extra-terrestrial domains, the importance of a master for intercession with God, the concept of *baraka* attached to a saint and his graveyard and seeking help through invisible beings beyond the cause and effect relation are some instances of controversial topics. The healing systems also verily depended on the practice of calling upon superhuman beings such as *jinns* and angels and the supernatural forces of disease causation, intercession between divine and human world, prayer to the dead saints and the belief in the individual charismatic powers. These beliefs, rites and practices are constantly subject to debate on their authenticity and validity according to the canonical sources of Islam.

The institutional power that designated the authentic model of practice is based on the belief that there exists a single and true religious ideology, namely '*ahlu-sunnati-wal-jamaa*' (group of original prophetic tradition and righteous ancestors in Islam) as recognized by scriptures. It is based on the belief on the true model of religion that the organizational identity of each debating group and the existence of an 'organizational other' has been produced in relation to the search for the *authentic Islam*. Notably, the healing practices have become critical cases for such investigation as the practice of authorization of knowledge in Islam is perceived as a moral obligation. Each group holds its own view of Islamic history and place themselves in accordance with the original

[6]*Mollaka* or *Mukri* is the local term for the man appointed in the mosque by the *mahallu* administration mainly to make *azan* (call for prayer five times a day). Apart from calling for prayer loudly through loudspeaker, some of the *mollakas* in the Sunni mosques, especially those who have the skill and knowledge to heal, attends those who approach him for healing. Details of the term *mahallu* and the sectarian aspect of mosque are to come in the coming chapters.

period while the 'other' is viewed as innovators in the religion, which is supposed to be rejected and fought with.

My earlier work[7] revealed that religious discourses are primarily scriptural with their own logical coherence and rationality. However, sectarian differences on the authentic sources of law do reflect Asad's (1986) conception of Islam as a "*discursive tradition that includes and relates itself to the founding texts of Quran and Hadith*". Further, the question of identifying as to which texts can be considered as the authentic source of religion is also part of discourse. The exegesis and commentaries on Quran, and the medieval interpretations could render *urukku* and *mantram* as authentic Islamic practice for one group, while not for others. Publication of books and treatises, conducting the conferences and oral debates, establishing religious schools and colleges operated as the institutional bases for the production and reproduction of discourses. The practices and assumptions about the relation between terrestrial and extra-terrestrial domains of universe contained in them were taken up for interrogation and debated amongst contesting Islamic groups. The themes around which the discourses centred were the definition of *ibadat* (worship), *istigatha* (practice of seeking help), *tawassul* (practice of seeking intercession) and the status of dead saints in the tombs. All these themes are crosschecked with the doctrine of *tawheed* (monotheism), the single underlying logic that is taken to be the hallmark of Islam though defined differently by different sectarian groups.

Analysis of discourses and classification at inter and intra-group level showed a complicated reality rather than a conventional picture of dialogue between two groups. All religious groups argued within the boundaries of tradition referring to the same authoritative texts within which alone their arguments could make sense. We understood them as differences within a same tradition in complex ways not simple dichotomies. It also showed the appearances, disappearances, and re-appearances of particular themes in the discourse in different periods which defined and redefined the organizational positions (institutions which authorize the practices) on the very concepts of health and illness.

Our work exposed that all debating groups, including Sunnis in Kerala who are referred as 'classical' or 'local' in the scholarly and academic literatures, and *Mujahids* or *Salafis*

[7]Zirajuddeen A (2013) *Religious Discourses on Classification of Healing Practices among Muslims in Kerala*, Unpublished MPhil thesis, New Delhi: Jawaharlal Nehru University

who are considered as 'scripturalists' or 'puritans' or 'fundamentalists', qualify to be referred as scripturalists. The textual references and scriptural allegiance was common to the contesting schools and did not entail a fading away of practices. Rather than understanding the scriptures as 'threat', extraneous to the local context, our analysis revealed that there has been a process of *Islamization* of 'local practices' by placing them inside the religious domain as part of the organizational identity. At the same time, healing practices did call for a reworking of founding conceptions about the relation of god to the world of human and non-human beings through interpretation and reinterpretation of the scriptures. The practices that are not amenable to the textual interpretations are classified as 'un-Islamic'.

The selection of particular themes for discourses such as *urukku* and *mantram*, *istighatha* (asking for help from the dead saints), *tawassul* (practice of intercession) and tomb visit stands in contrast to Asad's framework which saw all Islamic practices as discursive tradition which consisted of discourse to instruct its followers towards the correct form. Asad's 'Grand theory of Islam and Muslim rituals' does not address the issue of the complex nature of discourse and classification within the tradition. We found that healing practices of *urukku* and *mantram* have been among the most controversial practices based on which different religious groups broke up and new groups have been emerging with new arguments.

The shifting nature of statements and plurality of positions expressed on this question indicated the unfinished and tentative nature of the discourse on health and illness. The discursive character of the practices is embedded in the 'ethico-political' institutional forms of religion and the power of religious authorities. It means, defending and offending some controversial practices through arguments are inherently interlinked with organizational identity. An argument over a practice is nothing but the organizational decision in which the *ulema*, the authority of religious scholars who are the experts on religious texts, reserved the right. As Asad has rightly pointed out, authorization process and legitimating discourses among Muslims in Kerala have the power to define and redefine a practice as Islamic or un-Islamic which is understood as the moral responsibility sanctioned by religious texts.

We see that notions of illness, its aetiology, treatment methods, and their ethical dimension are produced time and again by the religious groups. To understand the pattern of change at local level, we have to grasp intellectual developments at global level too and their transformation. To be noted here is the question of how one set of reformist Islamic discourses endorse medical systems while delegitimizing other healing rituals, facilitating the medical perception based on biomedicine and birth of hospitals in the neighbourhood of modern Malayali Muslims. This thesis will address the health related beliefs and practices of Muslims in Kerala against the backdrop of religious discourses authorising or disallowing the health practices.

Profile of Religious Organizations among the Muslims of Kerala

We begin with an overview of the major Muslim religious organizations in Kerala and their significance for the health related practices among the Muslims. The socio-religious life and social structure of Muslims in Kerala has undergone major shifts and transformations due to political developments from the 18th century onwards such as, the emergence of British colonialism, modern education, and the emergence of various socio-cultural religious reform movements. The most salient religious development has been the emergence of a denominational pattern of religiosity and the formation of a number of organisations or sectarian groups with distinct ideological positions. In this newly formed religious field, majority of Kerala Muslims affiliate themselves as Sunnis. The organizations known as 'reformist' such as the Mujahids, *Jamate-Islami,* and *Tabligh-jamat* also have crucial presence in the religious field. Religious debates are primarily between the two prominent religious groups, namely the Mujahids and Sunnis who are key participants in the public discourse on various theological matters, notably on the healing practices.

Though all the religious groups active in Kerala belong to the universal *Sunni* tradition (in the categorization of world Muslims into '*shias'* and '*Sunnis'*), only those who represent the 'popular' Mappila religious beliefs and practices are identified as *Sunnis.* Hence, what we mean here by 'Sunni' is the local Sunnis who are thoroughly different from Sunnis of Saudi Arabia or Qatar. They follow *Shafite* School of jurisprudence and *Ahari* School of theology in Islam and maintain Sufi ways of accommodation and innovation of new modes of expressing religiosity. The major Sunni religious organization is *Samastha*

Kerala Jamiath-ul-ulema, popularly known as 'E K group' in the name of late E.K Aboobackar Musliyar who was its founding leader. Another major Sunni group is *Samastha- Kerala Jamiath- ul-ulama* which is the splinter Sunni group, separated from its mother organization in 1989 due to some organizational differences. It is popularly known as 'A P Sunnis' in the name of its founder and supremo A.P Aboobackar Musliyar. The third one is *Dakshina Kerala Jamiyyath- ul- Muallimeen* that is the south Kerala *Sunni* organization which keeps affiliation with the EK Sunni group. Another small *Sunni* group *Samasthana Kerala Jamiathul-ulema* formed its own organization due to differences with the official Samastha group on some theological issues such as, the question of using loudspeaker for the Friday sermon.

The 'reformist' groups[8]among Muslims in Kerala are called *Mujahid* who are opposed to the *Sunni* religious ideology. They question the religious life in the form of *Madhab* (four schools of jurisprudence) and *taqleed*[9] (practice of following any of four schools of jurisprudence) and *tareeqah* (the concept of master-disciple relationship for improving spiritual life) in the form of Sufi orders. Mujahids were split between the official group of T. P Abdullakkoya Madani and a splinter group of Hussain Madavoor in 2002 mainly due to the theological differences on the definition and nature of Jinns and their contact with human world. Official group of KNM has undergone another split in 2013 on the question of whether the act of asking help of Jinns and angels in critical conditions would amount to *shirk* (associating partner with Allah) or not. The two major *Mujahid* groups, namely KNM and Madavoor group except the new splinter group, merged in the much hyped 'Mujahid merger conference' of 2017 in Kozhikode. The major reason behind the merger cited was the necessity of 'Mujahid unity' against the increasing social amoralities, and the need of 'Muslim unity' in the wake of rising instances of violence against the Muslim minorities in contemporary India. *Jamaate-e-Islami* is a more politically oriented religious group with reformist ideas in religious affairs.

[8]They are widely referred as 'reformists' in the academic and scholarly literatures (cf. Osella and Osella 2013).

[9]*Taqleed* refers to the legal practice of imitating or adhering to the juridical rulings of the past without knowing its proofs (*dalil*) whereas its opposite *ijtihad* is the practice of the individual engaging in personal interpretation of the Quran and *Sunnah*. It is part of scholarly disputes on the question of whether the door of *ijtihad* was closed or not. While some scholars have argued that the gate was closed, others believe that *ijtihad* has been consistently practiced historically and still has to be practiced (Deblong-Bas, 2004: 105).

The reform movements started in Kerala during 1920s in an organizational form called '*aikyasangam*' (united group) in *Kodungallore* (a port town in Trichure district) that became the cradle of reformism in its initial years. The wind of religious reform blew from South Kerala in the person of Wakkom Muahammad Abdul Kadar Maulavi (1873-1932). The earlier reformers were Sayyid Sanaulla Makti Tangal (1912) of Ponnani, Chalilakat Kunhahaamed Haji of Tirurangadi (1920), and Sheikh Muhammad Hamadani Tangal of Vaikkam (1922) (Miller R, 1976: 270). However, each period of history brings its own experience of religious discourses, which shape the rituals in particular locations. For instance, there was a fierce religious debate known as *'Ponnani-Kondotty kaitharkkam'* (debate between Ponnani and Kondotty regions) in 1835 between two regions of Ponnani and Kondotti on specific religious practices. *Ulemas* from both the regions argued about the authenticity of the Sufi practices of a leader known as Kondotty *thangal,* who had come from Bombay and started a Sufi *Khanqa* in the place Kondotty. Ponnani *ulema* argued that these rituals were un-Islamic leading to a prolonged series of arguments and counter-arguments that continued for years (Zainuddin, 2012: 90-98).

The campaigns of Islamic associations in Kerala are centred around what constitutes 'anti-Islamic' and 'un-Islamic' practices, namely the practices that constitute *shirk* (antinomy of monotheism) and *bida* (innovation of new things in to the original doctrine). There is huge divergence in interpretations of these groups that the entry of a Sunni follower into the Mujahid camp or vice versa is termed as 'conversion' (Osella and Osella 2008). Public debates, books and magazines of both Sunni and Mujahid factions tellthe story of fierce conflict over the legal validity of given practices in Islamic theology.

The religious organizations continue to be fragmented and divided on religious and political differences. All the groups have their own *madrasa* (religious schools), colleges and universities to train the students in debate and oration, as debates have always been inherent to sectarian discourses in Islam. The syllabus and pedagogy of religious education differ according to its ideological orientation and the organization to which it belongs. For instance, Mujahid Madrasa does not teach *falakiyyath* (astrology) and Sufi philosophy since they are ideologically against those forms of knowledge. On the other hand, Sunni madrasas do not include text books written by scholars like Ibnu-Thaymiyya or Ibnu-Qayyim because they are renowned *salafi* (another term for Mujahids) scholars.

Nowadays, new platforms have emerged through which the sectarian discourses are disseminated to the public such as the video CDs of debates, ideological printing houses, TV channels, on-line programs, and public campaigns using the technological means of LCD and projectors, web portals, social networking sites and the like.

However, as we try to see in this thesis, it is interesting to explore how the discourses on health produced and disseminated through multiple technological means responded and lived in the field. We focus on the formation of subjects in the context of religious discourses on health in a Muslim site. Such an enquiry invites our attention to another vital form of disciplining authority on health, the state.

Towards the Research Problem

The present study has been designed to extend the enquiry into the field. Here, one further dimension can be added to the framework given by Geertz (1968) who saw scripturalism as a threat to the persistence of traditional practices, and Asad who said that the formation of religious subjectivity is through the attainment of religious truth produced by power and authority. Here, Asad (1986, 1993) seems to create the same problem as with Geertz that one should find out how a discursively constructed category and its deployment in social action is connected. We think the formation of religious subjectivity cannot be understood by focusing solely on the authoritarian discourses, disciplinary practices, and religious developments at macro level. Rather, it necessitates a study at micro level of everyday life. Disease and illness are imperatives which demand effective and quick action on the part of the sufferer. How far the religious discourses of the Muslim organisations condition the health behaviour of Muslims in Kerala is an important question. The state public health policy and communication constitute another crucial factor bearing upon their health behaviour and this thesis seeks to enquire into the dynamics of this triadic relationship between religion, state and the Muslim subject in relation to health issues. In other words, this is a study pitched at the micro-level focusing on the relative influence of state discourses on the health and welfare on the one hand, and on the other hand religious discourses on the health behaviour of the Muslim subject in the social context of Kerala.

Unlike the Middle Eastern Muslim countries such as Saudi Arabia and Egypt or Muslim majority countries like Indonesia and Morocco where the scholars like Geertz, Asad, Mahmood and Hirschkind carved out their research, the Indian context offers more possibilities of resistance on the part of religious subjects, especially in the domain of health. In the aforementioned countries, we see that the powerful religious institutions go hand in hand with the political authority in defining the religiousness. In India, resistance and creativity of actors in the domain of health have to be understood by placing them inside the tradition of Islam and the socio-cultural factors at local level.

Hence, it is pertinent to ask, how do social actors respond to the on-going religious and state discourses on health and illness, and, how far the classifications, modifications of healing practices are reproduced by the actors in their health practices. This poses a related set of questions: How do the individual actors make their own interpretation and classification through negotiation with the public debates? How does the authorization of health practices by state and religion operate in the Muslims' everyday life? How different actors accord legitimacy to their actions and practices as they are Muslims and citizens of state at the same time and how do they develop their own understanding of Islam and Muslim in their health behaviour? What are the ways in which the resistance by Muslim subjects become possible within the boundaries of religion and state? These questions are crucial because illness necessitates negotiation and compromise with authorized practices, of both state and religion. We also have to understand how different modalities of moral and ethical action contribute to the construction of particular kinds of subjects.

Here, the relations between the engagements with state, religious tradition, and authorization process of social practices have to be explored ethnographically, looking through the experience of actors in the field. Such an attempt explores the subjective aspect of illness, experience of disease and the meaning of suffering. It takes account of the role of the hospitals, state health institutions, market forces, and religious institutions in the health practices and lifestyle of households in a specific Muslim neighbourhood. Hence, the thesis tries to understand this problem by taking both, the subjective discourses at micro-level and the religious and state discourses at macro-level, which determine the possibilities and choices. It looks into the modes of everyday negotiation with power and authority within the religious tradition and state in the domain of illness and suffering. We

try to understand their discursive engagements at micro settings with religious tradition of Islam and state intervention that create certain moral and ethical sensibilities.

Research Questions

1) On what basis do Muslim sectarian organizations in Kerala approve or disapprove health practices and what kind of authority do they exercise on the illness behaviour and therapeutic choices of the Muslims?

2) What are the ways in which different religious organizations among Muslims in Kerala respond to the 'traditional' healing practices (such as *urukku* and *mantram*), and to modern science and modern medicine?

3) How do religious discourses shape the way individual members feel, experience, think and act in the domain of illness?

4) How do they classify health practices? How significant are religious values in shaping the subjective understanding of illness and suffering and what is the source of these values?

5) Do Muslims have their own understanding of health practices? How do they accord religious legitimacy to their everyday health practices within the Islamic tradition?

6) How do Muslims in Kerala organize their everyday life around understandings of religious text and religious authority and how are the texts interpreted locally?

7) What is the relative role of *mahallu* authority in the religious life of its residents?

8) Do these two forms of endorsements (of state and religious organizations) coexist or conflict with each other?

9) How do Muslims order or rank different kinds of rules and guidelines emanating from different authorities, namely, state and religion? How do they experience and respond to them?

10) What are the other determinant factors bearing upon their health behaviour? How do the specific changes in the occupational pattern and income make impacts upon their health?

11) How far do social categories within Muslims (based on class, caste, gender and occupational groups and denominational categories) influence in the conception and practices of health and illness, and religiosity?

Objectives

Our primary objective is to explore if we could talk of a '*Muslim medical subject*' formed through religious and state discourses in the context of Kerala. Towards achieving this objective, we have tried to do the following:

1) To explore the theoretical and methodological cues in the existing sociological and anthropological frameworks on Islam and Muslim societies.

2) To give the social history of the context, namely the region of Thirurangadi in Northern Kerala where we want to investigate the history of Muslim engagement with the religious authority, the state, and the colonial modernity.

3) To study a Muslim neighbourhood (*mahallu*) in northern Kerala intensively and understand the health behaviour of the residents.

4) To map the institutions, authorities, and individuals involved in medical care, healing and counselling services and making interventions relating to the health of the people.

5) To list the Muslim sectarian organisations that have influence in the *mahallu* and examine their rules and communications regarding health practices

6) To understand the subjective aspect of illness, meaning of pain and suffering of the families and their coping strategies in everyday life.

7) To trace the pattern of change in the health behaviour of Muslims in the *mahallu*, particularly after the Gulf migration from 1970s among different social groups within Muslims on the basis of the denominational category, caste, class, and occupational group.

8) To explain the ways in which the contemporary Muslims in the *mahallu* respond, participate, and avail the health facilities provided by state.

9) To identify the relative significance of private and public health care facilities for the families in the *Mahallu* and to study the influence of health communications from health authorities on the day-to-day life of the people.

10) To critically look into the Muslim engagements with the mandates of state in contemporary Kerala on the immunisation and contraception.

Approach and Methodology

The study covers experiences, interpretations, interactions, choices, and motives, and the institutions of religion and state. We attempt to go beyond the antinomies of methodological holism, situationalism and individualism and take the position that they are interconnected features, rather than dichotomized options. While trying to overcome the perennial problems of the bias of normative reductionism, we also aspired to do more than describing what the actors think about their world. The objective has been to explain why and how certain rules, concepts, experiences, and practices are held by the social actors, as they live inside the institutions such as *mahallu* (religious neighbourhood) and state.

Scholars like Karin Knorr Cetina and Aron Cicourel (1981) and Pierre Bourdieu (1980, 1992) have tried to bridge the methodological divisions between micro and macro realms by reconstructing social theory and a methodology towards the integration. Cautioning against the over determination of the rule and a naive subjectivism, Bourdieu seeks to transcend the dichotomy arising from individualistic subjectivism and abstract objectivism. He integrated the individual (subjectivist) and collective (objectivist) and rational and non-rational realms through his concept of *habitus*, which explains the pattern of action and order:

> *The relation between the social agent and the world is not that between a subject (consciousness) and an 'object' but a relation of 'ontological complicity' or a mutual possession as he put between habitus (socially constituted principle of perception and appreciation) and the world which determines it* (Bourdieu and Wacquant, 1992: 20).

Rather than the methodological antinomies of fact and value, he prescribes the 'methodological relationalism', where "habitus and field designate bundles of relations" (Ibid. 16). According to him, individual subjectivity is produced through sharing a habitus, that is individual disposition rather than internalized normative order by which the practices and structures are produced and reproduced. The objective structure is the frame within which the habitus is realized. Individual neither acts mechanically nor freely, rather, he is just like a football player who plays with his practical logic, rational strategies and calculations in order to fit to the soccer laws, that is the 'fuzzy logic of practical sense' (Ibid.19). Solving the methodological limitation of structuralism which fails to explain individual pragmatism and everyday sociology, which fails to analyze regularity and the obligatory nature of action, Bourdieu identified habitus as pre-reflective, collective and cultural structure with implicit dispositions shared among participants in strategic relationships. For Bourdieu, the habitus is both product and resource. Discourse and practice are unfinished and emergent and the rule is substituted by strategy characterized by improvisation.

Habitus brings together body-heart-mind and allows one to see how structures of domination are reproduced. Talal Asad (2006: 287) finds the relation between habitus and tradition where he employs habitus to refer to the predisposition of the body, to its traditional sensibilities[10]. The crucial difference Asad finds is habitus refers to the disposition that body acquires through repetition, generally through un-conscious and uncontrollable circuits of energy whereas in the habitus, the aspect of tradition, specific virtues are defined and attempt is made to cultivate and enact them (ibid: 289).

Thus, our selection of the *mahallu*as the context of study*,* an institution where tradition is enacted and lived, is aimed to meet this purpose, which seems fitting to the methodology. The individuals in the voluntary religious institution of the *mahallu* are free and 'powerful' to appoint and regulate the religious scholars and *mahallu* committee of their own area. Individuals are expected to follow the decisions taken by the *mahallu* committee which is controlled by the religious organizations. It is a site where we see both the individual subjects and the structures like religion and state. Conceptualizing the *mahallu*

[10]Scott. (2006). Appendix: The Trouble of Thinking: An Interview with Talal Asad. In. Scott and Hirschkind (Ed.). *Powers of the Secular Modern: Talal Asad and His Interlocutors.* Standford: Standford University Press.

as the methodological tool is one of the particulars of this thesis to which we are turning our attention now.

Understanding *Mahallu* as Methodological Tool

This research is based on fieldwork in Kerala, a south Indian state known for its high social indicators of human development. About 56 percent of Kerala's population are Hindus, 19 percent Christians, and 25 percent are Muslims (Lindberg 2009). We designed our study to collect data focusing on a particular Muslim neighbourhood known as *mahallu*. Among the many Muslim *mahallus* in Kerala, we have selected Chullippara *mahallu* in the region of Thirurangadi, located in Malappuram, a northern district of Kerala.

Majority of the residents are Muslims and they show relatively high literacy and educational progress. Malappuram is one of the two Muslim majority districts in south India (with 70.24 percent Muslims, 27. 60 Hindus, and 1.98 percent Christians), other being Lakshadweep. Malappuram tops in the population with 12.31 of total population of Kerala with the highest decadal growth of 13.39 (2001-2011) in the state. This Muslim majority district has the literacy rate of 93.55 percent (95.78 males, and 91.55 for females)[11] which is better than some other districts in Kerala, the most literate state in India. Sex ratio in 2011 was 1096 females for 1000 males[12]. Thus, the impression is that health and educational indicators of this Muslim majority district is far better than that of the Muslims in north India (cf. Basant and Shariff, 2010)[13]. We have selected Chullippara *mahallu* in Thirurangadi as our field for various purposes. Thirurangadi has a unique history in socio-religious reform movements in Kerala where the religious discourses are present on day-to-day basis.

Following Asad (1986), we were looking for a site where the relationship of power operates in the field in sustaining the orthodoxy in Islam. As he suggested, we must examine not only the practices but also the disciplinary activities, institutional forms of knowledge and practice within which dispositions are formed and sustained and through which the ways of attaining truth are marked out. Thus, we selected a Muslim *mahallu* in

[11]https://kerala.gov.in/census2011
[12]Ibid.
[13]Basant and Shariff (2010). *Handbook of Muslims in India: Emprical and Policy Perspectives*. New Delhi: Oxford University Press

Kerala as our unit of study where we see these powers are exercised in specific ways. It is a space where Muslims have the power to regulate, uphold, require, or adjust correct practices, and to condemn, exclude, undermine, or replace the incorrect ones. Thus, it is the domain of orthodoxy in the imagination of believers where one set of doctrines comes to be established over the other. We understood that it is through the institutions such as madrasa in the *mahallu* that we need to explore the teaching and argument of truth which are attuned to the idea of discursive tradition. However, in addition to Asad, the power with this body is always in negotiation with the laws of the secular state in the Indian context.

In contemporary Kerala, religious discourses are produced by the organizations. Their ideology has an imprint on the lived experience of the community through the micro unit of Muslim *mahallu* in which every Muslim household in the area is registered. Each religious organization has its own office bearers who coordinate with other *mahallus* throughout Kerala. For instance, the *mahallus* affiliated to the EK Sunni faction, the largest Muslim group in Kerala, are coordinated by *Samastha Kerala Sunni Mahallu Federation* (SKSMF) which works as an organizing wing of the supreme religious organization *Samastha Kerala Jamiathul Ulema* (SKJU). It is a particular socio-cultural space, a form of social organization that found peculiar among the Muslims in Kerala. The *mahallu* includes a mosque or various mosques, and madrasas which work as public forum, a site of authority and a symbolic representation. Apart from the administration of mosque, the *mahallu* committee functions as the arbitrator in familial issues like divorce and other socio-economic issues.

Confrontations between the organizations take place primarily through controlling the mosques and the administration of the 'religious divisions' of *mahallu*. *Mahallus* are the rudimentary form of religious authority controlling the large populations giving strength to the religious organizations engaged in the competition for the control of Muslim's religious affairs. The organizational positions on every practice are produced and implemented by *mahallu* in the administration of everyday religious practices. The households are connected to the *mahallu* 'administrative unit' through its institutions such as mosque and *madrasa* (primary religious learning centre). The mosque and *madrasa* in each locality are run and administered by the elected *mahallu* committee. The *mahallu*

committee acts according to the ideology and decisions of the religious organization to which most of its members are affiliated.

Generally, a *mahallu* committee has a president, vice-presidents, secretary, joint secretaries, treasurer, working committee, and the general body which include all households of the concerned *mahallu*. Individuals and households in a *mahallu* are supposed to join as members of the concerned *mahallu* and abide by the rules and guidelines failing which a member can be expelled from *mahallu*. A *mahallu* committee exercises their authority and 'jurisdiction', over the households in a particular geographical area.

The rituals in Islam include both individualistic and collective types, in other words, meeting of private and public domains. One can strive to be a good pious Muslim by offering the compulsory and recommended prayers (*swalath*), fasting during *ramzan*, and offering *hajj* which can be performed individually. However, the religiosity cannot be completed unless he becomes part of compulsory collective rituals such as the Friday *jumua* and imparting the basic religious education to the offsprings which work only through collective bodies. Thus, the community life intrinsic to the religious life in Islam necessitates 'public institutions' like *mahallu*.

Exploration into these rudimentary units in the field would help us to understand deeply the social life of the followers behind the textual discourses. Thus, for us, *mahallu* stands as the empirical representation of the organization of power and authority, which demands a 'willed obedience' from its subjects. Approaching the religious life in this way would help us understand the relation between the disciplinary authority and the subjects, different from the Orientalist characterisation of force and repression on the part of Islamic authority and submission and indifference on the part of those who are ruled (cf. Scott and Hirschkind, 2006:4).

Sometimes, this 'religious social' institution has also been used to circulate and implement the government projects and mandates. The area comes under the various levels of state's jurisdiction, the district and the local self-government bodies. Thus, a *mahallu* can be a part of a revenue division of state such as village *panchayat*, block *panchayat*. A member of *mahallu* committee can be part of the local administrative bodies of the government.

For instance, we have selected Chullippara Muslim *mahallu* as our context of study, which is part of Thirurangadi municipality with its own jurisdiction over particular number of households that include Muslims, non-Muslims, sunnis, non-sunnis. One of our old informants Kunju Haji was the president of the Chullippara *mahallu* committee and the elected ward member of the Thirurangadi *Panchayath* as well for a long time.

It seems that 'legal' and 'traditional' forms of authority[14] in the Weberian sense have come together. The *mahallu* committee enjoys a kind of 'obedience' and the legitimation of power in the religious life of its voluntarily registered members. Hence, selection of *mahallu* as our unique methodological and theoretical proposition stands different from the sites that appear in the anthropological studies by Asad (1986), Eickeleman (1987), Mahmood (2005), Hirschkind (2006), and Bowen (2012). It differs from the sites of Middle East regions like Egypt, Indonesia or Turkey in terms of the religion's role in the public life and the state. As a collective unit of religious life with certain amount of authority and legitimacy, it also stands away from the 'social contextualists' like Ahmad (1981) who disregards the religious authority and concentrate solely on the 'sociological' factors.

Though the features of a *mahallu* look similar to the hierarchical structure of Christianity such as *roopatha* and *athiroopatha* in Kerala, *mahallu* is different due to the 'democratisation' of power in the religious affairs between individuals, households, *mahallu* committee, and the religious organizations. As we see later, *mahallu* enjoys some kind of independent powers from organizations even in the theological matters unlike the structure of authority in Christianity which has a centralised system for religious interpretation. As Turner (1974) and Das (1984) say, the power of interpretation in Christianity rests with organized ecclesiastical hierarchy which can easily suppress the 'un-official' interpretation of religion. Whereas, the institution of *mahallu* facilitates the operation of what Veena Das (1984) pointed out as the 'folk theology', the micro-interpretation of religion within the tradition. The details of the *mahallu* we give below, the region, the sociological features, its power relation, and its engagement with the institutions of state will shed light on the case in point.

[14] For Max Weber, the legal authority is based on a belief in the legality of impersonal rules whereas the traditional authority rests on the habitual attitudes and beliefs in the legitimacy of sanctified practices. For him, power is obeyed only when men find legitimate reasons for their obedience. See for instance, Turner B. S (1974) *Weber and Islam*.

Even if the context of study is one *mahallu*, the centre of Muslim community life, the study also draws on outside influences rather than taking it to be a self-contained group. We need to move away from El-Zein's (1977) and Ahmad (1981)'s frameworks of negating the idea of a universal religious experience of Islam. Understanding the *mahallu* as a form of local orthodoxy in the Asad's theoretical framework, approaching it as disconnected and isolated will not work. As we give much emphasis on out-migration to Gulf countries as the harbinger of economic as well as religious changes, the change comes more often from outside than from within the local discursive realms through mutual interaction via new media and travel.

'Geographical' unit of religious life: Chullippara *mahallu* in Thirurangadi

Topography of Mahallu

We have selected a Sunni *mahallu* in the region of Thirurangadi, namely the Chullippara *mahallu* for the study which is situated in the hilly area surrounded by the vast paddy fields. It might have got its name because of its geographical feature of rocky elevated region (called in Malayalam *para*) sloping to the surrounding vast unused paddy fields. Roads are constructed across the field that connect this small town to the Kozhikode-Thrissure National Highway-17 and to Thirurangadi market which is the capital of the municipality. The hospitals, government offices, police stations, banks, schools and colleges, and the main market place of Chemmad are in the Thirurangadi main road.

Being the rocky area, shortage of drinking water is acute during the summer season and the mobile water supply service is carried out by the welfare organizations, especially the *pravasi* organizations (migrant) donated by the Gulf migrants. Many of *parambs* (garden land) have disappeared and replaced by the house plots which include courtyard, necessary vegetations for the household like coconut tree, drumstick trees, and boundary walls are constructed between each house. In most cases, big plots of *taravadu* (ancestral property) are divided between male children to build their own houses close to their *taravadu* and the married women shift to their husband's place. However, I could see a shift in the customs among the gulf migrant families where women married to a Gulf migrant stays in her natal home until he comes back for leave.

Padam (paddy field) is also in the process of disappearance, converted into *paramb* or into the coconut, plantain plantations and tapioca with rare grain cultivation. Habitation is spreading in almost all portions of lands; some of them were previously grain fields. Large portions of the grain fields are now prepared for the construction of houses. Due to the absence of seasonal cultivation, some portion of the fields is also converted into football grounds, the most popular game of the region. Major football tournaments are conducted after the monsoon season in the 'stadium', which was once the vast paddy field where Muslim tenants had worked for the landlords.

Now chullippara is largely inhabited and heavily populated area with large number of concrete houses. Rise of educated middle class and the nuclearisation of family and the economic backup from the remittances have led to a transformation in the design and size of construction and substantial increase in the houses being constructed; most of them are double storeyed, and some of them are large. Now the tendency is to build all-inclusive structure within a bounded space. Many of large trees, occasional fruit trees like mango and jackfruit are removed; the mud-plastered courtyard is replaced by the interlocked concrete courtyard, and the cattle shed is replaced by car porch. This is a clear geographical shift from the British census (conducted by Ward and Conner 1831)[15] which described the area as wetland agricultural area, and the flat and valley lands filled with dense grooves of coconut, jack trees, and other productive trees. These are the manifestations of the changes happening in the occupational pattern and largely in the economic life.

Farmers to Consumers

We see the rise of some families once agricultural labours or tenants in this portion of Thirurangadi becoming rich after the onset of Gulf migration. From the possession of land and paddy fields, that was the character of the rich, wealth has taken the form of big houses using attractive architectural designs, the latest model tiles and marbles, and costly wooden material, which are, so to say, the markers of successful migrant. Interior and exterior decoration is the sign of richness. At least one or two male members in every household are working in Gulf. It is a shift from farmer Mappila into Gulf Mappila. Women who are left at home have to take the responsibility of the home, attending to

[15]Quated in Ganesh (2009).

children, meet the affairs of the mosque and *mahallu* as one of the member households of the *mahallu*, looking after the health needs of off springs and elder people in the household and so on.

However, there are different strata among the Gulf migrants; the working classes in Gulf countries such as workers in restaurants, and the middle class migrants like those in salaried jobs in the Gulf. There are a few local salaried classes like government service men, some of them in private ventures and shops, and the *musliyars* employed in mosques and madrasas. There are a few whose households depend on daily wage labour. All classes among the Muslims stay adjacent to each other in the *mahallu* irrespective of their financial status.

As we noted earlier, the generational shift in the occupation and the place of occupation is visible in the area. One of our senior respondents Mayamakka who is above 85 year old shared his memories working as a tyre worker in many cities outside Kerala. He remembered the days of hardships that the agricultural labour in the *mahallu* experienced during the years of poverty and starvation. The standard of life has improved after the economy picked up with Gulf migration and remittance leading to a flourish in local businesses. Even when he imparted the skill of tyre works to his male children, only one of them continued with it and the rest migrated to the Gulf to find new occupations there. Now, their daily life runs without economic problems though any drastic improvement has not come about through Gulf migration. There are many like him, the poor migrant class whose wealth did not improve steeply due to Gulf migration.

There can be found many living examples for the generational shift in the occupation of Muslims here. Kunjamu Haji belonged to a rich farmer family holding acres of land; they used to cultivate most of the essential vegetables, rice, and grams in their farmland. Later, he migrated to Kozhikode and started a bakery shop and his brothers migrated to Gulf. They say their sons have lost their farming knowledge and skill and they have sold the paddy field when they got the price. Now, all of them are running bakeries in Hyderabad, and some of them work in the Gulf, needless to say, now everything are purchased from shop.

There are a few cultivators, skilled labours like carpenters and painters, construction workers, and wage labours like drivers in the *mahallu*. The growing scale of constructing new houses, mosques and buildings with newly found wealth has created a demand for more construction workers, specialised welders, tile workers, aluminium fabricators and their supporting aides. The vacuum created by the absence of local labours and workers who have migrated to the Gulf has been filled by the in-migrants from others states of India, mostly from Bengal and Assam. The huge influx of labours from other states into Kerala where they get better wages to take up the occupations left out by the Malayali labour class who prefer to work in Gulf has been termed as 'reverse migration'.

Communities, Denominations, and Groups

On the way to Chullippara *mahallu*, I noticed a gate that leads into a *bhagawati* temple, which is the only temple in the area, and there is no church in the vicinity due to the complete absence of Christians. Later I came to know that many Sunnis in the *mahallu* attend the *thalappoli maholsvam* (festival of palm leaf) held at this temple annually in a month of the Malayalam calendar. Those who affiliate with the reformist organizations generally keep away from the temple festivals due to their acclaimed organizational identity associated with the doctrine of unity of god. Majority of the Hindus staying in the geographical 'limit' of the *mahallu* are *mannan* communities (washer men caste) and Nayars. Unlike the temples and *kavus*, the mosques are the most frequently seen religious structures in the area. The mosques are of two types; one is *srambi* generally in a small structure which is meant only for the daily five times prayers. The Friday grand prayer is held at the grand *juma masjid* participated by almost all Muslims in the *mahallu.* The *jumamasjid* complex includes the mosque and the graveyard where the deceased from the member households of the *mahallu* are buried. The rise of sectarianism within Kerala Muslims can be seen in the site as number of mosques is built adjacent to each other. Each religious organization builds its own mosque as the marker of their assertion for the freedom to practice religion according to their own ideology.

Among the households in Chullippara, the majority are Sunni, and the two Sunni factions have almost equal number of households as their loyalists and some of them are activists. The posts, of the president, secretary, vice-president, and joint-secretary of the committee are shared by the two factions. At present, president's post is occupied by EK faction and

the general secretary is a prominent AP activist. There is one *srambi* (small mosque) for AP Sunni faction and one *JumaMasjid* for Jamaate-Islami. Mujahids have one mosque in Karumbil, one kilometre away from Chullippara, and another mosque and madrasa at Venniyoor adjacent to Karumbil. Those who want to perform their rituals according to the reformist organizations prefer to go to *Jamaat* mosque or mujahid mosque in Karumbil where the Friday sermon is conducted in Malayalam. In these two mosques, a separate entrance and a pathway to a segregated hall inside the mosque are built exclusively for women worshippers as their organizational ideology endorse the entry of women inside the mosque. The modification in the mosque structure is one of the visible manifestations, as part of implementing the ideological argument into practice.

There are two madrasas in this small *mahallu*; one belongs to EK Sunni faction and the other to APs. Establishment of two madrasas adjacent to each other in one *mahallu* has a long history of group formation within Muslims that tells us how the developments in the macro religious structures such as the organizations are reflected at the micro level. There was a common Sunni madrasa for the *mahallu* and all households had been sending their children there. When *Samasta Kerala Jamiathul Ulema*, the Sunni religious organization split into two factions as EK group, which is considered as the official *Samastha* and the AP splinter group due to some organizational reasons in 1989, it had far-reaching effects on all *mahallus* and their committees. EK leaders in the *mahallu* said that the APs captured the madrasa committee as their own and registered it under their '*Sunni Islam Matha Vidybhyasa Board'* with the support of Congress leaders even if the land was purchased using the common *mahallu* fund. After many attempts to recapture the madrasa, the EK faction with the support of Muslim League purchased a new plot and started their own madrasa. AP loyalists and the nearby households send their children to AP madrasa which is known as 'exclusive sunnis'. EK households, the League loyalists, Jamate-Islami loyalists, and Mujahids send their children to EK madrasa, known as 'comparatively inclusive sunnis'. Two separate madrasas bear the lineage of Sunni rivalry inherently coeval with the centuries old political rivalry between Congress and Muslim League, despite the fact that both parties are the constituents of UDF coalition in the state politics. Thus, the political context, not only the doctrinal discourses, is akin to the internal factions among the Muslims in the *mahallu*.

In order to be appointed as teachers at Sunni madrasa, one must be from Sunni background and have the organizational affiliation to which the madrasa is registered. Each madrasa has a *manhaj* (curriculum) and special guidelines for the teachers; the teacher has to be the torchbearer of the organizational activities in the respective *mahallu* where he works. He has to be firm in the organizational ideology and has to nurture it among the madrasa students and residents in the *mahallu*. The teachers are supposed to enact, implement, and organize the rituals authorized and endorsed by the organization like celebrating the birthday of the Prophet annually in the month of *Rabiul-awwal*. The teachers are assigned to instruct the students to deliver the speeches and songs on the stage in the grand *meelad* function commemorating Prophet's birth attended by all Sunni residents. Therefore, the *mahallu* works as the social institution in the micro setting through which the authorization discourses and classification of practices among the experts are lived, but then subject to the authentication and acceptance of the believers who run the institutions. We cannot see these kinds of practices such as *majlisunnor* or celebration of Prophet's birthday (on Rabiul-awwal, 12th in Arabic Calendar) in Mujahid or jamate *mahallus*[16].

Though new communication means like social media sites and online channels have been widely used by the organizations for their activities, yet we see the traditional ways in the public sites of the *mahallu*. Walls, trees, bus stops, and the constructed notice boards are filled up with pamphlets, program notices, flags, and banners of different religious and political organizations. Observation of these indicate sectarian and political trend of the area. The active regional units of the religious organizations also conduct public programs. In Chullippara for instance, two Sunni groups organize at least one program out of the following every month, *waaz* (traditional sermons), *Dua* conferences and *salat majlis* (prayer conferences conducted for well-being and protection from illness making prophets and saints as intercession), and the organizational sermons. Mujahid groups never organized such programs, all of them were ideological and propagation oriented in nature, never for a congregational prayer or celebrating the birthday of Prophet or martyrs or saints which they are not supposed to do.

[16]The Mujahids and Jamate-islami followers allege that celebrating the prophet's birthday is an innovation in the religion since it was not practiced by the righteous companions of the prophet after his death. Sunnis defend the practice saying that it is a good innovation which is endorsed in the prophetic tradition.

As there are seasonal rituals for Sunnis such as celebrating the Prophet's birthday and conducting *maulid* in the Islamic month of *Rabiu-al-awwal* and commemorating the magical powers of Sheikh Muhyuddin Al-Jilani in *Rabiul-akhar,* the Mujahids also conducted counter ideological programs to oppose them. They organized a program in the main road on 'whether celebrating prophet's birthday is Islamic?' in the month of *rabiul-awwal*. The area committee of Jamate-islami in Chullippara also organized one ideological program on 'what is the real *sunnath* (Prophetic tradition)' not followed by the congregational prayers as Sunnis in the *mahallu* usually do. Jamate islami area committee and its own new mosque in Chullippara were also busy in campaigning for its woman candidate for election to the Thirurangadi municipality. Most of its pamphlets addressed the political and social issues such as the equality in land distribution or to protest against the state efforts to shut down Calicut international airport. The sectarian differences were seen in the everyday life: distinct ways of praying, choice of practices and the distinct ways of cultivating a particular *habitus*, and the visible changes after the conversion from one to sect to other.

The influential households try to bring the leaders of their organization for their rituals such as marriage or housewarming while some of them look for the political leaders of their affiliation. Even the patterns of the household rituals change according to their religious ideology such as starting of house construction, *nikah* ceremony, or the post-death ceremonies. For instance, Sunni households invite Sunni scholars for their *nikah* ceremony and perform the ritual of *khutba* (giving sermon) in Arabic language while Mujahids and Jamaatis do it in Malayalam.

Apart from the sectarian groups, we also see some Muslim caste[17] groups in the *mahallu*. Muslim community in the area have developed largely through the conversion from the lower caste Hindus. Their former caste details do not exist today and such division is not visible with some exceptions. Caste divisions are less pronounced except for the occupational group of barbers known as *ossans* and women as *othachi*s. *Ossans* are traditional Muslim barbers; many of them have migrated to Gulf countries and work there as barbers. At home, immigrants from other states have taken that occupation. *Othachis*

[17]It is a matter of debate in Indian sociology that whether the groups among Muslims can be identified as caste as the term is considered exclusively to denote the hierarchy in Hindu religion. Scholars like Imtiaz Ahmad and Hamza Alavi (1981) have used the term caste to understand Muslim social structure in north India and Pakistan whereas some of them preferred to call them as 'caste-like groups'.

were the Muslim dais attending the deliveries, but as we will elaborate later, the deliveries are completely shifted from the home to private hospitals. Younus, one of our *ossan* informants said, majority of their women have stopped their occupation while some of them find their earning from the post-natal care. Ossan Muslims in the *mahallu* are an endogamous group. From their accounts, it was clear that they experience isolation and social distance on everyday basis among the Muslim households in the *mahallu*. It shows, there are Muslim groups on the social hierarchical base that exist beyond the sectarian lines.

Apart from the offices of religious organizations and political parties, there is one youth club office and one *vayanashala* (small library) in Chullippara where the young members of *mahallu*, school and college students gather for reading newspapers, playing carom, and watching TV especially the live telecast of football matches. Among these Muslim youth, some of them are the active members of the religious organization, conduct football tournaments and prepare their own football team and organising arts festivals. In similar ways, scholars like Samuli Schielke (2009) has observed the 'ambivalence' and 'fragmentation' in the moral life of young Egyptian Muslims, taking the example of football. Such 'fragmentations' in health practices are explored further in this thesis.

Religious Subjects and *mahallu* Administration

Chullippara Sunni *mahallu* is affilitated to the Sunni Mahallu Federation (SMF), an organizational wing of the patron organization *Samastha Kerala Jamiathul Ulama* popularly known as 'EK Sunnis'. Around 600 households are the registered members of the Chullippara Sunni *mahallu* committee. Among them, around 60 percent are loyal to EK Sunni organization while around 37 percent follow the AP Sunni group, and there are a few households (around 2-3 percent) who follow the Mujahid and Jamaate Islami ideology[18]. Even if they belong to different organizations, all household members regularly submit their monthly fees to the *mahallu* working fund and to run its institutions such as mosques and madrasas which are financed by the member households. The committee is accountable to each member household of the *mahallu* and their complaints

[18]Since there are no written sources available on the sectarian profile of the mahallu, I have collected this information from the interviews with the *mahallu* office bearers. Hamsaji, president of the mahallu and Ishaq Haji, the general Secretary have given the details about the pattern of affiliation among the households in which they are not able to intervene. Interviews were conducted several times in 2016 during my participant observatory study in the *mahallu*.

since they are the financial source. The *ulema*, (who have been identified in the social science literatures as 'religious authority')[19] may, often, be regarded as employees of the *mahallu* who can be suspended or dismissed anytime. Household member may be preferred over the *ulema* if there is any conflict. Former *mudarris* (main teacher at mosque seminary) of Chullippara main mosque Salam Musliyar was dismissed by the *Mahallu* committee in the wake of many complaints lodged against him by some members. One such allegation was the *mudarris* who is supposed to have unbiased approach towards the residents has been indulging in his own organizational activities. The Musliyar, an AP scholar activist was dismissed by the *mahallu* dominated by EK faction amidst the protest from AP camp. However, to the dislike of the committee, he has been invited by some AP Sunnis to the rituals and programs like the housewarming and post-death rituals at AP households even if he hardly holds any official posts.

The monthly fees collected from the households are used for the maintenance of *masjid* and madrasa, primarily, to give a monthly salary to the 'staffs of *masjid* and madrasa'. The staffs include *khateeb* (main preacher for Friday sermon), *mudarris* (main teacher in the *dars*), *mukri* (one who calls for prayer five times a day), and the *muallims* (teachers) in the madrasa. Apart from the monthly salary, the household members feed all 'religious staffs' in the mosque and madrasa. For the easy running of the *mahallu* system and its institutions, each household is requested to bear the food expense of *musliyars* at least once in month. They have to host them for a day providing breakfast, lunch and dinner. Some of them consider it as the worthy religious duty, to take part in the service of *din* (religion) while some of them do it under the persuasion from the committee. In return, after the meal, the 'religious guests' make a prayer for the wellbeing of the household. It is a desired voluntary act collectively binding upon all the members of *mahallu*. Apart from the regular monthly *chilavu* (food expense), it is also desired the registered households invite the employees of the mosque and madrasa (they are addressed locally as '*usthad'*) for the special functions at home such as marriage, housewarming, or post-death rituals and give them their reward in cash. Attending the occasions of life cycle rituals are also part of their earning from the *mahallu*. The household life cycle rituals which have the religious nature such as the post-death ritual on the third or seventh day after death, or

[19]Cf. Francis Robinson's works on authority Islam (for instance, Robinson 2009) where he takes *ulema* as the form of authority in Islam who provides the perfection of religiosity.

maulid or *ratib* conducted for the well-being of the households, need the presence of *usthads* who only know the liturgy to conduct them. They know how to practice them according to the texts and the classification of rituals approved by the Sunni ideology.

In the selection of *mahallu* committee, there is a trend of certain families dominating over others who claims the lineage of 'big *tharavadu'* (the rich familial tradition) in the social activities. Familial status and richness are not the essential qualifications, rather, participation and personal interest in the *mahallu* administrative affairs is preferred. Pious, active, rich men from the reputed families are preferred for the top posts because other households are expected to follow their decisions and that may not be possible if the lower classes may make the rulings. There is also a trend of increasing level of participation of youth in the *mahallu* committee and there have been some conflicts of interests between the young and the old committee leaders. We are to see here the complex ways in which the religion is lived and the religious authority operates in the field where sociological factors other than religion are significant.

Committee members selected by the member households appoint qualified religious scholars as employees in the mosques and madrasas. The organizational ideology dominant among the committee members and majority households define the selection procedure and recruitment. Religious affairs of the mosque and *madrasa* such as the mode of performing the rituals and preparing syllabus for madrasa education are regulated by the religious organization without any financial involvement. The mahallu committee using the 'public' fund of the believers owns the land and the buildings of the mosque and madrasa. Thus, the committee is accountable to both household members who finance and sustain the *mahallu* and the religious organization which provides ideological support. Thus, the power of organization operates through the micro institution of *mahallu* who can be selective in implementing the organizational decisions that suit to their own local conditions. Different actors, household members, elected committee, religious employees, and the religious organization in which the *mahallu* is registered with seem to share the power and authority in the institution of mahallu.

The decision to send children to madrasa or to feed the religious employees rests with the household. The *ustads* and the committee members can only inspire, encourage and endorse them, generally by citing religious rewards and parental duties in the religious

perspective. The committee endorse the household members to cooperate with the system at least by sending their children to madrasa regularly and not to stop it for the sake of school education. The households generally follow the *mahallu* norms and regulations to avoid the inconveniences in the social relations of *mahallu* life. Failure to meet the requirements and the disobedience without any reason may invite problems. For instance, the main source of income for the *mahallu* fund is the various forms of compulsory fees the households pay for marriages, to fix a date for marriage, to allocate the piece of land in the 'public' graveyard etc. These are the unavoidable everyday necessities through which the institution of *mahallu* exercises its power over the non-cooperating households. In order to book a date for marriage in the ritual calendar of the *mahallu*, one should be a registered member, and has to clear all of his pending dues and be in good terms with the 'system'. Booking a day in advance for a function, except for the death related rituals, is necessary to avoid other programs in the *mahallu*on the same date. It is better to ensure the maximum participation of the '*mahallu* public' in the function such as marriage and housewarming to show one's social relations and to collect the financial contribution.

The 'rebels' against the *mahallu* like the Muslim atheists and non-believing communists can freely live in the *mahallu* without any problem from the committee or the residents. However, the *mahallu* leadership may not cooperate and participate in any of their household events like marriage and they may not issue the clearance certificate for them, which is necessary to be produced before the bride's *mahallu*. In this case, the 'officials' may not allow to register the *nikah* in their *nikah* register and hence the marriage certificate from the *mahallu* cannot be issued. However, the *Mahallu* administration refuses to go for strict actions against its enemies such as ex-communication or ban to avoid the legal consequences of doing unlawful activities from the state. This was the response of the *mahallu* to a Muslim communist activist in Chullippara who filed a case against the *mahallu* for financial mismanagement and the *mahallu* had to pay monthly fine in large amount. Still his household leads a normal life in the *mahallu* but the religious leaders, the *mahallu* committee and *ustads*, do not cooperate with him.

Some of the *mahallus* raise their fund through constructing buildings and shopping complexes and renting them. Earlier, as I could see from Chullippara, the rich household would donate one of their coconut trees to the mosque forever. That is what my

respondent Kunjukka replied when I pointed to the coconut tree marked green in colour 'It is marked because I have donated it to the mosque; now it's not mine, all the fruits I get from this tree would be handed over to them, to the mosque'. The *mahallu* is not merely confined to the immediate neighbourhood for its financial needs. As we noted earlier on the relation between migration and religious activities in the home, each *mahallu* has its own committee in the Gulf countries. The fund collection by the Gulf committee of the Chullippara *mahallu* has been useful in many of its infrastructural projects and relief activities. Thus, there is a confluence of religion, development, and the everyday activities of the *mahallu*.

There are a few Jamate-islami households in the *mahallu* area who were part of the committee but formed their own *mahallu* recently, constructing their own *jumua* masjid and registering their *mahallu* under their *mahallu* coordination committee. However, they also have been giving their monthly dues to the Sunni *mahallu* committee because their dead (*mayyit*) have to be buried in the Sunni graveyards since they do not have their own separate graveyard now. Getting the portion of land in 'Muslim public' graveyard owned by the *mahallu* committee is one of the rudimentary human needs that connect the individual with the collective despite of differences in the religious belief or ideology. This is what the president of *mahallu* claimed:

> Everyone has to cooperate with *mahallu* someway or other, otherwise where they will go after they die? At the end of the day, all have to come to mosque to be buried.

There can be seen some visible identity markers in every household by which their ideological or organizational affiliation can be identified. One of them is the subscription to the newspapers, magazines, books, and the calendar published by the religious organizations kept in the living rooms or stickers pasted on the walls and the personal vehicles. The recorded sermons of the religious leader of their choice and affiliation, and the organizational songs, conference songs may be played in the personal vehicles which is also a visible marker of affiliation.

As historians pointed out[20]since the time of inception, Islamic learning centres in Kerala such as famous mosque colleges (*dars*) didn't have any other financial sources to run the centres of Islamic knowledge except the donations from the residents of the *mahallu*. That means, historically sustenance of religious authority, the preservation, and learning of doctrinal texts, and the running of the centres of religious education which produced the influential scholars, was dependent on the acceptance and finance of the common households and individuals of the respective regions. A close analysis of the religious life in the *mahallu* would explain that process.

It shows the power of the member households in the 'democratic' space of *mahallu* who have an agency in the structure of authority at micro level. It seems more of a shared authority, between households and *mahallu* authority, rather than the hegemony of organizations and their *mahallu* representation over households and individuals. As we explained earlier, if we come closer to the nature of relation between the *mahallu* authority and households, we find a more complex picture than a simple theory of religious authority dominating over the 'ordinary' households. It seems a religious system depended on the mutual dependence between the authority and households, which runs through the 'democratic' way of participation and election.

Educational Institutions: School and Madrasa

Children of Chullippara *mahallu*, mainly the economically backward households rely on Government Chullippara Upper Primary, Kaprad Lower primary schools for the primary education and go out of *mahallu* to Thirurangadi or Edarikkode for high school and higher secondary classes. Those who can afford, send their children to un-aided private English Medium Schools like 'National English Medium School' at Chemmad run by the EK Sunni faction or 'Kutubuzzaman English Medium School' run by the AP Sunnis. There is another 'Ideal Public School' run by Jamaate Islami in Pukayoor, which is a little far away from the region. It was a daily view in the *mahallu* on every morning that the school buses of different private schools picking up children dressed in different uniform after their madrasa classes. Some of them, mainly government aided school students walk or wait for the line buses. This sight is the demonstration of the changes brought about by the Gulf

[20] Cf. MoyinKutty (2016) *Role of Mala-Mawlid Literature in the Islamic Revival of North Kerala: An Analytical Study*, Unpublished PhD thesis submitted to Centre for Arabic and Africa Studies, JNU, p. 36

migration in the micro settings. The vast void historically created by the 'absence of state' in providing the sufficient educational and health facilities has been occupied by the private market players thanks to the flow of money capital from the Gulf migrants.

However, the newly found surge for the school education and the opportunities it provides in the labour market has made significant changes in the preference and mode of imparting the religious education to the off -springs. Nowadays, the madrasas are forced to fix their working hours according to the school schedule. It is a question of conflict of interest for the parents to decide between these two kinds of education, school, and madrasa. From my observations, I could see a visible shift among the Muslim community towards the formal school education which began to be seen as 'compulsory' and 'necessary'. Many households even stopped sending their children to *madrasa* when they felt that it affected their performance in school. Even if there are a few households who take the madrasa education more seriously, the trend of seeing school as most essential education and the latter as secondary or optional is very strong.

When large number of households could afford to send their children to private English medium schools which start early in the morning, they had to restrict the hours spent in madrasa; some of the students spend just fifteen minutes, or half an hour. Many of the senior students had to leave the madrasa very early to attend the private tuition classes arranged for school subjects especially those who appear for the state level public board examinations. Responding to the new trend happening in the educational preference of the community, Samastha Religious Educational Board has started a new madrasa system according to the schools' academic calendar, especially in the schools run by the Muslim management. In this system, Muslim students can avail both religious and school education from their school itself. We see here how the organization of the religious authority has to respond to the changes in the community, which seems to be a different picture from the conventional understanding of the relation between religious authority, the process of authorization, and the subjects.

Unlike before, when the women were discouraged to have religious education, the overwhelming majority of madrasa students now, as elsewhere in Kerala, are girls. The girl students perform well in all madrasa examinations and other competitive programs. In Chullippara madrasa for instance, top positions have been bagged by the girl students. It

has also been a trend that girls sweep the ranks in the public examinations conducted directly by the Islamic educational Board for fifth, seventh, tenth, and twelfth classes. However, despite of high participation and outstanding performance in understanding and writing the religious education, there has been total denial and discouragement for sending girls for higher education in religious studies. Some of the higher religious learning centres from all Muslim religious organizations have come up and started to enrol girls for higher studies in religion. It has been a new experience in the *mahallu* that the woman scholars who passed out from these new centres have been invited to take classes on theology for the elder women in the *mahallu* who did not get the opportunity to learn more. Now, women religious scholars are preferred to train and educate the women residents in the *mahallu* with the aim of imparting religious views regarding women's etiquettes, rituals, and health. Yet women are discouraged from participation in the premium religious seminaries and Islamic colleges, and the consequent absence of the female *ulema* (religious scholars) in the public religious discourses is noticeable.

Mahallu as Part of the Administrative Unit of the State: Chullippara Municipal Ward

Apart from the *mahallu* work, the committee members are very active in the political parties of their choice, the president is an active member of Muslim League, and the secretary takes different political positions close to CPI (M). The geographical area of Chullippara *mahallu* falls under the Thirurangadi Municipality, formerly Thirurangadi Grama *Panchayat*. The locality is 16th ward of the Thirurangadi municipality and the ward is reserved for female candidates. In the last election of 2016, the contest was between IUML's Rubeena and Mafida who contested on behalf of the coalition between three parties, jamate-islami, AP faction, and the communist parties. Rubeena defeated Mafida, even though the latter was popular for her social service-and very much active in the local politics. The election strategy of IUML was to convince the voters to defeat Mafida due to her affiliation to Jamate-Islami, considered as reformist organisation working against the Sunni practices. Even if Mafida was a favourite candidate especially for female voters, her reformist affiliation in the Sunni majority area and the political mobilization of *mahallu* in favour of Rubeena influenced the result.

Apart from the government and private sectors, one thing that is crucial in the everyday life here as elsewhere in Kerala is the cooperative sector. There are cooperative hospitals, colleges, and primarily the cooperative banks like the Thirurangadi Service Cooperative Bank. Since the bank is administered by the elected majority of the cooperative societies, banks are now ruled by the major party which is IUML. Given the inevitability and unavoidability of banks in the economy of the households especially the cooperative banks where the political participation is necessary, the way in which they have been lived up by the local Muslims has to be explored further. An analysis of the domains such as body, health, and survival that are always entangled with ambiguities and conflicts in the everyday life between state and religion would add much to the understanding of how the religious classifications are lived in the practice.

Samples, Techniques and Sources of Data collection

I stayed in a Muslim *mahallu* called Chullippara in Thirurangadi region for one and half year as a participant observer during 2015-2016 and carried out observation and interviews with persons from about 25 member households registered in the Chullippara *mahallu* and around 50 individuals. I interviewed various health care providers, allopathic, Ayurvedic, and Homeo doctors, health inspectors, health officials, health workers, administrators of government and private hospitals, acupuncture specialists (*hijama* and *fasd*), male and female healers (Muslim and non-Muslim), out-patients in government, private, ayurvedic, homeo, and remedy seekers in *fasd* and *hijama* and religious healing centers. The study also covered the organizational activists, religious leaders, *mahallu* committee members, and welfare and healthcare activists of religious organizations.

The nature of the problem at hand suggests the method to be used to study it, in other words, the problem selects the method. This study was primarily empirical. It demands the primary data to be generated through fieldwork using the ethnographic method which is qualitative in nature. Ethnography, a method contributed by anthropology, has been defined as the exploration of a particular social or cultural setting mainly based on participant observation which is used as one of the primary techniques of data collection in sociological fieldwork. Participant observation entails the method of data gathering through participation in the daily life of informants in their natural setting to elicit the social meanings, shared beliefs and values, and the nuances of everyday activity.

Using the ethnographic method, we used number of techniques for primary data collection from the field like observation, interviews, life histories, case studies, and narratives. Although relying largely on the qualitative data, we also use secondary quantitative data to substantiate our arguments. Narratives, life stories and other primary data were elicited through participant observation, conversations and interviews, and other forms of interaction. Semi-structured interviews were primarily used because of the flexibility, which allows greater freedom to ask in case of need of the supplementary questions. We used semi-structured interview along with conversations and discussions in my native language Malayalam, changing and adding appropriate questions according to the informants. Focused interviews were also used to understand the specific question in mind.

As sources of data, the visual (including photography, film, and videos) and print materials (including books and articles) were also collected. Print materials of interviews, diaries, letters, archival materials, news reports, discussions, historical documents, speeches, conversations, and public debates were used. We also used articles from magazine, public speeches, propaganda materials, books and pamphlets, official reports, public discussions, literary writings and the like produced in Kerala public sphere.

Organization of Thesis and Chapters

The thesis would address the research questions through five chapters which mainly contain the objectives we listed above. The First chapter gives an overview on the changing trends in the theoretical frameworks of sociology and social anthropology on Islam and Muslim societies and we see how far they help us understand the problem we raise in the thesis. Taking cues from Asad's framework that focuses on the authorization process in the production of subjectivity and Islam as discursive tradition, we move on to the second chapter on the social historical account of the specific location in the study. The chapter focuses on the ways in which the Muslims engaged with the religious authority and authorization process where we see the state comes as the powerful alternative. The chapter sheds light on the specific modes of Muslim engagement with the colonial modernity and the forms of medical knowledge it introduced. From the theoretical framework, and then to the history, we move on to the third chapter where we try to understand the concepts, experiences, perception, and practices of health in the micro

setting of a Muslim neighbourhood in the context of the ongoing religious discourses on the health practices. Along with the experiences and perception, we also investigate the problem foregrounding the sociological factors like the occupation and economy, the market and the state in the fourth chapter. One of the peculiar ways in which this thesis approaches the problem is that it takes into account both experiences of individual actors and the macro level institutions such as the state. The last chapter tries to focus on the modes in which the Muslim medical subjects that we tried to explore through other chapters are formed in the context of religious and state discourses on health. We enquired into the question by looking into how Muslims in Kerala respond to the state mandates on the immunization and family planning, the two aspects widely considered for the different mode of Muslim response. In next chapter, we begin the discussion by outlining the theoretical background the thesis tries to respond and moves forward.

CHAPTER 2

Religious Discourses and Muslim Subjects: Theories and Approaches

Introduction

After a stint of relative disinterest in Islamic religion in the early sociological writings on religion as in the case of Durkheim (1912), Marx (1959), and Weber's study of civilizations (1905, 1958), a number of brilliant studies came out later such as those of Geertz (1968) and Gellner (1981). Later works on Islam and Muslim societies also reflect the methodological shifts that happened in sociology. Weber's sociology of religion however, provided an approach to explore the dominant motives and worldviews of various religious traditions acquired by the social actors.

Sociologists and anthropologists have attempted to study Islam and Muslim societies through different approaches. Some of them have done it through exclusive analytical binaries like orthodox and non-orthodox, oriental and occidental, little and great traditions of Islam. Other conventional binaries are textual cities and ritual villages, *Sharia* in town and mysticism in countryside, elite *ulema* and the local and segmentary tribal, and so on. Muslim rituals have been studied as a cultural specificity, as shared Islamic tradition, as individual creativity and as something authorized by religious leaders. Responding to this theoretical tradition, this chapter gives an overview of the major studies on various dimensions of Muslims as they have been looked from different theoretical approaches of ritual, religion, and social change. We elaborate extensively on two authors, Clifford Geertz and Talal Asad who, for me, represent the two different major theoretical trends that would tell us about the shifts and breaks in the anthropology of religion and rituals among Muslims. As a beginning, foremost inspiration for the anthropological attention in this regard came from the comparative studies carried out by Clifford Geertz to understand the specificities of Islam. He understood Islam as a set of processes through which Muslims, rural and urban, North African and Southeast Asian adopted their respective

shared tradition in ways that made sense to them in specific historical moment in specific place.

Clifford Geertz: Doctrines and Religious Change in Two Cultures

The first significant anthropological study focusing explicitly on Islam was Geertz's '*Islam Observed: Religious Development in Morocco and Indonesia'* (1968) which was heavily influential both inside the discipline of anthropology and outside of it. This hermeneutic work is a comparative historical study of religious change, applied to Islam in two different civilizations, the Indonesian and Moroccan. He studied Muslim societies to observe Islam as it was actually lived. He looked at ways in which particular ideas, acts and institutions sustained or failed to sustain and how they defined what constitutes religious faith in different historical periods. For Geertz, the faith is sustained in this world by symbolic forms and social arrangements and the content of religion is embodied in images and metaphors that its adherents use to perceive the world. In other words, it can be said that Geertz's work is about 'writing a social history of the imagination and its change' in East Asia.

Explaining the religious change in Indonesia, Geertz argues that the faith or what is to be believed has not changed much; rather, what has changed is the way in which it was believed. Tracing the history of the 'traditional religion' or 'classical styles', he explains how gradually the conceptions of the divine and social orientation to the divine came to be crystallized in two Muslim countries. He says the classical style of religion broke during 15th and 16th centuries following the expansion of Islam via trading classes. It was against this *Indonesianized syncretic* folk tradition of medieval Islam that the counter-tradition of orthodox Islamic consciousness, based on the Quranic, puritan, scholastic worldview grew through the networks of *bazaar*. Hence, Geertz finds, all the terms we use to refer to the forms of religious life like mysticism, worship and tradition, which are the ways in which people in different localities have developed their conception of Islam that meant different things in the two countries, namely, the Indonesia and Morocco.

It can be well understood that Geertz (1966; 1968) develops a framework of understanding, to empirically discover the order of Islamic universe through the comparison with circumstantiality and particularism. The central task here is to find out

the appropriate terms of comparison and the appropriate frameworks to study 'different *islams'*. After elaborating Indonesian and Moroccan spirituality in classical times, Geertz explains how these two forms of' religion have undergone changes. Thus, the classical religious styles of Indonesia and Morocco, - *Illuminationism* and *maraboutism*- which were their mainline traditions lost their hegemony due to the attack from secularism and sripturalism. The shift was from the mentality of "*what shall I believe?"* to "*how shall I believe it?"* a shift from religiousness to religious-mindedness as a logical response to the doubts. It was a transformation of religious symbols from an imagistic revelation of the divine, evidences of God, to an ideological assertion of the divine importance.

Geertz finds the movement towards an Orthodox 'true' Islam of the book rather than the 'Islam of trance' or the miracle started with the scholastic discourses in 19th century among the religious students of Indonesia and Morocco. The students crusaded for the adherence to the legal, moral, and ritual demands of Islamic scriptures and against the devotion to the local spirits, charms, and domestic rituals mainly practiced by the mass peasantry. Other means through which the new ideology spread was the hajj pilgrims to Mecca, the newly established religious boarding schools and the social interaction in the *bazaar* (market) network. Later, this group with a new religious ideology formed into a sectarian community.

He says all of these groups worked for the teaching of the 'original' and 'true' Islam to the local 'ignorant', relying on the theological texts written in vernacular language. In the same century, after 1880, there was a rise of Islamic Reform movements throughout the Muslim world- the attempt to establish the 'plain', 'original', 'uncorrupted', 'progressive' Islam of the days of the prophet and the rightly guided Caliphs[21]. In the Middle East, revivalists like Jamal Ad-Din Al-Afghani and Muhammad Abduh led the propagation of 'back-to-the-Quran' and 'on-to-modernity'. It was a combination of radical fundamentalism and modernism, stepping backward in order to better leap forward, sometimes the veneration of the texts in order to justify the modernity.

Geertz explains the distinct ways the religiosity changed differently in Indonesia and Morocco, the two different cultures. Reform movements started at the end of 19th century by the Egyptian theologian Muhammad Abduh, usually known as '*Salafi* movement' from

21Caliph means the successor of the Prophet Muhammad.

as-salaf as-salih literally means 'the righteous ancestors'. They advocated the literalist interpretation of scriptures, questioning the post-Quranic commentaries, and rejecting Sufism which dominated all scholarly and popular discussions. In Morocco, it was a battle between the scripturalism and *maraboutism* (the Sufi way of Islamic life) which in turn led to the formation of the organized religious schools as agencies for the production of scritptuaralist ideologies. They delivered their message in every setting from the city compartments to tribal tents, attacked the practices of amulets and wiped out sorcery arguing that Quran is the only source of *baraka* to be detected. It can also to be noted that, the *salafi* scripturalist movements which sought 'religious self-purification' led to the political self-assertion and the rise of nationalism in both modern Indonesia and Morocco from 1920s to 1960s. Nationalism was the product of a contract between the community of *ulema*, the scriptural scholars and monarchs in Morocco and the elected president in Indonesia. The *ulema* recognized and legitimized the kingship as 'Islamic'. Thus, the nationalist movement was interpreted as the 'pan-Islamic movement'.

Geertz argued, while analysing culture, we must we view art, history and in our case, religion, against the commonsense notions, to see how they grow out of these common sense notions and go beyond them. Because, there is a dialectical relation between religion and the commonsense as there is between art, science and commonsense and commonsense is the total orientation towards life. In modern anthropology, this was a perspectival change from the concern with thought as an inner mental state to a concern with thought as utilization by individuals in the society of 'symbols'. Here, the focus is neither on subjective life as such nor on outward behaviour, but on the socially available "systems of significance"- beliefs, rites, meaningful objects- in terms of which subjective life is ordered and outward behaviour is guided. The main context in which religious symbols work is ritual, for which the sacred symbols give a worldview, which influence his actions and personality. For instance, in Geertz's perspective, it is the festivals around a saint's tomb, the bead telling in *zawiyya*[22] that keeps *maraboutism*[23] going. Psychological, social, and cultural factors make men participate in the religious rituals and accept the metaphysical beliefs implicit in them when they feel inadequacies in the commonsensical ideas in the face of complexities of experiences.

[22] *Zawiyya* is the special hut built around the graveyard of the saint or the Sufi master for the worship.
[23] *Maraboutism* denotes the strong spiritual bond between the guide and his discipline.

He discusses the encounter between religion and modern science and the ways in which Muslim scholars responded to science. As for Geertz, the failure of the classical religious symbols to sustain religious faith- a process of the 'secularization of thought'- is the major reason behind the religious changes and its response was '*ideologization* of religion'. Thus, the growth of positive science and the emergence of the struggle and tension between science and religion, in other words, 'the struggle for the real', made scripturalists[24] turn exclusively toward 'written sources'. According to Geertz, it is not so much on the basis of the theological contribution, but on grounds of the *ideologization* of religion that they called themselves as the 'innovators' and 'traditionalists'. They devised two strategies; on the one hand they separated the religious and the scientific domains and on the other, they were integrated it as well on the ground that it was already mentioned in Quran. Thus, the doctrines are protected from the human experience while at the same time, the secular reason left free to operate with full sovereignty in its own world that would not pose any challenge to the scriptures. In Indonesia and Morocco, these strategies operated differently. The former, with its syncretic stream, accepted the complementary relation and the latter, with its religious perfectionism, isolated the purified Islamic faith from any human contamination. In one case, science posed no threat to religion because it is seen as religious, in the other, there was no threat, because religion is seen as not science. The puritan scholars responded this way to the modern forms of knowledge in both settings.

We see many more studies in the context of Muslim societies that can be termed as 'post-Geertzian', either adding to the Geertz's framework or moving away from him, and there are critiques as well. Notable authors in this line are Abdul Hamid el-Zein, Dale Eickelman, and Talal Asad who tremendously contributed to the development of the theoretical framework of Islam and Muslim societies taking Geertz as their point of departure.

El-Zain's Dissolution of Islam

The thrust of Abdul Hamid el-Zein's (1977) conversation was with Geertz, wherein he sees that Geertz was also influenced by the idea of an essentialized universal Islam, a

24In both societies, it was only scritpturalists who responded keenly to the tension between the science and religion and participated in the 'struggle for the real'.

certain amount of homogeneity. He challenged the universality of Islam, opposing the existence of either Islam or religion as fixed and autonomous category; rather, for him, Islam dissolves as well. In order to avoid a static meaning through objectification of symbols, he suggests to stop looking for any search for structure or unifying factors in various local Islams. He argues that each expression of Islam creates its own web of meaning, and any attempt for coherence will give a web of frozen points of meaning over otherwise fluid, dynamic web of meaning that the subject inhabits (ibid). He thinks that given the diversity of cultural content, it is impossible to speak of a universal meaning of Islam. Anthropologically, then, Islam does not exist as a fixed and autonomous form. The problem here is that he overlooks the underlying coherence in the social life of Muslims amid seemingly various diversities.

Criticizing Geertz, Zein says, the culture becomes the central concept in Geertz's understanding of human existence even if he sees human phenomena as simultaneously organic, psychological, social, and cultural. When Geertz analyses culture as social and part of an intersubjective world, it becomes a positive science, because, he deals with the symbols as empirical expressions of thought. El-Zein says that Geertz develops a method of 'analysis of the meaningful structure of experience' or the 'scientific phenomenology of culture'. For instance, Geertz imposes the social 'constraint' of the 'tradition' for Islam as culturally shared meaning.

El-Zein says it is this method of 'scientific phenomenology of culture' that Geertz applies to the analysis of diverse cultural expressions of Islam in Morocco and Indonesia. Here, the creators of symbols become passive carriers of meaning, while the detached scientific consciousness takes over the active role. El-Zein says, focusing on the daily lived experiences of the local Islams, Geertz has left the study of theological interpretation to the Islamists, underestimating the importance of texts in their lives. Talal Asad (1986) criticizes Zein's contention that "there are diverse forms of Islam, each equally real", by saying that, Zein seems to assert an underlying unconscious logic. Here, Asad says, Zein slips from an anthropological *contextualism* into a Levi-Straussian universalism (Asad, 1986).

Eickeleman's Study of Islam in Local Contexts

Dale F Eickelman(1982) says the main challenge for the study of Islam in the local contexts is to describe and analyse how the universal principles of Islam have been transmitted and reproduced in various social and historical contexts. He tried to articulate the specific economic, political, and historical contexts where religious beliefs and practices are developed and maintained and how such beliefs shape social action. He said the interpretation of Islam and its relation to social classes and status are valuable in understanding Islam in local contexts. In the study of Islam in local contexts, he says, when adapted to new settings, class and status groups, religious ideologies often have implication far removed from the original carriers. To understand such transformation, concern with the internal differentiation of belief and practices within 'local' societies is pertinent. Thus, for him, "notion of context is wider than the non-sociological views of religious experience" (Eickeleman, 1982). He says the middle ground between these two extremes will be productive for comprehending the religious tradition.

He criticizes Geertz for treating 'classical styles' as constant and dominant factors shaping the interpretation of Islamic texts. Eickelman also challenges the dichotomy of 'great' and 'little' traditions. He sought to interconnect the textual traditions with the diverse socio-cultural and historical contexts. Following the Weberian method, Eickelman tried to grasp the social and historical phenomena, defined by the subjective meanings, through his study on *maraboutism* in Morocco. He takes the individual as his basic unit of analysis and religion as an ideology and views the individual as someone who can manipulate symbols in order to realize his social goals and interests, resting on five aspects: God's will, reason, propriety, obligation, and compulsion. They all render a coherent and meaningful social action. As El-Zein (1977) says, the paradox with this approach is that religion as an ideology of God's will, as understood by the Moroccans, dissolves history with the premise of eternity.

Discourse and Practices: Woodward's Model

Mark R Woodward (1988) looked into the relationship between the textual Islam and the popular Muslim piety by studying *slametan* ritual in central Java. It is a ritual meal at which Arabic prayers are recited and food is offered to the Prophet Muhammad, saints,

ancestors who are implored to shower blessings on the community. He argues that the *slametan* ritual is rooted in the essentialist texts whose pre-Islamic elements are interpreted in Islamic terms, so religion must be understood in relation with the larger Muslim tradition.

His argument stands as a critique to Geertz, for whom Javanese religion is the synthesis of animism, Buddhism and Hinduism and Islam, in which, animism is predominant and here, he finds that there is an underestimation of the role of texts in the religious life. Woodward says, the legalistic tradition and mystical piety are not mutually exclusive categories in Java, rather it coexist in the lives of individual. The functions of *slametan* (ritual meal offered to saints) parallel those of liturgical prayer though many of its components are drawn from Javanese ritual traditions. In totality, it exemplifies the use of esoteric Sufi concepts as a social as well as religious ritual. It is because of this link with the texts that *slametan* ritual has been redefined in the *Islamization* process. In Java, Islam has profound impact on culture, and the religious debates are between different Muslim groups committed to different modes of Muslim piety and not between Muslims, Hindus and animists. *Kejawan* Muslims believe that their practices were 'true Islam' while *santri* groups believe theirs was true and *kejawan* is false Islam.

Woodward provides a typology to understand the complexity of textual tradition and the various factors influencing the formation of local 'Islams'. One is *universalist* Islam, which includes the foundational texts of Quran and Hadith together with rituals including *hajj, salat, eid* festivals, and fast of *Ramadan* which are specifically referred by the universalist texts. The second category is *essentialist* Islam that includes the system of discourses, which extends beyond the local Muslim boundaries like the *dhikr* rites of Sufi orders, and the rituals at tombs of saints. *Received Islam* is that portion of universalist and essentialist categories present in specific local contexts, determined by the local culture and the nature of local interpretation of the essentialist materials. They may be changed according to new knowledge on the basis of new discourses and interpretations of texts. The changes happened to the Indonesian local practices after the new textual interpretations of reformists in early 20th century were an instance. Finally, the *Local Islam* is the set of oral, written, and ritual texts that are unknown of their area of origin, derived from the interaction of local culture and received Islam, like the Hindu cultural

elements in the Islamic rituals in India. So, to understand the ritual varieties at local level, he says:

> *More attention has to be paid to the ways in which received Islam are interpreted in local context and to the historical, economic, political and religious factors influencing the communication of texts, rituals and ideas within larger Muslim world* (Woodward, 1988).

Islamization of Anthropology

Responding to the discussion, Akbar S Ahmad (1984, 1987) and Richard Tapper (1995) tried to understand Muslim societies through a new paradigm of 'Islamic Anthropology'. Akbar Ahmad, in his work '*Toward Islamic Anthropology: Definition, Dogma and Directions*' (1987), argues, the analytical models, devised by the western anthropologists, to explain society combining theory and empirical inquiry like social structure, kinship and political organization, magic, belief and religion, have some limitations to understand the Muslim society. Thus, he defines Islamic anthropology as,

> *The study of Muslim groups by scholars committed to the universalistic principles of Islam-humanity, knowledge and tolerance- relating micro village tribal studies in particular to larger historical and ideological frames of Islam. Islam is understood not as theology but sociology so that not precluding non-Muslims* (Ahmad, 1987: 56).

He says, a Muslim is a part of the larger *Ummah* (the concept of world Muslims as a single community), which provides him social identity, so he belongs in part to his immediate group, in part to the larger *Ummah*. For instance, rules of marriage and inheritance are pre-determined for the Muslim groups in contrast to the west, where man is an individual first and last. There is only one Islam, but there are many Muslim societies, so, we must place the multitude of Muslim societies within the framework of one universal Islam.

Richard Tapper (1995), looking into the relation of 'Islamic anthropology' to the 'anthropology of Islam', understands Islamic anthropology as,

> *Doing anthropology inspired by the methods drawn in some way from Islam, Islamic approaches to the study of anthropological texts, rather than anthropological approaches to the study of Islamic texts* (Tapper 1995)

He says Islamic anthropology is a critique of western idea of knowledge and social science because western discourse is secular and sees religion as a human creation. This western idea and the original Christian view of Islam entails that west cannot understand Muslim civilization. In response to this, Islamic anthropology proposes social sciences should be *Islamized*, they have to draw approaches from Islam, so that Muslim societies can be studied on the assumption that God created nature and that society is based on the divine laws by constructing an ideal picture of Islamic social structure and Islam as ideology.

Talal Asad: Genealogy of 'Religion' as Anthropological Concept

An influential counterpoint to Clifford Geertz was provided by Talal Asad (1986; 1993) who urged us to focus our attention not on cultural specificities that created specific Islams, but on the powerful religious authority, texts, and doctrines which authorize some interpretations of religious tradition and suppress others. Asad's works offer not only a new approach towards understanding Islam, but also a critique of the major trends of sociological and anthropological theorization of religion, especially that of Clifford Geertz (1968).

Asad's significant work '*Genealogies of Religion: Discipline and Reasons of Power in Christianity and Islam'* (1993) explores historically the development of 'religion' as a concept and practice in the west under the assumption that western history has an overriding importance in the making of modern world. Asad looks into the ways in which western concepts and practices of religion define forms of history making, taking the cultural hegemony of the west as his main object of inquiry. Looking into the genealogy of religion, he discusses the emergence of religion as a modern historical object and the productive role of physical pain and the virtue of the self-abasement in medieval Christianity to produce religious truth. He addresses the aspects of the asymmetry between the western and non-western histories, the problems of anthropological translation, and the limitations when non-Christian religious tradition juxtaposed with the enlightenment

doctrine of 'critical reason'. Thus, he suggests that the anthropologist, who wants to study the Muslim beliefs and practices, needs to understand how 'religion' has come to be formed in west. Since 'religion' is a western category, there is danger in employing it as a normal concept when translating it to the Islamic traditions.

Asad deals with the question of what it means for a discipline like anthropology to be engaged in the study of 'religion' by discussing the notion of religion as found in the work of noted anthropologist Clifford Geertz. He argues, the definition of religion as separate from politics, law and science- space in which varieties of power and reason articulated in modern life- is a modern western norm, a product of post-reformation history. Then he examines how the theories of religion have separated religion conceptually from the domain of power. He takes the universal definition of religion offered by Clifford Geertz's 'Religion as a Cultural system' (1966) to explain this problem. He clearly shows how this definition rests on a conceptual framework deeply indebted to the developments within early modern Christianity, and thus limited to analyse other traditions such as Islam. Criticizing Geertz's (1966, 1968) emphasis on *symbols* to produce moods and motivation, Asad asks, what are the conditions in which religious symbols can actually produce religious dispositions? On the other hand, how does power (religious) create (religious) truth?

To answer these questions, Asad looks into the relation between the power and truth in the Christian thought such as the doctrine of St. Augustine on Donatist heresy. The doctrine indicated that *disciplina, coercion* and *punishment*, imposed by God had important role in the firm handling of human being against the denial of the Christian teaching. Here, it is not mere religious 'symbols' which bring dispositions as Geertz has argued, but it is power, ranging from the laws, sanctions to the social institutions such as the church, and human bodies like prayer and penance, which imposed the conditions for the realization of the 'truth'. Therefore, he says, particular discourses are systematically excluded while some are praised and included drawn into a narrative of sacred truth.

Asad argues Geertz does not consider how the *authorizing process* and *authorizing discourses* represent the practice and utterance or disposition and he does not look into how they redefine the religious spaces. In middle ages, such discourses of authentication, accepting and rejecting particular religious practices had worked as a model of truth. With

the help of institutional power, all practices were subjected to a unified, single authenticating authority which could classify and distinguish what is true religion and authorized practice and which one is false.

He argues, from being attached to the specific processes of power and knowledge which have a Christian history, 'religion' now is abstracted and universalized by the anthropologists. So, without regard to the *discursive process of authorization*, the meaning cannot be insisted, because, it is those discourses that exist beyond the observed practices, give the religious meaning to the events and practices. The connection between religious theory and practice is that of power- of disciplines that create religion, of interpreting true meanings, of forbidding certain utterances and practices and authorizing others. We will have to examine not only the sacred performance but also the disciplinary activities, institutional forms of knowledge and practice within which dispositions are formed and sustained and through which the ways of attaining truth are marked out. He argues there are different kinds of practices and discourses inherent to the field in which religious representations acquire identity and truthfulness. Therefore, their possibility and authoritative status have to be explained as products of historically distinctive disciplines and forces.

Asad notes the Christian monastic program[25] in the early middle ages was a clear example of the disciplined formation of self, based on the proper performance of already inscribed liturgy which had no distinction between outer behaviour and inner motive, and between social rituals and individual sentiments. He attempts to understand the ways in which particular rituals in Medieval Latin Christianity[26] depended on the physical pain and how their transformation changed the discipline in different periods. He investigates into the practices of 12th century judicial torture[27] in Western Europe and the sacramental penance of Medieval Christianity. These are connected with the formation of a particular kind of

25The rule of the Saint Benedict was established as sole program for the proper government of a monastic community and the Christian formation of its members. Although most Christians did not participate in such programs, the disciplined formation of Christian self was possible only through such communities (Asad, 1993: 62)

26By medieval Christianity, he meant, primarily Latin Christendom in Italy, northern Spain, France, Rhineland, the Low Countries, and England.

27Judicial torture is the application of pain to the body of the accused of witness, in order to extract a confession. It was treated as the early *inquisitorial* procedure in the history of Western criminal laws which are contrasted with the duel, ordeal, and sacred oath, the primitive forms of *accusatorial* procedure. Most widespread were the ordeal of branding, that of boiling water, and that of cold water (ibid.84).

politics, religious ritual, knowledge production and a particular kind of subjectivity, authorized and employed by the church. It shows how power- in its most direct, physical effect - works to produce truthful discourses and makes subjects respond to authority.

Michael Foucault has discussed this issue of shifting strategies of power in relation to the body in his book '*Discipline and Punish*'. Foucault said the investigation as an authoritarian search for a truth appropriated itself the right to establish the truth by regulating bodies. Rather than the beliefs of the individuals, the power had the key role which worked through different legal-moral structures like religion and state. Foucault's (1982) work on monastic asceticism shows how the Benedictine rule consisted of the 'technology of the self', which played a crucial part in distinctive production of truth. It entailed the complete obedience (for which Foucault used '*subjectivation'*) to the authority and discipline of abbot in an institutional setting of organized community life, making the individual a 'monastic body'. The discourses about the sins through preaching, publishing literature defined and formed specific types of Christian consciousness, a formation of disciplined religious subjects.

Following Foucault's line, Asad analyzes religion in terms of the disciplinary practices and the ways in which the religious discourses regulate, inform, and construct the religious selves rather than going through the conventional duality of ideology and social structure. He examines two kinds of power processes: formations of the self and the manipulations of (or resistances to) others. He examines the conditions within which the obedient wills (will to obey), desires and choices for humility are created through a program of communal living. He does not mean power as interpersonal as opposed to being institutional; rather, his attention is on the aspects of volitional power which were constructed by the Christian monastic project.

For Asad, the ritual has to be treated as the 'vehicle' of power and as a medium of persuasion, which can be seen as a shift from the major trends in the modern British, French and American anthropology which understood ritual as a domain of the symbolic and a form of communication not as instrumental. The Christian monastery has to be understood as different from other total institutions of hospitals or prisons as said by Goffman (1961), because, the obedience was a virtue of a Christian monk and the main element of his religious dispositions, not the order or strategy among inmates. For a

Christian religious subject, the correct dispositions necessary for a disciplined life were created after creating the appropriate psychological conditions. He concludes by arguing that:

> *In various epochs and societies, the domains of life are variously articulated as appropriate to it. How these articulations are constructed and policed, and what happen when they are changed (forcibly or otherwise) are questions for anthropological inquiry. Unless we try to reconstruct the historical conditions in which different projects and motivations are formed, we shall not move ahead in understanding agency* (Asad, 1993: 167).

Islam as a Discursive tradition

Many critical anthropologists and scholars of other disciplines who face the problems we raised through the works of Geertz, El-Zein, Eickeleman, Woodward, and Akbar Ahmad, have come to recognize the usefulness of the conceptual framework provided by Talal Asad to study Islam and Muslim society. He suggested that the diversity of the various local manifestations of Islam could be analysed through the concept of a 'discursive tradition'. Asad's understanding of Islamic tradition (1986) has been a profound contribution to the theorization and analysis of contemporary Islam where he tries to genealogically unpack the key concepts used in the study of Muslim societies like Gellner (1993) and Geertz (1968). As Scott and Hirschkind say, Asad's discursive tradition includes the discourses and practices of argumentation articulated with an exemplary past, dependent on the interpretative engagements with the foundational texts by which the practitioners of tradition distinguish correct actions from incorrect ones (Scott and Hirschkind, 2006: 8).

He saw that the Islamic tradition links its practitioners across temporal modalities of past, present, and future through pedagogy of practical, scholarly, and embodied forms of knowledge and virtues. For him, the past is the means through which the subjectivity is constituted and sensibilities are created which in turn facilitate the reproduction of the tradition. Relations of power are necessary for the propagation of tradition in relation to other discursive traditions and for certain practices and arguments to become hegemonic within a tradition.

Criticizing the dichotomous understanding of Geertz, he says, narratives about culturally distinctive actors must try to translate and represent the historically situated discourses of such actors as responses to the discourses of others. It is wrong to represent 'types of Islam' as being associated with the types of social structure (as Geertz has done). Rather, he argues:

> *Islam as the object of anthropological understanding should be approached as a discursive tradition that connects variously with the formation of moral selves, the manipulation of populations (or resistance to it) and the production of appropriate knowledges* (Asad, 1986)

He says, this discursive tradition includes and relates itself to the founding texts of Quran and Hadith. Islam is neither a distinctive social structure nor a heterogeneous collection of beliefs, artefacts, customs and morals. Rather, he says, it is a tradition, with no essential difference between 'classical' and 'modern'. A tradition involves discourses that seek to instruct practitioners to follow the correct form of a given practice, precisely because it is already established and has a history. These discourses relate conceptually to the past (when the practice was instituted and from which the knowledge of its proper performance has been transmitted) and a future (why it should be modified or abandoned), through a present (how it is linked with other practices, institutions, and social conditions).

Asad says the practitioner's conceptions of what is 'correct' performance are crucial for tradition. Therefore, the discourses in which the teaching is done and the correct practice defined and learned are intrinsic to all Islamic practices. There is a notion of 'correct model' to which all practices ought to follow, which is conveyed in authoritative principles in Islamic traditions. A practice is Islamic because it is authorized by the discursive traditions of Islam as it taught to Muslims. Therefore, the statement made by a practice relates to its authenticity. The arguments and debates over the form and significance of any practice are, therefore, a *natural* part of any Islamic tradition. The process of trying to win over someone on a traditional practice, using reason and arguments, not to demolish him, is *necessary* part of Islamic discursive traditions. It does not mean that 'the tradition is in crises' as Geertz (1966) explained.

Thus, Asad argues, anthropologists have to find out the kinds of reasoning and motives for arguing by discovering the central modality of power and resistance it encounters. The

variety of traditional Islamic practices in different times and places indicate that, there were different kinds of reasoning that different social and historical conditions had and have been experiencing. He reiterates, Islamic religious, legal and political ideologies are part of changing institutions and discourses which are contested and re-constituted. To understand this, one must focus on the religious discourses emerging in a given historical situation and not on a supposedly original Islamic ideology, which cannot be considered in isolation (Asad, 1983).

For him, tradition is more mobile, time-sensitive, more open-ended concept. It looks not just at the past, but to the future as well. There is a possibility of a 'new revived' tradition, a new story about past and future, about new virtues to be developed[28]. We need to note here the fact that criticizing the universal and abstract notion of religion in anthropology rather than being a set of rules attached to the specific process of power, Asad himself seems giving a universal definition of Islam and the methodology to study Islam. We will explore this point in detail later.

Inspired by Asad's framework, many anthropological works have come up recently which have tried to add to his theoretical legacy to which we are turning our attention. These studies have enriched our understanding and taken the theoretical frameworks into further domains. In the next section, we engage with a few ethnographic studies that tried to delve deep into the understanding of Muslim subjects in the contexts of Muslim majority societies such as the Middle East, Far East and North Africa.

Saba Mahmood: Cultivation of Moral Self

American anthropologist Saba Mahmood is one of the few who offered certain crucial insights on Muslim subjects inspired by Asad's framework on Islam. Mahmood (2005) questions the predominant assumptions of the concepts of 'subject', 'agency', and 'freedom', through her ethnographic investigation of urban Muslim women's mosque movement in Cairo. She critically explores the notions of *agency* conventionally understood as "the capacity to realize one's own interests against the weight of custom,

[2828]Scott (2006) Appendix: The Trouble of Thinking: An Interview with Talal Asad, in. Scott and Hirschkind (Ed.). *Powers of the Secular Modern: Talal Asad and His Interlocutors.* Stanford: Stanford University Press, p. 290-291

tradition, transcendental will, or other obstacles (whether individual or collective)" (Mahmood, 2005:8).

In line with Lila Abu-Lughod (1990), Mahmood argues that the analysis of subjectivity, and the meaning and sense of 'agency', 'subject', and 'individual autonomy' cannot be fixed in advance, but must emerge through an analysis of the particular concepts that help to understand specific modes of being in specific settings . For instance, agency cannot be necessarily understood only in those acts that resist norms, but also in various ways in which one inhabits norms, including the desire for submission to recognized authority (Ibid. 14-15). She wanted to attend to the different forms of personhood, knowledge, and experience elicited through understanding the specific logic of the discourse of piety that are articulated by practices which are supposed to constitute a particular discursive tradition.

She says in religious discourses, political and ideological differences between Muslims of various persuasions are expressed through arguments related not only to whether a practice is to be enacted or subverted but also on how it should be. Notably, each view posits a very different conceptualization of rites and ritual, pious self, bodily behaviour, ethics and morality, and generally the religious life of a Muslim. What sorts of ethical and political subjects presupposed by these two discourses, and what forms of ethico-political life do they enable or foreclose? She argues that these questions cannot be answered as long as we remain within the binary logic of doing and undoing of the norms (Ibid. 24).

Here, she goes away from the long tradition of feminist scholarship that treated norms as 'external' social imposition that 'constrain' the individual to Butler's view that social norms are the necessary ground within which the subject is realized and enacts her agency (Ibid. 19). Hence, she tries to conceive of individual freedom in a context where the distinction between the subject's own desires and socially prescribed performances cannot be easily presumed, and where submission to certain forms of authority is a condition for achieving the subject's potentiality.

Exploring the agency of women located in a historically contingent discursive tradition, Mahmood questions the distinction between the private and public in the realm of morality, ethics, and politics. She argues that the movement she studied questions the distinction between the realms of 'individual' and 'social' commonly found in the theories

of moral and political action. Understanding the relationship between the self and moral codes, structures of social authority, she goes beyond the anthropological theories of cultural construction for self-formation and the idea of homogeneous notion of self. Rather, she thinks of different configurations of personhood in the same cultural and historical space, each configuration as the product of a specific discursive formation, not the culture at large. For instance, she wants to think about different conceptions of self that operate within economic, legal, familial, and medical realms which is complexly intertwined and overlapping (Ibid. 120-121).

She says the focus of women who participate in the mosque movement on *ibabat* (worship) is itself a critique of the secularization and westernization of contemporary Egyptian society. Individual self-fashioning was at the heart of these women's practices. They see their action as an effort to cultivate their individual capacities to feel, think, and practice their religion within the interpretative Islamic tradition. These women spoke of their dress as part of improving their piety, patience and perseverance in the path of God which can fashion the self in the direction demanded by Islam as they understood it.

Mahmood's understanding of piety movement also comes in contrast with the anthropological definitions of ritual which presuppose the distinctions such as 'ritual' or 'pragmatic' action, 'conventional behaviour' or 'mundane action', 'conventional' or 'intentional' and the polarity between 'spontaneous' and 'theatricality' of emotion and action (Ibid. 126-131). Such views, in Mahmood's understanding, cannot explain those rituals and performances like the piety movement which are conventional, volitional, and intentional aimed at the formation of spontaneous expression, and the moral formation through rituals is intentional. She points to some aspects of rituals among Muslims which are conscious actions directed at making certain behaviours unconscious.

Mahmood's (2005) work helps us explore the specificities and the reasoning in its own terms if we want to understand the forms of ethical life and the subject they entail. She says:

> *All forms of politics require and assume a particular kind of subject that is produced through a range of disciplinary practices that are at the core of the regulative apparatus of any modern political arrangement* (Mahmood, 2005:33)

Mahmood's work has inspired many scholars throughout the world to approach the Muslim subject and practices in somewhat different perspective. Sociologist Erin Augis (2012) studies religiousness using ethnographic interviews of Muslim reformist women in Dakar, Senegal, a Muslim country in North Africa. She says the reformist Muslim women's discussions on religious practices expose the links between the 'institutionalised liturgies' and women's appropriation of them for their piety. Their own discourses at micro level also tell us about the debate within the Senegalese Islam which has to be linked to the economic liberalisation and the surge of global markets in Senegal. The subjective accounts of the women who belong to the reformist Islamic organizations revealed their political perspectives not as underlying motives for their religious actions but as a mutual relationship between their religious and ethical sentiments, and their criticisms of other Sufi Senegalese Muslim groups.

Muslims through Discourse

John R. Bowen (2012) sees these two approaches- Geertz's cultural emphasis, Asad's political one- not as irreconcilable opposites, but as an approach to Islamic traditions that takes seriously both religious thinking and social frameworks which generated new ways of understanding Islamic tradition (Bowen, 2012: 7). He says this new way entails taking Islam as a set of interpretative resources and practices which include texts, ideas, and methods. It assumes that all Muslims participate in a long-term and worldwide tradition. This new anthropology tries to make sense of how individuals grapple with those resources and shape their practices in meaningful ways through their own interpretation which is socially embedded. It focuses on intentions, understandings, and emotions related with specific practices with great attention to the individuals. Along with the analysis of 'inward', it also looks into the 'outward', means social significance of, and conditions for, these religious practices (Ibid. 3-4).

Thus, he says the different ways in which Muslims practice their religion have come to be 'diacritic indexicals' which can tell to which group or organization he or she belongs to. The choices about how to practice can signal certain positions about his idea of Islam (Ibid.54-56). These choices, also, have to do with both working on the self and engaging in social performance, in a way that makes the practices as key locus for debates about

piety and sociability. Thus, some of them engage in a social and moral critique of the ways in which other Muslims practice their religion (Ibid. 74-75).

Bowen uses this methodological framework to study the healing practices of *Gayo* Muslims in Indonesia which he calls as 'powerful words'. He understood the *Gayo* healing practices as 'highly discursive' in the everyday sense of the term. Even if they are not included in the scholarly definitions of the religion, discussions of their Islamic character are very much part of the *Gayo* villagers who depend on these practices for health and good crops (Bowen, 1993: 77-81). Practitioners of the spell believe that the power of spell comes from the holy texts and the intercession of Prophets. The spell is addressed to a spiritual agent under the expectation that the spiritual agent will be persuaded or coerced by the words.

Influenced by the discursive practices of 'speech events' on the Islamic character of these practices, *Gayo* Muslims began to make complex classifications between spell and request (addressed to spirit), recitation and prayer (addressed only to God) (Ibid. 82-83), and between 'religious' and 'magical' by the modernists. However, the *Gayo* men and women who employ spells perceive them as part of Islamic knowledge authenticated by extra scriptural sources whereas the spell which comes from harmful spirits such as devils is seen as 'black magic', opposed to the divine knowledge. Bowen explains the rigorous debate between 'modernist' and 'traditionalist' scholars over these issues. They argued on which uses are correct and which are not allowed in Islam (Ibid. 264-72).

Islamic Discourses on Health and Production of Muslim Self-hood

We get somewhat similar accounts of the articulations about the Islamic healing practices in Rasanayagam's work. Based on his study of the healing practices of Uzbek Muslims, Johan Rasanayagam (2006) observes that the movements which might be termed as modernist or revivalist which have challenged the rituals derived from the local tradition as 'non-Islamic' are at the forefront of the debates on the correct form of Islamic belief and practices in Uzbekistan. He says, through local practices, Muslims are trying to shape and reshape their Muslim self-hood and healing practices are one of those practices through which one seeks the correct form of Islam.

Nonetheless, thanks to the continual intervention of *ulema* in public religious life, a distinction between un-Islamic shamans and religious healers has always been maintained even if it has been historically blurred. Religious healers emphasize that they were working according to the religious knowledge (good healer) and they state that they were different from the incorrect form (bad healing). Some shamans claimed spirit healing as 'Islamic' and included some Islamic rituals while some healing *mullahs* used spirits for healing. Here, a distinction between '*un-Islamic*' shamans and '*Islamic*' religious healers was always maintained.

The scriptural interpretations hostile to the healers have become more influential and widespread in post-Soviet period through reformism and revivalism which necessitated healers and practitioners to review their practices. These are reflected in the healers' perceptions of their own actions and the patients' experiences, as they are tended to emphasize the sanctity of healing and its affiliation to god. All these historical developments in the religious discourse have brought forth a trend among practitioners and agents to place them inside the Islamic framework. Rasanayagam (2006) points out, through this authorization process at micro level, social groups have made their own interpretations to face others. This selection process has been no longer strategic and practical, rather authoritative in nature to cope with the notion of correct form of being a Muslim. Even if the post- Soviet discourses on the 'universal ideals' of Islam could not necessarily help the formation of Muslim self-hood in Uzbekistan and could not alter the religious life of majority Muslims, they are however reflected in the healing practices.

Ethical reasoning through Practice of Sermon Listening

Charles Hirsckind's work (2006) is another major contribution to the anthropology of Islam in the light of Asad's theoretical framework. He studied how the recorded cassette sermon or the practice of listening as an aural media could contribute to the revivalist Islamic movements in the Middle East. He says the cassette sermon is a popular Islamic media that has a deep influence in the formation of politics and religious community. It not only facilitates indoctrination but makes doctrinaire discourses a habit of its massive audience (Hirschkind, 2006: 2). He says the audition is a listening practice which is a complex part of ethical and political project and it gives expression to the religious sensibility that deserves to be engaged in the study of Muslim societies. Hirschkind

argues, from the early development of Islam, the sermon audition has been essential to the embodiment of practice with its ethical sensibilities and moral action. Rather than cognitional, this process is volitional dispositions which turn body toward moral conduct and 'right' actions (Ibid. 9). These kinds of practices define the discursive conditions of Muslim social life.

Hirschkind (2006) notes the sermon givers emphasize the importance of arousing the proper emotions in listeners, instruct them in Islamic beliefs, and link the narratives of the Quran to their everyday lives. He found Young Cairo men who listen to these sermons felt that listening practice brought tranquillity, humility, and regret, and emotions that should be seen as ethical responses to the sermons. He says the practice of listening to the speeches articulates a fierce critique in the form of public discourse or public reason as a normative ethical project which is based on the questions of pious conduct, social sensibility, and religious piety (Ibid.5). This has been called as 'soundscapes', that is, ways of configuring the social space through the use of Islamic media forms. According to him, these developments make us think of the inadequacies of the binaries such as moral/political, disciplinary/deliberative, emotion/reason that have shaped our normative understanding of public sphere. Here, the cassette sermons are infrastructural to the public reason like other agencies such as market, and formal institutes (Ibid: 9).

Sociology of Muslims in India

Given the theoretical frameworks we elaborated earlier are based on Muslim majority societies like the Middle East and Indonesia or South Asian Muslim countries like Pakistan or Bangladesh, and hence limited to understand the Indian realities, there is a need look into the major trends in the sociological study of Muslims in India, and the theoretical and empirical issues that are emerging. Foremost thing to be mentioned is, as Satish Saberwal observes, Muslims have been notably inconspicuous in the sociological understanding of India (Saberwal, 2010: 37).

As Nazreen Fazalbhoy (1997, 2005) reviews, one notable trend is that the studies on Muslim social structure and practice and the sociological study of Islam in India always move in the shadow of the concepts related with Hindu societies. Politicisation of Hindu-Muslim relations and their interactions impinge upon the theoretical frameworks on

Muslims in India. Thus, in terms of social structure, the focus has been on caste among Muslims, and with regard to religion, the concern has been on the rate of intermingling between Hindu and Muslim rituals[29]. Nevertheless, the theoretical and methodological debates on Islam among Indian sociologists also reflect the issues we raised earlier, notably the question of understanding the text, authority, and practice in Indian context.

For instance, Imtiaz Ahmad's works (1872, 1976, 1978, and 1981) on the topics of family, kinship, caste, religion, and modernization and change among Indian Muslims move in this direction. He argues even if Islam is an extremely reified religious tradition and its doctrines and practices are supposed to be universal, the day-to-day practices of Muslims are found varied from place to place. Therefore, he says, there is a considerable divergence between the 'formal' and the 'actual' religious beliefs and practices of Muslims.

Ahmad's work (1981) explored the nature of these 'actual' religious beliefs of Muslims in India, because, for him, Islamic belief in India has acquired an *indigenous* flavour. Citing the inability of religious scriptures to adapt these local varieties, he says, sociology should not be concerned with the theological and philosophical tenets but it has to look into the actual life of the people, taking Islam as 'practiced faith'. In other words, it is not the 'book view' but the 'field view' that has to be explored. He asks, the sociological and anthropological studies show the wide presence of folk-beliefs and syncretic elements in the rituals and practices among Muslims India, so, whether those folk beliefs and syncretic elements should be treated as a part and parcel of Islam in India? In the 'syncretic' framework he attunes, many of the Muslim practices associated with rites of passage, customs, beliefs, and social institutions were accounted for either as 'survivals' or as 'diffusion' from Hindu rituals.

Ahmad (1975) proposed that there are several levels which exist in the religious system of Muslims in India. One of them is the set of beliefs and practices traditionally described as belonging to the scriptural Islam derived from the texts. At the second level, there are beliefs and practices which are not derived from the texts and sometimes opposed to them but regarded by Muslims who hold them as part of their religious system. At the third level, there are beliefs and behaviour patterns described by sociologists and social anthropologists as pragmatic or practical religion which contains non-philosophical

[29]Fazalbhoy (1997) comments that syncretism always means impact of Hinduism on Islam, the majority culture on minority culture, not vice versa. There is hardly any sociological study which looks at the impact of Islam on Hinduism. Thus, it appears that the problem of syncretism is a problem of the minority religion.

elements, such as the supernatural theories of disease causation, propitiation of Muslim saints, spirit possession and evil eye. Since most of these elements are antithetical to other two levels, these are observed secretly.

Ahmad says the Islam introduced to India was quite different from its original heartland, diluted through the conversion with many pre-conversion beliefs and customs. So, the religious tradition in India should comprise of distinct elements, one is the ultimate 'formal' derived from Islamic texts and the other is 'local' validated by custom. Islam adopted the indigenous elements by inscribing Islamic content to them in which Sufism played a major role. Practiced Islam is more pluralist which cannot be given a unified definition of what is truly orthodox or 'true Islamic'. Each community carries its own definition of true Islam and they practice it.

There can be cited number of ethnographic studies in the Indian context following Ahmad's approach. For instance, Mattison Mines (1981), who studied the *Islamization* process among Tamil Muslims, finds them adopting a midway position between Tamil culture and Muslim values. They perform practices otherwise believed to be orthodox by them but actually they are local beliefs and practices like *urs*, saint worship, and *maulid-u-nabi*. In the same manner, Lina M Fruzzutti (1981) who studied the life cycle rituals among Bengali Muslims found them adhering simultaneously to the fundamental orthodox principles of Islam and to a Bengali culture (*deharachar*) without creating any contradictions between these two spheres like tying amulet (*maduli* in Bengali) to the new births. Some of the social scientists have studied Muslim rituals in India taking '*Hindu-Muslim syncretism*' as their main approach. For instance, Joy Burman (1996) takes saint veneration as an example for syncretism. He says the cultural roots in India are of re-conciliation rather than refutation, cooperation rather than confrontation. There have been 'ritual borrowing' between Hindus and Muslims which can be seen in many practices such as '*dhikr*' and the 'curing saints' facilitated by the Sufi tradition in India. Muslim *pirs* have adopted a medium of cultural communication by accepting the prevailing symbols which given birth to 'religious-secular-mythical blend', placing Islamic tradition in Hindu framework. The cultural roots, which are syncretic, are different in Eastern, Western, and Southern India according to its own historical particularities.

However, it was interesting to note the rare moment of dialogue between historians and sociologists of Islam in India over Robinson's (1983) critique of Ahmad and Gail Minault

and Veena Das's (1984) response to Robinson[30]. Taking up the question of text and context in Islamic tradition in the context of prevailing trends in Indian sociology, Veena Das (1984) says Imtiaz Ahmad's and his followers' 'tolerant' framework has overstressed the uniqueness of the syncretic elements. She says they have also overestimated the diversity in Indian Islam because these are found among every society Islam has spread even in its homelands. She also criticizes Francis Robinson (1983), the historian of Indian Islam who sought to emphasize the other end, namely the perfect standards of Islamic knowledge and *ulema* (scholars) ruling out the existence of various 'dubious' practices which will be swept away in the historical process of Islamisation. She says, though these two views seem divergent, both are similar because these two authors believe that the normative or orthodox Islam has a single pattern of perfection with an unchanging nature and Islamic knowledge as substance (Das, 1984).

On the contrary, she argues, the revealed normative texts are also subject to further canonization. The holy revelation also includes the *human* listener, thus, the constitution of Islamic knowledge is subject to the ongoing tradition of reinterpretation. She says, the social scientist has to address the problem in terms of the social conditions which bring about these variations in emphasis on the interpretation. For instance, in the case of customary practices of protection from evil, one has to look into the question of how people explain these and whether there is a difference in the way in which Hindus and Muslims view and practice them. She says:

> *We need many more studies on the manner in which the sacred text is integrated into a variety of religious beliefs and rituals and one hopes we can move from the atomistic approach of labelling items of belief and rituals in terms of received dichotomies-Islamic vs un-Islamic, elite vs folk Islam, great vs little traditional, orthodox vs heterodox.*
>
> *Let me suggest that between the contrasting dichotomy of elite and folk Islam, or theology and anthropology, we insert the mediating terms, folk theology and theological anthropology* (Das, 1984).

Thus, the folk theology of Islam would show how people live their everyday lives and the relationship of their lives to the texts.

[30]The exchange of ideas between these scholars appeared in the journal of 'Contributions to Indian Sociology' during 1983-86. For details, see Robinson (1983, 1986), Das (1984), and Minault (1984).

There can be cited number of ethnographic studies on Muslim societies in India which engage with the discussions we raised here. Deepak Mehta's work on Ansari Muslim handloom weavers in UP (1997) focuses on the Ansari conception of work and their claim to an Islamic heritage for whom means of livelihood was self-consciously a way of life. Thus, combining 'doing' with issues of being Muslim, he argues, Ansaris combine discourse and practice in their mode of work, ritual, and festive life. He says, "In their practice they are like Bourdieu's Algerian peasants[31], but in their discourse they are literate people who belong to a great discursive tradition" (Mehta, 1997: 2). It seems, he follows El-Zain (1977) and Das's (1984) framework when he argues that since Ansaris are low caste Muslims, generally illiterate in sacred affairs, they typify a 'folk' imagination of Islam, limited to a local context (Mehta, 1997: 178).

Summing up, the discussion above gives us the impression that the sociological and anthropological studies of Geertz, Asad, Woodward, Eickelman, El-Zein, Bowen, Mahmood, Hirschkind, and Akbar Ahmad are either based on Muslim countries like Middle East or Muslim majority countries like Indonesia and Morocco. Hence, they are limited in their scope in understanding the realities in India, which need different perspectives to address the nuances of Muslim subjects who live in a complete different political context. We want to emphasize the context of *India* because it looks different from that of the other Muslim majority countries of South Asia like Bangladesh and Pakistan. Magnus Mardsen (2013), Maimuna Haq (2013), and Humaira Iqtidar (2013) through their studies on different contexts in Pakistan and Bangladesh shows the various ways in which Islam is taken into the realms of state and public life where a complete distinction between Islam and state is not possible.

Muslims in the Middle East experience the state in different manner. In an essay addressing the impact of secularizing reform in modern Egypt, Asad has explored how modern, legal, moral, and political vocabularies created new spaces of (secular) actions. However, he says, they are also inflected by sensibilities and embodied aptitudes rooted in the tradition of Islam (Scott and Hirschkind, 2006: 10). Thus, he argues, secular should be approached not separating the religious and political authority. We also see the instances like modern Egyptian state becomes engaged with defining orthodoxy in Islam and the

[31]Bourdieu (1977) presents his theory of practice based on the fieldwork among *Kabyle* of Algeria wherein he thinks *Kabyle* Algerians are important in their way of doing things, not because they are Muslims (Mehta, 1997: 2).

Muslim government taking sides in theological quarrels in order to secure the religious legitimacy (cf. Zubaida 1992 and 2001; Anjum 2007).

If we turn to Indian sociological writings on Muslims, the works that deal with the question of how Islam as a tradition contains the question of power are not easy to find. Conflicts over the right to define the tradition, articulations of truth, authority and disciplining of religious subjects, and the way the power of tradition is linked up with the state power in Indian contexts seem to be important issues to be taken up.

As John Bowen's (1996) and Rasanayagam's (2006), clearly show, the authorization discourses and religious authority on the health behaviour work in the field very differently. Their works on the production of truth in the healing practices make it clear that the necessities of illness demands an alternative perspective which seems different from Mahmood's (2005) observations on cultivation of piety. It demands us to revisit the Mahmood's notions of ethicality and self-fashioning and her argument that the subjects in order to inhabit the given norms, desire to submit to the recognized authority. Her ideas of intentional, volitional, and conventional mode practices aimed at the formation of spontaneous expression of piety do not help here. Hence, what we see is health practices stand unique in the Islamic practices that demand a different perspective.

It is in this context that the study of health behaviour of Muslims in Kerala assumes significance. Health behaviour is poised between necessity, state health policy and services, medical science and of course, Islamic discourses. The relative influence and power of these institutions vis a vis the everyday character of health needs is the problematic of our study and it offers interesting insights into the relation between religion, state and subjectivity. Hence, the thesis tries to engage with the question of the formation of Muslim medical subjects in the context of Islamic authorization discourses and state's directives and mandates in order to produce the health behaviour it wants. The next chapter on the social history of Muslims in a particular context in Kerala would shed light on the specificity of the relations of power between religious authority and subjects in Indian context that we have raised.

Chapter 3

Between Religious Authority and State: Muslim Community in Social History of Thirurangadi

Introduction

The chapter gives the social history of the field, Thirurangadi; the history of the formation of the Muslim community in the area. We will focus on understanding the Muslim subjects in the background of their response towards the state and the state apparatuses like laws, institutions with specific attention to the response towards the colonial modernity, primarily the modern medicine. Later, we provide an in-depth analysis of the socio-economic and political contexts of the time and space that shaped the positions of religious authority and conditioned their acceptance among the community.

Investigating the role of religious authority in the formation of positions and practices, we give the historical account of the immigrant *Sufis* and *thangal* healers in Thirurangadi focusing on how the religious authority and their authenticating discourses were responded, received, and accepted by the religious subjects. The section attends to the question of Muslim engagement with two forms of authority, the state and religion. We also see how the concepts and practices of health among Muslims differed from the British state's ideas and guidelines in combating with the outbreak of cholera epidemic in Thirurangadi.

The fact we need to read along with these accounts is the transformation of medical practices among Muslims; from the mainstream Ayurvedic practitioners of *thangals* and *musliyars* to the contemporary mainstream allopathy and the 'controversial' Muslim healers. We also see how some specific concepts and practices related with illness and health became 'controversial' that led to the socio-religious reform movements and internal splits among Muslims and to the onset of religious organizations in the contemporary Islam.

Formation of an Early Islamic Community in Thirurangadi

In an attempt to understand how the individual Muslim religious community originated, developed in a particular region, many works have appeared giving different explanations about the growth and formation of Muslims as a religious community[32]. Here the region is Thirurangadi in Malabar which lies in the West coast of southern India, now the northern part of modern Kerala state and in the North Western part of Malappuram district. Common to all of these historical explanations is the 'peaceful' expansion of Islam through trade routes, expansion of community settlement, conversion, intermarriage, and migration. As Historian Stephen Dale (1990) has admitted that writing a comprehensive historical account of the evolution and formation of Muslims in Kerala is hardly possible. Their social history is sketchy until the mid-eighteenth century of British period (Gough, 1961).

Historically, Thirurangadi has been considered as one of the key spaces for the development of Muslim society in Kerala, as the centre of revolts and rebellions against state, moreover as the destination and centre of Sufis and missionary networks sailing across the Indian Ocean[33]. Malabar, with its wealthy reserves of spices and timber and as a strategic port in Indian Ocean, had well established trade networks with the Middle East, Near East, and the West. The Arabs, rooted in coastal Kerala as a commercial community acted as the source of this new cultural, social, and economic relation. Formation of an Islamic community in the West coast of the Indian subcontinent is explained as the result of this socio-cultural and ethnic blend as some of the historians called it as 'Arab-Islamic' community on the Southwest coast of India (Gangadharan, 2012:13, Lakshmi, 2012: XV, Dale 1990). Many of them intermarried with the local women, built their houses, and taught them their religion with the royal patronage of local kings like the Zamorines of Kozhikode. The travel accounts of Sulaiman, Ibnu Kurdad, Ibn-ul-Faqih, Idrisi, Yaqut, Ibnu Batuta, Mahuvan, and the European travellers like Marco Polo, and Duarte Barbosa,

[32] More often, Muslims in Kerala are addressed locally as '*mappilas'* and the name has been used in many of the administrative records like that of British. Many of the historical works also use the term to signify the Muslims of Kerala like M Gangadharan's 'Mappila Studies' (2012). Considering the nature our topic which focuses more on the sociology of religion, we want to use the term 'Muslims' and the term 'mappila' may appear while presenting the historical accounts.

[33]Scholars like Engseng Ho (2006) have worked extensively on *Hadhrami* sayyids, their transnational network, their religious voyages in Indian Ocean seas, expeditions in Malabar and the subsequent social formation of Muslims connected with them. Thirurangadi was one of their prime destinations due its closeness to the coastal regions and its vast Muslim settlement.

which are the only available sources on the early history of Muslim community talk about the presence of Muslim community in the coastal area (Hussain K, 1997: VII).

Monopoly of this Arab-Islamic community in the foreign trade continued until the European arrival in 16th century which redefined the economy and religiosity of the community. From 16th century onwards, most of the Muslim community started to migrate to the inlands from the ports and commercial hinterlands. Portuguese and then the British invasion of the ports and diminishing monopoly of Muslims in the trade made them abdicate and migrate to inlands as small merchants, traders and agricultural labours under Hindu property owners. Thirurangadi has been considered as one of the early Muslim settlement developed as the result of this kind of migration to the inlands and the conversion of lower caste Hindu peasants into Islam. Historians see the possibility of the Kadalundi river route facilitated the transportation of spices and cash crops from the hinterlands to the coasts of Parappanangadi, Kadalundi, and to the Calicut which was then an international trade centre (Ganesh, 2009: 143). As the traders, buyers, suppliers, merchants, cultivators, and workers settled along the banks of the river, *bazaars* and *angadis* (market centre) grew along the riverside. Thirurangadi was the largest *angadi* of the area which is considered as crucial in the Muslim history of Kerala from the beginning of British rule.

Thirurangadi has been under different political regimes, from *samuthiris* of Kozhikkode, the Mysore sultans, and in the early 19th century onto the hands of British government. When Kerala state was formed in 1956, Thirurangadi became part of the Kozhikode district, and later it was added when a new district of Malappuram was formed in 1969. After independence, the region is part of Thirurangadi assembly constituency and has been won by Indian Union Muslim League (IUML) for fifty years since its inception in assembly and parliament elections. It has been considered as one of the strongholds of Muslim League in Kerala. In its first election for the Madras assembly, Congress was surprised by its defeat to the comparatively new party of IUML. When it comes to the Panchayat election (it has been upgraded into municipality recently) some of the wards show peculiar choice as independent and CPI(M) backed candidates could also win in many LSGD (Local Self Government Department) elections which show the regional complexities and political dynamicity in different periods.

Immigration of *thangals*, Sufis, and Healers

Migration of Muslim missionaries from southern Arabian Peninsula to the ports situated on the Indian Ocean coasts and their settlement in the inlands like Thirurangadi is also considered to have contributed to the formation of an Islamic community here (Gangadharan, 2012: 15). Being the destination of Sufi missionaries in the Indian Ocean was one of the main reasons that made Thirurangadi historically vital in the political and religious map of Muslims in Malabar (Dale 1990). The region became popular in the 'spiritual map' of Muslims, especially for Sunni Muslims as it became the destination and centre of *baalawi sayyid* clan from Yemen in eighteenth century. Many *thanga*[34]*l* families in Kerala like *baalawis*, *jamalullails*, *shihabs*, *jifris*, *bafaqihs* trace their origin to the region called 'Tarim' at Hadarmout city in Yemen (cf. Ho, 2006).

Sayyid Hasan jifri of *Jifri* family who belonged to the *alawiyya* Sufi order came to Thirurangadi and settled in Mamburam on the northern bank of Kadalundi river. His nephew Sayyid Alawi arrived in Calicut in 1766 and was taken to Thirurangadi by his uncle. Sayyid Alawi, known later as Mamburam thangal and his son Fazal thangal made a crucial impact on the religio-political developments of Malabar during the colonial period as catalysts for mass conversion, religious leaders of anti-state agitations, and as miraculous healers (Lakshmi, 2012:7, Dale 1990). This family, known in the Kerala Muslim history as 'mamburam thangals', has been considered as sacred by the Muslims and rose into fame during the British period. They constructed a mosque in Thirurangadi with the support of locals and acted as intellectuals, healers, and the ideological leaders of the Muslims in Malabar.

As Engseng Ho opined, this centuries-old economic and cultural relation with the far regions is central to our understanding of the formation of Muslim community (Ho, 2014: 37). Arabi- Malayalam language was one of the products of this relation. For the least, it demands to reflect upon the oceanic perspective, going beyond the history of land in the case of Muslims in Thirurangadi. With these cosmopolitan features, some of the historians classified Muslims in Kerala as the typical 'Diaspora community'. Due to this reason, the

[34] Thangal' is an honorific local term widely used to denote the descendents of the Prophet Muhammad who migrated largely to the various regions in the west-coast India from the Arabian Peninsula. The term originated from the word 'thangal' which means 'you' with due respect. The descendents of the Prophet are generally addressed using the suffix '*sayyid'* means 'leader' linking them to prophet's status in the community. However, in Kerala thangal is the lexicon to address them.

cultural anthropologists like Engseg Ho have pointed to the limitations of anthropological methods that seem too insufficient to study a complex community like Muslims who cannot be placed inside the boundaries of a region and nation. He says anthropology is yet to produce the methodological devices to help delve deep into the understanding of the communities with no boundaries and to make sense of the cross-cultural realities there (Ho, 2014: 38).

International trade in the medieval period was a nexus of trading centres located at the Indian Ocean coast connecting India, China, and Islamic world of Middle East, Africa, Persia, and Southeast Asia (Dale 1990). Historians like Samir Amin called this as 'oriental' economic order or 'oriental world order' or as the Mediterraian system. It was a network of faith and trade creating a new 'world order' in 13th century. The *sufi* missionaries and Islamic scholars were part of these Arab and Persian tradesmen.

Some of them like *hadrami sayyids* claimed 'sacred genealogy' that connected them to the Prophet. Assimilated into the life of host society, the sacredness of *sayyids* (Prophet's lineage) gave to them special powers and status in religion and politics. Even now, it is common practice with all *thangals*, especially the healer *thangals* keeping the list of their ancestors that connect them to the Prophet. With the acceptance of their leadership, the *sayyids* were instrumental in the formation of Islamic society in inlands like Thirurangadi. The role of the sacred leadership along with their personal qualities is visible in the power dynamics of the anti-colonial struggles and the post-colonial political formation of Muslims in Kerala. Apart from the sacredness of their genealogy, their knowledge of the Arabic healing books and the healing skill, and moreover, the popular belief in their 'miraculous' healing powers is understood to have attracted the local Muslims to respect them and non-Muslims to convert into Islam.

Apart from the *thangals* of mamburam, whose shrine has been the most visited and consulted healing shrine of Kerala, *shihab thangals* of Panakkad are the best known *thangal* healers in the area known as '*panakkad thangals'*. The *thangals* of Panakkad are the descendents of *shihab sayyid* family migrated from Yemen to Kerala in 18th century. The first *Shihab thangal sayyid Ali Shihabuddeen* came and settled in Panakkad, also on the banks of Kadalundi River. Cultural roots of the region with the Arabs especially with the *hadramis* of Yemen can be identified by the predominance of the followers of *Shafi*

School of jurisprudence in the area. Many of the practices like *maulid* and *ratib* which has roots in the Yemeni Sufis can be seen wherever they travelled such as Malabar, Indonesia, Malaya, and Java. The seasonal rituals and rites of passage such as *maulid*, domestic healing rituals like *ratib* and recitation of *mala* practiced by Sunnis today are traced back to the Sufi orders who had migrated to Kerala from the middle east.

Muslim Response to the British State: Land, Economy, and Religious Authority

What kind of response the Muslims had towards the authority of state? What were the reasons behind those responses? Who defined the Muslim political response? How did their response to the British state influence their acceptance of the colonial modernity, particularly the Western medicine? To understand them, we need to delve deep into the changes brought about by different political systems in the economic life of the region.

Changes brought about during the military expeditions of Mysore Sultans in 19th century were related with land and tenant-land lord relations that affected their life. Evictions were blocked, property owners had to pay direct tax to the government excluding the intermediaries, and the cultivators got a stake in the land as long as they paid tax. The socio-economic reforms of Mysore Sultans were welcomed by the local Muslim tenants and the lower caste Hindus who were subjected to the social sanctions and economic exploitations before. Hyder Ali and Tipu Sultan were helped by the local Muslims to fight against the British. Mysore army built a fort at Thirurangadi, now known as Kottapparamba and had to engage with rigorous battles with the British troops on the banks of Kadalundi River. The participation of Thirurangadi Muslims in the Anglo-Mysore battles was the first instance of Muslim mobilization and collective action against the British. At last, during 1790-1792, British troops led by Col. Hartley defeated the Mysore army which included number of local Muslims and conquered the fort in Thirurangadi. Lose of Mysore meant the British conquest of Malabar and Thirurangadi went into the hands of British India (Ganesh, 2009: 152). Formally, the district of Malabar was taken over by British India following the Srirangapatanam treaty of 1792 between Mysore and British forces.

Transfer of power to the British was followed by the establishment of new political and legal system, the series of Acts and legal reforms which helped the exploitation and aggravated the condition of farmers. Landholders were treated as taxpaying landowners, their privileges repealed by the Mysore Sultans were restored, they were given proprietary rights over their land and the right to fix the rent and evict the tenants whenever they wanted. New land relations particularly in the paddy fields produced only forced labour and chronic exploitation of tenants.

Under the British regime, the region was reformulated into new administrative system and revenue divisions and new power centres were created like *adhikari* in order to collect tax and keep records of the land. Except a few Muslim *adhikharis*, majority of them were from higher caste landlord families; it hardly brought any change in the repressive legal system and economic exploitations. Customary legal system was replaced by the British Judicial system and a *katcheri* (registrar office) was established at Thirurangadi and a local court at Parappanangadi the next major town controlled by the head quarters in Calicut. Railway networks replaced the river routes to transport goods easily but not for the local exchange. Local trade and exchange declined and the agrarian labours were exploited due to the new economic policies and revenue system with excessive taxes introduced by the colonial state.

The settlement records show a small minority of upper caste families and a few Muslims owned sizeable portion of land while majority Muslims and other Hindus were either small landholders or labours. It shows the concentration of land holdings were in a few hands and the majority of Muslims and Hindus were at the bottom of economic system. It means the social conditions and miseries produced by the property owners and colonial state set the background for rebellious response from the tenants, majority of them were Muslims. Discriminatory attitude of British government towards Muslims in the official appointments, the injustice in the judicial proceedings, their prejudice about Muslims as pro-Mysore community, and the price hike in essential commodities made some of the Muslims and their *ulema* (religious scholars) anti-British.

In Thirurnagadi, where wetland cultivation was the major source of income for majority Muslims, most of them were tenants, agricultural labourers under Hindu higher caste *janmis*. In Thirurangadi and nearby areas, the major portion of land was under higher caste

nambudiries and *nayar janmis* and a few old Muslim *taravadus*. During my field work in the area, one of my informants pointed to the grand mosque in Venniyoor and its vast courtyard and said to me: *"the large portion of the land where this big mosque and its pallikkad (graveyard) is situated was donated by the higher caste landlord of kaprad illam"*. This was the situation, the land and paddy fields which were owned by the Hindu landlords are now transferred into the hands of Muslims in the area. The place called kaprad got its name from this land lord *tharavadu* name kaprad *illam* which once owned the major portion of land.

Religion and the Anti-State Rebellions

Chronic exploitation of labour and the frequent evictions made the landlord-tenant relations into continuous tensions and conflicts. The British rule which was instrumental in protecting the rights of landlords aggravated the situation and created antagonism between Hindu landlords and Muslim tenants. The continued social and economic oppression resulted in the social conflict and anti-British revolts. It was in this context that the Muslim peasant uprisings in nineteenth and early twentieth century are analysed by the historians (Lakshmi, 2012: xxiv, Panikkar, 1989). Here, Panikkar argues religiosity was a decisive influence in the uprisings, but not as an immediate cause, rather, as a mediating factor (Panikkar, 1989: 88).

Even if there are different explanations of the outbreaks like religious fanaticism, the agrarian discontent and uprising against the feudal classes, or as part of national freedom movement or revolutionary, one common factor accepted by the historians is the fact that religion of Islam and Islamic leaders had provided the philosophical basis for the anti-British, anti-landlord struggles. It was through books and treatises written by the *ulema* (scholars) that *jihad* (Islamic holy war) was declared against the British state and accredited the death in the struggle as *shaheed* (martyr in religious war).

The 'official' explanation of the British government given in the commission reports on revolts, and the official correspondence letters point to an effort on the part of the colonial government to see the religious 'extremism' as the sole instigator of the anti-British movements. This mono-causal approach is, no doubt, an administrative strategy of divide and rule policy with little reference to the economic crises. T. L Strange commission,

appointed by the British Government in 1852 to look into the causes and inspirations behind the revolts can be summarised as: Looking into the causes and inspirations, the Malabar revolts were simply the religious act to be *shaheed* (martyr), a desirable status the extremist Muslims aspired for. Their actions were validated by their religious authorities through Quran and Sunnah[35]. Strange commission report stated:

> *A feature that has been manifestly common to the whole of these affairs is that they have been, one and all, marked by the most decided fanaticism, and this, there can be no doubt, has furnished the true incentive for them. The Mappilas of the interior were always lawless, even in the time of Tippu, were steeped in ignorance, and were, on these accounts, more than ordinarily susceptible to the teaching of ambitious and fanatical priests using the recognized precepts of Koran as handles for the sanction to rise. The most perverted ideas on the doctrine of martyrdom, according to the Koran, universally prevail, and are fostered among the lower classes of Mappila. It is well known that the favourite text of the banished Arab priest or Thangal, in his Friday orations at the mosque in Thirurangadi, was 'it is no sin, but a merit, to kill a janmi who evicts* (Thurston, 1909: 476)

Many legislations were passed following the submission of the commission report such as the 'Mappila outrages Act' in 1854 that recognized the distinct ways in which the political behaviour of Muslims was understood. There were some reports which raised the local issues and poverty such as that of Malabar collector William Logan who was appointed in 1884, but it was rejected by the Government. The government was rooted in the *essentialisation* of religion while dealing with Muslims. Logan had substantiated in his report that the British land revenue policies and agrarian laws were the harbinger of the unrests and he suggested some policies government should enact to curb the anti-state revolts (Panicker, 1989: 126-127). Logan finds that, Mappila outrages were designed

> *To counteract the overwhelming influence, when backed by the British courts, of the janmis in the exercise of the novel powers of ouster, and of rent-raising conferred upon them. A janmi who, through the courts, evicted, whether fraudulently or otherwise, a substantial tenant, was deemed to have merited death, and it was considered a religious virtue, not a fault, to have killed such a man, and to have afterwards died in arms, fighting against the infidel government* (Thurston, 1909: 477-478)

Another district collector expressed himself as:

[35] Correspondence on Moplah Outrages, P:455, Gangadharan, 2012: 28

Perfectly satisfied that the Mappila outrages are agrarian. Fanaticism is merely an instrument, through which the terrorism of landed class aimed at (ibid)

We see here the ways in which the role of religion and religious authority in the response towards state conditioned by the factors other than religion primarily the economic life. The historical accounts also show the distinct modes of Muslim engagement with two agencies of power, namely the religion and state.

Between two forms of Power: Religious authority and State

A cursory look at the history of Muslims in Thirurangadi in the colonial period gives some crucial points to understand various sociological questions we raise here. It tells us the ways in which Muslims as a religious community engaged with the rules and guidelines of the colonial state, formation of religious authority, and their role in the political behaviour of the community. The rules and guidelines given by the religious leaders in the form of *fatwas* (religious opinion), books, treatises, and their Friday sermons influenced the community behaviour in a significant way. Apart from books and treatises, the British records refer to the direct activism of these Thirurangadi *sayyids*[36] in the armed battles against the state around Thirurangadi (Dale 1990).

Prominent among the *sayyids* was Kutubuzzaman Sayyid Alawi Thangal, popularly known as Mamburam thangal, in British records as 'Thirurangadi Thangal'. A close look at his life history would tell us the distinct ways in which religious authority was accepted and recognized by the community and how their religious doctrines were responded. Mamburam thangal's popularity was based on his unique *karamath* of healing skills with amulets and sacred threads. He is believed to have the ability to predict the future, find the lost objects, effectively pray for rain in the drought-hit areas, and read the minds of people around him (Panickar, 1989: 83).

Mamburam *thangal* built mosques and *othupallis* (religious seminaries) at several places in the region making Mamburam as the centre. Being the spiritual leader of the locals, he also arbitrated the civil cases. For the British, he was believed to have emerged as an alternate power centre and it was assumed the establishment of modern institutions such as

[36] *Sayyid* literally means the 'leader', widely used to refer the descendents of the Prophet Muhammad.

police stations, courts, laws and jails, and the taxation were challenging the customary powers and privileges of the *thangal* family. *Thangal* proclaimed a *fatwa* that killing an oppressing landlord is not a sin. He was framed for the allegation that fighters sought his benediction before going for rebellious activities and the responsibility was laid upon him. British officials also assumed some of the rituals conducted by *thangal* like *dhikr* and *ratib* could make the participators in a frenzy mood that may lead them to murder and to desire to be a martyr. The state of going out of consciousness was known among Muslims as '*halilakkam*' (disturbed state of mind). He was brought before the magistrate but the attempt to arrest him was given up fearing the public uproar (Ganesh, 2009: 177-184). Another reason for his acquittal was the blessing and providing amulet is not a crime which cannot be taken as evidence for the war against the state.

Being the spiritual leader of the region and a reputed healer with supernatural skills, the *thangals* also intervened in giving proper religious opinions (*fatwas*) in religious affairs and classifying the practices as Islamic and un-Islamic. They were also vigilant of the blind beliefs and un-Islamic practices that Muslims in the region were doing. When a new Sufi *sheikh* appeared in Kondotty, near Thirurangadi, Mamburam *Thangals* judged him as fake Sufi saint and his practices as heretic that belong to *shiesm* (opposite group of Sunni Islam) and thus un-Islamic (Moyin and Mahmood, 2009: 55). The Kondotti *thangal* could also wield the popularity due to the popular belief in his superhuman skills. Once, the mappilas could win a war against the Nayar army led by Paranambi. His disciples had claimed that the victory was due to the miraculous powers of Kondotti Thangal, as the superhuman work of his favourite *Jinn* who was under his control. This legend earned support and acceptance for him in the Kondotti region (Hussain, K, 1997: 229).

There were public debates between the *ulema* supporters of Kondotti *thangal* and those of Ponnani and Mamburam *thangals* where Ponnani faction won the debate and many returned to their former belief. Since Kondotti *thangal* and his practices were declared by the *ulema* as practices that amount to *shiesm* and heretic, social and religious boycott was declared against Kondotti *thangal* and his supporters. As per the boycott, they were not allowed to enter the mosques, it was not allowed to eat animals slaughtered by them, they will not get the inheritance of property of their Muslim relatives, they cannot lead the prayers, and the marital connections with them will be broken (Ibid. 26-262). We see the

religious sanctions entered into the civil affairs which are under the jurisdiction of the state. What makes us interested here is the fact that, to counter this social boycott declared by the religious authority of *ulema*, Kondotty faction approached the courts and the verdict was in favour of Kondotty and they were allowed by the courts to control their mosque (Ibid. 264). The incident tells the history of the existence of two forms of authority among Muslim community; one is religious and the other is the state and the conflict between the two that keep on changing over time conditioned by the socio-political contexts.

Religious Discourses on Political Position

Mamburam Thangal's work *Saiful batar alaman uvalil kuffar* (The sword against those who authorize infidels as rulers) was a jurisprudential work which discusses the political positions Muslims should take against the infidel colonizers. It gives the religious opinion on the British sympathisers among the Muslims in the light of Islamic doctrines. *Thangal* gives the judgement; those who submit his will to the sovereignty of British state and obey their rules wholeheartedly, is out of the fold of Islam, and there should not be any relation or pact between Muslims and infidel colonizers[37]. The *fatwa* also warns against Muslims abiding by the laws made by the British state and being contempt with them (Ibid. 282)[38].

His son Fazal Pookkoya Thangal also authored another book titled *Udathul Umara Val Hkkam li Ihanathil Kafarathi wa Abadathil Asnam* (requirements for leaders and rulers to prevent disbelievers and idolaters) and was exiled for his leadership in the anti-colonial struggles. On the recommendation of the regional administration, British government of Madras decided to deport Fazal Pookkoya thangal and his family from Malabar to Egypt in 1852. It is reported that more than 8000 people assembled in Mamburam shrine and Parappanangadi beach to pay adieus to their leader blessed with supernatural powers (Ganesh 2009: 186). The reasons the collector Connolly listed for his exile were numerous; the fighters visit him for permission and blessing; he did not prohibit them from unlawful activities; being the arbitrator of the local issues, he acts as the alternate power centre; even if there are legal authorities like *adhkari* and *thahsildar,* many in the area considered *thangal* as the real authority, and most of the revolts were erupted in

[37] *Saiful Batar*, translated by Moyin and Mahmood, 2009: 508-509

[38] The cotemporary literatures on Mamburam *thangal* and his son Fazal Pookkoya *Thangal* and their war literatures reiterate the fact that the books have to be read in their context, their interpretation of the necessity of *jihad* was applicable only to that point of time (for instance see Moyin and Mahmood, 2009: 302-303). The explanations point to the importance of time and space in reading the doctrines and religious discourses.

Thirurangadi and its nearby areas where the Mamburam thangals lived[39]. As revenge for exiling their *murshid* (guide), Malabar collector William Connolly was killed in collector's bungalow at Kozhikode 1855 by a group of his *murids* (disciples) because he was considered as the main conspirator behind thangal's exile (Moyin and Mahmood, 2009: 443-447; Gangadharan, 2012: 24)

The then Malabar collector Connolly admits this; he had written to the government that the ideological source of the revolts is Thirurangadi *Thangal* for his *fatwas* and Friday sermons and rebels were seeking blessing and permission from him before every battle. He says the anti-state revolts could have been avoided and the Muslims would not have spoiled their life in suicide had *thangal* given the fatwa and interpreted the revolts as undesirable. After his death, they were taking his blessing by visiting his *maqam* (graveyard). Another collector James tried to arrest Mamburam Thangal but failed fearing the public uproar, and he wrote to the government that Muslims in Malabar have been considering this *thangal* as 'holy man' and leader, any attempt to arrest him would invite large-scale revolts (Moyin and Mahmood, 2009: 341). Writing on the Muttichira encounter in which 9 Muslims were killed, collector H V Connolly mentions the attitude of the 'future martyrs' (those who were determined to be killed as martyr in the battle against land lord and British forces) as they consider it as the holy war against infidel British and they were proud to die as martyrs. He says government has limitations to deal with these kinds of situations and he suggests for different approach to seek help of the pro-British Muslim scholars.

However, along with the ideological tradition produced by the holy men we elaborated here, we need to look into how they and their ideas were accepted by the community if we are to understand the process of the formation of positions and practices. We see the outbreaks happened when the doctrinal interpretations of 'sacralising' the death and the validation of killing the exploiting landlords and state officials, given by the leaders who were authenticated by the community, got accepted by certain sections within the community. It was accepted mainly by the poor tenant peasants in southern Malabar regions such as Thirurangadi unlike the northern part which was living primarily on cash crops and plantations.

[39] Correspondence on Moplah Outrages, Vol. 1, p. 33-35 (Quoted in Moyin and Mahmood 2009).

The fighters who were attracted to martyrdom were influenced by the acceptance and sacralisation they get before and after their death by the major section of the society. War songs and hagiographical ballads were written about the major encounters in Thirurangadi like *Cheroor padappattu* and *Cheroor chintu* explaining the valour and holiness of the martyrs and the holy leadership of Mamburam thangal. The sympathisers of martyrs discussed about their valour and greatness in markets and Friday prayers and later, taken up by the song troops as folk songs. These songs and ballads in Arabi-Malayalam were sung in public and domestic rituals and its romantic and ideological tune was transmitted to generations to come. Thus, singing these songs publicly and their publication was banned by the colonial government.

As we said, the martyrs were considered as holy men and their burial places were treated as sacred and *maqam* was constructed on their graveyards visited by the ailing people for healing. British officials understood it as the 'canonisation' after death; a tomb erected over the graveyard and light burned there (Thurston, 1909: 464). According to the Sunni theological tradition, graveyards can be elevated and *maqam* can be constructed only over those of 'special' and important men and women, and it cannot be constructed on the graveyards of ordinary people. Sacralising ballads and songs, progression from the status of ordinary men into the sainthood in the popular memory, visiting their *maqam* attracted more Muslims into the battlefield against British. District officials had reported this and the government had banned visiting the graveyards of *cheroor* martyrs in Thirurangadi (Ibid. 357-358). It has been reported that Muslims used to visit their graveyards and take the grass and plants grown over there 'believing' them as medicine for illnesses. The *maulids* written on the *cheroor* martyrs were recited in many Muslim houses for healing and fulfilling the wishes (Ibid. 367-74)..

The next prominent religious scholar to lead the Thirurangadi Muslims in their resistance against the anti-agrarian stand of British Government and landlords was Ali Musliyar. Unlike Mamburam thangal who was born in a *sayyid* lineage, Ali Musliyar was an ordinary man who got the leadership for his religious scholarship. The *mahallu* committee of Thirurangadi appointed him as the *Mudarris* of the main mosque (the main teacher at Seminary) in 1907 (Ganesh, 2009: 196). Later he worked as the leader of *khilafat* movement cooperating with the non-cooperation movement and the congress party. He

was proclaimed as the *khalifa* of Thirurangadi and this symbolic *khilafat* existed for six months.

To suppress the forces behind the large-scale mobilization in the area, Thirurangadi mosque and its *mudarris* Ali musliyar and his followers were the targets. 200 armed soldiers marched from Parappanangadi railway station in the early hours of August 20, in 1920 and surrounded the Thirurangadi mosque and some Muslim households to arrest Ali Musliyar and his *khilafat* volunteers. Adhering to the rumour that the Thirurangadi mosque was demolished by the British troops, some groups of Muslims from different part of Thanur, Parappanagadi, Kottakkal Marched towards Thirurangadi to resist them. On the way, they were blocked and fired by the police and nine of them were killed. Those who assembled in front of the mosque waited throughout the day without any incident as per the Musliyar's orders and the talks were going on between *khilafat* leaders and the British officials. Suddenly with a provoking attack from the soldiers, a violence erupted on the outskirts of the mosque in which 20 of the rebelling crowd and three soldiers were killed (Gangadharan, 2012: 63).

After the incident at Thirurangadi mosque, rebellions broke out throughout south Malabar and Thirurangadi became the centre of armed resistance. Ali Musliyar declared Thirurangadi as the *khilafat* kingdom and himself as Emir, and Kunjalavi, his close aid and disciple was selected as his prime minister. In an encounter with the British one month later, Kunjalavi was killed and Ali musliyar along with his aides surrendered and was sentenced to death and executed for war against the country and the British Kingdom. Military marches, and raids for the rebels followed, and the women and children were made refugees. The post rebellion period was of anarchy, lawlessness when women were raped in the absence of men deported or arrested or killed, many houses were looted and plundered, and the pro-British landlords were targeted.

The vast majority of the participators in rebellions and later the *khilafat* movements were the tenant cultivators, and it was, following Panicker (1989), an armed rebellion against their *lord* and *state*. There was not any major outbreak of rebellion reported after the British suppression of 1921 and the conciliatory tenancy legislation of 1930 brought by the British government. It could hardly bring substantial change in the agrarian life but percentage of large land holdings declined among cultivators and small landholders

increased due to the redistribution of land according to the new Act (Ganesh 2009: 207). Another change was the increase in the share of *parambs* (garden lands) with multiple crops.

There were many who opposed the violent mode of *Khilafat* movements[40] like Muhammad Abdurahman Sahib who was the general secretary of All Kerala Khilafat Committee. He was of the opinion that the movement should be in tune with the ethos of *ahimsa* (non-violence) and the non-cooperation movement of Mahatma Gandhi and Indian National Congress (Ibid. 47). However, majority of the congress leaders in the area were from the upper caste Hindus and it could not attract the mass support of local Muslim tenants. Many *ulemas* rejected the existence of holy war against British and they considered it as un-Islamic action. For instance, Mammad Kutty Musliyar's pamphlet called *Mahaqq-al-Kalafa ala Ism al-khilafa* (rebellious destruction in the name of *Khilafat*) regards the *Khilafat* movement as against *sharia*. Some of the scholars like Kuttiyamu Musliyar raised another point; the futility of coalition with *mushriks* (polytheists) to fight against British who are part of *ahlu kitab* (the communities of Jews and Christians), so, the anti-British struggles seemed to them as un-Islamic (Saittu, 2016: 55).

We also find some of the second generation of family members of the martyrs were arguing in favour of the British and adopting their policies for community progress. Even Sayyid Abdullakkoya Thangal, the grandson of Mamburam thangal, the famous anti-colonial Muslim leader, was a staunch British supporter who started a magazine and published a book with British help to promote modern education and pro-British mindedness among Muslims in southern Malabar. The colonial administration had endorsed the pro-British scholars and *thangals* by allocating tax exemptions and awarding honorary titles like 'Khan Bahadur'.

Sanaullah Makti Thangal, later known as the Muslim reformist, had campaigned for English and Malayalam education among Muslims and endorsed the community to accept government job under British administration, and he was himself a government servant (Gangadharan, 2012: 37). He said learning Malayalam is religious obligation. He had also

[40] For a detailed understanding of *Khilafat* movement, see Minault. G. (1982). *The Khilafat Movement: Religious symbolism and Political Mobilization in India*. Delhi: Oxford University Press

campaigned throughout the revolting areas of southern Malabar inciting the futility of becoming martyr in the encounter with the British forces from the religious point of view. For him, revolts against government and suicidal fights would lead the community into disaster, and the belief about the worthiness of martyr was superstitious. Killing others and the desire to be killed by the force is a sin in Islam (Ibid. 41-43). However, even if they were *thangals* and *Musliyars*, these pro-British leaders could not attract the support of majority section of the Muslim community in Thirurangadi. Attending to the reasons may answer some of the questions that guide us.

Apart from *ulema*, some Muslim groups like the merchant groups of *koyas* of Kozhikode tried to establish modern schools, dispensaries, and clinics with the blessing of colonial administration. Koyas started *Himayathul Islam* School in 1908, and *Madrasathul Muhammadiyya* vocational high school in 1918 and donated land and money for the construction of dispensaries and clinics in the Muslim neighbourhood (Osella & Osella 2008). In a meeting conducted by the *Maunathul Islam Sabha* at Ponnni in 1908, the president condemned the wrongful interpretation of scriptures to justify the murders and opposition to the ruling power and he said that the loyalty to the sovereign was a religious duty. He reiterated the need to educate the *ulema* and the ignorant villagers not to preach rebellion anymore under the assumption that there would not be any martyr without the blessing of *ulema* (Thurston, 1909: 481-482). In addition, it was a mixed response from the community towards the British attempts to recruit Muslims into the army. Some of them recruited into the Madras infantry in 1896 and subsequently the 17th and 25th regiments of Madras infantry were converted into 'Mappila corps' and named the '77th and 78th Moplah Rifles'. British authorities considered them as the 'notable examples' of the policy of taming the 'pugnacious' race by making soldiers out of them (Ibid. 486-7)

There were also substantial number of supporters and activists from Muslims for the Nationalist movement and there was a home rule league established in Malabar in alliance with the congress (Salahudheen, 2007). The spirit of the movements was also in accordance with defending the Turkey *Khilafat*. Scholars like Kattilasseri Muhammad Musliyar worked along with congress leader M P Narayana Menon and propagated the message of '*tarke-muwalat'* (non-cooperation) by Abul Kalam Azad and the *fatwas* given by the *Khilafat* central committee leaders.

The underlying factor that is common to all British records and the historical accounts on the relation between Muslims of Thirurangadi and British Government is their religious background in their political behaviour. The religious institutions such as mosque, *dars*, graveyards of martyrs and saints were used to mobilize and unite them. As it is written by Hitchcock who was the superintend of police in southern Malabar and later as the superintend of Malabar Special Police, all Muslims in the region gathered at least once in a week for the Friday prayer where they could share their opinion and form a political position (Gangadharan, 2012, 43). We saw, it was through the weekly Friday sermons that the *Thangals* of Mamburam could address the Muslim masses to promulgate their positions and declare *fatwas*.

As we noted earlier, the formation of Muslim subjects has to be understood taking into account the religious discourses among them and the ways in which they got responded and accepted by the community which is complex on various lines. We also noted the process of response and acceptance was influenced by multiple factors. From the historical accounts we have given, we see the economic life of the community at that point of time and the context was the crucial binding factors of that response. The economic condition of Thirurangadi Muslims, majority of whom were peasants, was not still a favourable situation to influence their response in favour of British state. Hence, the pro-British *thangals* and scholars were not accepted and authenticated by the majority of the community as their leaders the way Mamburam thangal and his son Fazal thangal were accepted with their extraordinary healing skills.

Establishment of Modern Schools and Hospitals

The history of state welfare measures in the three political units later united to form the state of Kerala- the British Indian district of Malabar, and the princely states of Cochin and Travancore- shows significant contrast between the regions where Malabar with its specific political experience has always been lagging far behind. In Travancore, the modern welfare state took shape quite early in nineteenth century under colonial power. Welfare policies, especially in education and health, were implemented in Travancore and Cochin from the late nineteenth century which underwent dramatic expansion between the 1860s and early 1940s. Meanwhile, Malabar district of northern Kerala, as part of Madras presidency, remained much behind in education and health until after independence to

catch up with the other two regions (Devika, 2008: 18). The death rate in Malabar was double that of Travancore and Cochin in the mid- '50s with the outbreaks of different contagions like the cholera epidemic (Ibid: 20). Thus, we have to keep in mind that these regional variations in the public health machinery where state was variously 'present' have great impact upon the response of the contemporary Muslims in the region towards the state mandatory enactments on public health.

During the rebellions, the colonial administration tried to introduce schools to bring Muslims into the 'mainstream' and it was assumed the modern education would alleviate the anti-colonial mentality. A Muslim educational committee was formed in 1871 and many British sponsored programs were introduced to teach English and Malayalam to Muslims. Schools were started under Malabar District Board under the supervision of district collector, and Muslims were appointed as officials. However, majority Muslims were reluctant to the English education since it was colonial language and they were against Malayalam also because it was considered as the language of landlords and higher caste Hindus (Moyin and Mahmood, 2009: 455). Shamsuddin, the grandson of C H Muhammad who started a modern press in Thirurangadi for the first time, explained to me the reason behind the aversion towards English and Malayalam:

> How can the majority Muslims in Thirurangadi support the British language? Even the later generation had the grudge against anything related with the British who killed their fathers. They learned and purchased books in Arabi-Malayalam. However, the situation has completely changed now; most of our books are now published in Malayalam.

Recognizing the distinctive forms of authority among Muslims, the colonial government used pro-British *thangals* and scholars to spread the modern education. Mamburam thangal's grandson, Sayyid Abdullakkoya thangal was one of them, who encouraged modern education among Muslims and started a monthly named '*hidayathul ikhwan'* (righteous path of brothers) in this regard. Government supported him to publish his work '*al ilmu wal Islam*' (knowledge and Islam) in Malayalam and Arabi-Malayalam language to spread the need of education (Ibid. 456-457). We have to note here that these kinds of interpretations and discourses by one section of the religious authority even if they were *thangals*, could not get acceptance from the majority of the community. They could not win the support because their positions did not correspond to the prevailing existential

conditions of Muslims that defined the social response to the religious discourses produced by the scholars.

Schools were started in the years after the revolts. Basel Evangelical mission started a school in Parappanangadi. Some of the *othupallis* (religious learning centres) were converted into schools or a particular portion was used for classes. As the government sources and the oral testimonies of the early school teachers in the area point out, people were reluctant to send their children to the schools unlike the religious *othupallis* and sending girls to schools was unthinkable(Ganesh 2009: 222-223) . The learning meant the learning of religious education and the traditional craft or trade as livelihood means. Government also started 'special Mappila schools' only for Muslims according to the Muslim calendar with Muslim holidays and *ramadan* vacation. The British assumption that lack of education was one of the major reasons behind the Mappila revolts is considered to have led them to establish Mappila schools throughout the region. In 1904, the government had opened a Mappila Sanskrit School for the pupils of the Muslim physician families who were good Sanskrit scholars (Thurston, 1909: 480). Majority Muslims in Thirurangadi did not receive the formal education at all or only up to the primary level. This can be found from the formal educational level of the old generation of Thirurangadi.

Muslims and Medicine: *Thangals*, *Ustads*, *Vaidyars*, and Doctors

The antagonism towards the British state was also visible in their response towards the modern medicine and there were supporters too for the modern education and medicine. As we elaborated earlier, the religious authority and the believers were divided between the majority who opposed everything that was English and the minority who endorsed the Western education and modern institutions such as hospitals to attain the progress. What was seen as Western medicine was also the object of different positions. Even as the British organized the Public Health Department in 1925, the development of modern health facilities started only in the second half of 20th century. Kottakkal Aryavaidya Shala was established much before that, in 1900 (Ganesh, 2009: 225). Thus, Ayurveda was the most prevalent therapeutic method in the area before the modern medicine which became prominent under the state patronage as the official system by the colonial and post-independence governments in India.

Historians note the prevalence of *nattuvaidya* (folk medicine) practiced mainly by *mannans*, *velans* caste among Hindus and the Muslim *thangals*, and *musliyars*. Some of them, along with the *nattuvaidya*, also practiced the healing with *urukku* (amulet) and *mantram* (blowing with sacred words). There were some healing families known for their specialisation, who continue to practice in the area like *Jifri thangal* family of Kakkad, Panambuzha *thangals*, and Thalappara *thangals* etc. For instance, Parakkadavu *thangals* are visited for the problems related with the land, the construction of home, and house planning. The healers of *nattuvaidya*, generally from Hindus, were known as *vaidyars*. There is a place called '*Vaidyarangadi'* (town of *vaidyars*) near Kondotty, a few miles away from Thirurangadi, considered as the hub of *nattuvaidyars* (Ganesh, 2009: 224).

In this background, there were conflicts of ideas between the Muslim community and state about the causes and therapeutic methods especially in combating the epidemic diseases. The people of Thirurangadi still bear in their mind the gruesome picture of the catastrophic cholera epidemic in 1940s. Some of our old informants shared their memories of combating with the epidemic. The *mayyits* (dead bodies) were taken to mosque one after the another and people were fearful to touch and bury the inflicted and the dead bodies. Some of our Sunni informants like Mayamakka are firm in his belief that many calamities such as the drought and epidemic diseases were healed by carrying the flag blessed by the *jaram* of Mamburam Thangal. Thirurangadi *Yatheemkhana* (orphanage) was started in Thirurangadi in 1943 to give shelter to the orphans of those killed in rebellion and epidemic diseases. It has also been written in history works that the community had turned more to the supernatural methods for the treatment and protection from calamities. To save the locality from epidemics, they recited litanies and prayers and used talismans and amulets (Hussain K, 1997: 390). The records in the annual report of the Basel Medical Mission (1907) explain them in different perspective:

> *Cholera and small pox were raging terribly in the months of August and September. It is regrettable that people, during such epidemics, do not resort to the hospital medicine, but ascribe them to devil's scourge. Especially the ignorant and superstitious Mappilas believe that cholera is due to demoniac possession, and can only be cured by exorcism. An account of how this is done may be interesting. A Thangal (Mopla priest) is brought in procession, with much shouting and drumming, to the house to drive out the cholera evil. The Thangal enters the house, where three cholera patients are lying; two of these are already in collapsed*

condition. The wonder-working priest refuses to do anything with these advanced cases, as they seem to be hopeless.

The other patient, who is in the early stage of disease, is addressed as follows. 'Who are you?'-'I am the cholera evil'. 'Where do you come from?'-'from such and such place'. 'Will you clear out at once or not?'-'No I won't'. 'Why- 'because I want something to quench my thirst'. 'You want blood'-'yes'. Then the Thangal asks his followers and relatives to give him what he asks. A young bull is brought into the room and skilled on the spot, and the patient is made to drink the warm blood. Then the Thangal asks him to leave the place at once. The patient, weak and exhausted, gathers up all his strength, and runs out of the house, aided by a cane which is freely added to his back. He runs as far as he can and drops exhausted on the road. Then he is carried back, and, marvellous to say, he makes a good recovery (Thurston, 1909: 467-468).

He says Mappilas were very much superstitious; doing witchcraft, many *Thangals* pretend to cure diseases by writing selections from Koran on a plate with the ink or ashes mixed with water to the patient to swallow, they dispense scrolls for elassus, small flags inscribed with sacred verses to avert pestilence and misfortune. They believe and propitiate *jinns* that correspond to the demons among Hindus. Use of love philtres, and talismans was very common, and precautions against the evil eye were universal (Ibid. 489).

It is also pertinent to note here that the management of contagion was an important strategy of control developed by the European states in late nineteenth and early twentieth centuries especially on the colonial population. The preoccupation with the health conditions of the colonies, especially the control of epidemics became part of state actions such as the series of legislative actions enacted by the European states namely, the Compulsory Vaccinations Acts, Lunancy Acts, and the various forms of Contagious Diseases Acts. In the case of colonies, the public debates constructed the inhabitants of the colonies as credulous, unhygienic, irrational, and thus, in need of discipline (Das and Poole, 2004: 26).

Historical accounts also show the beliefs and practices called as 'occult' among the Muslim community and the history of long existing confusions and controversies regarding them. Though there are similarities and links between the beliefs and practices of this kind among different communities, among Muslims, we see a process called *islamization* of the healing practices in the form of language and symbols. The healing

texts prevalent those times were written in Arabi-Malayalam which introduced the concepts and methods of healing in a new language having visible similarities with the already existing systems of belief. It was a two way process: translation of Arabic healing texts into Malayalam and appropriation of regional concepts and beliefs into an Islamic form, in Arabic language. Arabi-Malayalam, the vernacular language of Muslim community in Kerala before the Malayalam, facilitated it. The healing texts introduced the Arabic healing works and gave their correspondent terms in Malayalam adding the Islamic content. For instance, the Sunni publishing houses still sell the translations of Arabic healing books such as *Shamsul-maarif-ul-Kubra* (sun of Great knowledges), and *Manba-usoolil-Hikam* (source of the roots of wisdom) authored by the north African occultist Imam Buni. At the same time, the books written by local scholars use the Arabic names such as for zodiac signs and planets like *shams* for sun. The local healing tradition among Muslims also contain the names such as *karinkunnan*, *chekkutty*, *karinkutti*, the local terms to denote the local devils.

Before the prevalence of modern medicine, many healing books were written in Arabic and Arabi-Malayalam which deal with different therapeutic methods, Ayurveda, *Nattuvaidya* (folk medicine), *Pravachaka vaidyam* (prophetic healing), and the occult practices. Most of the writers were religious scholars too. Konganam Veettil Bava Musliyar's book '*Mughanimul Ikhvan fil tarajimil adwiyathi wal hayawan'* written in 1891 contains the human and veterinary medicines. He also wrote a book on Ayurveda titled '*Vaidyasaram'*. Another book *shafa shifa-visha chikilsa* deals with the healing of affected with venom. Parappil Muhammad Musliyar's *Thibbunnabawi* is about the Prophetic healing tradition whereas Pattalath Mahin Kutty Vaidyar's *Vaidya Jnanam* was taken from *Ashtanga Hridaya*. Paloli Abdulla Musliyar's *Ilajul-Atfal-shishu chikilsa* is about the therapeutic methods for infants. M K Kunjippokkar's *Vasoori chikilsa Keerthanam* talks about the healing of smallpox and Puthiya Valappil Kunjhammad Musliyar wrote the largest volume *Tibbul Amarad* which includes 1111 methods of treatment, and his *Unani Vaidya Murakal* is about the Unani modes of healing (Moyinkutty, 2016: 95-96).

Arabi-Malayalam works written on healing with names (*ismu*) were *Upkara saram* (beneficial meaning), *Upkara tharjuma* (beneficial translation), *Paropakaram* (mutual

benefit), and *Pala ulsaram* (various inner meanings) written by Konganam Veettil Ahmad Bava Musliyar in 1892. He claimed they were written compiling sixty Arabic books. The books contain the warning that use of these methods is prohibited in religion, and they are written only for the purpose of 'study', not to believe or to practice them (Hussain K, 1997: 230-240). It means the healing books were written and they were practiced with a belief in the classificatory scheme inherent to them as *ruqya* (good practice), *shaitani* art or *sihr* (sorcery).

As Seema Alavi (2007) talked about the *Islamization* of unani in the north Indian context, we see here the '*Islamization'* of ayurveda by the Muslim *vaidyars*, the *thangals* and *musliyars*. It means, the *musliyars* and *thangals* who were *vaidyars* also added some Islamic elements such as amulets and *mantram* in their healing practice along with the ayurvedic medicines. Some of them retain their tradition in the ayurveda in the name of '*paramparya vaidya'* (traditional medicine) and the remaining *thangals* and *ustads* have now become only the 'religious' healers leaving the major share of health care to the 'doctors'.

Mamburam Shrine: Emergence of an Invisible Healer

The shrines known among Muslims in Kerala as *maqam* also occupy significant place in the medical history of Muslims. The Mamburam *maqam* in Thirurangadi is the most visited shrine in Kerala and one of main centres of pilgrimage in south India for comfort, wellbeing, and healing of various illnesses, ranging from physical, mental, and other problems. What concerns us here is the question of why this particular *maqam* attracts a large number of care-seekers in Kerala. Such an enquiry will tell us the history of specific ways of authentication and authorization process in a local context that took organizational form in the wake of the emergence of various religious denominations in twentieth century.

Local historical accounts show that Muslims and Hindus visited the tomb of Sayyid Hasan jifri, (Mamburam thangal's uncle, and his father in law) during the thangal's own lifetime. Sayyid Alawi thangal extended it to a *maqam* and 11 members of the Mamburam Sayyid family were buried over there including his wives, cousins, and grandchildren including the pro-British Abdullakkoya thangal. It was after Sayyid Alawi thangal, known

as Mamburam Thangal, the only one *Kutubuzzaman* (axis of age) in Kerala, passed away in 1844 and buried in the same place, the *maqam* rose into fame and began to be known as Mamburam *Maqam*, the most visited Muslim shrine in Kerala. Due to his exemplary status in the Sufi-Sunni world, his graveyard was elevated as the highest of all other graveyards of *Jifri* family members even if they were also thangals. His knowledge and special skills, along with his religious opinions were widely accepted in the authentication process of the community that responded well to the socio-political conditions of the time. As we will see the detail in next chapter, the experiences of efficacy and result of the healing from the *maqam* helped this authentication process.

What makes Mamburam *maqam* unique among the healing shrines in Kerala is because Mamburam *thangal* has been considered as the *Kutubuzzaman* (the axis of the age) which is the apex position in the hierarchy of all *auliyas* (Sufi saints) of the world. According to the belief among sufis, there will be only one *Kutubuzzaman* at one point of time and Mamburam Thangal was the *Kutubuzzaman* of his age. The one who possess this highest position in the Sufi world is believed to have extraordinary superhuman qualities (*karamath*) such as the healing of any illness and solving such calamities as drought or epidemic diseases. He was the *sheikh* (teacher) and *mushid* (guide) in the *qadiriyya* Sufi order and many of the martyrs in the battles against the landlords and the British were his *murids* (disciples) in the *qadiriyya* order[41]. It is believed that his distinct holy skills persist even after his death; the increasing throng of devotees at his *maqam* (graveyard) everyday is the manifestation of the belief in his invisible presence still today.

There exist many legends about the incidents of his *karamath* widespread in the area transmitted through the memories of the local people or written in the *maulids* and *ratibs* (hagiographical ballads) on Mamburam thangal and the devotional songs of *malas* about the holy wars he declared. They say, once, a Hindu devotee of Thangal prayed to him from his home which is far away from Mamburam when he was suffering from an acute illness. Thangal responded to this call surprisingly, even if nobody had informed him, and sent to him a banana; he got relieved of his illness after having the banana sent by thangal. British official Edgar Thurston writes, Loftus- Tottenham informed him that,

[41] For an interesting anthropological account of the Sufi saints of the *tariqath* (Sufi order) in the war frontier against the empire, see E. E. Evans Pritchard's (1949) *The Sanusi of Cyrenaica*.

> *It was quite common now for Mappilas to invoke Mambram thangal when in difficulties. I have heard a little Mappila, who was freighted at my appearance, and ran away across a field, calling out "Mambram Thangal, Mambram Thangal" (Thurston, 1909: 463)*

The residents of Thirurangadi share the beliefs and stories about the *karamath* (miracles) of Mamburam thangals, many of them are related with his healing powers. It is believed that some of the old mosques in the area like muttichira *palli* and kodinji *palli* have the aura of the thangal's spiritual power. Once, *thangal* could successfully heal a major illness of a landlord in Kodinji, and in return, the landlord donated some portion of land where the kondinji *palli* was built.

Local beliefs hold that the beneficiaries of the healing powers were both Hindus and Muslims. In popular memory, a story narrates how Thangal offered an amulet to a Hindu family near his home that was traditionally engaged in construction work. The family preserved the amulet as it was regarded as the sacred source of their flourishing wealth and joy. But when the amulet was lost, the family lost their prosperity. It is also believed that several *vaidyars* got *kaipunyam* (efficacy of hand) on the receiving the blessing of *thangal*. His standing as religious leader continues to linger in the popular legends.

The Muslim printing press and the emergence of Devotional and Reformist Literature

Social scientists have been keenly interested in the impact of printing press on the religious authority of Islam. Robinson (1993) says the printing of texts and translation in vernacular languages caused a diminishing of the authority of *ulema* as the interpreters of Islam and their monopoly in the transmission of religious knowledge. The text replaced the author who was significant in the knowledge practices of Islam in the past. He says the first development under the impact of print was the emergence of the concept of 'new way of being Muslim', called 'Islamic Protestantism' through the transmission of scriptural knowledge. Print was central in broadcasting this knowledge and in the successful working of their school system. He says printing of books became the main forum in which the religious debate was conducted and it resulted in the rapid florescence of sectarianism (Robinson 1993). As Neil Green (2013) observed, the print had various

potential in the history of Islam, homogenizing, proselytizing, entering the domestic space for the large unseen readers (Green, 2013: 84). In the case of Sufi practices, it was a change from the more closed sphere of manuscript and oral instruction to the open access of devotional literatures.

The history of Thirurangadi however presents a different picture where the print increased the publication of reformist books and the devotional literature. By the beginning of 20th century, there were significant changes in Thirurangadi and one crucial development was the establishment of Muslim printing presses. The first of its kind in the name *Madharul Muhimmat* was started by Karakkal Saidali of Thalassery, from northern Malabar eying the demand for Arabi-Malayalam publications of devotional works in the region. Following the printing of *Cheroor chinth* which was a famous battle song on the Muslim-British encounter in Thirurangadi, the press was sealed and the manuscripts were seized on the charge of anti-government activities (Moyinkutty, 2016: 88). Presses were also attacked by the rebels on allegation of Pro-British stand and was reinstated by the support of British. It published textbooks for the religious learners in the mosque (*dars*). *Misbahu-uloom* press published *nafisath mala*, the healing litany primarily recited by the women during the delivery. Thirurangadi Press was another of its kind established later in 1992.

Chalilakath Kunjahammad Haji started a press in Thirurangadi and it continues in the name of 'C.H Muhammad and Sons Press'. It has published many traditional Mappila literary works in Arabi-Malayalam language and later, literature in Malayalam language also came to be published. A new literature culture was beginning to emerge among the Muslims of Southern Malabar and Thirurangadi was its capital. Printing of prayer manuals, litanies, and songs at cheap price popularised them and they became available in every household. As we will see, the `printing press was instrumental in accentuating the reformist tendencies as well as the reactionaries, fuelling a full blown public discourse.

Religious Reform Movements in Thirurangadi and New Discourses

Reformism is considered as a heuristic category that subsumes a multitude of movements, agenda, ideologies emerged in Islamic world over a long period of time (Ingram, 2009).The genealogy of the religious reform movements among the Muslims in Kerala and the biographies of their leaders is referred to as the 'Kerala Muslim *navothanam'*

(Kerala Muslim renaissance). The renaissance is considered as the move away from the 'blind beliefs' and 'darkness' of old pagan practices to hospitals, acceptance of triumphant 'rational' medicine, and the 'true' Islamic ritual which is supposed to be 'the light'. Most of the practices labelled as 'superstitious' by the reformists in some way or the other, are linked to health practices. However, it is to be noted the terms 'renaissance' and 'progress' have been appropriated and acclaimed by all Muslim religious groups in contemporary Kerala that make the term a contested category.

It was from 1920 onwards, that an organization of Islamic scholars called 'Kerala Muslim Aikya Sangham' (Kerala Muslim United Association) was formed, and Muslims' religious life began to be defined by organized bodies and the domain of *ulema* was relegated to the religious organizations. This is a critical development, namely the shift of power from Islamic religious institution to the emergent organizations led by scholars. *Aikya Sangham*, first of its kind, campaigned for modern education and representation in government services. Some of its member scholars who were attracted by the socio-religious reformist ideologies from Egypt and Saudi Arabia rallied against what they considered as '*anthavishwasam'* (blind beliefs) and '*anacharam'* (bad practices). Along with religious speeches, conferences, and writings against what they regarded as un-Islamic practices, they also established schools and colleges for the progress in Muslim education. The reformist ulemas' campaign for modern education, primarily the colonial scientific education which got their momentum during 1920s in an organized form, were seen by the 'non-reformist' *ulema* and their followers with suspicion, as loyalty to the British, and thus anti-Islam.

The traditional *ulema* also started moving into the new organizational mode. To counter the reformist campaigns against the traditional practices prevailing among Kerala Muslims, a new *ulema* organization came into being in their first meeting in 1926 in Kozhikode named *Samastha Kerala Jamiathul Ulema*. The controversial practices that divided the Muslim scholars into two blocs of organized religiosity' were mostly related to health and illness such as, *dargah* visits, recitation of *malas* and *maulids* for well being, and use of amulets and *mantrams*, calling saints and Jinns for help and the like.

The 'reformist' history of Thirurangadi region is connected with the name of K M Maulavi, one of the founding leaders of Mujahid organization in north Kerala. On exile

from Thirurangadi, fearing the arrest by the British Police, he was attracted to the reformism in Islam (Gangadharan, 2012). Vakkam Abdul Qadar Maulavi, a famous reformist scholar from South Kerala who was greatly influenced by the religious ideology spearheaded by *Al-Manar* magazine published by the Egyptian reformist thinkers, changed K M Maulavi's religious thought during his exile years. Following the acquittal policy of the new Madras government, he returned to his home Thirurangadi in 1933 and started his new organizational activities. Known as a 'reformist' scholar, the Sunni *ulema* and the public were reluctant to cooperate with him initially. But he was supported by some patrons like Chalilakath family and M K Haji who was then running a hotel in Madras (Abdul Kareem, 2005: 144-145). Later on, M K Haji became a known household name in the reformist history of Thirurangadi, and a private hospital called 'M K Haji Memorial Hospital' (known as MKH) was established.

K M Maulavi was known as '*al-katib'* which means 'the writer' and a press, named 'katib press' was started in his name in Thirurangadi from where many 'reformist' literature were getting published. With his backing, a new madrasa 'Noorul Islam Madrasa' was opened in Thirurangadi in 1939 that taught the Salafi version of Islam. Following the mass death in the cholera outbreak, an orphanage was started in 1943 known as 'Thirurangadi *Yatheemkhana'* (Thirurangadi Orphanage) to look after the orphans whose parents were dead of cholera (Ibid. 110, 145). Later on, many institutes were started under this *Yatheemkhana* such as 'Seethi Sahib Memorial Training School', 'Pokkar Sahib Memorial Orphanage College' (PSMO College, Thirurangadi), 'K M Maulavi Memorial Arabic College', and 'M K Haji Memorial Hospital' (MKH) (Ibid. 146). The grand Mujahid mosque in Thirurangadi is now known as 'Katib Masjid' in the name of K.M Maulavi, the late Mujahid leader of Thirurangadi.

The socio-religious reform movements among Muslims have been examined in different dimensions like the religious discourses, the social composition of the followers, the impact upon the existing practices, and the novel ways in which a Muslim subjectivity was emerging[42]. The explanation on the reformism in Kerala are however presented as a theoretical binary between 'tradition' and 'modernity'. The social composition and support

[42] Mahmood's (2005) work is on the ways in which Muslim female subjects enact the ethical sensibilities the reformist discourses produce, see Bowen (2006) for Muslims through discourse in Indonesia, Osella and Osella have edited volume on the different themes regarding Islamic reformism in South Asia.

base of the reformist organizations lead scholars like Osella & Osella (2008, 2009), Samad (1998), Miller (1976) to conclude that the aspiration for modernization and progress was found especially among the modern educated, property owning, elite middle and upper strata Muslims. By aligning with the reformist *ulema,* they were seen as distancing themselves from what they understood as 'traditional' in social, economic, and religious life. They were found to be striving for a 'modernized morality', technocratic qualifications, and civilized way of life. Modern education was used as coterminous with reform.

Perhaps because of their research among the Muslim entrepreneurs or middle class, Osellas (2009) tend to associate everything about Kerala Muslim reformism with Western capitalism, individualism, hyper-consumerism, and what they called the cultivation of 'systematic dispositions'. They also locate Islamic reformism against the background of reformist tendencies among many other religious communities of Kerala like Nayars and *Ezhava* backward communities. While acknowledging the reformists' link with the Arab world in the Gulf countries, they argue that reformism was produced locally as well, within its given geographical, historical, political, and social context. Like Christians and Hindus, reformism is seen as self consciously 'modern', backed by 'middle class', promoting education while orthodox traditionalists as 'backward', 'superstitious', doing 'un-modern' practices, located in the rural low-status groups.

Nevertheless, there is a problem here. Even when they recognize different strands within reformism, they seemed to have missed another aspect, namely the peculiarity and uniqueness of the discourses that make the reformism among the Muslims somewhat different. *Salafis* in Kerala, for instance KNM, who follow the strand of Gulf *salafism*, do not necessarily address the demands of Western modernity, rather, their practices and discourses of reform respond to the local conditions. We argue, the primary concern is formulations and re-organization of practices according to the 'true' model demanded by the religious texts.

Indian National Congress and Muslim League

Analyzing the formation of political parties and the political choices of Muslims in the area would tell us more about the complex ways in which religion is connected with the

political domain such as state. It has to be explained why Indian National Congress and Communist parties could not mobilize the Muslim majority even though the region is known for its agrarian conflicts and the rebellions against landlords and the state in the past.

Indian Union Muslim League (IUML) which was formed in north India in 1906 began its activities in Kerala from 1937 onwards and was reorganized after the independence and partition (Gangadharan, 2012: 114). A Muslim League Committee was formed in Thirurangadi at the same time the first state committee was formed in 1935 under the leadership of reformist scholar K M Maulavi (Abdul Kareem, 2005: 107). The Muslims in Malabar were politically divided on the question of Pakistan formation and the idea of a new country in the name of their religion. Congress leaders in the region like Abdurahman Sahib had opposed the IUML resolution for Pakistan (Gangadharan, 2012: 45).

Muslim League was formed in the circumstances of the popular discontent with ambivalent attitude of the Congress, to the anti-British revolts and the post-revolt rehabilitation activities. The formation IUML which is popularly known as 'Muslim League' was carried out by Muslim elites in Malabar who successfully utilized the Muslim alienation from the Congress (Ganesh, 2009: 236). The party has been identified with the Muslim identity politics or minority politics and came to be considered as the most influential political party among the Muslims in the area ever after it fetched a surprising victory over the Indian National Congress. In the 1934 election to the Central Legislative Council, prominent Congress leader Muhammad Abdurahman Sahib lost to IUML' s Abdul Sathar Seth for 322 votes. Muslim elite in the political leadership is a clear shift from the direct intervention of *ulema* in the Muslim politics that had been the character of the region. Now onwards, the *ulema* adopted the new role of organizing the Kerala Muslims on religious matters, particularly the religious education.

Nevertheless, the contemporary Muslim politics has been inherently interlinked with the grouping of religious organizations. Even though any religious organizations except Jamaate-Islami[43] does not actively participate in politics, all of them work as the pressure

[43] Jamaat-i-Islami which introduces itself as the organization that intervenes in religious and political affairs of Muslims, largely posits the political change as their main objective, cf. (Ahmad, Irfan 2013, Shehabuddin 2013, Iqtidar 2013, Haq 2008).

groups in gaining their objectives. The official Sunni organization known as *Samastha* (Samastha Kerala Jamiathul Ulema) which has the largest support base among Muslims in Kerala and all Mujahid groups (including the Official group of KNM and the splinter group of Wisdom) have been supporting IUML since their foundation. Bringing these two major Muslim organizations into its fold amidst their theological differences has been the winning formula of IUML which has been the major constituent in many of the ruling coalitions in Kerala with at least four ministers and around 20 MLAs. The splinter Sunni group known as 'AP Sunnis' have been supporting the CPI(M) led left coalition alleging that they cannot cooperate with IUML which has many Mujahid leaders. Thus, we can see the religious organizations work as the pressure groups of the major political parties in Kerala to deal with the affairs of the state such as getting the control of Wakaf Board, the Hajj committee, or getting the state approval for the educational institutions and hospitals. It is a major shift in the position of *ulema* towards state and its institutions, from the active anti-state stands in colonial period to the beneficiaries of the state in the contemporary times. Therefore, we argue, the dynamic aspects of the socio-political, and primarily, the economic conditions shape the religious authority and the authorization process. The specific ways in which such authorization process operates in the field through an interaction between the authority and subjects will be dealt extensively in the last chapter.

In this chapter, we presented the socio-historical processes that shaped the Muslim community life, political agency, and the religious authority over the past two centuries. Against this background, we will locate the health behaviour of the Muslims in one *mahallu* in Thirurangadi and examine how far the religious organizations influence the health seeking by Muslims. Accordingly, the next chapter looks into the concepts and ideas about disease, health, and well-being among the Muslims in the *mahallu* and also describes the remedial practices observed by them.

Chapter 4

Concepts and Practices of Health in a Muslim Neighbourhood

Introduction

This chapter focuses on the concepts and practices of health among the Muslims in Chullippara *mahallu* and the complex ways in which religion shapes their health behaviour. We get into understanding of the concept of illness and the classification of the coping strategies, selection of remedies for illnesses, and their terminology to denote the illnesses and its symptoms. We attend to the advent of medicalisation of religious rites of passage connected to the body, namely, male circumcision and childbirth. We will also try to see the specific ways in which the concept of hygiene is understood and practiced by Muslims through the religious concept of *adab.* Apart from interviewing the professional healers, we also enquired about home remedies practiced inside the household and about domestic rituals, which bore both religious and the locally embedded concepts and principles of health. A look at the history of the emergence of such practices will show us the genealogy of discourse and practice inherent to the domain of health.

The chapter also engages with the question of how the residents of the *mahallu* who affiliate to different religious organizations with different ideological positions hold on to distinct concepts and beliefs on illness and health. We will show the conflicting views and beliefs about invisible beings such as the *Jinn* and its contact with the human world. In addition, there are conflicts between multiple notions about the sources of religious

knowledge. The problem has also been discussed in a section on the main categories of Muslim healers namely the *thangals*, *ustads* (male healers) and *beevis* (the female healers), and their healing system, and sources of their skill and knowledge. Our objective is to address the question of how the healers and their practices are accepted and recognized by the Muslim community and how they are classified into 'good' and 'bad', and 'effective' and 'non-effective' healers. We also look at the legal provisions enacted by the state that certify 'legitimate' Muslim healers. We will see how the concepts of efficacy, validity, and credibility are experienced and explained by Muslims, and how the religious discourses that are changing over time shape these health related ideas.

The chapter includes the ethnographic accounts of Mamburam *Maqam* (shrine) in Thirurangadi and its role in the health behaviour of Muslims in the neighbourhood. This section tells us the details about the 'invisible healers' in the tombs, the visitors and their illnesses, the solutions given from the shrine, and how the shrine adapts to the emerging diseases in the area such as the lifestyle diseases. With its major share in the health landscape of Sunnis and a section of Hindus in the area, we focus on the ways in which the contested concepts and practices related to shrine, mainly the *isthigatha* (asking for help), and *tawassul* (intercession) work in the field. The central point that guides the whole chapter is the investigation into how the contested categories debated among the *ulema*, the religious experts are reproduced as concepts, ideas, experiences, and practices of health among the Muslim subjects in the field.

Health Behaviour in the Context of Religion

Studies are galore in understanding the health behaviour from different vantage points particularly in the context of culture. In medical anthropology, disease and medicine have been increasingly considered as point of the 'cultural domain' against the empiricist positivist approach of compartmentalizing science and culture (Good, 1994: 2). This shift has been in line with the epistemological shifts in social anthropology, from the rationalist to the cultural relativism of Boasian[44] tradition, and to the meaning centred interpretative tradition such as that of Arthur Kleinman (1980) and Good (1994).

[44] Cultural relativism was the theoretical framework developed by American Anthropologist Franz Boas as a major shift from the empirical rationality and comparative method that ruled social anthropology for a long time. His students took his tradition forward; prominent among them was Ruth Benedict (1934), who with

Here, '*belief*' has been the central category in the history of medical anthropology, especially in the cross-cultural studies in the context of religion where medical anthropology has had to face the realist claims of biology. Conventionally, 'belief' has always been projected in opposition to empirical and rational category of '*knowledge'* about disease and cure. Evans-Pritchard's study *Witchcraft, Oracles and Magic among the Azande* (1937) is a classic example of such perspective in the modernist tradition. These studies recognize a distinction between the language of knowledge, those ideas that accord with objective reality, the medical practice of deriving diagnoses from symptoms, and the language of belief which is derived from culturally specific traits (Good, 1994: 13).

However, new epistemological trends in medical anthropology provided by authors such as Good (1994), Kleinman (1980), and Das (2015) help us study the health behaviour through experience, suffering, meaning, and interpretation as well as through the role of social institutions, without having to make a distinction between the empirical aspects of society's medical knowledge and its beliefs. According to their interpretative paradigm, '*disease is not an entity but an explanatory model*', which is knowable only through interpretative engagement. They investigate how meaning and interpretative practices interact with social, psychological, and physiological processes to produce distinctive forms of illness and illness trajectories. For them,

> *Biology, social practices, and meaning interact in the organization of illness as social object and lived experience. Multiple interpretative frames and discourses are brought to bear on any illness event* (Good, 1994: 53)

In this tradition, which aim at making the bio-medical model as 'self-reflexive', Kleinman (1980) provides an 'ethnomedical model' which can compare different culturally constituted frameworks for construing illness and will provide the phenomenological accounts of the way sickness is experienced and the conflicting interpretations of illness (Kleinman, 1980: 18). He looks at how the illness behaviour is shaped by a specific cultural system and how it is influenced by social class, education, and lifestyle.

Taking this theoretical background, our work moves away from the idea of cultural construction of illness and see how the ideological differences in religion shape the

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her relative psychopathology questioned the conventional ideas of positivist psychology. See Good (1994) for the detailed account on the epistemological shifts that occurred in medical anthropology accordingly.

concepts and practices of illness. However, we see they are inseparable from the existential features of the community in the region like the economic life and the social institutions at macro level, most importantly the state. Here, the critical perspective like the Marxist tradition in medical anthropology comes with an alternative to fill the theoretical lacunae. They (like the studies of Nancy Scheper-Hughes 1990 and Navarro 1980) study the health in the light of larger political and economic forces that pattern interpersonal relationships, social behaviour, social meanings, and the collective experience (Good, 1994: 56-58). Nevertheless, they may not help us to examine the choices, resistance, interpretations, and negotiations on the part of individuals inside the tradition of religion.

Hospitalization of Rites of Passage: Delivery and Circumcision

In the previous chapter, we mentioned the medical history of Muslims; a transformation from Ayurveda based *ustads*, *thangals*, and *vaidyars* to the modern medicine as the 'mainstream' mode of health seeking. To be read along with this transformation is the alteration introduced to the mode of carrying out vital practices related to the body among the Muslims, namely childbirth and circumcision. Both the lifecycle related events have undergone transformation that can be seen as medicalization of domestic health rituals. This shift also tells the story of structural changes within the Muslim society; the changes happened to the caste groups who were traditionally performing body related labour. As Deepak Mehta (1997) observes, implicit in the circumcision is the disciplining of the male novice's body, evident in the importance placed on various hygienic practices. The discipline and surveillance of bodies is central to the discourse on the idea of a 'Muslim'. It is the first act of pain a Muslim feels to legitimate his body to enter the Muslim social, to take membership in the Islamic community of men by which the individuals are socialized into group. Here pain and suffering are seen to be synonymous with belief (Mehta, 1997: 32).

The circumcision, which is compulsory for every Muslim boy, used to be conducted in the realm of the home. For the childbirth, *othachis* were called to attend to the delivery and some Sunnis approach *musliyars* or *thangals* to get the water blown with *mantram* for safe

delivery. *Othachis*[45], the Muslim midwives, are the females of *ossan* caste among Muslims who were considered experts in attending to childbirth. *ossans* are considered lower caste group among Muslims in Kerala who were performing work of a barber and were also called to Muslim homes to perform the circumcision. The relatives of the *ossan* families in Chullippara and many among the older generation in the *mahallu* recalled that they were born with the helping hand of the *othachi* in Chullippara, and that they were 'safe deliveries'. Because of their traditional labour, the *ossan* families face selective discrimination especially, in marriage and they are more or less an endogamous group.

Many of them have left their traditional job and migrated to Gulf or other states except a few like Yousuf who runs a barbershop in Chullippara and his mother was a reputed midwife in the area. Since the childbirth has been taken up by the gynaecologists, the traditional Muslim midwives like her perform the role of post-partum care givers for mother and child. She says she does not have enough 'courage' and 'confidence' that she once had to attend to the childbirth anymore. She also mentioned that such knowledge and experience is disappearing and most of the women of her cast do not know how to perform it. Post-partum care, including oil massage, oil bath for mother and child, preparation of special herbal medication, and most importantly the cleaning of used cloths that many are reluctant to do is also a lucrative service for them due to the unavailability of such caregivers. However, nowadays, women of poor background from other castes are also coming up for this work. Mira Sadgopal (2012) has mentioned this process of transformation of services among the midwives especially in south India as she says; the situation is not one of simple decline but of transformation of the role (2012: 218).

It was a ritual in every Muslim household in the area to conduct circumcision of their boys generally when they reach seven years old. Not all *ossans* performed the circumcision. Some of them, generally the experienced ones were called, and they came with their special knife, ointment, and bandage and other paraphernalia that may be incompatible with the bio-medical perspective. Along with *ossans*, *ustad,* the staffs of the mosque were also called to make prayers prior to the circumcision. Thus, it is a religious-medical rite of passage among the Muslims. While the old generation experienced pain as Mehta (1997) pointed out, the contemporary 'updated' *ossans* came with sedative injections and anti-

[45] *Ossans* and *othachis* are the nomenclature for the barbers and dais among Muslims in Kerala, the males and females respectively. In north India for instance, they are called *naai* and *naain*, the local midwife (cf. Sadgopal, 2012: 216).

infection tablets. *Ossans* made 'rounds' after three days to clean and change the bandage and also administered special medicines if there was a swelling. The Muslim poet Veeran Kutty has written a memoir in Mathrbhoomi weekly about his childhood experience of circumcision. He recollects his awful memories of being frightened whenever he saw the *ossan* and the nightmare of all local Muslim boys to be circumcised and how the elders threatened mischievous boys that they would call the *ossan* if they did not stop their pranks.

Campaigns 'to be medical' in order to be 'reformed and progressive' under the rubric of religious organizations have also played a part in the process of medicalisation. IMB (Islamic Medical Brotherhood)[46], the organizational wing of medical doctors under the KNM (Kerala Nadwathul Mujahideen) formed in 1987 had attempted to medicalize the circumcision as part of their large-scale medical programmes in the progress of community. Dr. Aboobackar, the ophthalmologist in Thirurangadi and one of the early office bearers of IMB, recollected his experiences of such campaigns:

> As part of forming an organizational wing for each professionals under KNM, we formed our group among the Muslim doctors, most of the members were from Mujahid background. Conducting a circumcision camp was one of its early programs in 1990s, aimed to lessen the burden of the poor in conducting it as a grand ritual. It was first of its kind in this area and people were hesitant, they were hesitant even to call doctor for delivery. Now the mentality has changed, people here are rushing to specialist doctors for everything.

Ossans are now replaced by specialist doctors in circumcision and *othachis* are not called and their services have been taken up by the female gynaecologists like Dr. Laila in Thirurangadi. Circumcision has come to be seen as a 'surgery' to be conducted post anaesthesia injection; earlier it was a painful experience suffered for the religious cause and *ossans* used to pacify the boys with their sweet words. Delivery and circumcision have lost their religious character and have become medical procedures due to the factors within the religious community and the general social trend in favour of the allopathic medicine and the comfort it offers.

[46] IMB is the organizational wing of Mujahids in Kerala. Detailed analysis of 'religious organization and medicine' will be presented in the next chapter.

Vaikkom Muhammad Basheer, the famous Malayalam writer has mentioned this transformation in the community; delivery from the hands of midwives to doctors which began to be seen as a status symbol. He writes about a Muslim woman undergoing delivery pain and her outcries against all attempts to make her calm saying 'please call the doctor' and 'take me to doctor'. Here she wants to get the privileged status of delivering the child with a 'doctor's assistance'. Now social status is attached to delivering the baby in a private hospital. Naseer, a full time political activist in the *mahallu* says he always prefers government hospitals except for the delivery of his wife because for him, childbirth is a complex process and he is 'fearful' to take risk by going to government hospitals. These two medico-religious rituals reflect the way Muslims perceived the body practices and practiced inside home that underwent the transformation we elaborated in the last chapter; namely, medicalisation of religious rituals.

Etiquettes of Hygiene: the Concept of Adab

Etiquettes of hygiene are also part of the concept of disciplining the body in Islam. Hygiene pertains to the activities of daily life, individual, and social habits. Here our interest is to focus on the way some of such habits are conditioned by religion in everyday life irrespective of the ideological differences. Religiously prescribed hygiene habits are described by Muslims as *adab* (religious etiquette). However, as our informants testified, while enacting such religiously recommended habits (*sunnath*) they are not concerned about the aspects of health, rather, following Mahmood (2005), it is a kind of inhabiting the recommended rituals for the body. An enquiry into some of the activities pertaining to their daily routine called as *adabs* would throw light on a new perspective on the understanding of hygiene in the context of religion, in other words the 'Muslim body practices'[47].

Generally, Islam proclaims hygiene or purity (the concept of *tahoor*) as part of religious belief and practices. It can be seen the religious orators and writers talk about the importance of health given by Islam citing these *hadiths* when the issues of health and purity in Islam are discussed. Muslim conceptions of purity and impurity are transient,

[47] Nile Green has used the term Hindu and Muslim body practices while studying the concept and meaning of 'breathing' in India and argued that reform was merely an intellectual process of doctrinal dispute, but a means of reconditioning the physical body into new ways of being, both private and public (Green, 2013: 81).

derived from bodily processes such as urination, menstruation, sexual intercourse, birth, and death that can be removed by acts of purification (Barth, 1960: 139; Simpson 2003). Even if some souls (*ruh* or *nafs*) may have purity over others, the corporeal characteristics of all human bodies such as blood, urine, and sexual fluids are impure which runs against the concept of 'purity of blood'.

However, many of the etiquettes cited generally as necessary part of the 'healthy life' are presented in religious learning centres such as madrasa text books[48] primarily as obligatory for the performance of religious practices. For instance, *taharath* (purity) from *najas* (impure objects like urine) and to be pure from *hadath* (impure conditions like sexual intercourse) is a precondition to perform the daily prayers. Conditions for purifying one and qualify to perform the daily prayers is *ghusl* (to take bath) as purification from big *hadath* such as delivery or death and perform ablution (purification from small *hadath*). Bathing and ablution become valid only with its own *niyyath* (intention) in mind. In that sense, *ghusl* the major purificatory ritual of the body is different from the normal baths.

The obligatory and recommended liturgies such as the suggested habit of *miswak* (brushing) five times a day along with the ablution are explained and practiced as religious and the purposes can be cleanliness or just following a religious practice. There are many practices given along with the apparently healthy habits whose purposes are purely religious and practiced just because they are directed to do so. There are some practices suggested as habits with each movement in everyday life. For instance, *fiqh* textbooks from primary classes lists the etiquettes (*adab*) of going to toilet such as covering the head, wear slippers while going, not to speak in toilet, and not to look towards urine and human waste. The textbooks endorse washing hands before eating, eat with right hand, eat less till one third of stomach is filled, get up early in the morning and not to sleep after *subah* (early morning prayer), to have disciplined sexual life with partners only. They also recommend reciting appropriate prayers before and after eating, before and after sleeping, while going to toilet and coming out, before sexual intercourse etc. The primary purpose of 'performing' all of them is to get *sunnah* (recommended practices), to get additional rewards after life.

[48] See for instance the *madrasa* textbooks of *fiqh* (jurisprudence) as taught in 2nd and 3rd classes run by SKIMVB.

To be noted here, the prescribed prayers recommended to be recited with everyday activities and other etiquettes are *sunnah* (recommended acts) for some groups whereas some of them like ISM group of Mujahids consider them as the authentic *mantram* (sacred words of healing) authenticated by Islam. This is the way some of the Mujahid activists responded to the question of Islamic *mantram*:

> What meant by the Islamic *mantram* is the prayers given in the text such as the prayer you recite while going toilet which would protect you from the devil effects. Islamic way of healing is what you pray personally by yourself whereas visiting the professional healers is prohibited.

Another observation is related to the perception about illness from the religious perspective that prevailed among some people. As some of them said illnesses, especially the acute illnesses like cancer and diabetes are in fact the blessings from the God to test the belief and perseverance of his pious subjects which are part of *adab*. One is supposed to look for the medicines and remedies, but should not lose his belief and firmness even in the case of critical illnesses. The more one tolerates here more he will be rewarded hereafter. The Quranic verse "tolerate you believers, the God is with those who tolerate" was seen written on the walls of the MKH hospital in Thiruranagadi. We see here the specific concepts and practices of hygiene designated by the term *adab* innate to the idea of desirable Muslim self.

Religious Remedies for new Diseases, Misfortunes, Calamities, and Contagions of the times

The way in which the illness, problems in life, misfortunes are seen differ according to the denominational background of the households. For instance, some Sunni households organize *maulids* during Arabic month of *Rabi-ul-awwal*, and *kutubiyyath ratib*[49] in the month of *rabi-ul-akhar* to avoid misfortunes and illnesses. Apart from conducting them in the given season, they are also performed for specific purposes and needs. Comparatively *kutubiyyat* is longer and costly including the feast and the reward given to the invited *ustads*. They understand the illnesses and misfortunes can be dealt with the help of

[49] *Qutubiyyat Ratib* is the collection of prose and ballads about Sheikh Abdul Qadir Jeelani, named after Qutub which is the attribute given to Sheikh Jeelani. He has been considered as the cardinal *Qutub* (axis) above all *qutubs* in the hierarchy of holy men in Sunni Islam.

muhyuddeen sheikh[50] if anyone believes in healing abilities and practice the given *ratibs*. Shaikh Abdul Qadir Jilani invoked by the continuous repetitions of his name thousand times in congregation, in darkness to help in need and protect from any kind of illnesses.

Kutubiyyat also conducted when to go for a new venture in life, to start a new business, to start construction of new house or the day before one sets out his journey for Gulf. I was invited to four houses in the *mahallu* to participate in the *kutubiyyat ratib*, one of them was going to rebuild his house, the other was shifting to a new residence , the third person was performing the ritual as part of his son leaving for Gulf following day. And in the case of the fourth house the family had recently lost one of its members in a car accident. Here, three of them had misfortune in the past; their sons were killed in a car accident in Gulf and the other in the home. Experiences of deadly misfortunes such as premature death, accidents, and chronic problems are more causative to inspire Sunnis to think of more effective remedies like *qutubiyyat*. During the *kutubiyyat,* generally conducted in the central hall of the house after switching off all lights[51], the household members keep bottles and vessels of water opened and put them in the centre. It is believed the effect of the whole rituals would be evoked into the water and it can be used as medicine in needs. Those who practice *maulids* and *ratibs* are seen by others as 'original Sunnis' or 'practicing Sunnis'. The non-Sunnis in the *mahallu*, even if they may consult a healer in need, never practice *maulids* and *ratib* as they are the public rituals considered as the manifestations of the ideological identity.

The 'introduction' of *maulids* and *malas* lists benefits and advantages the user would get if one practices it with good intentions. For instance, *badar* mala starts with the short description of the benefits of its use, whoever recites it with the intention of remedy from frustration, ailment, and epidemics of the region will serve his purposes. Each of these books has its own distinct way of usage and purposes. People were asked to recite *mawlids* in their home in order to curb the calamities and epidemic diseases. The most popular

[50] Muhyuddin Abdul Qadir Al-Jeelani (1077-1166), reverently called by Sunni Muslims as *Sheikh Muhyuddin* is celebrated mystical teacher, jurist, and theologian born in Baghdad considered to be the founder of Qadiriyya tariqa (spiritual order) which has the followership throughout central Asia, Africa, and south Asia.

[51] According to the Sunni tradition, it is suggested to turn off the light and make the room dark when one calls *sheikh* during the *ratib* ritual. Dark rooms are the preferable condition to make sheikh *hazir* (present) where the ritual is conducted. It is believed that the Sheikh Muhyuddin will be *hazir* in the *ratib* ritual if it was conducted correctly following the liturgies laid down by the tradition. My informants shared that a good smell that we experience at the consummation of the ritual is the sign of his presence.

mawlid recited in the region is *Manqoos mawlid* written by Zainuddeen Maqdoom senior, the renowned jurist of the time in the context of plague and cholera in the region. The *dua* (prayer) at the conclusion of *mawlid* includes prayer for the protection from *vaba*, *museebath*, and *qahth* which meant the outbreak of epidemic and contagions such as cholera and small pox.

Tracing out the historical contexts of the creation and compilation of the many of the prayer manuals, *maulids*, and *ratibs*, we find that the social need for them is created by the occurrences of calamities, epidemics, and other social miseries. However, the community as a whole is sought after for a remedy when any ailment affects the collective as a whole; say a village, or a region not the individuals. Outbreak of cholera and plague was the social cause for the establishment of number of such rituals in order to prevent the spread and protection from the havoc. Some of such works start with the description of the context of its creation; they were written to fight with *bala*, *waba*, and *museebath*. During the outbreak of epidemics, special huts were constructed to conduct *ratib*s in congregation of the village to protect their area, these huts were known as *ratib pura* (*ratib* houses. Even after the causes ceased to exist, some of them still recited and practiced it for the prevention from the newly emerging menaces like cancer.

We could see such 'preventive measures' from religion to handle epidemic diseases that afflict the public in contemporary times as well. Recently, Panakkad Sayyid Haider Ali Shihab *Thangal*, widely considered as the supreme leader of Muslim community in Kerala has called for reciting a new form of *mawlid* and liturgical song publicly once in a month in every *mahallu*, and it was named as *Majlisunnoor* (session of light). His call came in the context of increasing cases of cancer and kidney failures reported among the community. Asked to explain the motive behind attending *Majlisunnor*, one of my Sunni informants suggested to me that I should travel once in the Rajya Rani express train from Malappuram to Trivandrum, the capital city of Kerala. He said most of the travellers to Trivandrum are cancer patients going to RCC (Regional Cancer Centre) in Trivandrum. The media reports also testify their fear; according to the annual reports of RCC Trivandrum, the second highest number of patients registered as cancer patients are from Malappuram after Trivandrum district. To cope with the situation, there is large number of pain and palliative clinics in Malappuram district alone started by different groups including the religious organizations.

Responding to the call by Haidar Ali *thangal*, the *mahallu* committee of Chullippara also 'enacted' and initiated *Majlisunnor* conducted once in every month, after the dusk, the favourable time to recite. On the day of ritual, I saw the Sunni men and women flocked to the Chullippara EK madrasa to participate in *Majlisunnor* and returned after having the food prepared for the participators. In the course of ritual, they repeatedly sung the lines written in Arabi-Malayalm:

Ella balaum afathum edangarukal museebathum
Badreengale barkathinal emey kakkanam yaa rabbana

(Oh our Lord, Please protect us from all epidemics and calamities with the *barkath* of the martyrs of *badr*)

Dennam waba wasooriyum mattulla deenam adangalum
Badreengale barkathinal shifayakkanam yaa rabbana

(Oh our Lord, cure us from pain and suffering, contagions and small pox, and all other terrible diseases with the *barkath* of martyrs of *badr*).

Even when epidemics like plague and small pox are eradicated now which were once the social contexts for the composition, the same lines have been recited for prevention from the new age diseases like cancer, stroke, and kidney diseases. Interestingly, Sunni religious leaders made a call to conduct these rituals in the wake of the outbreak of Nipah virus[52] in Kozhikode and Malappuram district during April and May of 2018 and the death of seventeen people. The call which spread through social networking sites again caused a debate among Muslims in online media on the futility of the rituals in combating the catastrophic contagion while the 'believers' argued that every means, including spiritual can be used to prevent threat.

Since the reasons behind the diseases such as cancer are subject to debates amongst health systems, here, prayer is considered as the only option for prevention. New and emergent diseases are followed by new rituals, and then subject to the religious discourses to

[52] Nipah virus infection is a newly emerging zoonosis which causes severe diseases among animals and humans. The natural carriers of the virus are the fruit bats.

legitimise and classify them. The belief that an acute disease like cancer and other contagious diseases could only be prevented through the rituals like *maulid,* the authenticated practice in Sunni tradition, is behind the reorganization of such rituals in contemporary times. Such belief persists even though we see a change from the belief in the devilish influence on the emergence of contagious diseases like smallpox (as reported in the Basel mission records on Thirurangadi Muslims that we saw in the previous chapter) to the prevalence and dominance of biomedicine in the health culture of the region. We see here, as Good (1994) pointed out, the 'belief' has been, increasingly now, considered as inherent to the idea of 'disease' and 'medicine' not restricted to the ideas of illness[53]. In addition to what Good (1994) says, we see here the multiple belief systems related to the disease causation on the basis of ideological background and the practices of remedial measures differ accordingly. The 'belief' of disease and medicine is not a homogenous category; rather, in the context of Islamic community, we see it as discursively formed. However, we also see in the next chapter, the specific ways of such 'discursive formation', which, I argue, is peculiar to the domain of illness.

Home Remedies: Region, Religion, and Culture

The therapeutic practices such as use of home remedies include herbal ingredients with specific processing method accompanied by the use of Islamic *mantrams* to make them more effective. These therapeutic practices in households or neighbourhood level and their mode of transmission of knowledge over generations display characteristics of what is referred to as the 'medical lore' of their region (Sujatha 2003) which also have links with that of other regions.

> *Their knowledge and practices are not merely a bundle of home remedies strewn amidst magical beliefs, but products of living experience accumulated and modified over generations, and that their knowledge and practices continue to survive not because of sheer tenacity of beliefs but because they are efficient, effective and are compatible with the conditions of their existence* (Sujatha, 2003: 18-19).

[53] It is widely accepted classification in medical anthropology between 'illness' (culturally defined), whereas the 'disease' is understood as physiological reality (cf. Sujatha, 2003: 44). What we present from the ethnographic account seems questions this classification.

Elder women in the *mahallu* shared their ideas about the medicinal preparations for various diseases which were widely used during their childhood. *Arootha* herb (rue) is used for the cold and cough problems in children, whereas *tulsi* (basil) for the elderly people. In every Malayalam month of *Karkkidakam,* a special medicine is prepared in every home for strengthening the immune system and to flourish the body, specially prescribed for mothers after their delivery. This special annual preparation and for the mothers is a combination of 101 ingredients mainly ghee, dry fruits, and the roots of some medicinal herbs. The root of *kurunthotti* plant (sida netusa) is widely considered as the medicine for rheumatism. These medicinal preparation using the herbs in the vicinity is called as *ottamooli* (medicinal formula) mainly prescribed for the diseases which do not require the doctor's help. They are used for the diseases like normal fever, cold, dirreohea, and the minor illnesses referred in local terms like *vayaru kadi* (stomach problem), *vay punnu*, *vay nattam* (bad smell from mouth), *kuzhi nagham* (swelling on nails) etc. Books on different *ottamulis* for illnesses that can be cured at home are widely published and circulated in the region. For instance, Dr. M P Abdul Gafoor, a Muslim Ayurvedic physician has authored a book called *sarvaroka chikilsa vidhikal* (cure for all illnesses) which describes the preparation of *ottamoolis* for the problems faced in everyday life like *mundi neeru* and *vayaru kadi* (stomach problem). The book also includes the medicinal qualities of the herbs available in the vicinity and their uses.

For Muslims in the region, changes in the climate, ecology and its effect on the body require changes to be made in the food are identified according to the Malayalam calendar. For instance, the drumstick considered as good for health is avoided during *Karkkidakam* because it is toxic to have drumstick during this period, rather; mush with fenugreek seeds is the prescribed food of the time. The ecology of medical lore, as we can see, bears synergy with Kerala/Malayali health practices.

After the dusk (time of *Maghrib* prayer), women were seen circling the heads of little babies with green chilli and salt. When asked, they said the regular practice would protect the babies from the *shaitani* (devilish) problems like evil eye, fever out of fear from human and inhuman beings. The time after dusk is believed to be a period when non-human beings get down to earth generally and their attacks become acute that time, and the babies are most vulnerable to devilish illnesses. I found a Prophetic saying that asks the mothers to shut the doors and keep the children inside the house in the time of nightfall

to protect them from devil problems[54]. It is also believed that angels come to the earth in groups for *Maghrib*. It was because of the importance of the time after nightfall that the Sunnis, mostly the Sunni women who believe and practice them, were seen reciting the devotional songs and litanies for the protection and well being, after *magrib* and before the *isha* prayer (night prayer) falls.

There are prayer manuals; booklets known as *mawlid kitab*, *Sabina kitab*, *salat kitab*, *dhikr kitab* for daily usage are kept in the bookshelves of Sunni households along with the Quran. Earlier, the prayer manual in the name of '*dalailul khairat'* (evidence of virtues) was widely in use. Now, as my informants said new booklets of prayer manual with Malayalam meaning have come in the market and I did see copies of these series in the title of *manzil* (which means 'home') in the Sunni houses. The main buyers of these series are women from Sunni households. On my query, they replied that the reason is that the manual includes the prayers which can be used as solutions for the daily needs in the home, to avoid evil eye, for the well-being, to have good children, to be performed mainly by women. I could also see the elder female members who do not have literacy in Malayalam read the old manuals in Arabi-Malayalm and the young generation resort to the new editions of Arabic prayer with Malayalam meaning. *Manzil* prayer manual composed by a 'reformist' minded scholar includes only those prayers that are considered by some group as 'allowed' and 'authentic' claiming all of them are authenticated by *dalil* (evidences from doctrinal sources). Responding to the high demand in the book market and to assert the authenticity of 'controversial' prayers, AP Sunni organization has come with new *manzil* edition adding many more words and prayers which are authentic for them.

Analysis of those home remedies show that the techniques and content of these types of healing have the flavours of local tradition with some Islamic elements to them. The domain of health has more of these practices interwoven with regional culture and religion.

[54] To make me convinced of the vulnerability of the time after nightfall one of them related it with the Hindu ritual of lightening the lamp in the front of the open door after the dusk, he said, they keep their doors open and light the lamp to welcome the invisible devils whom they worship and we fear.

Concepts and Practices of Health in the Context of Religious Discourses

Classification of Illness and Care Seeking Behaviour

One of the peculiar characteristics of the health seeking behaviour that we present here is the way in which classification of illness and therapy is clearly connected to religious belief which in turn is aligned along ideological lines. This seems to be an addition to the similar researches on the health seeking behaviour such as Ritu Priya (2012) on the treatment seeking behaviour of Dalit workers.

One such theme that shows the patterning of illness by the multiple ideas of religious belief is their engagement with the mental illness. In the *mahallu,* Sunnis consult the *tangals*, *ustads*, or *beevis* for the illnesses felt, explained, and experienced by them as evil eye, sorcery, and the shivering fever due to the instant fear. It is also considered that this category of healers are the only option who can respond to the seekers of well-being, fulfilling the wishes and purposes otherwise impossible. As we see in the plethora of field studies (Quack J 2003; Halliburton M 2005; Tarabaout 1999; Lang L 2014), this category of healers share a prominent role to 'deal' with the illnesses felt as mental problems. Relative absence of other practitioners like psychiatrists and psychologists in the vicinity points to the preference of the former group in the area of mental illness.

Very often, the illnesses understood as related to mind (mental illnesses) were considered better handled by *thangals* and *musliyars* or *Beevis*. In most cases, psychiatrists and psychologists are consulted only when the first line of resort fails. Mental illness has been considered as something which only religious men can intervene effectively. It was a famous *thangal* whom Muhammad in Chullippara had consulted first for his daughter's problem and he moved to 'doctor' when the usual system failed. Shreeni, a clinical psychologist in the area, adds further dimensions into this particular illness behaviour in the domain of mental illness. From his perspective, the illnesses classified by him as 'neurosis' are exclusively referred to the 'black magicians' and those which come under the category of 'psychosis' are referred to psychologists or psychiatrists as the final option after the trails with the former groups. Sreeni says, the family of the psychotic patients make recourse to them when the 'usual' traditional systems fail to deliver and they look for a solution to control the problem, especially if the patients are aggressive and 'harmful' to others. The general stigma attached to the mental illness, especially for girls might have

led them to consult the healers to solve it 'secretly'. The patients too make use of the 'mysterious way' in which these healers work and they go to them 'secretly'.

The specific terms employed by the respondents to refer to the mental illnesses throw light on their own notions of illness, complaints, symptoms and diagnosis. As Das (2015: 33) noted, these are the linguistic means through which the illness acquires social existence. The terms can also show the specific ways in which the religion patterns the expression and experience of mental illness. The term *Manasikam* (mind related) is used for paranoia which may come under the category of psychotic diseases and they are rarely used. They are 'negative' problems one will always try to get rid of even from the allegation of it. However, if *manasikam* is uncontrollable and uncured by the local healers, then they are taken to the psychiatrists and then to the mental hospitals like Kuthiravattam mental hospital in Kozhikode.

Some general problems of children are addressed as *vikrithi* (naughtiness) *kali kooduthal* (hyperactive action), *shradhakkuravu* (inattention) *padikkan mosham* (autism) *budhikkuravu* (mental retardation) which are understood solvable minor problems with the help of specialist *thangals* or *ustads*. These are the problems seen similar to the everyday domestic illnesses of infants like long crying, shivering fever, being freighted, which is the exclusive domain of *ustad* in the mosque or other 'professional' *ustads*. However, the inborn mental disabilities are called as *mandabudhi* (mentally disabled) that requires the help of both doctors and healers. The mental problems for the elder people explained as '*manassugha kuravu'* (mind not well), the very term subsides the problem. Even if the 'frightened' cases of elders are more serious that may lead to paranoia or dual personality disorders, the general term used is '*pedichathu'* (feared) which needs the support of amulet or blown water. *Budhikkuravu* (failing consciousness) in old people are called *chenni* which may occur because of age or acute fever. According to them, the main symptoms of *chenni* are forgetting, saying something repeatedly, and saying something out of context. For *chenni* of fever, the treatment is sought to lessen the fever and that of the old people are understood as 'normal' for which treatments are generally avoided.

Kunju Haji was once the founding father and the president of mosque and madrasa in Chullippara and was the member of Thirurangadi municipality (it was *grama panchayat* before) elected repeatedly for his acceptance among the *mahallu* residents. Going around

in the *mahallu* as part of fieldwork, I met him regularly and he recollected his activities in the *mahallu* with pride and honour. Other residents warned me not take him 'seriously' because he has the '*chenni'* problem related to his age. However, he was not taken to the psychiatrist, *thangal*, *musliyar* or any other doctors, rather; other residents still respected him because of his past deeds and it was understood as his normal 'condition' that comes with age but his 'official' powers in the *mahallu* were taken away and his advise were never heard. In fact, the conditions of illness as explained by the people like this demand us to think beyond the conventional categories of 'normal' and 'pathological'.

The parents of some of the under-performing students in school and madrasa, notably from a same family, have told me about a famous 'miraculous' *thangal* working in the northern district of Kannur. They regularly visit the *thangal* along with their children to find a solution for the repeated complaints from madrasa and school for their inability to learn. Some of them have claimed improvement in the performance after several visits. A mother of two children from another household who is the close relative of the former parents shared her coping strategy with me. She could bring bright success for her children who also had learning disabilities after she consulted a specialist doctor in Thirur and gave medicines prescribed by him to her children. She was happy that her elder son who once struggled to pass in examinations had passed the senior secondary board examinations at school and madrasa with high percentage and she gave the credit to the doctor. She did not find it as problem to disclose to me the mental disability of her son and her visit to a psychiatrist since they do not come under the category of *mandabudhi* or *manasikam*.

However, apart from the general health behaviour mentioned by Shreeni, the psychologist informant, we have to add some specific points related with Muslims. For those who believe in the influence of invisible beings in the human illnesses like the Wisdom group of Mujahids,[55] there is no treatment except *ruqya* (blowing with sacred words) for some diseases, especially the diseases that doctors failed to diagnose. They did not consider them as mental disease or a 'problem', rather the patient is treated as a 'victim' affected by

[55] 'Wisdom Global Islamic Mission' is the title by which the new splinter group among the Mujahids are working in the Muslim public. It was formed by a group of Mujahid scholars like Zakariyya Swalahi who were expelled from KNM, the official organization for their argument that there is no problem in calling the *Jinns* for healing. They say seeking the help of *Jinns* in critical conditions does not amount to *shirk* (associating partner with Allah) which was against the official Mujahid doctrine. For the details see Zirajuddeen (2013) *Religious Discourses on Classification of Healing Practices among Muslims in Kerala,* Unpublished Mphil thesis, New Delhi: JNU

the harmful attacks of the invisible bodies like *Jinn*. This has also been recognised by the Muslim doctors except the former Madavoor group of Mujahids. Dr. Muthukkoya, the retired director of health services and now running 'Modern Private Hospital' at Venniyoor confirms this:

> There is evil eye and *sihr* (sorcery) and it has affected even the prophet. Their only solution is Quran. Prophet had prayed for the protection from *sihr*.

A young Mujahid doctor who works in a private clinic in Thirurangadi shared his belief in the power of *ruqya* to heal the illnesses unable to be diagnosed by the doctors. For him, the Mujahid ideology of Wisdom feels authentic, with their belief in the influence of *Jinn* and other invisible beings on humans to cause illnesses and to heal them. This case is an example of shift from a psychiatrist to *ruqya* when the former failed in a Mujahid setting who oppose the religious healers in the form of *thangals*, *ustads*, and *beevis* and started to endorse *ruqya* (lit. *mantram* done by self or its experts from Quran and hadith only). He says:

> My friend's daughter was graduated in pharmacy and she was married to an educated man. The couple had a failed marital life due to some problems in sexual life. As Mujahid activists, the couple refused to visit *Thangals* or *Musliyars* or *Beevis* and chose to consult a reputed psychiatrist. After many examinations and trails, the psychiatrist revealed his helplessness. Without having any diagnoses, how can I prescribe medicines for her unnecessarily? He asked. They decided to rely upon the *ruqya*, the healing with Quran, not visiting the fake *Musliyars* and *Thangals*. After many trials with Quran healing, the girl began to feel better and she demanded more healing with Quranic *ruqya* as it could help her overcome the problem.

Sunnis in the *mahallu* make a classification of illnesses and decide to whom they have to go for the treatment and shift from one place to another if one system fails. There are many who began from *Musliyar* and ended up with the doctors and got treated and those who depended on doctors first then to alternative systems like *homeo* and Ayurveda and got treated by *ustads* or *thangals*. Muhammad, an old man, the retired tyre worker, and the regular visitor of Chullippara mosque for prayers, and a Sunni, explains his 'policy of health seeking behaviour', it is his journey from one system to another until his illness got cured:

> For each type of therapy, we should consult its own curers. You recognise me only when I call you. Likewise, sometimes we may start from *thangals* and at the end, we rely upon doctors and sometimes we go to doctors first and eventually end up with *thangals*. Once when I was working with tyre, my hand began to swell due to the injury caused by a screw. I went first to a reputed doctor known with *kaiphalam* (efficacy of hand) and it did not cure. Then, on the advice of my brother, I 'showed' (consulted) my hand to Jifri *Thangal* in Kakkad. He prescribed to whisper with *mantram* on an amulet and to rotate with it on the head seven times and dump it in the fire. Next day, I found the tumour in the hand was broken and it was cured.

This is his journey from doctor to *thangal*. He also gave his experience of other way round, from *thangal* to doctor. He tried many *musliyars*, *thangals*, and even Hindu *panikkars* to cure the minor mental problem his daughter suffered after her marriage but they could not fix it. They were his first choice because of the nature of illness. It was only when he went to a doctor as the last option that he could get a solution through medication. He explained the classification of illness citing another example. His grandson who departed for gulf the day we made our conversation had failed in the medical test in Gulf for three times. It was 'cured' only after they consulted Thalappara *thangal*.

I met Musthafa, a young Sunni, at outpatient block of Taluk hospital; who came to seek treatment for his wife for the cat bite she suffered. His words will make it clearer; the classification of illnesses and seeking the therapy influenced by his personal belief, ideological orientation and his personal responses to the ongoing discourses and formation of his opinion and practice:

> It is neither one after the other nor one instead of another; each of the therapeutic method has its own. Why I came today to the Taluk Hospital? It does not mean that I do not believe in the power of *thangals*. Where the tablets and medicines needed then they should be served, where it is blown water that is needed it should be served there, where the amulet has to be tied then it should done so, when it is necessary to go to Mamburam then we should go there.

There is coexistence of different health systems and there are conflicts that appear in complex ways that we will touch upon later. However, the belief that some diseases have to be taken to *thangals* or *musliyars* is very strong. The account of an old woman who is given the responsibility of the household's health says,

> Actually, we did not have 'such situations' to go to *ustads* of *thangals*. Once I had arranged a thread blown with *mantram* from an *ustad* for my sister. She also drank the water blown with *mantram* before she was taken to the operation theatre for delivery. We did not have 'such illnesses'. We did not have the illnesses that doctors are unable to treat. We pray such illnesses may not come to us! We consult doctors for fever, scab etc. and for pain and strain in the legs, we go for Ayurveda.

Another feature noted among the patients, remedy seekers, and the patients in all departments of hospital OP is the majority of them are women, especially in the courtyards of *Beevis*, the female Muslim healers. The women informants gave different explanations for it such as "our men do not like us going to *thangal*s" and "there are many women who visit beevis without informing their husbands". Some of them replied, "Women have more 'problems' compared to men like suspicion" whereas others responded, "most of the men in this area are working outside and they don't have time to look into the health of the household members". Getting into the experiences and positions of women informants would tell us ways in which the categories within Muslims on the basis of gender, class, and caste respond to the religious discourses and their health practices.

The accounts of Mujahid doctors, and that of Muhammad and Musthafa, the Sunni informants, and old woman's response reflect what Marshal Sahlins' (1976) has called '*subjective utilitarianism'* to denote the care seeking behaviour where the individuals make choices appropriately, proceeding rationally toward gaining health (Good, 1994: 42). However, we have seen our informants in this section do not act 'freely' to make choices as Sahlins (1976) and Gupta (1988) understood. Instead, they used their 'interpretative freedom' inside the religious tradition while acknowledging the classificatory scheme of Islam on the care seeking. We hardly get here the rational, autonomous, value free care seeker; rather, it is more of an 'ideological' model that varies considerably during the management of chronic and critical illness. Negotiation with the tradition happens when dealing with these kinds of illnesses.

Property, House Construction, and Wellbeing

Taking precautionary measures and ensuring protection and well-being is very much visible in the earth related issues such as constructing houses. Majority of the *Mahallu* consult a *thangal* who is 'specialist' in land related issues or an experienced Hindu

carpenter with their house plan to make construction 'proper', in order to avoid the interventions of *pishachs* (devils, the non-Muslim *Jinns*) in the new house. There are many things to be taken care of while planning a new house; taboos in building toilets in the most important corner, the *kannimoola*. It has to be preferably used for prayer hall like Hindus build *pooja muri* (room for worship) in *kannimoola*, the front sight should be towards the east and the backside to the West, sometimes one has to make a hole across the house to allow the passage of invisible beings. Some of them also believe the household members have to face serious challenges like chronic illnesses or economic problems if these requirements were not met.

Most of the households follow the methods as a norm, while some of them do it following the advice of family members. There are a few individuals; most of them are followers of Mujahid ideology like Abdul Nasser, a 'reformed' gulf returnee, who dared to build houses for him and for his off springs against these beliefs as a deliberate religious action. He said each portion of the earth is good. Mansoor Ali, the former vice president of ISM group of Mujahid also reiterated his unconventional way of construction:

> Look, I have built the toilet in my house in the so-called *kannimoola*, and with the grace of Allah, we did not have any problem because of that. We have to build our house according to our convenience and the availability of the plot, especially in towns. These all are the blind beliefs taken from Hindus.

The disbelief in following the conventional norms comes from the fear of conforming to the beliefs of Hindus or it has been understood as 'Hindu *Shastra'*. Afsal, a young Sunni activist and an architect who always has to deal with such beliefs of the customers while drawing a house plan, explained it:

> These beliefs are according to the Hindu concepts of impressing the gods and deities of earth and sun. I do not believe in them. Our *musliyars* and *thangals* are repeating the same thing. Ninety percent of Muslims in the area are blindly following the beliefs of Hindu carpenters. If we believe them, we are disbelieving in the power of Allah who made the earth pure and clean everywhere, there are no such forbidden places to build houses. However, most of the females are strong believers of such blind beliefs. In fact, we should ensure that there would be air passage inside the home so that we get relief; we should not make a hole across the house to let the 'invisible beings' pass through.

Thus, the ideas of illness are inherent to house and properties also and not only to body and mind. In this section, we see the ideological differences in building homes and buying properties according to their differing concepts and ideas of health and illness, conditioned by sectarian background.

Differences on 'Universal' Practices

We have to understand the reproduction of local sectarianism in the sites of universal practices in the background of theoretical frameworks that classify Islamic practices into 'local' and 'universal'. For instance, we saw Mark Woodward (1988) giving a typology to analyse the practices among Muslims which is expected to help understand the role of textual doctrines in the practices. In this typology, he classifies the practices as 'local' such as tying amulets and the practices of *hajj* and *umra* (two forms of pilgrimage to Makah) were understood by him as 'essential' and 'universal' practiced by Muslims throughout the world with lesser debates and controversies about them.

Zamzam water served to the pilgrims of *hajj* and *umra* is considered by all Muslims throughout the world as the sacred water without being added with any *mantram*. However, back in Kerala, Muslims of different ideologies see and use it differently. It can be considered as a symbol of 'universal' Islamic tradition practiced with different 'local' beliefs. Old Muhammad who is a Sunni describes his belief on Zamzam:

> It is a miracle; *Zamzam* well in Mecca will not be dried up even if used abundantly in any season. Its effect is for what purpose it is served. For any purpose we drink it, it will be fulfilled. Some of us buy a separate white cloth and wash it in the *zamzam* and keep it to be used as *kafan pudava* (white ritual dress for the dead body) for our funeral, so that it will protect us in our tomb.

Newborn child fed *zamzam* water for the first time and the prescribed *adabs* may conflict the prescriptions of medical science. In one instance, a *thangal* advised a mother against breastfeeding her newborn child and he was subject to ardent criticism among Muslims and the public media.

The sectarian differences and organizational ideologies at home in Kerala are reproduced in practices considered 'universal' such as the *hajj* pilgrimage. Sunni pilgrims of Kerala consider the visit to Medina (the Prophet's city) and the prayer at the tomb of the Prophet

as important as the formal *hajj* pilgrimage whereas the reformist pilgrims consider it as *shirk*. All Sunni pilgrims shared their experiences of being warded off by the police when they made a prayer at the tomb. Old Muhammad and Ahmad Haji said:

> The Saudi Arabians are Mujahids and they do not allow us to pray at the *rawza* of prophet (prophet's tomb is known as *rawza* which means 'garden'). When we prayed, the Saudi police told us 'prayer is to Allah only' and turned us towards Makah.

Another instance of the reproduction of religious ideology and the local organizational conflicts, as the local pilgrims say, is the question of entry of women to the two holy mosques in Makah and Medina. They say the AP Sunni Hajj groups who strongly oppose the Mujahid ideology in Kerala strongly discourage their women from going to the mosques in the holy cities where women are permitted to enter perform the five times prayer. Instead, they were asked to do them in their hotel rooms and it is interpreted by them as more worthier than getting the worth of the sacred space. At the same time, their group (the EK Sunni faction) generally send their women to these two holy mosques in order to bag the special virtues of the holy spaces as offered in the *hadith* for which alone they have to travel the long distance.

Organizational Differences and Beliefs about Invisible Beings

It is always an epistemological dilemma before the sociology when to deal with the supernatural or superhuman beings. The definitions of 'social' in the sociological investigations of religion like that of Durkheim, Weber, and Mauss generally exclude these beings (Turner B, 1974: 42). In contrast, our in-depth account of the concepts of illness among the Muslim community unveils the world of superhuman beings, namely the *Jinns* who are inherent part of the 'social' life. The *Jinns* are superhuman actors who are significant agencies in Muslims' interactions and interpersonal relations. We need to make a sociological inquiry into this aspect, the meaning towards the man-superhuman, in our case the man-*jinn* encounters and the specific ways in which the religious discourses produce those meaning. Meanwhile, reducing the belief about these creatures as 'mystical', away from the 'commonsensical' worldview, does not help because all Muslim groups, including the self-acclaimed 'rationalists' and 'traditionalists' recognize the existence of *jinn* as it is validated by Quran, thus becomes the core belief in Islam which lies beyond the sectarian contestations.

Muslim belief in the distinct creatures called *Jinn* is an important aspect of the health behaviour. All of my Muslim informants, the allopathic, Ayurvedic, and Homeopath doctors, the practitioners of different therapeutic methods, health officials, and the activists of all religious organizations in the *mahallu* confirmed this; as a Muslim, they believe in the existence of another kind of creatures, the *Jinns*. They said a Muslim should believe in them, otherwise, he is not a Muslim. However, all Muslims with different ideologies believe in the existence of *Jinn*s as it is mentioned in Quran, they differ in their nature and life, their special skills, their contacts and relations with human beings.

Dr. Raihan, a Mujahid doctor said he believes in *Jinn* only because Quran has mentioned about them; he cited a separate chapter from the Quran revealed particularly on *Jinns*, the '*surah Jinn'* (Chapter on *Jinns*). Those who believe in the human-*Jinn* contact say the *Jinn* can enter human body and travel through each and every vain and vessel and can talk through the human's tongue. The complete *Jinn* possession is called '*jinn koodal'*. The same was opined by Naseer, a Muslim health inspector in the region who negated all types of healing with *mantram*, amulets, or visiting the shrines but he said, "*However*, *Jinns do exist, we are not allowed to not to believe in Jinns*".

It has been a nagging question for the reformist scholars in Islam who tried to present Islam in consonance with the modern scientific rationality of Europe, to define the nature of *Jinns*, interpret scientifically the verses of Quran and *Hadith* on *Jinns*, and to explain the human-*Jinn* contacts in illnesses. In order to present Islam as the reasonable socio-political ethic, completely compatible with the modern science, it was necessary for them to rid Islam of the irrational beliefs and blind following. Creatures like *Jinn* were an important theme that needed scientific interpretation. From the different streams of reformism[56] in Muslim world, the scholars connected with Egyptian reformism like Jamaluddin al-Afghani, Muhammad Abduh, and Rashid Riza were the ones who gave scientific explanations to the doctrinal sources on *Jinns*. Some of them explained the *Jinns* as particular tribal group and *Jinn* possession as epilepsy. These tensions between the religious beliefs rooted in the doctrines and the aspiration to be known as 'progressive'

[56] For instance, Samira Hajj (2009) in her work '*Reconfiguring Islamic Tradition: Reform, Rationality, and Modernity*' gives an extensive account of the two streams of reformism in the Muslim world; in Saudi Arabia and Egypt. She says, these two regions experienced the reformist movements in different ways thanks to their socio-political conditions of the time. Egyptian was of a surge for interpreting Islam in accordance with modern scientific temper due to its direct encounter with the European colonial modernity of the time.

can be seen in the positions on *Jinn*. Nasser, a Sunni who was 'reformed' after gulf migration explains his 'new' belief:

> I believe in *Jinn*s, otherwise I am not a Muslim, and there is *Jinn chikilsa* (healing with the help of *Jinn*), but it has to be practiced by its experts, and they are very rare. Dr. Zakir Naik also has the same opinion. However, we should not ask help from them, it is futile and *shirk*. We can directly ask help from Allah, then why *Jinns*?

Here, his citation of Dr. Zakir Naik to substantiate his opinion shows his wish to be with comparatively more progressive version within the religion. The controversial *Salafi* orator Dr. Zakir Naik, a medical doctor by profession, is known for his innovative campaigns giving scientific validity for all Islamic concepts and beliefs.

The organizational splits among Mujahids following the different positions on *Jinn*-human contact[57] were observed in the beliefs of its adherents and sympathisers, many of them are newly 'indoctrinated' beliefs. The Mujahids are divided on whether *Jinns* can cause illness for human beings and whether asking their help in healing would amount to *shirk* (associating partner with Allah). KNM, the official Mujahid group says they can cause illness but asking their help is *ibadat* (worship) to them and the only way to have protection from the devil influenced illnesses is the recitation of *ruqya sharia* (*mantram* authenticated by *Sharia*). ISM (*Ithihadu Shubbanil Mujahideen*), the then splinter group under the leadership of Dr. Husain Madavoor, argued that *Jinns* are another kind of beings who can never influence the human world or cause illness and asking their help is futile because they cannot help and it is *shirk* as well. Wisdom Mujahids, the new splinter group says, asking their help is not *ibadat*, thus not an act of *shirk*. They say there are many illnesses where only *Jinns* can find a solution because they have unique powers and skills like finding out the lost things.

During an informal discussion with a group of patients and doctors in a private clinic in Thirurangadi, some of them who identified themselves as Sunnis made a joke and laughed at their doctor who is the follower of Wisdom group of Mujahid. They disclosed the primary identification marker of the doctor by jokingly saying, 'he is the follower of *Jinn*'.

[57] For an extensive account on the ideological differences among the Muslim religious organizations on the question of *Jinn* on the human illness and their help in healing and the organizational splits within the Mujahid group following the differences on the religious validity of asking the *Jinn*s' assistance in healing, see Zirajuddeen (2013).

In response, the young doctor positively nodded with firmness in his belief. Dr. Mehboob, the young doctor claimed that it was the Mujahid leaders like MK Haji of Thirurangadi led the Muslims from *anthavishwasam* (blind beliefs) to the 'light' of modern medicine through the establishment of modern hospitals like MK Haji Hospital. He said it was the *islahi* (renewal) movement that first convinced people to seek the medical treatment for the illnesses like allopathy or Ayurveda. However, on *Jinns*, his opinion was different that stood away from his acclaimed campaign for 'rational medicine', he said,

> However, believing in *Jinn*s is not *anthavishwasam* (blind beliefs) because it has been proven by the Quran and Hadith. Any fact mentioned in Quran is not blind belief. It also says, the illness affected by the devils has to be cured by *ruqya shariyya* which is the authentic healing in Islam. This position taken by our group does not mean going back to the irrationality or blind beliefs we eradicated, as our opponent Mujahid groups blame us of.

Whereas, Dr. Abdu Rahman, the senior doctor at MIMS and the veteran leader of KNM and later joined Madavoor group after the split, explained his belief differently,

> There is no doubt in the existence of *Jinn*; otherwise, it would be against Quran the main source of knowledge in Islam. However, they cannot influence the human beings 'physically' by any means; if they can, then Quran would have mentioned it, so there is no proof for that. In fact, they can influence human minds to go astray; it is their main course of action, to inspire human beings to go immoral. Therefore, they are commonly found among the human habitats and crowds, not in the desolate places or public graveyards as the 'common' Muslims believe.
>
> This has been the official position of Madavoor group, but now, they have merged with the official group of KNM in 2017. However, personally, I do not follow the merger and the new positions emerged thereafter, this is my personal belief. I think the new positions of the Mujahid organization on the matters of *Jinn* and *mantram* is not *navothanam* (renaissance) that we proclaimed earlier, it is stepping back to the blind beliefs we eradicated.

As we found out, the critical questions against the general beliefs on *Jinn*, but believing in the existence of *Jinn*, also arose from the Sunni activists. They were not sectarian differences, rather 'practical' questions. The question put by Afsal, a Sunni activist, an elected ward member, and an architect is important:

> *Jinn* are there, but the *chikilsa* (healing) cannot be done using them. If so, they could be used to destroy an individual or an organization. They can neither cause illness nor heal human body. I have met and discussed this issue with many religious experts. However, this is my personal opinion, not at all by reading Mujahid books or from the internet.

Dr. Abdu Rahman and Afsal give their personal opinions on religious matters against the organizational decisions that show the mode of the formation of religious subjects through religious discourses that we will examine in the last chapter.

Enquiring about the belief in the creatures of *Jinn*s and their contact with human beings which is seen as an inherent part of Muslim health behaviour, we need to think beyond the conventional variables such as the educational background, especially the modern health education, exposure to different worlds, and the medical orientations. Crosscutting all these factors, we found the religious ideology and sectarian background pattern the beliefs, experiences, and coping mechanisms regarding the illness related with *Jinn*. Another medical doctor in Thirurangadi government Hospital said:

> I believe in *Jinn* because Quran has testified it, but they cannot influence humans, Quran says that also. Not believing in *Jinn*s means rejecting the Quranic verse. There is no problem in believing in them because still there are many micro beings in the world that we cannot see with our eyes.

Healing Power of Jinns: The Sunni Beliefs

There are Muslim healers depending on *Jinn*s as their helpers in healing and solving problems generally impossible for the human beings. The beliefs and practices of these healers and the large section of the community who consult them lead us into a different world with distinct concepts on body, illness, and cure sanctioned by the religion. They say creatures of *Jinn* are invisible, normal human beings cannot see them in their original form, but they can see us. The *thangals*, *ustads*, or *beevis*, who are specialised in *Jinn* healing can see and talk with their *Jinn* friends and *Jinn*s with their distinct skills and knowledge share the details about the human illness, its causes, and its therapies, details about the lost objects. Those who are affected with *sihr* (sorcery) can also see and talk with their possessed *Jinn*s. *Jinn*s can take the form of any animal like snake or dog, and human being, and then they become visible to us.

Munavvar Ali, a famous *thangal* healer and a religious scholar in the region explains the need of their assistance in Healing:

> If the healer is powerful enough, he or she does not need the help of *Jinn* or even any medium like amulets or egg. Instead, a mere touch or his presence will work as healing touch like the famous saint of Ajmer or Mamburam *thangal* used to be. Saints like them could heal the illnesses of the masses before them with just a blow or a healing touch. The absence of such individual qualities makes the healer in need of the external help such as the 'powerful' *Jinn*s. They get access to the possession of *Jinn*s either being their body possessed with *Jinn* or through the sole meditation in a dark room for a particular time and following specific norms and taboos such as avoiding the non-vegetarian diet during the meditating period. After the completion of the successful meditation, the *Jinn* will become *hazir* (present) and he can be requested to assist the healer in healing and can be called at any time through specific method. Minor children who are supposed to be pure from sins are asked to call them looking at the specific ring and they will be visible in the ring stone. The healer can rise into fame and earn if the possessed *Jinn* is an effective healer; it depends on the skill of the *Jinn* he is 'possessed' with.

Sunnis believe in the possession of *Jinn* on human bodies and their utility with their unique powers in *chikilsa* as the famous *beevi* in Chullippara does. We could get their beliefs and ideas on *Jinn* from the everyday conversations and group discussions among them. Here is a conversation between Ahmad Haji, a regular visitor of mosque and *Beevi's* home and the Sunni religious scholar appointed in the mosque. Here we see this common person's beliefs on *Jinn* and their validation by the 'official' religious scholar of the *mahallu*:

> **Ahmad Haji**: I came to know that one person in the next locality is possessed by *Jinn*, but, it is good for nothing, not efficacy now!
>
> **Scholar**: It is true, anyone is possessed with *Jinn* and wants to make money out of him then he has to take utmost care of *Jinn*, otherwise, the *Jinn* will leave away.
>
> **Ahmad Haji**: Yeah, mostly the women are being possessed, and most of the visitors of 'our beevi' are also women, they come there if they have lost anything. And beevi makes lot of money through *Jinn* she is possessed with.
>
> **Scholar**: there are many who go to Ervadi maqam in Tamil Nadu, the famous *maqam* for the healing of mental illness, to get possessed with any 'liberated' (dispossessed

> *Jinn*s with the grace of the Ervadi saint) *Jinn* there. After getting possessed with *Jinn*, they come back and start to 'sit' here as *beevi*. There are many 'freed' *Jinn*s available in Ervadi 'dispossessed' from the body of patients with the power of saint buried there and looking for another body to possess; those who want them can get them sometimes.

Suddenly Shabab enters, he is known in the *mahallu* as lenient to Mujahid ideology recently after migrating to Hyderabad for his bakery business and watching the ideological clips through online groups. He also participates in the discussion.

> **Shabab**: if beevi could heal others' problems, why she could not save her own husband? She did not even know about his illness getting aggravated and he succumbed to death.
>
> **Scholar**: it is written in the Islamic history that Prophet Sulaiman (Biblical prophet of Solomon) was given the power and sovereignty over *Jinn*s but *Jinn*s did not know about the death of their boss.
>
> **Shabab**: However, I heard a sermon by a famous Sunni scholar; he says we should not approach the Hindu healers.
>
> **Scholar**: in emergency conditions, if there is no other option we can seek treatment from the Hindu healer like *Panickers*.

This is the way the residents of *mahallu* share their beliefs and debate with each other in everyday life. Here, the beliefs seen by others as 'irrational' are considered 'empirical', observable in the light of doctrines and religious authority of scholars.

Religious Communities among Jinns and Notions of Normalcy and Pathology

Muslims believe that like in humans, there are male and female *Jinn*s. In addition, among them, there are Muslim and non-Muslim *Jinn*s. All of my healer informants often call upon their *Jinn* friends to fix some problems; and all of them are Muslim *Jinn*s, they say calling upon or relying upon non-Muslim *Jinn*s is against Islam. Here the difference is the religious affiliation of the *Jinn* called for healing or being possessed with. The very belief system itself involves this categorisation, namely, all invisible beings except human beings are *Jinn*s, the non-Muslim *Jinn*s are addressed in Quran as *shaitan*, and generally called in Malayalam as *chatan* derived from *shaitan* and *satan*, or *pishach,* the evil forces.

In this categorisation, the possession of a Muslim *Jinn* or befriending a Muslim *Jinn* for healing is not seen as a problem to be solved, rather as a fortunate development. The *Jinn* healer can hand over the *Jinn* under his possession to his off springs after his death. However, being possessed with a non-Muslim *Jinn* is a serious illness to be solved by a *Thangal* or *Musliyar* or *Beevi* which is called as '*pishach badha'* (possession of *pishach*, the non-Muslim *Jinn*). It is also believed that generally, the Muslim *Jinn*s will not harm or frighten the human beings, rather, they help or befriend them, whereas the non-Muslim *Jinn*s, the *shaitans,* always try to frighten and intimidate the human beings. Humans become vulnerable to their harms especially if they do not take the preventive measures like reciting special protective *dhikrs* or *surahs*, especially if they walk alone in the night through desolate places, particularly in graveyards. Women are more vulnerable to *shaitani* harm because they become easily frightened due to their 'mental weaknesses'.

It is also believed that *Jinn* can be used to cause illness for others such as separation between husband and wife, cause damage or loss to one's business etc. Here, the healer serves the *Jinn* (known as *Jinn seva*) as his master for his own needs. These kinds of practices are understood as *sihr* (sorcery) and as a major sin in Islam by all healers. A famous *thangal* healer in the area said that he does engage in sorcery to break adulterous relationships and to reunite husbands and wives. He said most of the cases he attends now are related with the illegal relations within the Muslim families. For him, there are some instances he may have to intervene to serve if their family does not approve of the relationship or if the boy is a non-Muslim.

If someone were affected with *sihr,* he has to call another *Jinn* healer to cancel the *sihr* done against him, and then it would be a fight between the *Jinn*s of these two healers, perhaps a fight between a Muslim *Jinn* and non-Muslim *chatan*. More 'powerful' will win the battle, and sometimes the healer with no precautions and protective measures may have to cost his life if the opponent is powerful. The *Jinn*s are helpful to find out the objects on which the *sihr* is worked out and to destroy them in order to cancel its effect. Objects of sorcery like a bottle, coconut or eggs are buried deep in the courtyard of the opponent or left in the flowing river; only the *Jinn*s can find them out and destroy it.

To my query about the experience of meeting with *Jinn*s and cohabiting with them, a *thangal* healer gave me a book in Arabic language titled '*An Interview with a Muslim*

Jinn' which talks about the life of *Jinn*s. The book is written by an Egyptian religious scholar and journalist on the basis of his long interactions and interviews with a Muslim *Jinn*. The *Jinn* reveals the mysteries of their life and the preventive measures the human beings can take to protect themselves from their harms. Interestingly, the book starts with the word: '*prevention is better than cure'*. One thing to be noted here is, the similar ethnographic studies on *Jinn* healers like Das (2015) and Kakar (1982) show there are several regional differences among Muslims in such beliefs even though the textual references on *Jinn* are similar. In her 'dwelling' accounts of a Muslim healer in Delhi, Das (2015) talks about his smooth and troubled relation with their 'family owned female *Jinn*' and other inhuman beings, especially when their ancestors had to migrate to Pakistan in the course of partition. They had to make a decision on the future of inhuman beings as well just like the other properties if they migrate (Das, 2015: 133-158).

Differences on the Sources of *ilm* (knowledge)

The conflicts and debates on the two sources of knowledge, namely, the *zahiri* (literal or exterior) and *batini* (inner or hidden) meanings have been an inherent part of Islamic history which is intertwined with the concept of healer, saint and holy men (cf. Das 1984; Kakar 1982). In Thirurangadi for instance, Muslims were divided on the Islamic validity of a saint who had claimed to have rare knowledge through invisible sources like *ilham* (information given by Allah instantly to holy men). A *thangal* from Bombay settled in Kondotti near Thirurangadi, professed that he rose to sainthood through meditation of for years in forests. These kinds of practices like acquiring sainthood through meditation which are addressed in anthropology as 'esoteric'[58] (interior knowledge) or 'Sufi' Islam were always questioned by a group of scholars. The 'esoteric world' includes the belief in the supernatural power a saint gets through meditation, preferably in forests, the saint can progress into the post of '*sheikh'* and he can appoint the *khalifa* as his representative. The Sheikh who acts as *murshid* (guide) to his *murids* (disciples) gets the consent of disciples through their *biat* (consent); he can give *ijazath* (permission) to his disciples to practice any sacred word (*dhikr*) which may have particular effects. The same practices done by Kondotti *Thangal* were opposed by the *ulema* of Ponnani and Mamburam *Thangals*. They

[58] The dual concepts of esoteric (*batiniyya* or interior) and exoteric (*zahiriyya* or exterior) are fundamental to the Sufi world which seeks to reach the esoteric knowledge going beyond the texts and the 'created' world (cf. Werbner, 2013: 51-52).

rejected his practices as un-Islamic in the light of *sharia* laws. Mamburam *thangal* and Ponnani *ulema*, even if they were Sufis, believed in the Sufism which is grounded in normative moral order of *sharia*. In defence, the *ulema* who supported Kondotti *Sheikh* like Qazi Abdul Aziz Musliyar claimed, "*theologians are nothing to do with the actions and methods of Sufis who are outside the purview of shariah"* (Hussain K, 1997: 229).

Kashf is another concept related with the source of knowledge among the healers, which means the vision one gets after a long meditation, an unveiling of mysterious knowledge, inaccessible to the commoners through meditation practices, sleeping near the tombs of *Sheikhs*, and recitation of prescribed words (Ingram, 2009). In Sufi thought, the accepted religious knowledge is that which is acquired under the guidance of an acknowledged master or supervisor without whom religious insight could not be achieved. Whereas for reformists, such as Mujahids in Kerala, Islamic knowledge can be directly accessed from texts taught by a teacher. They consider Quran and authentic *hadith* as the accepted sources of religious knowledge in Islam. They argue the divine revelation from the sky (from God) to the human beings has ceased to exist, only the prophets can get the revelations from God and it was stopped with the demise of Prophet Muhammad, the last prophet. Existence of these two contesting belief systems on the sources of knowledge among Muslims is inherent to the concept of the healers that we are exploring in the following sections.

As we noted in the first chapter, approaching the Islamic knowledge tradition in this way and situating the healers and patients inside this tradition stands away from the thinkers like Ernest Gellner (1993). Gellner was one among many scholars who understood the Islamic phenomenon like Sheikhs and holy men and the acceptance of their practices only through the sociological categories like class and tribe. Gellner observed, the urban elite could do without meditation since they have access to the written sources while the illiterate tribal majority required the direct experience of religion through intermediaries. In this way, he says, there developed a sharp and enduring contrast between two religious styles. But for him, this contrast is purely on the basis of social stratification. For Max Weber, this contrast is of the distinction between asceticism of the puritan and the mysticism of the saints (Turner B, 1974: 55).

Nevertheless, as we mentioned about the religiosity of Sunni groups in Kerala in the introduction of this thesis, in order to understand the nuances of religious life in the field, we need to think beyond the simplistic stereotypes. For instance, we may see 'reform Sufism' or 'puritan Sufism' and 'mystic reformists' or 'piety Sufis' that may crosscut the given anthropological categories.

Thangals, Ustads, Beevis: Forms of Hierarchy and Authentication of Healers

Many anthropological works have come out on different aspects of Muslim healers in various sites (for instance, Kakar 1982; Flueckiger 2006; Das 2015, Lang 2016). However, our focus here is to explain their share in the health of Muslims in a *mahallu*, and the ways in which process of authentication takes place in the religious community among three categories of healers, namely *thangals*, *musliyars*, the male healers, and the female *beevis.* It also shows the complex ways in which distinct groups within Muslims profess their health behaviour in the background of religious discourses. Our focus on the validation and acceptance of the healers by the community would show the religious validation happens not only through the production of scholarly discourses, but also through the ways in which they are accepted by the actors in the field. The process of validation inside the tradition becomes complex and nuanced when it is the matter of health and illness.

Thangals: Sacred lineage and Validity of healing

Thangals are believed to have special religious status and sacredness among Sunnis. They claim their lineage to prophet's family, and that sacred lineage helps them to have special respect and treatment unlike ordinary Muslims. Their presence is highly sought after by Sunnis in the *mahallu* for their housewarming, shop inauguration, *nikah*, and for putting the foundation stone of the new house. All *thangals* have organizational affiliation; some of them follow the Mujahid ideology, and there are *thangals* in EK Sunni group and AP Sunni *thangals*, and there are some who support *jamaate-islami*. However, it is important to note that all *thangals* who 'sit' for healing are exclusively Sunnis either AP or EK faction because Mujahid and Jamaate-islami *thangals* will not be healers; they are ideologically against the special status accorded to *thangals*. However, majority of *thangals* are Sunnis like the 'ordinary' Muslims are.

Most of the healers in the area are *thangals* like Panampuzha *thangals* of *Jamalullaili* family, *Thurab thangals* of Parakkadavu, and *Jifri thangals* of Kakkad and there are many other *thangals* who do not sit for healing. I could hardly find any female member of any *thangal* families who sits as a female healer; all of them are males. There are 'successful' and high earning healers and 'failed' ones who are dependent on the range of acceptance of their piety and efficacy among the community. The acceptability can be analysed as the healers in the area explained it, *mantram* (sacred words), *thanthram* (healer's strategy), and *yanthram* (power of medicine). They say those who make the best use of these three features can only succeed in the 'healing field' which is also subject to the response of the community who always watch and certify them on the basis of multiple factors. Most important of those factors are their religious life as healers, and the efficacy of their healing.

Case of Successful *thangal* Healer

'Being a *thangal'* or being part of *thangal* family itself is the factor that helps him to claim as an effective healer. Their acceptance among the seekers and their rush depends upon each one's reputation in delivering the result. There are highly visited 'busy' *thangals* and there are *thangals* without seekers. Muthukkoya *thangal* who belongs to the PKS family of Parakkadavu *thangals* sits for healing in the attached building to his home in Thalappara and he has a pharmacy to distribute Unani and Ayurveda faced to the national highway. He can be considered as a successful healer *thangal* who attends around 60 'patients' in a day; one has to book two days in advance to get his consultation. Another *thangal* belonging to the same family who sits in a nearby village however gets only one or two patients a day. The varied level of acceptance of healers indicate that there are certain factors that condition the believers' strategy of selection and classification of healers even if they are from *thangal* family.

Let us take the case of a successful healer *thangal*, PKS Pookkoya *Thangal* known in the area as 'Thalappara *Thangal*'; his consultation room and pharmacy is situated in Thalappara on the side of NH 17, two kilometres away from Mamburam. It was very difficult for me to get an appointment to have a conversation with him because of his busy schedule. Apart from the working hours (9 am to 4 pm, from Saturday to Wednesday), he is busy with attending prayer conferences as invited guest and completing the prescribed

course of *dhikr* assignment as part of his *ijazath* for healing. Regular whispering of the sacred words for prescribed times is necessary to remain as the effective, successful healer. He says:

> Being a *thangal* has made me a healer, 99 percent of my family are healers. *Thangals* have the qualities of *vakku punyam* (effect of word) and *kaipunyam* (effect of hand) blessed by Allah. However, you have to maintain those blessed qualities; a *thangals's* life should be pious keeping these virtues in order to possess these qualities and to have position in society. There are dissolute *thangals* in our family who deprive of their blessed qualities.

He attends to a variety of illnesses, from physical, mental, seekers for well being, fulfilling the desires, solution for family problems and prescribes accordingly, sometimes giving amulets, or just giving his 'words', or giving the Ayurvedic and Unani medicines through his pharmacy. Sometimes he advises the patients to make a vow to contribute to the *nercha* (annual commemoration ceremony of deceased) conducted on behalf of his late father and son. When our conversation was going on, a woman came with her *nercha* contribution; *thangal* received it and prayed for her instantly. He then explained to me that her son met with an accident and suffered serious head injury; after making a vow to contribute to the *nercha* she observed a slight improvement in her son's condition.

He reported that though he prescribes Ayurvedic and Unani medicines, his patients mostly seek help for the illnesses caused by the devils. These illnesses, according to him, cannot be detected in the MRI or CT scans and cannot be found and diagnosed by the doctors even if the patients experience acute pain, which are exclusively taken to the healers like him. These are the 'unseen' illnesses diagnosed and prescribed exclusively by the healers like *thangal* which cannot be traced to the anatomical defect in the body of a person who suffers from acute or chronic pain which is regarded by the biomedicine as 'illegitimate' or as the 'imagination' of the person (Sujatha, 2012: 79).

Thangal attends to 50 to 60 'patients' (he calls them '*rogi'* which can be translated as patient) everyday; he calls the seekers in a group in case of heavy rush except when 'some secret cases' that need privacy. He explained how only healers like him could find a solution for private problems such as breaking an adulterous relationship and 'implant' a

new bond of love and togetherness between the couple. He revealed about the most surreptitious methods of healing used in 'emergency':

> Our grand fathers wrote in our hereditary healing texts about the *thaksirs* of *firaq* (separation) which can be used only for good purposes, otherwise it would be *sihr* (sorcery) usually done by the disbelieving healers. Many husbands and wives come here who complain about the illegal relationship of their partners. These are the common problems I have to attend daily because of the misuse of mobile phones and internet. I give a piece of paper written '*oh Lord, please separate between these two'* to be put in the path tread by the secret lover. When he or she steps on, it will influence their mind and make them rethink their illicit relationship and hate each other. Then I give the 'patient' handful of sugar after endowing it with *mantram* of reunion to be put in the sugar pot used everyday. As much as he or she consumes the sugar with tea of coffee, the bond of love between them will increase day by day and they will become a happy couple.

His family has the collection of healing texts which are the compilations of the general healing books available in the market. However, sometimes he has to invent new *thaksirs* [59] to prescribe for new illnesses if they are not mentioned in the texts. The new *thaksirs* will be added in the family texts so that it can be used by the next generation healers of the family. For certain other kinds of illness, he approaches other *thangals* or *sheikhs* specializing in dealing with them to receive new *ijazath* (permission) to heal particular illness which, according to them, is essential for the healing to be effective. *Ijazath* is granted on conditions that reciting any *dhikr* particular time everyday helps the healer to have a connection with the holy men and through them with the invisible beings of angels and *Jinns*.

Apart from being *thangal* healers, his family began to learn Ayurveda to take advantages of the mainstream healing systems of those times which has given him a wider reach than other *thangals*. He was also trained in Unani medicine but it has become a meagre percent of the total business whereas Ayurveda practice has been his family tradition and the dominant feature of his profession as a healer. We have noted in the previous chapter

[59] *Thaksir* is the end result of the calculation with the representing numbers of the patient's and his mother's name. *Thaksirs* are written in form of tables given as prescriptions for different illnesses to be kept in the amulet or put in the water and drink. Each illness has its own *thaksir* and *table*. For details of healing system among Muslims in Kerala see Zirajuddeen (2013).

about the history of *thangals* and *ustads* in the region who had primarily practiced the Ayurveda adding some Islamic elements such as *urukku* and *mantram;* they were the *Vaidyars* of the region consulted for every illness.

His case is a counterpoint to some of the anthropological studies on healers in the context of Kerala (Tarabout 1999, Halliburton 2005, Lang 2014). They argue that the 'ritual healers' appropriate psychology and the 'modern universal categories' to express efficacy which has become the dominant reference point for religious healing, not only because of its virtues but also because it is associated with a technologically and politically dominant West. Instead of engaging with the 'modern discourse of psychology as part of increasing rationalization and scientification of therapeutic practices' (Lang 2014) as these studies argue, Thalappara *thangal* in our case, engages with the discourses of authenticity and acceptability through Ayurveda which has been historically part of their family profession. Being a *thangal* and *Vaidyar*, his experiences with the seekers give a different perspective to approach the discussions on '*somatisation'*, '*psychologisation'*, '*dissociation* to the third enemy', and '*religionisation'* of illnesses which are the general themes in the studies on the 'ritual healers' like *thangals* (cf. Kleinman 1983, Lang 2014, Halliburton 2005). Illustration of a case that *thangal* has cured will serve our purpose. Thalappara *thangal* says:

> As you know, in some cases, we also diagnose the illnesses and prescribe through the numerical calculation of alphabets, it is a kind of augury, just like taking an umbrella looking towards the clouds. But, there are many fraud *thangal*s who frighten their clients by fabricating the unreal things and making money out of it, such as telling them that one of their loved one is going to die or their enemies have done 'something' against them. In addition, they will prescribe some rituals and demand huge money to conduct them; it is *haram* (forbidden practice).
>
> I had an experience of meeting with a family trapped by a fake healer while healing the chronic crying of their little baby girl. He frightened them that 'somebody' had done *sihr* against them and one of them was going to die within 10 days, he demanded ten thousand rupees to conduct the 'ritual solution', but her problem did not cure, and they have gone to a doctor as well. When they approached me, I prescribed to her some medicine and blown on her with *mantram* and told them to come again after three days if it did not subside. Her primary problem was allergy in

> the nose along with the evil eye fallen on her because she was a smart girl. When I described the reason behind the problem, they were repeatedly asking me '*still, is there 'anything', thangal*?' I scolded on them; "*don't ask this question, why are you insisting on sihr, don't believe in anything blindly, who will do sorcery against this small baby*? The unnecessary queries like these will invite deceit and dangerous traps. She is suffering from snuffle, so she cannot breathe well and not able to feed milk properly, nothing else. The third day they came again and she was cured.

Here, *thangal*, the religious healer, rejects the possibility of other forces such as sorcery and locate the illness back to the body, disassociating from the 'invisible third enemies', and his words are believed by the seekers. Instead of associating the illness to the external 'forces' that may save the afflicted person from the blame such as female infertility, as we see in Unnithan (2011), Lang (2014), and Kleinman's ritual healer (1980), *thangal somatises* the illness. His expertise in Ayurveda along with the religious healing might have influenced his explanatory model.

Apart from the norms of acceptability from the community, the other agency he has been engaging with, like many other healers, is the *state* and the legal requirements and restrictions enacted by it. State government in Kerala conducted an extensive survey and widespread inspections among the healers like him following the arrest of fake healers. There have been raids, inspections, and new enactments when any instance happens such as the Ervadi tragedy. All state governments had to make inspections and submit affidavits following the Supreme Court's suo motu intervention in the case (Davar and Lohokare, 2012: 256). Common to the affidavits filed by all states was their recommendations to establish modern treatment facilities in order to prevent people flocking to the religious and other 'unlicensed' places such as Dargahs, temples and churches that do not have 'expertise'.

Here we see Pookkoya *thangal* has to go through the validation processes and prove his authenticity in two ways, one from his religious community and the other from the state health department that is yet another form of authority. He explains his experience of going through the authorization process of the state:

> The state government has brought a new regulation in the form of a compulsory course for the *paramparya vaidyas* (traditional vaidyas) and it was mandatory to pass the course and give an interview for the health department to heal anymore. When the

> law was enacted, the Mujahids here threatened me that my *chikilsa* would be closed down. I decided to go through the legal procedures in order to make my *chikilsa* legal. I went to health directorate in Malappuram and gave an application and appeared before the interview board comprising the DMO, drug commissioner, and the official *vaidyars*. The interview was conducted in the district collectorate. They asked me 14 questions such as 'what are the medicines you prescribe? I said, *amritarishtam* for fever, *dashamoolarishtam* for tiredness, and then they asked me about the ingredients of the Ayurveda medicines. Later, I got the license through the excise department to see and consult the patients, prepare medicines and to sell them.

We see here the ways in which the non-institutionally qualified practitioners like him engage with the legitimating discourses of the state and the newly emerging institutional requirements for professional healers to practice and sell drugs. He attempts to make his practice 'legitimate' by placing his healing system under a label approved by state which is *paramparaya vaidya* (traditional medicine) and Ayurveda which was once the 'official' medical system in the region.

To my query as to why most of the practitioners are *thangals*, the *thangal* healers' the response was that *thangal's* hand is more powerful in healing than others and their lineage is pure; all in the chain are Muslims until Prophet unlike the 'ordinary' Muslims in Kerala whose ancestors could be non-Muslims. In the healing to be more effective, one's background and his routine religious activities are important; that it should be 'pure' and religious. Another *thangal* healer who is also working as the *mudarris* (main teacher in the mosque) explained it with more textual details. He said for the healing to be effective, one should have its own *ijazath* (consensus from the concerned authority of healing) and we are getting the *ijazath* from our ancestors. Here, the *ijazath* has been transmitted from one generation to another; in the case of *thangals*, it has been easily transmitted because all of them in the line of our genealogy are 'pure' from being non-Muslims. He says it is sure that all in the line of genealogy until the Prophet are Muslims.

As we noted earlier, the healing involves handling powerful forces in annulling the sorcery done by enemies and could put the healer and his family at 'risk' of bouncing back. There is a possibility of nullified devils bouncing back and attack the healer or his family members. In addition, there is possibility of possessed *Jinn* may be reluctant to leave the body even after the healer's death. So, the healer always needs a spiritual 'back up' for his

safety and the position of *thangal* is a supportive one that works as an 'immune system' against the harmful devils.

The *mudarris thangal* also added that generally, he refrains from healing with eggs, coconut, or cucumber because, for him, they may contain the fragment of *kufriyyat* (infidelity). According to him, the healing methods of *asma* and *thalsamt* are to help somebody engulfed in any major problem; the methods to recourse on when in dire necessity in order to rescue human being from the devil clutches. As part of his religious piety, he restricts his healing on blowing on water, thread, or amulets, the daily needs of the *mahallu* residents under his jurisdiction in their everyday life. Many religious scholars like this *mudarris,* well versed in the healing texts and practices too, had refrained from the full time professional healing because of the possibility of infidelity.

Failed *Thangal* Healer

Now we turn our attention to another *thangal* healer who was unsuccessful in bagging the recognition of the community as an authentic and effective healer. We are trying to illustrate that the idea of a 'good' healer is subject to the authentication process of the community which depends not only on the doctrinal validation, but the result of healing as well certified through experiences. PKS Kunjikkoya, a *thangal* healer from *thurab* family started the conversation citing the authentic historical sources that testify the *thurabs* are original *thangals* whose ancestors migrated from *khurasan*, now part of Iran. He also showed me the chain of his ancestors that connects him to the Prophet. *Thurab thangal*s are considered as 'specialists' in earth, consulted mainly to find appropriate site for making a house and digging a well along with other illnesses such as finding out lost objects. One thing that seemed interesting from his observations on the seekers is the fact that it is men who visited him for the earth related issues such as finding appropriate land for constructing house or the plot for digging wells or site for companies. For problems such as children's illness or finding out lost objects, most of the seekers are women[60].

[60] The gender based division of labour in the domestic space that allocate the rearing children and taking care of their health for women and construction of house and buying of properties for men might of course reflect in the gender composition of remedy seekers. Majority of the cases who visited our healer informants were women looking for their lost gold jewels for which they are accountable to their husbands. Analysis of this aspect among the seekers is an interesting area for further research which comes beyond the scope this thesis.

There is speciality for the place they select for 'sitting'. To avoid the fixation of particular cases and to attract the multiple seekers, he sits in Parakkadavu from morning to evening and sits in another place from evening. As a result, he gets male seekers for the solution of property and wells in Parakkadavu and women patients in Thayyilakkadavu for variety of illness. He claimed his ancestors got the *ijazath* (permission for healing) from Mamburam *thangal* and they are continuing their profession with the power of this *ijazath*. When asked about the sources of his knowledge and intuition to fix the appropriate sites on the earth, far away sitting here in this room, he said,

> It is a special power Allah has given to us. When somebody approaches me to fix the site for well or house, I could give them the written slip of the appropriate site. It happens through *ilham* (special surmise) given to my mind at that point of time. Many have told me that they could find subsoil water digging at the exact site I suggested to them; it is the power of my *ilham*. Sometimes I may depend on the calculation of letters and tables of *ismu*, but we could get only 70 or 80% accuracy through *ismu* calculation. What matters is the power of *ilham*, *ijazath*, and the power of 'word' given by *thangal* that the ordinary men do not have.

He also said that even though he possesses some healing *kitabs* (texts) written by his ancestors and inherited by him, generally he does not read and depend on the texts. All *thangal* informants shared to me the same; all of them have their own healing texts compiled by some of their ancestors and inherited only through their family, which are not available in the market. The scholar *thangal* showed me some strange lines in their ancestral healing books. His explanation was some of the lines in the books were written in code language, not in Arabic or Malayalam or any other language, the learned men could only understand it. They contain 'big secretes' and 'mysteries' written so as not to be used by fools or errant healers. For instance, the poem of *jaljalooth* composed by Ali, son in law of Prophet Muhammad, contains the ideas of all healing knowledge and the 'secrets', but in a mysterious language that ordinary scholars cannot understand.

Sometimes, he prescribes to the patients to make a vow to contribute to Mamburam maqam. When our conversation was going on two families came; one of them was looking for their lost jewel and the other for the hysteria of child. He assured to the former that the jewel did not go outside and insisted to check inside the house itself. To the second family he gave a thread blown with *mantram* and a 'written egg' to stop the hysteria.

On the classification of healing practices into 'allowed' and 'forbidden' his response was:

> The prescription is according to the illnesses, sometimes I write on eggs, tender coconuts, or cucumber. If the illnesses are due to *sihr* (sorcery) or evil eye these items are suitable to make them *batil* (cancel). I will not do the 'other works' considered as '*sihr'* such as segregating between husband and wife even if somebody offers crores, I will repel him strongly. It is very easy to earn lots of money if we do not follow the categories of *haram* (forbidden) and *halal* (allowed).

He cannot prescribe medicine because he does not have the government license and does not heal with *Jinn* since he did not learn that skill. He is not able to attract more number of care-seekers because he fails to make best use of the three essential qualities a healer should have to be 'successful' as mentioned by them, the best combination of *mantram* (sacred words), *thanthram* (personal strategy) and *yanthram* (prescribing appropriate medicines).

The Learned Skills of *Musliyars*

Musliyars are the title of the male religious scholars addressed by other people in the *mahallu* as *ustad* that means the teacher. For *musliyars* or *ustads,* their scholarship in religious books accredits them as authentic healer. Generally, they work as teaching staffs in the madrasas or in mosques. Some of them, who have learnt the healing knowledge from the healing texts along with *ijazath* from authentic *shaikhs,* utilize the free time after the madrasa and mosques duties as healers; but they are not *thangal*s. Shamsuddin Musliyar of Kondinji and Majeed Musliyar of Chullippara are such healers called by the people as *ustads* or *musliyars*. Other common *ustads* who do not work as specialist healers are also consulted to blow the water with *mantram* or to write in the ceramic plates to wash and drink. When I was living with ordinary ustads, our food was fixed in different homes on monthly rotations between the *mahallu* households. On one of such days, after dinner, the elder female member of household handed over a pot of water to the main *ustad* to blow with *mantram* as a solution to the incessant crying of the kid in the house. He had learnt the method because the principal *ustad* in a Sunni mosque was expected to perform them as well. Sometime later, he was given the job of writing on the plate. *Ustad* went to the market to purchase this medicinal ink which is rare to find and available only in the Muslim Ayurvedic shops like '*Thangal*'s pharmacy'.

Women and Healing in Islam: Case of a *Beevi*

For the female healers among Muslims, known as *beevis,* only the possession of powerful *Jinn* who are generally considered male, sustains them as an effective healer. If not *Jinn* then her discipleship to a 'powerful' male saint, dead or alive, will be the source of her healing 'power' and 'validity'. The independent powers they are believed to possess are accorded a negative connotation. For instance, a Islamic scholar explained the prevalence of female presence among the Muslim healers unlike other religious positions. He said, the women's whispering is more powerful in the efficacy of sorcery and they are rarely seen as the holy saints or scholars.

Flueckiger (2006) finds that the power of female healer depends on her male master or her husband's qualities. In contrast, we have found some positive religious explanations that give them independent healing power that they acquire through their piety and religious observance. The *thangal* healer who is also the *mudarris* in the *mahallu* explains the reason behind more number of women in Islamic healing,

> To be efficacious, the healers should keep circumspection in their religious and personal life. Thus, they have to keep away from doing sins and they should fulfil the requirements of religious piety such as performing the compulsory and recommended rituals regularly. In this sense, women are getting less chance to commit sins since they are very less frequent outside their home and they get enough time to perform the religious rituals regularly and focus on the growth of 'pious self' which bestow upon them the power of words. Men who are generally engaged in other works, find it unable to maintain the required rituals regularly and lose the concentration on the growth of personal piety and deprived of the 'healing power'. Hence, the healing among Muslims becomes the apt field for the women to try their expertise.

Let us take the case of the *beevi* in Chullippara. It has been said among the *mahallu nivasis* of Chullippara that she once became a *beevi* (the Muslim female healer) as she was possessed of a *Jinn* from the outskirts of Chullippara madrasa when she was a student there in her early age. After this incident, she got 'special' powers and skills and the 'patients' and seekers began to reach there even from far areas. In addition, they claimed only the people from outside are coming here while most of the locals 'do not go there'. One of them explained the reason which will tell us the ways in which the authenticity and efficacy of a healer is formed through the acceptance of the community.

Ismail Baqawi, a reputed religious scholar in the *mahallu* known for his piety and knowledge in religious affairs and possesses a prestigious degree from an Islamic higher institution, has lost faith in her 'authenticity' because he has some reservations on her religious life in the past. For his problems, he usually visits Bapputty ustad and avoid visiting the *beevi* of his own locality even if she 'works' just near to his house. For him, Bapputty ustad is a 'good' Islamic healer who is very pious and serves Ayurvedic medicines. Like Ismail *ustad,* the president of the *mahallu* also kept a distance from her, even if he did not criticize; he said 'I don't go there, but I don't oppose her'. At the same time, I could also find some hard supporters of *beevi* as well, like Ahmad Haji. For him, she is fine; she contributes to the mosque and madrasa, conducts *swalats*, *dhikrs*, and *ratibs* at her courtyard, which are allowed by Sunnis. However, he does not go there for *chikilsa*, rather; he is a regular visitor to participate in the *maulids*, *ratibs*, and *nerchas* conducted to commemorate the death anniversaries of saints whose help is crucial for the healing to be effective.

These kinds of 'insecurities', one from her opponents in the *mahallu* and the other from the state in the form of police raids might have made the *beevi* take enough precautions before meeting the strangers. It was only because Hamsa Haji, the *mahallu* president accompanied me to meet her and introduced me that she agreed to have conversation. She generally avoids face-to-face interaction with strange men; the male patients have to sit outside and can talk to her since inspection of body and 'seeing' (using Foucault's term) is not required in these kinds of healing. She could give the prescriptions from behind the curtain. Avoiding the interaction with men which is discouraged in Islam will add weight to her authenticity as 'genuine religious healer' even if the patient-doctor interaction between men and women is allowed in Islam. Since I went with the *mahallu* president whom she knew well, I was invited to sit inside.

Her healing room was set with green cloths just as inside the *dargah* and a block of perfume tree *aud* was fumigating with good smell[61]. There were small bottles of medicine and tablets kept in the shelf behind her. She also gives Unani medicines for some of her patients. The courtyard of the house was well set as a small stage for congregation with

[61] *Bukhoor* (fumigating with good smell) in the healing room is an important element in Islamic healing. According to the healing books such as *Manbaa Usoolil Hikam* and *Shamsul Maarifu-ul-Kubra,* fumigating with good smell is essential to attract *Jinn*s and make them present in the healing process. Even if she is not aware of the healing books as she says, she followed the general features inherent to the Islamic healers.

big sound boxes to conduct the fortnightly *dhikr* congregation which she says is her main healing method. Her own explanation about the source of her skill and knowledge in healing points to the specific ways in which the female healer among Muslims functions and gets acceptance in the community through the institution of *mahallu*,

> I do not have formal educational qualification in religion and school; I went to madrasa only up to second standard; what made me a healer is the miraculous experience I had when I was six years old; I was possessed of a *Jinn* which all of them in the *mahallu* know. I am not like many other *beevis* who were possessed with *Jinn* from Ervadi *dargah* because I became a healer from here itself. I would not tell the details about that incident[62]. Now with the grace of Allah and the prophet of *Khidr*[63] everything goes fine. I did not learn the formal religious texts or the healing books; the source of my healing is dependent on my connection with the holy men like CM Valiyullah and Mamburam *thangal*. When each patient approaches me with different problems, I recite a *fathiha* (first chapter of Quran) in the name of these holy men following which the solution and prescription will come to my mind.
>
> Another method of healing is we conduct *dhikr* on every Sundays and Wednesdays as per the *ijazath* (permission) from CM Valiyullah. I ask my patients to participate in the *dhikr* with the intention of the purpose they have come for and it will be fulfilled. I do not tell them that 'somebody' has done 'something' against them; it is very easy to make money through these ways. I do not use the calculation and tables of *ismu* or *thwalsamat* because all of them are *anthavishwasam* (blind belief). However, I do *ziyarath* (visiting the shrines of holy men) regularly which is my strength.

Most of the cases she attends daily are those who have lost their belongings; she advises them to recite some *dhikr* and tell them to make a vow to contribute coconut and jaggery to the rice gruel prepared on the day of *dhikr* on Sundays. She says people are 'afraid' of her name; if somebody lost anything and says publicly that 'I am going to see the *beevi* of Chullippara' the thief would give it back out of fear. Many of the visitors are getting back their things. There are visitors suffering from the physical problems as well; their

[62] The texts on healing like *Manbaa* also mention, as it is generally followed in the Islamic mystical tradition, to keep 'particular' things revealed to them as a secret unless those who are to receive them reach the mature stage of spiritual growth.

[63] *Khidr* is the name of a prophet mentioned in Quran. According to the Sunni teaching, as it is mentioned in their madrasa text books, Prophet *Khidr* is one of those who are immortal (they will not die and live until the day of judgment) along with prophet *Isa* (Jesus Christ), Prophet Idris and Illyas. Based on these textual references, local beliefs have it that Prophet *Khidr* who is blessed with various secret knowledge and skills given by Allah may appear for good human beings.

'medicine' is to drink the water kept in the midst of *dhikr* and some of them will take the water along with them. She says the patients with *badha* (possession), *branth* (paranoia) are brought to her with chains in hand and the treatment is to let them sit in the *dhikr* and when the *dhkir* ritual rises to its high magnitude they will become tired; "they are self-cured; I don't touch or hit them" she said.

Apart from her 'contacts' with the invisible holy men in the shrines, her association with powerful *Jinn*s is also part of her being as an effective healer. She says:

> I told you that I do not believe in the magical tables and the calculation with numbers and letters. However, I believe in *Jinn*s because I have seen them, talked with them, and walked with them; those things cannot be disclosed. I am getting their help in my healing. Now I generally avoid telling these things publicly because I am afraid of the controversies and suspicions it will have. I did not have the fear when my husband was alive.

Along with the *mantrams,* the objects on which the *mantrams* are written are important for the efficacy of *mantram*. Most of our respondent patients and healers used egg, and the coconut, cucumber as well. According to the healers, the letters are medium to connect with the devils and they will be attracted to the letters and invoked in the objects on which letters are written. He also gave some 'general principles' of attraction between things. For instance, chicken eggs, cucumber, and tender coconut will attract the devils and they will be attracted to some particular trees such as *pala* tree and astonia scholaris which is the reason why the stings invoked with devils are hammered on these trees only. Some of them are considered as the final word to diagnose and fix the solution. This acceptance is very much dependent on the range of the *viswasam* (belief) of the patients in the piety of the healer and his efficacy recognised after the long observation by the believers or their previous reputation.

Validity, Credibility, and Efficacy in Healing

In the area of healers and their practices, the conceptions of 'validity' work in different ways. Validity of the healers depends upon the religious merit of her/his practices, the genuineness of the healers and the outcomes. The first one, the religious merit is overwhelmingly ideological/sectarian in nature and depend on the denomination a seeker is subscribed to. The second and the third, the explanations of efficacy and genuineness (to

be not a fake healer) are criteria established beyond the ideological differences. Rather, it seems more of the differences in personal standpoints and observations of the seeker. However, the three types of conceptions of the validity are interdependent and overlapping with each other that the healers considered genuine are also efficacious. The first criterion is primary such that only if they are pious will their authenticity and efficacy be regarded.

Let us see how the sectarian belief system influences the ideas of credibility and efficacy. The followers of the Mujahid group, especially the former Madavoor group recognised the credibility of *mantram* and its effect to heal the illnesses. However, whenever asked about *mantram* they quickly added:

> The credible prayers are those that are quoted in Quran and Hadith that anyone can blow on his own body and his own family; we do not need to approach a specialist healer; that is what we oppose.

Here, the belief of credibility is attached with the use of the word 'prayer' for '*mantram'* when it is practiced by oneself, which becomes invalid when it is done by others such as healers. The efficacy is understood to have attached to the written prayers in the text not to the power of the person, like the healer. As we mentioned earlier, we see a conflict between the concepts of efficacy of the prayers and the words used in the healing and 'reputation' of the healer as a person and his religious piety rather than the symbolic aspects of the things used in healing.

Dr. Aboobacker, a senior medical doctor in the area and a veteran leader of KNM, the first and official Mujahid organization explained:

> The solution for those who are affected with *shaitan* is Quran itself, not running towards the *thangals*, *ustads* or *beevis*. Rather; he has to treat himself with Quran and prayers, we should heal ourselves, which is what is meant by *ruqya shariyya* (authentic *mantram* in *sharia*).

Interestingly, such organizational beliefs are subject to constant changes and modifications with the emergence of new standpoints among the denominations engaged in the ongoing process of discourse. For instance, the followers of WISDOM, a splinter group of Mujahids recognised the effect of the controversial *asma talsamat* practices which the official group prohibited. They ridiculed the position of the madavoor group and KNM

against *asma* healing which the WISDOM group finds to be in consonance with Quran and Hadith. Whereas the Madavoor group leaders, even if they merged with the official group of KNM in 2014, insistently ruled out the human-*Jinn* contact as well as the efficacy of *thangals*, *ustads*, and *beevis*.

The discussions on religious merit involve an attempt to explain the ineffectiveness, and 'irrationality' of the practices and the improper personal life of healers. The core objection is the element of '*shirk'* (polytheism) in the practices. For instance, Dr. Aboobacker explained the practice of invoking *Jinn* or dead saints as *shirk*; he warned of calling anyone except Allah. He explained how it becomes *shirk* from a theological point of view, based on the real definition of *tawheed* (oneness of Allah) citing quotations from the texts with examples and logical arguments. Hearing him, I found many of his explanations were exactly matched with the teachings of Mujahid groups in their publications. He also added that one is not in need of relying on the healers such as *thangals* when he has his God to ask directly without a mediator.

The notions of efficacy formed in this way raise some questions for the discussion on the anthropological theories on the efficacy. Well-known among them is Claude Levi-Strauss's (1963) classic essay on the symbolic efficacy of healing or 'effectiveness of symbols' (Levi-Strauss, 1963: 186-205). He says the healing ritual 'works' through the '*psychological manipulation*' through symbols and metaphors that underlay his illness. It is the effectiveness of symbols and the shared symbolic space which guarantees the harmonious relationship between myth (supplied by the healer) and action (performed by the patient). He discusses the homologies (structural similarities) between physiology (body and internal organs) and shaman's song and the shared myths (myth of the spirit world) through his elaboration of the *Cuna* birth process. The shaman's arrival is with lot of preparations such as the fumigations of burnt coca-nibs, the invocations, and making of some sacred figures the symbols of which work for the efficacy.

'Experience' as a Form of Authentication

The perceived results of the practices of the *thangals*, *musliyars*, and *beevis* in the experiences of the seeker are the real points that validate their practices as an effective method of therapy. It is the stories of the result that bring forth *vishwasam* (belief) among patients in these kinds of practices. As Caton (2006) observes, in these kinds of domains

such as healing, we see the local legends; the stories of the experiences are also part of the authorization process of the practices, not just the doctrinal sources. We see below the instances of 'experiencing' the result rather than textual references, define the 'truth' in the healing practices.

My informants shared many of their 'empirical experiences' of the result from their own, or relatives, or someone they know about the result from the 'successful' *thangals*, *ustads*, and *beevis*.

Beeran's experience is about curing the chronic headache of his sister:

> For her chronic headache and dizziness, she went to many doctors, she felt better whenever she had medicine but it came back quickly. Then 'somebody' suggested the name of a *thangal*. The *thangal* prescribed to make a small hole across the house, and the headache cured after they made a hole. The experiences of watching these kinds of instances happening in our lives make us nothing other than believe in them. Let me tell you another experience of same kind. Once my neighbour built a new wall around his house and suddenly he got ill; fever and shiver. Once a beggar came and advised him to remove a rock in the wall. His illness was treated when he removed that rock!
>
> Once I was fishing from the river in the midnight, when I threw my net into the river to fetch fish, 'somebody' jumped into the river, I could not get my net back, when I switched on my light nothing was seen, I was freighted and got ill. There was a *kavu* (temple) nearby the river. Therefore, my mother approached a Hindu healer. The healer suggested not to go at that time because I had stood up in the way those 'beings' go and come from one temple to another, I had interrupted their passage, and they are 'powerful' beings.

Even if Mujahids and Jamaathis see the *thangals*, *musliyars*, and *beevis* as un-Islamic and 'irrational' healers and claim they adopt their practices at a personal level which is 'allowed', some other Sunnis in the *mahallu* however exposed how Mujahids 'deviated 'during moments of personal crises. The 'assertive' seeker Muhammad exposed such incidents which have substantiated his firm belief in the validity and efficacy of their healing practices by their known 'opponents':

> I have seen some of the Mujahids and Jamathis approach *thangal*s seeking their *chikilsa*. However, they visit the healers secretly without letting anyone know that they are going. Recently a follower of Jamaate Islami went to *thangal* for his wife. Another man from Mujahid has also gone to *thangal*. They will also go if it is 'necessary.

We see here the experience of efficacy helps to have the acceptance and the efficacy rests on many factors that we deal in the next section. The cases we illustrated also show the ways in which the *viswasam* which is necessary for the efficacy, is defined by the sectarian background and ideological positions. It is more of a specific phenomenon within the religious community than the shared cultural universe and homology considered as crucial for the healing in medical sociology (cf. Bode, 2012: 74).

Conception of 'Good' and 'Bad' Healers

One thing that is common to the healers is the controversy and doubts that they encompass like, whether someone is 'good' or 'bad' healer inside the Islamic tradition. As Rasanayagam (2006) notes, this categorisation is the product of the emergent religious discourses that always produce a 'true' version in every practice especially on healing. Veena Das (2015) has also noted the ambivalences healers of this kind bear in their practice through her accounts of a '*reluctant healer'* in Delhi. He is reluctant because he has to maintain the tightrope line between the 'light' and clandestine forms of knowledge and face the hardships dealing with the evil forces that may take his life. Das says:

> *The occult practices evoke a sense of the clandestine but the ambivalence with which they are regarded is not purely a function of modernity; they are transgressive within both tradition and modernity, yet they are widely sought as we saw in the case of studies (Das, V, 2015: 134)*

The specific ways in which the opinions about the healers work beyond the dichotomous regimes of modernity and tradition, concern me in the accounts below. We see certainties and firm belief as well as ambivalences in the attitudes of health seekers, the offshoot of the interplay between sectarian ideology, the personal religious opinions, and the experiences of suffering. We see below the specific ways in which the categories of 'good' and 'bad' are accorded to the Islamic healers in the region. The healers are subject to the authorization process not only from the part of *ulema* but also from the observations of

care-seekers and common believers which shows the specific form of orthodoxy inside the healing tradition.

Many respondents in the *mahallu* generally held the view that most of the healers were exploiting the seekers for money and true healer will not do that. The extant of doubt was in accordance with one's own personal belief and interest in these kinds of practices. Those who were reluctant to consult healers have said, "ninety percent of them are for exploitation; the true healers are very rare and they will not sit for 'business". One of them described his personal experience: "I had consulted a healer in Mukkom in Kozhikode for my wife, and later I came to know that he was arrested by the police".

There are many measuring points adapted to judge whether one is 'true' healer or not. For instance, the payment for the non-vaidya *thangal*s, *ustads*, and *beevis* is the discretion of the health seeker, because, quoting a price for the services rendered invalidates the healing power and such a person cannot be genuine healer. Anyone who craves for money is not an Islamic healer, and thus, not a 'good' healer. However, those who prescribe medicines among them, generally Ayurvedic medicines may demand the cost of the medicinal ingredients and the labour cost for the preparation if they are prepared from their home. Thalappara *thangal* responded to the query from one of his clients about his fees as, "it is according to your capability. There are some who give fifty rupees or hundred. While some may give two or three hundred. But, if medicines are prescribed then you have to pay the costs".

One of the elements that becomes important when we discuss the efficacy or credibility and the idea of 'true' and 'false' in the religious tradition regarding these types of practices is *vishawasam* (personal belief in the practice). The health seekers also have selective personal beliefs as reflected in responses like, 'I have strong belief in these kinds of practices' or 'I do not have any belief in these practices' or 'I have belief in this, not that' and sometimes 'even if the *ulema* and tradition says that I don't believe in it'. As we said in the case of *Jinn*, sometimes, the personal belief which claims to be qualified as 'empirical' or 'rational' or 'progressive' is conditioned by the religious belief; '*simply because religious tradition accepts it'*.

The efficacy is also explained on the basis of the religiosity of the healer and method of healing. Healer's everyday life scrutinized from the religious point of view. The main

reason why most of the *mahallu* members are not in favour of the single female healer in Chullippara *Mahallu* is because she fails to get the recognition of the Sunnis. Use of *dhikr*, *swalat*, verses from Quran is another instance of being authentic. The retired school principal now works as the chairman of Sunni education centre assessed the healer his neighbours consulted for their child as valid because he uses the *dhikr* and *swalat* which are *authentic* and he uses 'nothing else'. He interprets that the illnesses healed with the power of these authentic *dhikrs* and *swalats* that he uses is just a medium.

Another woman respondent shared her personal experience of accompanying her neighbour and close relative to visit a male healer in Waynad, far from Thirurangadi. They had consulted him for a solution for her chronic headache. She had 'firm belief' in this treatment and her husband had not. He said to her, "if you believe in it you may go and I will give you the money". The healer was sitting in a room. His way of dealing with female patients was, according to her, against the Islamic teaching on the male-female interaction that was not expected from *ustad*. She saw him touching women patients' forehead and hand. It is interesting to note here that this kind of norms and ethical etiquette mandatory for the religious healer required to be a 'valid' and 'good' healer are not prescribed for an allopathic or Ayurvedic male doctor while checking female patients. She said she lost her 'belief' in these practices after this incident.

She also suggested the names of some of the *thangals* and *musliyars* in the area who have been using proper methods.

> *Thangal*s of Panakkad are good healers; they examine and heal without looking at women's face. There is another ustad here whose name is Bapputty ustad. He also heals patients without looking at women's face. He blows *mantram* on men and children only, not girls and women.

We see here the validity of the healing practices attached to the personal conduct of the healers. Her son observed a healer in his area and judged him as 'fake' because the healer does not fit to his understanding of 'original Islamic' healing.

> We had *auliya* (saint) healer here. I know his lifestyle very well. Suddenly he became a healer one day. How can it be happen? There was another beevi here. People here run to her if they lost anything like gold chain or something or if somebody has stolen their things. However, when a theft happened in beevi's own house and some of her

> belongings were stolen, she ran to police station to lodge a complaint! You see. People caught her and handed her over to the police. Exploitations are happening in the name of healing, so that people are losing 'belief' in these practices.

The oppositions against *thangals*, *ustads*, and *beevis*, are also countered by defenders in the *mahallu*. Musthafa, a daily wageworker, gives his logic:

> There are many fakes among them; but the fake ones are everywhere even among the doctors. It is a religious issue; these practices have their own *kitabs* (religious texts) and it is the religious scholars who handle them. It will be efficacious only when they are practiced with *ijazath* (consensus from the teacher). I can cite many examples in our family when we visited them. My nephew had a chronic headache and was admitted in many places. At last, we took him to a *thangal* in Kottakkal as somebody advised us. *Thangal* said 'it will be cured', and prescribed some medicines which we bought from '*thangal*'s pharmacy' in Kottakkal. After two times of having medicine it was cured. Once we went to Panakkad *thangal* for a solution to the issues related with my brother's passport. The problem was solved as assured by *thangal*.
>
> However, sometimes it will not be effective it is because of our destiny; for getting the result the decision of Allah is also necessary, that is true with all other medicines and therapies. There are many fakes in the name of '*thangal*', their *chikilsa* wont effect.

The interesting fact here is the use of *marunnu* medicaments, namely the Ayurvedic and Unani medicines, enhances the validity of religious healing. Despite his image as Mujahid, Shabab defends his wife and mother who visited a *thangal* for the health of his children:

> *Thangal* prescribes medicines. If they heal with medicines, there is nothing un-Islamic in it. The problem is with amulets and prophesy.

As we noted above, the *thangals*, *ustads*, and *beevis* of the region put some efforts to augment their healing by adding up some medicines in their healing. As some of them secretly shared with me, the attempt to display the 'medicines' and pharmaceutical products became widespread when the government started to bring *mantram* healers into check. It was essential for them to have a certificate on '*paramparaya marunnu'* (traditional medicine) from the state health department in order to continue their healing practice. Here, our point is to show how *marunnu* (medicine) becomes the enhancing factor of religious validity. Moreover, the advice by *thangal*, *ustad*, or *beevi* to consult a

particular doctor has also been seen positive weight adding to their reputation as genuine and lack of exploitative motives. The best-known names of the healers the patients in our *mahallu* quote are *thangal* of Thalappara, Bapputty ustad in Parappur, and Panakkad Shihab *Thangal*s. All of them, the male healers consulted for all kinds of illness, prescribe Ayurvedic or Unani medicines and suggest Ayurvedic or allopathic doctors or Hindu healers if it is needed.

Nevertheless, even for Sunnis, the defenders of healing practices, there is an important precondition for the healer to be Islamic, he or she has to be a Muslim healer. Panicker castes among Hindus are known to be foretellers. Many of my informants considered consulting Hindu healers as un-Islamic because Hindu healers were depended on beings like *kuttichathan*, the non-Muslim *Jinns*. Yet, a few Muslims had to consult the Hindu healers under emergency and chronic conditions. Musthafa, who firmly believed in the religious objection to visiting Hindu healers, had to go to them for the sake of his brother under the compulsion of his family. He explains

> When we do not have other ways, when all other ways closed before us, our penuries will leave no other option than consulting them, and we may get the cure, but we have to try maximum to avoid it.

The idea of 'end justifies the means' in classifying 'good' and 'bad' healers is somewhat different from the similar studies in this regard. For instance, looking into the healing system of a Muslim spiritual healer at Patteshah dargah of Delhi, psychoanalyst Sudhir Kakar (1982) talks about the classificatory scheme inside the Islamic healing tradition, produced by the healers. He notes that the system of knowledge that underlies the Islamic healing classifies healing knowledge into two kinds. Kakar found that the healing practices under the domain of 'soul knowledge' (*ilm-ruhani*) are classified into two branches, namely, '*white* magic' (*ulwi*, *rahmani*) and the '*black'* arts (*saitani*, *sihr*, *jadu*). He says, the healing practices of *Baba* of Patteshah constitute only a small part of the vast domain of the 'soul knowledge' where Sufi mystical tradition is at one end and the occult practitioners are at the '*other*' end (Kakar, 1982: 32-33). Here, the health practices are conceptualized as two oppositional ends such as the exclusive religious domains of 'sacred' and 'profane', in other words, Islamic and non-Islamic healing systems.

Joyce Flueckiger's study (2006) also points to the classification by the healer but misses the nuances of interpretation of what is right and wrong in Islamic healing. The female healer, in her study, claimed that her healing was based on the Quran and identified her practice as 'religious' while classifying some 'other' practices as *kala ilm* (black knowledge) that could be used to harm others (Flueckiger, 2006: 60). The author says the healer did not consider the practices, intended to bring about some harmful effect on another person whom she has never seen, as 'black knowledge' even if she repeatedly insisted that while she knew the mechanics of 'black knowledge' she would never use it (Ibid. 119). Flueckiger makes it clear that most of the practitioners in the Islamic spiritual healing distinguish and classify between 'black' and 'light' knowledge (*kala* and *nuri ilm*), that is, the knowledge that can be used for healing and for destruction. But, the narratives from the fieldd show that the same healing practices might be experienced as 'light' from one perspective and 'black' from another point of view.

Invisible Healers as Mediators

In many religious traditions such as Islam and Christianity, those who mediate between humans and gods are often the focus of controversy and moral ambiguity who have caught the attention of the anthropologists of medicine and healing (cf.Simpson. E, 2008; Eickelman 1976; Gardner 1993). The shrines are their burial places entombing the *barakath,* charisma of the deceased that seeps into the human world, to be harnessed and transferred into the objects and people around to cure or to enhance the life of the clients. They are considered as closer to the divine, possessing the power to work miracles and to transcend the boundaries between the living and the dead. Their powers of mediation and healing in fulfilling the individual desires, curing the perilous realms of illnesses like infertility are based on the Sunni ideology which states 'some souls are more powerful and precious than the ordinary human souls'.

One Sunni scholar writes in a magazine[64] that the whole world is divided into two, the *alamul ajsam* (material world) and *alamul arvah* (spiritual world). The dead holy men from the human beings are part of this *alamul arvah* (the world of souls) who can protect from the illnesses in the material world. The practice of seeking their help from the living human beings is known in theology as '*isthigatha'* (asking for help) which is one of the

[64] Najeeb Maulavi, in *Bulbul* 10th annual edition, p. 200

main themes of debate among Muslims in Kerala. Another practice related with contact between *alamul arvah* and *alamul ajsam* is *tawassul* (intercession) which means to make the holy men, holy names, and the holy objects respected by God as mediators of prayer for well-being or protection. We get into the nuances of these concepts, beliefs, and practices related to our topic through our ethnographic accounts of Mamburam *maqam*, the most visited shrine in Kerala exists in our field, Thirurangadi.

However, against the catholic practice of the canonization of saints, posthumously declared by the central authority of Pope through institutional mechanism of papal court of inquiry[65], *sheikhs* in Islam are recognized by the people in their lifetime itself. Whereas the catholic saints are officially declared and defined by the Church and given for the public veneration, an institutional technique to prevent the sectarian splinter formations (Turner B, 1974: 61). Here the *sheikhs* are canonized by Sunnis that continues after their death in the form of dargah or *maqam* made available for human purposes. The attempt to understand this process of authorization that occurs in the field is the central objective that guides us when we deal with the 'invisible' and visible healers.

Illnesses and Healing in Mamburam Maqam

Generally, the shrines or *dargahs* are most cited in the discussions on mental illness as 'faith healing centres' in opposition to the state's idea of mental health through psychiatric institutions. One thing to be noted here is the fact that it is *dargahs* not the mosques regarded as the Muslim mental healing site along with the churches, shrines, cults, and temples (cf. Davar and Lohokare, 2012: 259).

We present here the ethnographic account of the most visited shrine (called locally as '*maqam'* which means the graveyard of saint) Mamburam *Maqam* in Thirurangadi, the *maqam* of celebrated saint and martyr in the ideological and armed fight against the British state, Sayd Alawi Mauladdawila, known as 'Mamburam *thangal*'. We see here the wide variety of illnesses including the physical illnesses such as the wounds and fractures that the *maqam* caters to on a daily basis. It tells us the domain and ambit of this healing space is wider than mere psychological or psychiatric illnesses that they are generally associated with (as Davar and Lohokare argue in their article, 2012: 262).

[65] For the detailed account of the saints in Christianity and *Sheikhs* in Islam, see Tuner B, 1974: 56-71

Moreover, we also find the constant changes in the 'problems' reported in the *maqam* according to the emergence of new diseases in the community as reported in the hospitals. It shows *maqam* is *dynamic* in nature as it responds to the changing health conditions of its visitors. The accounts of attendees, the visitors and the observation of the pattern of illnesses brought to the *maqam* and their change denote the fact that the new problems experienced in the society as part of the social change such as the economic change are reflected in the problems reported in the *maqam*. They say unlike before, they have started to hear new problems or the increase in some problems related to infertility, diabetes and the learning disabililities in children.

Inside the *maqam,* there are three separate counters, one for Muslim men, the second for the Muslim women, and third counter is reserved for non-Muslim visitors. The overwhelming majority of non-Muslim visitors are Hindus and the Christians come very rarely. At each counter there is an *ustad* standing listening to the problems of the visitors and giving appropriate solutions for each problem. The *ustads* standing inside the *sacrosanctum* say there are rituals designated as solutions for specific problems and this comes from the 'tradition of this *maqam'*. These solutions are unique to the Mamburam *maqam* and the source is "it has been practiced like this for a long time". Since Mamburam *maqam* is not known for the healing of mental illnesses like the Ervadi *dargah*, mental patients are not brought here in significant numbers. Each *maqam* is known for its healing for particular set of illnesses and each has its own remedial rituals. As for instance, the following are the solutions for some of the illnesses reported in Mamburam *maqam*:

Illnesses	**Remedies**
Mange (contagious skin diseases like scabies)	Submit black pepper
Breathing problems	Take a vow to offer rice to the regular pigeons in the *maqam*
Urination problems	Vow to make offerings of 2 litres of coconut oil
Infertility	Offer ghee (for non-Muslims)

	Particular *dhikrs* for Muslims
Bleeding problems	Cover the graveyard with red cloth
Diabetes	Vow to give sugar
Piles	Vow to give 21 eggs
For marriage to take place	Vow to donate dates (for boys), completing *qatmu*[66] of Quran (for girls)
Learning disabilities, mental retardation, autistic features especially during examinations	Give honey after touching it with the *maqam* and prescribe to blow with particular chapters from Quran

The illnesses reported in the *maqam* have a pattern. They say major problems submitted by Hindus are alcoholism of their relatives, mostly of the husband and financial debts or fulfilling the wishes such as sanctioning a loan. The remedy for alcoholism is to give the alcoholic the sugar blown with *mantram* from the *maqam* and taking a vow to give 313 rupees to the *maqam*. There are also many patients coming along with their medicines, mostly the allopathic medicines, to be blown with *mantram* from the *maqam*. Small packets of rice and black pepper are distributed and they are kept inside the rice tins to have *barakath* and increase in their livelihood amenities.

There were many seekers at Mamburam who have been referred by the local healers; the Hindu Panickers, Muslim *Thangals*, *Ustads*, and *Beevis*. We see here Mamburam *thangal* who is invisible (dead) is the most reputed healer than the living healers. The *ustads* in *maqam* said:

> Even the Hindu healers suggest to their Muslim patients to visit Mamburam and to recite the chapter of *Yaseen* 21 times or to cover the grave. Sometimes, Muslim healers send their Hindu patients here and ask them to make a vow of completing the whole Quran; we have a separate list of non-Muslim *khatmu*. In fact, their problems

[66] *Qatmu* means a complete reading of Quran from its first chapter to the end for once.

> are solved with the *barakath* of Mamburam *thangal* and these healers are taking the credit and earning money out of it.

From the accounts of patients and healers in the *maqam,* we also see the role of space in the understanding of efficacy and validity. The *ustads* also mentioned that whenever they are inside the *sacrosanctum*, they seek the permission of Mamburam *thangal* everyday before they prescribe the remedies for new ailments. The prescriptions which they have memorised would not yield result when they are out of the *maqam* or when they are at home; it is the inner space of the *maqam* which gives effectiveness to the ritual prescription.

Controversies of Intercession

Un-Islamic practices such as prostrating before the tomb, making *pradikshina* (circumambulation) around the *maqam* complex, placing rose flowers over the tomb that we may see at some of the shrines in north Indian dargahs are not permitted in the *maqam*. This means we place the Mamburam maqam inside the 'formal Islam' that classifies the practices as 'allowed' and 'forbidden', which are recognized by the Sunni purists in Kerala. Ours is a clear departure from the studies like Daver and Lohokoare (2012), Ahmad (1981), and Ahmad and Reilfeld (2004)[67] which posit *dargahs* as 'syncretic' and 'local' away from 'purists'. They say,

> *Dargahs retain a distant relationship with formal Islam, formal Islam frowns upon what it sees as expressions of abandonment, such as shamanism, ecstatic trancing, drumming, music and possession found in these places (Davar and Lohokare, 2012: 259-60).*

In similar way, Pnina Werbner (2013) has given the account of Sufi practices in dargahs in Pakistan, arguing that they are posited in conformity with the *sharia* standards. She uses the term, 'reform Sufism' attractive to both elite and rural Pakistani masses (Werbner, 2013: 54). She connects her ethnographic accounts with the history of Sufi reformists in south Asia such as Ahmad Sirhindi who advocated that *sharia* should be the touchstone of Sufi experience and mystical practices should be in conjunction with the strict adherence

[67] Notable exceptions of this trend of dichotomizing between 'popular religion' and 'reformism' on the basis of Islamic shrines are the works like Alam (2008), Green (2011), Mardsen (2005), and Simpson (2006) who have paid attention to the complexities of the positions.

to the *sharia* laws. We see such reformism inside Sufism in the Deobandi criticism of shrine practices in north India, while thoroughly embedded within the Sufi discourses of the Indian subcontinent. Rashid Ahmad Gangohi, a noted Deobandi scholar and Sufi master by himself had criticized many of the practices at tombs without rejecting such Sufi practices out rightly (Ingram, 2009). It is within this framework that we should locate shrine healing in the Sunni Islam in Kerala.

The *maqam* is not a universally accepted religious space to which all Muslims relate uniformly. One can divide the Muslim individuals in Thirurangadi as those who go Mamburam *Maqam* regularly or at least visit once and those who have not made a visit yet. This could give us an insight into the divided opinion on the religious validity of *Maqam* visit. Visiting one of the most visited *maqam* in South India that is located in their own town makes the choice significant to understand how organizational discourses condition the positions and classifications in the health practices. For instance, administrator of MKH hospital which is located adjacent to the *maqam* said, he goes to Mamburam *maqam*, and added that he goes there not to seek the help of mediators of Allah, rather just to visit the tomb of a great leader in Muslim history. Musthafa, another Sunni young man has also said to me that we should respect the holy men in the grave; but we should not directly ask their help, rather; we may ask them to help us with the powers given by Allah.

Whereas when I put this question to a student in the *dars* of mosque run by the AP Sunni faction, his reply was that he goes very often to the *maqam* which is adjacent to their residence and he added his purpose was to ask the Mamburam *thangal's* help in distress. He believes that the prayer to the God with *thangal* as the mediator will be quickly responded. He tried to convince me the process through an example:

> We do not directly approach the chief minister for our purposes, do we? Rather, we do it with any influential mediators like other ministers or any person who is close to him. Likewise, Mamburam *thangal* is the *wali* of Allah, he is the Kuthubuzzaman who is close to Him, if we make him as mediator while praying to Him, it would be easily accepted.

This response directly draws from the Sunni preaching and publications in defence of visiting *maqam*, and this informant is conditioned through his training in the *dars* of what

has been considered as the 'strong Sunnis' in Kerala. Afsal, a young Sunni activist, a common person who is not a religious scholar, tried to classify the practices based on his observation:

> I had visited Mamburam shrine once when I started a new venture. However, what really happens in the shrine is *aradhana* (worship); I have directly seen it. They are kissing on the cloth put over the grave. What is the speciality for the cloth? Suddenly his mother interrupted the conversation and commented, "If you don't go its fine; but don't say curses on them in this house". He continued, visiting shrine is sunnah (recommended), and I do it when I visit Panakkad. We do not need mediators to pray to Allah, we can do it directly to him. I believe there is nothing worth or beneficial in visiting shrines.
>
> I also visited the *jaram* of Munambath beevi once along with my friends to 'see' and 'watch it'. The men in the maqam pray for us according to our contribution. They spread the flags with different colours which are put on the grave. Nobody knows about the woman who is buried there. Now it is run by AP Sunni faction. In another *maqam* we see so many ladies who don't offer their compulsory prayers! How can we accept these kinds of practices? Is it part of Islam? These are the reasons why the arguments of Mujahids become relevant.

Here he explains his religious ideology followed by his observations which apparently seem to be that of Mujahid's:

> I am a strict Sunni. I do not believe in anything because Mujahids say it. We should get a conviction in our mind, I have to be convinced as 'right' or 'wrong' in every practices when I see them, that is important.

The purposes of the visit are various; visitors come for any problem in life like chronic illnesses or 'not feeling well', and before the crucial moments like before examinations or departing for Gulf. That means, Mamburam maqam stands as the 'consulting centre' for the life as a whole, from physical, mental, protection, calamities, to the social problems. A daily wageworker who visited Mamburam maqam along with his family tells about his strong belief:

> We usually go to Madavoor *maqam* and most often to Mamburam and it is convenient too to come here. We have come today as my daughter prepares for her school examination this week. We tell our each *vishamam* (distress) and *sangadam* (grief) to

> *thangal* papa, I have strong belief that he will not leave us and will protect us, and he will find a solution. It is a *viswasam* (belief). It is an *aswavasam* (relief) to come here. It is just like the relief we get if we express our problems to a doctor and he enquires and examines well, and the illnesses will come down. It is our belief and practices we have from my ancestors. Now there are different groups with different beliefs. Nevertheless, I did not go into anything 'new'. I am following the old path shown by my ancestors.

Here, this illiterate man and Afsal, MSc holder from PSMO College are same in submitting their application to the Mamburam *maqam* before the examinations. What we see is their *viswasam* based on ideological background defines the practices irrespective of the educational qualifications. Afsal, working as the secretary of the Sunni student wing as well, feels relieved while visiting Mamburam. He makes visit before and after most of the important examinations amidst the challenging ideological questions from his Mujahid-lenient college mates. Muhammaed, a 4th standard pass out and now a cook in Oman takes his children to Mamburam to solve their mental retardation reported from schools and madrasa.

Some of the Sunni accounts denote the role of the invisible holy men in the tomb in their everyday life, including their appearances in dreams or in 'living' representatives. These kinds of 'interventions' are explained not through arguments, but through listing the experiences. Musthafa shared his 'experience' like this; seeing my wondering face, he said this event is *haq* (true):

> Once I was saddened with grief due to the quarrels within the family and I came to Mamburam for a relief. There was exchange of words between me and my father and mother. When I was standing in front of a shop in Mamburam a strange man with sandal colour shirt approached me and said, "do not quarrel with your father and mother". I was frightened to see this, how did he know about my problem? This was my experience that really happened.

Similar accounts are given in some extensive studies on the shrines like Katherine Ewing's (1997) work on the shrine in Pakistan. She exposes, through the meaning of the followers, the invisible relations between saints and their followers which form an infinite form. Our accounts show how the meaning and experience of such relations are conditioned by one's

religious ideology which may undergo to the constant transition based on the individuals' learning and observation.

The purpose of Sindhu while visiting Mamburam Shrine is the same; she has a belief that Mamburam *thangal* will hear any of her grief and problem. She visits *maqam* once in five or six months; on the day of visit she observes a complete *shudhi* (cleanliness) taking bath and avoiding the non-vegetarian food. The employees in the shrine will ask her about the problem and give a *barakath*, generally a small packet of rice and black pepper; if the problem is fear then a sacred thread will be given.

Another young political activist who is very concerned about the validity of practices also explains his selective strategy on visiting the shrine:

> When I visit the shrines, I pray for them! Not for me to fulfil any purpose! If I ask anything from them, it is an embarrassment with my trust and belief in *padachon* (means creator, the God)? Soon after I joined my current organization, I had read a Malayalam translation of Quran. I learnt that the first chapter says 'to you only we pray', so why should we pray to others? At the same time, we should not harass the *auliya* as Mujahids do. In addition, we see many *anacharams* (blind rituals) there at shrines as well. Personally, I am against these practices. I cannot accept any practice which sees some humans above the Prophet and God.

Another important *maqam* in the region is the *maqam* of Muttichira martyrs who were killed in the encounter with the British forces, which can be seen as secondary to Mamburam *maqam*. The *maqam* is constructed in the public graveyard adjacent to the mosque. In the vast graveyard of the *mahallu*, the graveyards of the martyrs were selected and a wall built to separate them from other common people because they were considered as special men with healing skills. Even if most of the devotees do not know exactly the historical background of the martyrs, they were seen standing in front of the *maqam* and reciting the selected chapters from Quran and praying to God to solve their problems. All of them have come not solely for healing or solution of problems, rather some of them are making regular visit as a habit just like their daily prayers.

The maqam has been visited by very less number of people, but the committee members said that the mosque, the adjacent madrasa, and the salary of the employees in the mosque is met from the contributions and *nerchas* (vows) to the *maqam*. Large amount of money

is collected during the annual celebration of their martyr day, which is conducted every year for six days. The devotees bring 12 pair of rice cakes and after collecting and mixing up every cake, they are distributed among the devotees to take back to home. The organizers believe that the *nercha* celebration was started by Mamburam *thangal* himself.

Seeking healing from *maqam* and establishment of new *maqam* has been related and practiced within the *Sunni* ideology and *Sunni* worldview. There was an incident in Chullippara *mahallu*: a graveyard was discovered from one's courtyard who follows the Sunni ideology and works as the active member of *Sunni* organization. The *Sunnis* in the area believe that the graveyard arose in height automatically due to the *barakah* and power of the unknown saint buried over there. After the discovery of this unusual *qabr,* the man who owns the courtyard started to conduct *maulid* and feast in his respect. Men, women, and their children were seen in a long queue to receive the rice distributed in the memory of this unknown saint. It is only because the practicing *Sunnis* live in such worldviews that the graveyard of important saint will rise automatically that signifies his position and status. However, there are many Sunnis and non-Sunnis in the *mahallu* who oppose it and they say any graveyard would not arise automatically without being constructed by anyone.

Our ethnographic account of the Mamburam shrine shows that it is more closed and contentious space than noted by studies like Davar and Lohokare (2012) and Simpson (2008) and deeply imbricated in religious denominational discourses. Simpson (2008) tries to go beyond the dichotomy of devotion and aversion to the shrine and places the sectarian rivalry in the political and economic factors as they do with the debates of authenticity. However, our first hand impression of the beliefs and rituals connected with the shrine is their discursive character primarily, as an 'ideological practice', that are more prominent than the economic and political factors. This theological prominence make the Sunni visitors proclaim that theirs is not 'worship' (as many anthropologists like Simpson (2008) would say) even if the ritual is prostrating in the tomb or offering the flowers, instead; they all are, as they believe, the multiple ways of expressing the respect to the deceased holy men.

We saw the stories and legends in the local collective memory authorizes the practices for Sunnis, not only the foundational texts. Thus, adding to Asad's framework (1986), we

have to note there are several discursive practices at work which are analytically distinct. There are no theological texts that prescribe the liturgies of how they are to be performed in the *maqam*, rather, it is part of the locally authorized tradition, considered something that 'people do' and 'have been doing like these for a long time'. Authorization process also depends on whether they yield desirable results.

Conclusion

The chapter tried to explain the complex ways in which health behaviour of Muslims in a specific *mahallu* is shaped by religious discourses. Our aim was to explore whether we could suggest that there is 'Muslim medical subject' in that their religion conditioned their concepts, ideas, experiences, and practices of health, more strongly than other religious groups. We saw that Muslims have particular ways of understanding and classifying the illnesses and the selection of remedies like the unique power of *ruqya* (mantram) to heal particular diseases. We called this unique selection as '*ritualisation'* of particular diseases especially the mental illnesses. Thus, we argue that the aspect of religious discourses are important variable to analyse the health and medicine of Muslims. However, as we see in more detail in the last chapter, the subjective responses to the religious discourses on health tell us to add much to the existing theoretical frameworks that understood Islam through discipline and power that shaped meaning and experiences of the subjects.

We presented the ethnographic accounts of the seasonal and domestic rituals, and habits observed among some Sunni households in the *Mahallu* for the protection and avoiding misfortune. Along with the rituals, we can find some remedies inside home using herbs and medicinal preparation, many of them are regionally specific knowledge and practices other than religious affiliation. We found that the outbreak of epidemic diseases like cholera and small pox in the area was the social context behind the establishment of the rituals like *maulid* and *ratib*. They are considered as 'religious preventive measures' or 'religious medicine' to fight the prevalence of catastrophic diseases. Therefore, we think the emergence of new social diseases are followed by the emergence of new rituals to prevent which undergo to the religious discourses that classify those practices.

The chapter moved into the question of how organizational differences pattern the beliefs and practices of health and illness. It tells us to think beyond the conventional variables of

educational background, modern health education, and the class differences in the concepts and practices of illness and health. Rather, exploring the new idea of 'Muslim medical subject', our thesis showed that the religious ideology and sectarian background pattern the beliefs, experiences, and the coping mechanisms. From the accounts of the *Jinn* healers such as the *beevi* in the *mahallu* and the conversations and discussions among the *mahallu* residents, we got into the 'world of *Jinn*s', and their unique powers in healing which lead us into the different concepts of body, illness, and the ideas of 'normalcy' and 'pathology' among Muslims.

The section on the male healers of *thangals*, *Musliyars*, and the female healers of *beevis,* the three main categories of healers among Muslims showed the specific ways in which the Muslim community in the *mahallu* accepts them and their healing methods that are discriminately different in the case of these three groups. We saw even the 'achieved' quality of *thangals* in the healing was subject to the 'approval' of the community. In the process of authenticating their practices, they have to engage with two forms of authority, the religion and state, to deal with question of legalisation and legitimacy. The question of efficacy of their practices also contained these specific features.

Throughout the chapter, we see the presence of one common factor, the understanding of the classification of health practices and the interpretations and claims to be regarded as 'right' practices. Nevertheless, the concept of 'right' has also undergone to multiple interpretations by the individuals according to the contexts. Hence, we argue that the domain of health offers 'flexibility' but it is within the ambit of 'discursive religious tradition', differently believed and interpreted by its followers. Here, the concepts such 'religious cross roads' or 'vernacular Islam' attached to the domain of healing in many literatures cannot help us to make sense of the religiosity of these healers and their patients. The domain of health inside the Islamic tradition allowed the flexible interpretations on the part of the subjects, which means, they are not going out of tradition or transgressing it. Hence, the concept we explore, namely the 'Muslim Medical Subject' in the context of religious and state discourses offers a more nuanced and complex modes of the formation of religious subject in the field. We would try to depict the process of such formation in the next two chapters.

Chapter 5

Economic Change, Diet Patterns, and Health Behaviour

Changing Trends in Economic Life

Thirurangadi is characterized by uplands, slopes, low lands and the Kadalundi River ends up in the Arabian Sea snaking across the region, branching out as different rivulets watering the paddy fields. Historically, there were primarily an agrarian society in the landscape of Thirurangadi with *parambs* (hard land) and fields which are undergoing major changes in the last few decades. Large part of *padam* (wetland) and *parambs* were owned by a few landlords, mostly the higher caste Hindus, and a few old Muslim *taravadus*. Edgar Thurston (1909: 482-484) reports that Mappilas were traders or merchants on the coasts and towns and cultivators in the interior, and poverty is exclusively confined to this area where field and farm furnished the only means of support. Some of them were petty traders and shopkeepers in the towns.

Apart from the trade of spices, controlled by Arab merchants and a few local Muslims, agricultural labour in paddy land was the major source of income for the majority of Muslims in the area. In Thirurangadi, situated in south Malabar, agriculture, mainly the cultivation of paddy on wetlands was the predominant feature of economy (Lakshmi, 2012: xxii). Economic condition of the labour was insecure and the tenant-landlord relation was ridden with conflict and tension that led to the violent uprisings in nineteenth and early twentieth century. The first known reference to Thirurangadi by the British merchants in Calicut in 1745 confirms the majority of Muslim population in the village and its vicinities were living as agricultural labourers economically subordinate to the dominant Hindu caste (Dale 1990). We have noted there were rebellions and revolts against the state in the background of miserable conditions of the agrarian community in Thirurangadi. There were changes in the economic life of Muslims in the post rebellion era; the exposure of the community into large-scale out-migration was one of them.

At the same time, the situation was different in northern part of Malabar and the coastal regions of Calicut where Muslims flourished with mercantile economy, garden crops and cash crops like pepper, coconut, areca-nut, cashew nuts, dry ginger, cardamom and coffee and tea plantations (Lakshmi, 2012: xxii). We do not see any outbreak or revolt on the part of Muslims in northern Malabar against the state. As we mentioned, just as the North-South difference in the economy and politics historically, there can be seen differences in other aspects too; in customs, practices, lifestyles, and food patterns that make their religiosity different from their southern counterparts. Muslim women in the families of north did not go to the paddy field for farming, may be because of the existence of matrilineal descent whereas it is patrilineal and patriarchal in the south. Cathleen Gough (1961) in her study on the matriliny among the Mappila Muslims in Kerala has stated the difference in the pattern of descent between the north and south Malabar Muslims. As Lakshmi observes (2012: 33), the geographical location played an important role in determining the social behaviour of people in the Malabar region.

However, the present trend reports on the livelihood patterns of contemporary Thirurangadi (cf. Ganesh 2009) point to the significant shift from agrarian to non-agrarian mode of livelihood, although the region is entirely agrarian. Agriculture has declined totally, but without any increase in the non-agricultural mode of production, but trade, commerce, and construction activities have increased. In other words, despite the decline in the agricultural sector and the absence of any industrial unit or non-agricultural form of production, we see a remarkable expansion in the trading centres and construction of houses and buildings. It points to the growth of capital from remittance based on which the majority of households sustain and save. Large number of households depends on remittances from members who have migrated to the Gulf. Despite this prosperity and the substantial growth in educational and health care facilities, a large number of people, especially, the women are unemployed (Ganesh, 2009: 7). It means that the major share of population here are dependents of work force in Gulf. Before the large-scale migration, women of the lower classes, primarily agrarian, had to go out for agricultural work, which has now stopped completely.

Landlordism has been replaced by small holders due to the upheavals and various kinds of land reforms throughout Kerala. However, the low price of agricultural products which is

insufficient to meet the increasing cost of living, increasing wages for agricultural labour, absence of skilled workers, and the reluctance of Muslim household members to work in the farm fields has led them towards other livelihood options such as migrating to the Gulf, and petty trade. The region also witnessed a remarkable shift from paddy cultivation to the cash crops, and transformation of fields into gardens, especially coconut trees. The regional demands for the crops like coconut, for coconut oil production made it one of the important products in the market.

The trend also shows a substantial increase in share of the construction workers due to the construction boom in the region and the development of transport. Analysis of data also shows the decreasing percentage of cultivable land, problems of water logging in many of the paddy fields in the area in rainy season. In a road travel through Thirurangadi during monsoon, we can see the vast acres of unused paddy fields like *Mani padam* and *Venchali padam* flooded with rainwater and overflowing waters of Kadalundi river. The trend in the last two decades indicates that the percentage of cultivators is 5.41 and agricultural labour is12.91[68]. This is a sharp decline from the figures recorded in the colonial period (Malabar District census-1901, quoted by Genesh 2009: 166) that showed more than 62.2 percent of the region was agricultural population including the labours and their dependants whereas trade and industrial activities were secondary.

Apart from the dense concrete houses constructed in different styles, a walk through the main roads of Thirurangadi would show that a large number of shopping complexes, super markets, showrooms, hotels and family restaurants, furniture showrooms, and bakeries have emerged in last three decades. Trade and commerce have been expanding with the transformation of the region into large and mini-urban centres. Traditional *chantas* (markets) depending on *kadavus* (shore) like Thirurangadi *chanta* have been shifting to newer trading centres like Chemmad with more road, rail and air-cargo facilities. Growth of literacy, educational institutions, communication technology has given boost to the jobs in service sector. Despite the disappearance of agriculture and the absence of alternative sources of income in the region except the increasing share of service sectors like education and health, we see how remittance income sustains the economy of the region.

[68] Census of 2001: provisional population tables, Quoted by Ganesh, 2009: 8

Growth of a commercial and consumerist economy from Gulf remittances was also in line with the corresponding change in lifestyle and taste.

Migration: Emergence of New Classes, Lifestyle and Religious Activism

In Kerala, known for its migration, the emigration is dominated by Muslims; their share of total emigrants is 44.3 percent, much higher than their share in Kerala's total population which is enumerated as 26.7. There are 59.1 percent emigrants in 100 Muslim households whereas it is only 18.1 percent for Hindus and 29 percent for Christian households. 53.3 percent of Muslim households has at least one emigrant or return emigrant whereas it is 19.6 for Hindu households and 21.3 for Christians. The remittance to Kerala from abroad in 2011 was estimated approximately at Rs.49, 695 crores that is 63,315 rupees per households. Of them, Muslim households received Rs. 23,089 crores in 2011 which amounts to the 45.6 percent of the total remittance, compared to 36.4 percent share of Hindus and 17.1 percent of Christians (Zachariah K C and Irudiya Rajan S, 2012: 6-7)[69].

However, only a small fraction of the Kerala households (17.1 percent) receive the foreign remittance in 2011 and the vast majority are not the direct beneficiaries of this large amount of money. The interesting fact is that the proportion varies considerably by religion and district. 11.4 percent of Hindu households and 14.4 percent of Christian households receive the foreign remittance whereas it is 36.6 percent among the Muslim households. In the district wise distribution, it is as high as 36.6 percent among the households in Malappuram district which received Rs. 9, 040 crores in the year of 2011, which is 1,14313 per household[70]. The study also denotes the presence of emigrant or return-emigrant has made positive impact on the quality of the life of the household, possession of luxurious house and consumer durables and the increase in the proportion of food intake, consumption of cooking gas etc[71].

If we go to the Malappuram district where the share of Muslim population is 70.9 percent, the percent of migrants per 100 households in 2011 is 71.2 percent, a decline from 88.5 in 2008[72]. It shows the largest number of emigrants from Kerala is from Malappuram district

[69] Zachariah K C and Irudiya Rajan S (2012) *Inflexion in Kerala's Gulf Connection: Report on Kerala's Migration Survey 2011*, Working papers 450, CDS, Thiruvananthapuram, p. 6-7
[70] Ibid.61
[71] Ibid.62
[72] Zachariah K C and Irudiya Rajan, 2012: 25

and it shows a decline in its share in recent years (from 21.8 percent in 1998 to 17.9 in 2011). The proportion of 'Gulf wives'[73], i.e, married women in Kerala whose husbands work or live in Gulf is highest among the Muslims (24 percent of married women). Zachariah and Irudiya Rajan who prepared the survey report on 'Kerala migration-11' says this decline in Malappuram, the traditional centre of emigration, points to the fact that "*migration from Kerala seems to be approaching an inflexion point in history, Kerala's Gulf connection is edging towards a turning point*" (Zachariah and Irudiya Rajan, 2012: 44).

Any of the Gulf countries which include UAE, Saudi Arabia, Qatar, Oman, Bahrain, and Kuwait is the destination for 90 percent of Kerala emigrants. Among them, UAE receives the highest number (38.7 percent of total emigrants) followed by Saudi Arabia (25.2)[74]. However, Muslims, the highest emigrant group, are lowest in migrating to other states within the country which is 11.4 of total out-migrants (Ibid. 39). Apart from the emerging trends in the economy, occupation, lifestyle, and their impact on the health of population, another factor that concerns us is the ideological changes that happen to the migrants in the destination countries. We have to note here the fact that all of these Gulf countries practice Salafi stream of Islam, or what we refer to as 'Gulf *salafism'*. It is a matter of interest to see the ideological changes among the migrants who live in different countries of Gulf for a long period.

With the decline of agriculture as the major source of income and the dismantling of feudalism as the labour system, the individuals were to make their life finding new pastures outside. For the majority of uneducated Muslims, unable to compete in the job market at home with their chronic educational and social backwardness, migration opened new possibilities. For Muslims, travels and migrations were an 'accepted' and 'respected' means of survival and prosperity. After rebellions and the decline of paddy cultivation, many families from southern Malabar migrated to hill stations like Waynad and Nilambur as plantations workers in the tea and coffee estates recruited by the British companies. For instance, we can still observe the cultural similarities of the Muslims in the estate regions of Waynad with that of Southern Malabar.

[73] Though the term has been used widely in the public discussions and popular writings, the male and female informants in the *mahallu* never used it once during my fieldwork. Instead, they mentioned '*Gulfukarude pennungal'* (women belong to men of Gulf).
[74] Zachariah K C and Irudiya Rajan, 2012: 29-31

Another form of migration, particularly from Thirurangadi was to the cities and small towns in South India, mainly Madras, Bombay, Hyderabad, Banglore, Mysore, Thiruppur, Selam, Erode, Coimbatore as hotel labourers, small traders, shop keepers and a few of them as industrial labours (Ganesh, 2009: 218). Some of them made fortunes by running hotels, biscuit factories, textile factories and import-export firms (Lakshmi, 2012: 32). A large number of Muslims in Thirurangadi made their living through the migration to these cities and Shimoga, Hasan, Kolhapur as bakery workers and later as bakery and hotel owners. One of the main features of the early Muslim migration was that only male members of the family migrated at a very young age as unskilled labours in the hotels and bakeries without availing the formal education at home. We see the changes in the character in the later migration.

Considering the early trends in the international migration, there were early migrations to Rangoon (Burma), Karachi (now in Pakistan) and some of them returned after independence while some of them opted to stay back with their livelihood. Some of them make casual visits to their relatives with official permission or secretly. In 1950s, they had migrated to Sri Lanka, Malaysia and it was during 1960s and 1970s the Gulf countries, preferably, Saudi Arabia, UAE, Qatar, Oman, Bahrain, and Kuwait became destinations (Ibid. 31). Now we see the role of Muslim diaspora in the urbanization of Kerala. Since, 1970s, the factor which makes the greatest impact on regional economy, labour market, consumption, savings, and poverty, income distribution, and economic growth has been Gulf migration and Gulf remittance, especially in the 'high migrant areas' or 'Gulf pockets' (Kurien P, 2003)**.** Sailing through sea in the past is replaced by quick access through jets and now the Malabar region itself has four airports. The establishment of Karippur airport to the east of Thirurangadi municipality has augmented the trade and mobility of people.

Unlike the first generation migrants who lived with menial jobs, the second generation took off comparatively with basic educational qualifications and it kept improving. As some of our student informants from low-income families reported, they have to attend the school at least up to the secondary level in order to qualify to apply for a passport and a job visa. Most of the unemployed youth in the area have already taken their passport and ready to fly to Gulf countries whenever they get a call from their relatives or friends. The

early migrants facilitated for their relatives and neighbours to migrate. As migration became rampant, new visa rules and regulations came into practice. The situation was and is that, any political development in the Gulf, namely war, or labour regulations had repercussions on the economic life of this region. Saudi Arabia's labour reforms called *nitaqat*[75] has been widely discussed in public media as a threat to migrant workers' aspirations. I could see some shops were opened in the region named '*nitaqat'* and '*pravasi'* (lit. migrant) by the Gulf returnees to demonstrate their return back to home.

Substantial number of households in Thirurangadi have their family members in Gulf and there are many returnees. The general objectives have been repayment of debts, buy land and construct own house, conduct marriages for daughters and sisters, bear the cost of education of the children or improve the facilities and quality of life. As the successful migrants find regular jobs in Gulf, the daily expense of the dependents at home respond to the new source. Farhana, a female dependent says, after she was married to a 'Gulf husband', she always opts for the specialist doctors and private clinics considered expensive in the region. Before the marriage, she had to go for public health care institutions because the paid treatments were not affordable. To my enquiry about the plans to return home and settle here, Asghar, a high paid HR manager in a Dubai based firm said:

> Personally, my dream and passion is to come back and engage in academics and religious activities, but as my salary increased, my dependents' standard of living gone up and they cannot adjust with their previous life anymore. Therefore, I have to continue as a Gulf migrant against my personal wishes.

Prema Kurien (2003), taking the case of different migrant communities in three localities, points to the different patterns in which the emigrants consume and spend their money. She finds the patterns of consumption, investment and exchange were distinctly different in three areas, due to their socio-cultural differences. Among three communities, namely Mappila Muslims, Ezhava Hindus, and Syrian Christians, the migration to the Middle East

[75] Enacted in 2011 by Saudi Arabian government, *Nitaqat* law made it mandatory for all business firms in private sector to reserve at least 10 percent of total positions to the Saudi nationals which affected the expats, most of them were Indians. Later on, *Nitaqat* was implemented in other sectors too with increasing percentage. In 2016, telecom sector was covered under Nitaqat law with 100 percent of jobs in the mobile phone sales was given to the locals which made thousands of Malayalees jobless. See http://english.mathrubhumi.com/news/nri/indian-expats-to-be-hit-as-nitaqat-expanding-to-more-sectors-english-news-1.1020422

and the consequent enrichment has reconstructed their ethnic identity. She argues it is due to the social meaning attributed to the foreign remittance that we see a particular pattern in the economic behaviour of international migrants. She says one of the attributes of the emigrants is that they get comparatively higher income than the amount paid for the same job at home, and there is a social assumption that it earned more 'freely' and it can be disbursed freely. This amounts to the pressure on them to spend more, opt for private hospital even if the public health care facilities deliver better service.

Conspicuous consumption and conspicuous generosity, as they are expected to perform, also expressed in the changes in the lifestyle of the migrant household, taken them into a new pattern of life. Therefore, the argument is consumption and investment pattern is influenced by the way income is earned and the specific characteristics of the community within which the income is spent. In some cultures, income from international migration is seen fundamentally different from the income generated from the local work. Apart from this broader pattern, she says, there can be seen local variations in the ways in which the remittance income is used for consumption and investment. Amid the broad similarities among these three communities, she finds significant differences in the mode of consumption, exchange, and investment.

In the case of Muslims, she says, the remittance is disbursed to the large circle of people within the community, business activities, and to support religious activities whereas Ezhava Hindus spend lot of money for life cycle rituals and Christians' income confined within the immediate family and saved for education and marriage. In addition to religion, the ethnicity of the community is seen as comprised of the complex nexus of factors, mainly, income, occupation, education, and family structure which conditioned the three different community response to the migration. At the same time, the economic change brought about by the migration has reformulated the community in three localities. Historian C N Ganesh in his survey report on Thirurangadi (2009) says that the Gulf migration has created a group of floating middle class based on uncertain market forces by which there is a phenomenal rise in the cost of living especially in the cost of land and home appliances. Facilities of education and health increased in recent decades serving the needs of these rising economic classes (Ganesh, 2009: 316).

The Gulf migrants invested their earnings at home, constructed or modified houses in concrete, altered the food pattern of their dependents, boosted the purchasing power, and brought modern gadgets. Some of them owned land and started new shops mostly hotels and bakeries. From the change in the pattern of household spending, Gulf remittances are crucial to the working of religious organizations, the establishment of new religious schools and colleges, hospitals and charitable institutions. For instance, the mega conferences conducted by every religious organization such as silver jubilees, golden jubilees, and the annual conferences, the fund collection from the Gulf committees is critical. It is also crucial for the philanthropic aspect of the organizations such as relief activities and palliative care. Higher educational facilities were brought in to their area thanks to the migration and the social life reformed with new worldviews and lifestyle that can be seen in buildings, food pattern, consumption, and religious views.

Many studies have come out on Kerala Muslims to trace out the links between their everyday life and Gulf migration, the changes it brought about on Muslim social life. Osella and Osella (2009) finds the Gulf migration has produced many Gulf based Muslim entrepreneurs and business ventures who invest in charities and Muslim social life. Mushrooming of multi-speciality private hospitals and health care firms in Kozhikkode, Kottakkal, and Perinthalmanna, and Gulf styled English medium 'international' schools, owned or run by Muslims are from the contribution of the migrant investors. In the light of study among Gulf based Muslim entrepreneurs, Osellas (2009) opine that 'Gulf' stands for the successful blending of Islam with aspiration for technological skills, and liberal business practices, wealth and self-confidence, a stark contrast to the literatures on most of the Indian Muslims. Gulf provides an example of 'modern Islam' and the Gulf labour market works as a 'pull' factor demanding education and skill development.

They cite the life histories of some of the ordinary migrants turned successful businesspersons under the favourable economic conditions of the Gulf cities especially Dubai. They are also 'concerned' or and feel 'responsible' about the upliftment the Kerala Muslim community and are hence involved in the community organizations, running of orphanages, schools and everyday politics. Osellas (2009) argue following the rise of reformist influence, Muslims are oriented towards the ideas of transformation through education, , generalized 'rationalization' of practices, and are now mobilized for the new

forms of ‘capital accumulation’ taking Islam as the moral background to deal with the neo-liberal economy. They say the metaphors of instrumentalist or political Islam or public pietism (as Mahmood 2005 says) cannot explain this process among contemporary reformist oriented Muslims. Instead, they focus on the articulations between the politico-religious orientations, Islamic reformism, and economic practices in the production of contemporary Muslim subjectivities. Here the educational upliftment of the community is taken as the common objective amidst the plurality and contradictions in their mode of engagement. All the discussions on education in connection to development discourse relating to the Muslims, point to the reluctance of Muslim leaders in the past towards English language and modern education during *khilafat* movement against the state and the deprivations they led to.

One thing that makes migration interesting in individuals’ life is the increased level of solidarity and proximity with the subgroups of religious organizations that work in Gulf. The participation in the organizational activities become stronger after the migration. Every political party in Kerala, religious organization, *mahallu* committees, *madrasa* committees, welfare, and palliative initiatives have a unit in every Gulf country. Participation in the group and the active unit ensures the reproduction of home environment amongst the migrant communities. However, as Osellas (2008) pointed out, migration has given to millions of Malayali Muslims an exposure to what is believed to be the heartland of Islam or the birthplace of Islam, and life in Muslim majority societies. The exposure to the everyday practices of the Arabs, and the association with the networks of ideologically ‘other’ organizations which are very active, could be the reason behind largescale conversion to the reformist denominations after the onset of Gulf migration.

Emerging Diseases

The changes in the occupation, income, and food pattern are understood by the regional health officials and the Muslim informants to be the primary causes behind the emergence of life style diseases like diabetes, heart problems, cholesterol, blood pressure, cancer, and kidney diseases. Responding to the increasing number of lifestyle diseases in the area, MK Orphanage hospital in Thirurangadi has started ‘Diabetoloy and Endocrinology’ department to deal with the metabolic disorders such as Diabetes Mellitus. Dr. Muthukkoya, a former director of health services under the central government and

currently working as a private practitioner in general medicine at Venniyoor features these issues behind the changes in the health of the locality. Based on his observation on the cases reported at his private clinic and hospital, he points to the prevalence of lifestyle diseases like diabetes and blood pressure imbalances even among the youth and the lack of nutrient food among children. Therefore, the doctors and health officials in the region confirm that most of the people in the region have lifestyle diseases, and the speciality clinics have mushroomed widely. The accounts of Shabab who regularly visits Dr. Saifuddin in the Diabetology department at MKH, and a migrant youth, who was once a farmer, will tell us the change:

> Once, during the times our grandfather, we used to go to our paddy field in Chullippara and work for a long time with him even if he was ill. Now farming is not a profitable occupation. During those times, we gave one kilogram of rice for the workers for every seven kilograms we reaped. Now we have to give the daily wage around 700 to 800 rupees and it is very hard to find the paddy field workers. After that, many of our family members migrated to Gulf and I was employed in a restaurant in Dubai. I think even if we have deficit of physical exercise, the workers in the Gulf countries have less chance of diseases because they are working very hard. The diseases are for their dependents here; their family members. I had to start medications for cholesterol problem when I returned from Gulf and settled here.

The physical work is restricted to some working labours in the Gulf countries like the restaurant and bakery workers and it is almost absent among the dependents at home, especially the females. We noted in the social history part in the second chapter that their predecessors used to follow their males to work in the paddy fields in Thirurangadi, that habit has disappeared now. This is the result of the economic transformation of the community from the physical occupations of agrarian economy to the varieties of gender specific occupations of remittance economy. We also see here the gender selection in the migration to Gulf[76]. Economic transformation of this religious community in this way could define their health behaviour in multiple ways that we see in the coming pages.

[76] Predominance of men in the migration of the labour force to the Middle East is specific to the Muslim community especially in the northern Kerala. We see the large scale female out-migration from the south Kerala mainly because of the migration of female nurses to the Middle East and other Western countries, See for instance, Marie Percot and Irudaya Rajan (2007) 'Female Emigration from India: Case Study of Nurses'.

Many in Chullippara who spent decades of their life in Gulf reported the presence of migration induced diseases. Hamsa, an old Gulf returnee who worked in Saudi Arabia for 30 years said, for a manual worker like him, it is very difficult to spend in Gulf more than 25 years. By that time, he would have become habituated to the medicines for lifestyle disease. He has been living with blood pressure imbalances and diabetes for 28 years, which started in the early days of his migrant life. He pointed to the migrants' diet with high content of fat and sugar along with the mental stress and strain as the causes behind what we call the 'migrant diseases'.

Dr. Abdu Rahman, the physician in the department of general medicine at MIMS (Malabar Institute of Medical Sciences) puts it:

> Some diseases are reported high when the prosperity of the community increases. In the case of Muslims in the area, some diseases like the lifestyle diseases are 'significantly high' which are the result of the economic boom; the diseases are changing and they are detected very early.

The figures show that generally, ill health[77] is comparatively low in Malappuram district (cf. Kannan & Kabir& Krishnakumar, 2009)[78]. They mention the difference in the socio-economic features the district has, and availability and access to health care services might be the mediating factors for the observed variations in the morbidity (Kannan et al,. 2009: 16). As we see in the later section on Muslims and state health facilities, Malappuram has the highest number of public health facilities among all other districts in Kerala[79]. Another reason is because of the highest percentage of young population among Muslims amidst the aging of population in Kerala with low birth and low death rate. At the same time, Muslims have 50 percent more risk of ill health than other communities in the age group of 35-52 (Ibid. 20).

[77] The diseases they consider as the determinants of ill health are diseases of bones and joints, hyper-tension, viral fever, diabetes, common cold, asthma, diseases of nerve system, cardiovascular diseases, cough and acute bronchitis which account for about 75 percent total illness in the morbidity level of Kerala.

[78] Kannan & Kabir& Krishnakumar (2009) *Morbidity Patterns in Kerala: Levels and Determinants*. Working Papers, CDS: Trivandrum

[79] *Rural Health Statistics*, District wise Health Infrastructure, Ministry of Health and Family Welfare, Government of India, 2015: 129-30

Food: Region, Religion, and Cultural assimilation

Food and eating involve, among others, the existential factors as well as the religious and caste values; in any case, they are crucial in understanding the health profile of the community (Sujatha 2018). Food has been studied as a social idiom and culinary symbols as the contextual markers of social boundaries (Douglas 1966), as the marker of social relationship (Dumont 1970, Khare 1976)[80] which are inherent to Indian social system. We try to add to the studies on food as cultural construct influenced by norms and principles (Nichter 1986: 185), as part of health knowledge system among the people explained through the connection with the physiological effects (Sujatha 2003). For these authors, whose main concern is health, the dietetics is central to the popular health culture.

In our field, the informants consider the change of lifestyle and the change in food habits as important aspects of their health and the same is confirmed by the local health authorities, doctors and the religious orators. Dr. Aboobacker, the senior doctor in the area says:

> I was the only one doctor in the area when I started working here since 1960s; the main health problem we used to face during those days was nutrition deficiency. I could see many patients lost their eyesight due to the deficiency of Vitamin A. Now, the problem is hyper-nutrition.

Patients' own explanation of the reasons behind their diseases supported the doctors' expert opinions. Muhammadka, a senior journalist who usually visits the Janatha private clinic in Chemmad for physiotherapy in order to avoid the prescribed surgery for his arthritis problem observes:

> Thirurangadi has now become an area of patients with multiple ailments; it has most number of doctors, you can see a street here is named as 'Doctors colony' lined with a number of private clinics, and all of them are getting good number of patients. All private hospitals, private clinics, and laboratories are making huge returns from the large number of patients. If you come to this laboratory early in the morning, you will see a long queue to test their sugar or cholesterol or thyroid or pressure.

[80] Nitcher, M (1986: 185)

> Muslims in Thirurangadi were the worst affected people during British period due to our poverty and political conditions; now the affluence we got from the immigrant returns from other states and the Gulf is the problem. I think the main reason behind the morbidity in such an alarming increase is the change in our food pattern, which changed after the rise of income among the households. New dishes are introduced to our dining table especially in special occasions with more importance to the taste. At present, you can see the trend has a dim after the demonetisation by the central government. Even I have been diagnosed with many problems like blood pressure, paralysis, and uric acid and all of them are the result of my new habits.

Based on her study in rural Tamil Nadu, Sujatha (2018) has given a scheme of four categories of food that varies according to different situations. They are mundane or daily diet based on what is available in the surroundings and most convenient. The second is ideal or aspirational food that people actually like to have and consider as healthy but may not be available for various reasons. Customary or ritual food is the third category which is what people have during rituals like religious rituals and they are relatively unchanging. The fourth is indulgent foods which are tasty and fashionable, desired by people, but generally less-healthy. She says, the emotional, social, and cultural aspects of eating are reflected in this categorisation. In the field accounts that we give below, we see many similar instances but with many additions. For instance, we have to discuss at length about the religious aspect of food which has been changing over time.

When I tried to observe the food pattern of the region and its change, three things seemed to be explained here. One is the regional specificities in the food pattern of Muslims. For breakfast, I could see most of households have the snacks made of rice and vegetarian or non-vegetarian curries. For the lunch and dinner, rice[81] is common and a common curry in yellow colour made of white gourd or Indian cucumber, curd and coconut, sometimes the yellow coconut curry with drumstick, the common vegetation in the courtyard. Along with the rice and this common 'yellow coconut curry', most of them buy fish almost on daily basis that may differ everyday according to the availability of fish in the nearest fishing harbours at Parappanagadi or Tanur. The daily purchase of fish, mostly sardine or mackerel will cost around 50-60. It was a routine scene in the *mahallu* that a pickup

[81] Nichter (1986: 188) notes this importance given to the rice among the southern Kanara district of Karnataka. He says the meal is defined as the consumption of boiled rice which is inherent to their 'cultural' sense of nutrition. The same can be seen in the south Indian dietary habit.

rickshaw with two or three items of fish coming everyday around ten in the morning and all women in the households approach them and purchase their favourite fish, generally the sardine and mackerel. Many of them pay on monthly basis when they get the remittance from their husbands or sons in Gulf. Fish curry added with coconut and fried fish is common dish of the households in the region. This combination of yellow curry and fish prepared in particular ways is peculiar to this region, different from the dietary habits of Muslims in other regions such as the northern Malabar and South Kerala.

For the special occasions such as marriage, post-marriage parties, post-death rituals, or *maulids* and *ratibs* conducted for wellbeing, or to host the guests, non-vegetarian food is considered essential, generally chicken or beef *biriyani*. From the accounts of *mahallu nivasis* (*mahallu* residents) and my observations, one thing noticeable in the eating habit is the increase in the frequency of 'special occasions' that have become almost a daily happening. 35-year-old Yusuf told me that now feasts are common in the *mahallu*; he has to attend all of them as the token of interpersonal relationships. He thinks this habit has increased his cholesterol level beyond the danger mark and he mentioned to me his present cholesterol level. Increased income from the Gulf remittances accompanied by growth of population in the *mahallu* has led to the frequent rituals and ceremonies related to birth, marriage, or death. Preferance given to non-vegetarian food and delicacies has become common part of hospitality on several special occasions among the Muslim community. Explanation of this peculiarity leads us to the second factor inherent to the food pattern, the religion.

Irrespective of the region and organizational or ideological affiliations, there is a food culture common to the Muslims here. My informants cited the religious importance of non-vegetarian food, especially beef and mutton. According to the Islamic tradition of feast, meat is the best of all food items, and mutton is said to be the prominent of all meats, dates has that distinction among the fruits. Another tradition says giving a social feast for marriage is *sunnah* (recommended practice) for bridegroom and it is also recommended that he has to serve mutton at the feast. Muslims believe in the worthiness of meat to eat, to donate, and as the premium food. There is a comical saying widespread in the locality that "those who do not buy beef on Fridays they are out of the fold of Islam" that means it has been considered as essential part of dietary habit at least once in week. This saying is part of the 'local religious belief' which can be seen as 'customary' because

the buffalo meet does not have any mention in the textual tradition of Islam unlike the mutton. Thus, sometimes, aspirational food that is served in the customary rituals have an inherent connection with the endorsement of religion where the textuality of food also matters.

Every single Muslim household, rich or poor, prepares special meat items on the two main religious festivals of *Eid* and in the month of *Ramzan*. That is why, as they said, we can hardly find any Muslim ritual, domestic or public such as the annual *nerchas* of Cheroor martyrs or Mamburm *maqam,* serving the vegetarian food for the devotees. Muslims strictly avoid serving non-vegetarian food in the households where a death has happened during the first three days after death to signify the 'simplicity' and 'sadness'. The duration of first three days is for mourning and pacifying the relatives of the deceased which ends on the third day. It is recommended to serve the non-vegetarian food on the third day to mark the end of the mourning period. It is condemnable in the Muslim society if one were to serve vegetarian food on special occasions, even if the price of non-vegetarian is cheaper than vegetables. However, the traditional non-vegetarian dishes served on special occasions are also in the process of transition mainly due to the migration which is the third factor to be noted, the assimilation of dietary pattern.

Another noticeable feature in the dietary pattern of the Muslims in the region was the introduction of foreign food items, largely from the Middle East, into the ceremonies, restaurants and hotels in the area. During my visits to the households, they offered rice and curries on normal days whereas favourite items on frequent 'special' ceremonies were *kabsa*, *kuzhi manthi*, *Saudi manthi* served along with local *biriyani* or as separate dishes. They said *manthi* is the common daily food of the Arabs in Gulf countries and served in Kerala as the special item. For the marriage feasts, serving *kava* (coffee made of ginger and ghee) is a necessary drink after the main course. They said drinking *kava* after heavy non-vegetarian foods helps reduce the cholesterol, which has been taken from Arabs' *qahva*. These are part of Arabian cuisine, introduced in Kerala by the Gulf returnee cooks or permanent settlers in the Gulf. Many were exposed to the Arabian food and got used to a different food culture from Gulf. The decades-long stay in Gulf has brought in new food habits and new diseases. For instance, one of the regular visitors in the Chullippara mosque Ahmad Haji said he was a helper in a Bakery in Saudi Arabia and his son has

been working as a cook in a native Saudi's kitchen from where they learnt the Arab dietary style.

Apart from the domestic space, the locality has seen mushrooming of 'food huts', 'food courts', and restaurants constructed as they are in Gulf countries with Arabian menu card, all of them open from four in evening till the midnight. As my young journalist respondent shared, it is a habit in the area among youths and families to go out for dinner and have *kabsas*, *manthis*, *kubboos*, along with the grilled chicken. He even finds women having these food items in the eateries from outside. New food items are introduced to households here, he explained, after the women and families migrated and settled in Gulf. He always prefers non-vegetarian food even if he is aware of the health risks and the public campaigns on the problem associated with it.

The results of the large-scale migration from the area are multifarious; increase in the consumption, change in the lifestyle both related to dress and food, and the transformation of locality into a reproduction of a Gulf souk with Arabian food courts, malls and supermarkets, innovations in the architecture of mosques in Arabian style etc. During my evening tea breaks, I could see some of the famous restaurants and bakeries were packed with local schoolchildren having *shavarma* and grilled chicken. A local resident explained that migrant fathers have filled up their pockets with money and now they can afford these items and they are reluctant to eat at home. Even if some of them retain their old style of food, all of them pointed to the overall change in the food and lifestyle. The reason for this that all of them traced is the increase in the income due to the Gulf migration.

Even if there can be found a regional pattern of food general to all households which belong to different religious organizations, there are differences according to the choices of households. As we mentioned earlier, there are other important categories beyond the sectarian ideology such as class which is relevant to analyse the behaviour related to health. A gist of what we said here and above can be clearly understood from the words of Abu Mash, a retired schoolteacher:

> As a teacher in government school, food pattern in my household is controlled and balanced even if we have family members working in Gulf. Mostly, it is fish, the small fishes like sardine. In order to control the diet, we buy beef and chicken once in a week. The food among Muslims changed after the Gulf migration due to the

> increase in income level. Often my elder son goes to restaurants and Arabian food huts and brings the hotel food in parcel, we do not have to cook on those days. I personally propose to include vegetables in the dish. Years ago, when we were economically struggling, we could not afford the non-vegetarian food. The situation has changed now, but we control it for the sake of health. On some occasions, we do not have other option than having only meat such as the feasts and the religious festivals of two *Eids*. On the day of *Eid-ul-Adha* and at least two weeks after that, we will not buy fish because our refrigerator will be filled with meat we get from the animal sacrifice rituals practiced on *Eid* days.

The growth of lifestyle diseases in this area have been identified and attempts on the part of administrative bodies to combat them are underway. Recognizing the rising percentage of the lifestyle diseases among Muslims, Thirurangadi Government Thaluk hospital has started a clinic to provide early treatment. The hospital authorities point to the excess of food and lack of exercise, mental stress due to the migration as the reasons behind the rise of lifestyle diseases. They have also been related to the increasing infertility rate as the stress and strain from migration reduce the sperm count. Thennala Grama Panchayat has initiated a program to cultivate organic rice and distribute at lower prices in the name of 'Thennala rice'. They have also promoted the cultivation of organic vegetables. The Panchayat member said all of them were started in response to the menace of increasing number of cancer and kidney patients in the region. Therefore, as it is pointed out by the health officials, from District Medical Officer (DMO) to the health inspectors, the doctors of PHC, and the health profile of the region, the prevalence of the lifestyle diseases such as diabetes, and cancer is the particularity of the region's disease pattern. Emerging diseases are understood as the consequence of the changing food consumption, the offshoot of the new occupational pattern mainly the Gulf migration.

Looking beyond the cultural patterning or indigenous health culture, we identified the region, religion, and the dietary assimilation as central in analysing the changes in the health status of Muslims in the neighbourhood. We argue the contextual determinants such as the eating behaviour are pivotal in shaping the health profile of the Kerala Muslims beyond considerations.

Health seeking Behaviour: Preferences and Ranking

Institutions of Cure and Care in the Area: a Brief Profile

Malappuram, the Muslim majority district in Kerala has been successfully overcoming the discriminatory gaps in the health and educational infrastructure created by the state-community tensions during colonial period. Contemporary Malappuram has been projected as the fastest growing region in health facilities through burgeoning private sphere and the implementation of state projects, which is different from the Muslim majority regions in north India. Malappuram District Panchayat has been assessed as a successful PRI (Panchayati Raj Institution) model in Public Health Delivery System (PHDS), in the field of palliative care and community psychiatry. It raised funds for the public health from the citizens of the district and the community participation. The political and bureaucratic leadership of Malappuram District Panchayat and the local community strengthened the collaborative governance[82]. Malappuram has 578 sub centres, 84 PHCs (Primary Health Centre), 22 CHCs, six sub divisional hospitals, and 3 district hospitals which is highest of all other districts in Kerala[83]. It has one district Ayurvedic hospital, eight government Ayurvedic hospitals, and sixty-eight dispensaries. Homeopathic hospitals in Malappuram include 2 government Homeo hospitals and 42 Homeo dispensaries. In Malappuram district, there are 333 allopathic, 355 Ayurvedic, and 192 Homeo, and 29 Unani institutions in the private sector[84].

Thirurangadi has been considered as one of the major hubs of medical care in Malappuram district. Apart from the primary health centres in each municipal division, there is one Government Taluk Hospital, and one major private hospital, the M K Haji hospital, known in the area as MKH, and government Homeo dispensary at Karumbil (a small town, one and half kilometres away from Chullippara *mahallu*), and Thirurangadi government Ayurvedic hospital. Kottakkal Aryavaidya Shala is also very close to the area and many patients here take Ayurvedic treatment as outpatients and in-patients. There are also new healing experiments such as the *fasd* (acupuncture) and *hijama* (cup healing) and a few consulting centres.

[82] *A study on Effectiveness of Panchayati Raj Institutions in Health Care System in the State of Kerala*, Kerala Development Society, 2012, Planning Commission, Government of India
[83] Rural Health Statistics, District wise Health Infrastructure, Ministry of Health and Family Welfare, Government of India, 2015: 129-30
[84] Ibid.

M K Haji Memorial Orphanage Hospital was started in 1996 as charitable hospital by Thirurangadi Muslim orphanage committee that was opened in 1943 to give shelter to the orphans due to the outbreak of Cholera during 1940s. The new hospital was named after MK Haji, the founding secretary of the orphanage. It is known as the 200 bedded multispecialty hospital with around 25 specialist doctors and 150 nursing and paramedical staffs. The hospital claims that it provides health care services for very moderate rate and free of cost for orphans and poor families. One caption is written at the entrance of hospital that 'We only care, but He alone cures', and another Quranic verse which reads 'Be patient in difficulties; Indeed the God is with patients'.

Establishing orphanages is an important religious duty among Muslims that is strongly encouraged by the doctrines. Any project to help orphans finds enthusiastic responses from individuals and organizations at home and in the Gulf. The experience of one of our non-Muslim respondent Sindhu says, she also had enjoyed the benefit of Muslim piety of looking after the orphans when she lost her father. Recently, modern hospitals are also started and is considered as 'progressive' step towards community development. Every religious organization has number of orphanages registered under them and they are also establishing hospitals under the religious endowments funds. In Sindhu's case, she was taken care by the local Muslim philanthropists after her father's death and her father's surgery expense was discounted by the MKH hospital as she was an orphan.

Apart from MKH, there are large number of private practitioners and small and medium private hospitals in specialties known for its services in particular field. Those who can afford more luxurious medical services can travel a few miles to Kottakkal city which has risen to be the city of Multi-speciality and super luxurious hospitals like Malabar Institute of Medical Sciences (MIMS) under Aster-MIMS, the multinational medical corporate company.

A very recent development is the establishment of private Homeo clinics, in every part of Thirurangadi. Old style of government Homeo hospitals are replaced by new buildings, with expensive glasses, modern style air-conditioned reception, waiting room and consulting room; all are under surveillance of the doctor through the CCTV camera installed in the reception. The same style and facilities were observable in the *fasd* and *hijama* centres which gave them a 'medical ambience'.

In every small town and market centres in Thirurangadi municipality, there are medical shops and dispensaries of *nattuvaidya* (folk medicine), some of them affiliate to the Ayurvedic drug companies like *mangalodaya* or *nagarjuna*, or Kottakkal aryavaidya shala. Apart from the registered Ayurvedic medicines, there can be seen private practitioners who prescribe and sell their own medicines. Some *thangals* generally considered as religious healers sell 'Ayurvedic' medicine along with the religious prescriptions. Thirurangadi has number of such pharmacies in the name of '*thangal*'s pharmacy'. Medical care is hence a visible institution in the area and pluralistic option are available.

Public Health and Private Health Market

Under the constant interference and vigilance of the Muslim elected representatives of the region in the state legislative, the local self-government bodies, and the better implementation of district administration of Malappuram, Thirurangadi Taluk hospital has seen progressive transformations. Specialities and super-speciality OPDs were started; family planning clinics, new surgical departments like knee replacement and many other treatment concessions were introduced. It provides free home services for old, destitute, and runs the palliative care unit and free dialysis centre. As Abdul Raheem, its public relations officer claims, the image of government hospital as 'endowment hospital' or 'hospital for poor' has changed now. He thinks the change is due to the increase in literacy and education of Malappuram district.

Talking about the Muslim response towards the public hospitals, we see many have stopped going to the government hospitals fearing the risk of long queue and they admitted that they used to go for the government health centres amidst these rush. The elder informants recollected the memories of the past when government health care centres were the sole option and they explained the economic betterment in recent decades as the cause for their new habit of running after private hospitals that have mushroomed in every nook and corner. They said the economic capacity to afford private health care is the reason and it has become a habit to seek private facilities.

However, a closer look at this trend points out the role of class distinction within the Muslims in the region in the choice of public and private medical facilities. There are people like Moydeen, Muhammad and Beeran in Chullippara, the working classes and the

poor Gulf migrant families who rely on government Taluk hospital in Thirurangadi only because the consultation and medicines are free of cost. They visit the outpatient block in the Kottakkal Arya Vaidya Shala also for the same reason, '*because it is free, and we cannot afford the private hospitals'*. They are willing to wait in the queue for a long time which many in the *mahallu* avoid after they could afford the convenient methods. Here we see the emergent class formulations such as migrant poor, poor returnee, and working class at home and Gulf and the class differences in treatment seeking.

Amidst the class differences in choice of government and private facilities, we have noted the availability of treatment for some diseases, primarily the lifestyle diseases exclusively at government health centres, attract the patients irrespective of their class. On every Monday when the check up and medication given particularly for lifestyle diseases, government hospitals in Thirurangadi and Venniyoor are packed with luxury vehicles of those who regularly visit for collecting medication. It shows that government hospitals are visited for 'some diseases' irrespective of class. For 'some' diseases such as fever, seasonal diseases, diarrhoea, headache, paediatric diseases, minor fractures and wounds, one has to go government hospitals, they said. The medicines for some conditions such as, snakebite and dog bite are only available at government hospitals. Whatever the diseases may be like leptospirosis or jaundice in critical condition they cannot reject the patients unlike the private hospitals because the government hospital has the responsibility to accept every case.

The records in the Thirurangadi Taluk Hospital and the physicians' observation on the pattern of diseases reported from the outpatients, point to this fact. I could see long queues especially of women with their relatives and children at Thirurangadi Taluk hospital during OP time and heavy traffic of their luxury vehicles. Despite the belief that only the government health centres can provide medicines for some diseases, they were reluctant to be admitted there as in-patient. Even the poor patients regard being admitted to a government hospital as *madi* (indolence) and *kuravu* (shame) to lie in a bed in the public ward and to be known as looking for free medicine.

One of the outpatients in the Taluk hospital explained his 'confidence' in the quality of care at government hospital though he prefers private hospital for childbirth in his family. He observed:

> Most of the doctors posted here have graduated from government medical colleges on merit whereas the doctors in the private hospitals may not be qualified because they have done their study by giving heavy fees. And it is very difficult to get job here. Still people are reluctant to stand in the queue. Even if the doctors are highly qualified, the staffs here are arrogant since they are working for fixed government salary.

At the same time, all of them consider the government medical college at Calicut as the last resort for diagnosis and treatment and it is the most efficient biomedical hospital in the area. They believe every problem would be sorted out from there and avoid visiting medical college due to heavy rush. They also identified RCC (Regional Cancer Centre) at Trivandrum run by the government as the only effective centre for cancer treatment. Beeran said:

> From Kozhikode medical college, they will refer the patients to nowhere, it is the end point. They receive the patients referred from the so-called private hospitals, any kind of patient, and at any stage of disease they admit. That is government hospital. One of my friends, after losing all of his wealth in treatment from private hospitals was taken to Kozhikode medical college and he was cured. A decision will be taken from there, either will be saved or succumb to death. I have seen two or three doctors treating my friend.

Other factors that attracts patients is the reputation of the doctor's skill, be it a government doctor or private, or Ayurvedic or allopathic. The term used to denote the doctor's efficacy is *kai-punyam* (translated as 'merit of hand') and *kai-phalam* (efficacy of hand) which has been considered as the cardinal factor in the cure; more effective than the additional qualifications like MD (Master of Medicine) or DM (Doctor of Medicine). *Kai-punyam* is an ascribed merit by birth or blessed upon by any other holy men. Dr. Abdu Rahman of MKH hospital is the busiest doctor in the region. It is believed, as our non-Muslim informant Sindhu said, that he does not need the lab reports to diagnose; he can 'tell everything' by just holding the patient's hand. Another elder Gulf returnee disclosed that it is the 'blessing' of Panakkad *thangal* that made him a famous doctor. Another belief of the *kai-punyam* in the region is about Ayyappan vaidyar in Edarikkode, a famous Ayurvedic vaidyar, best known for his skill in healing fractures and bone setting. It is believed he received blessing from Bapputty ustad, a renowned healer *ustad*. It is also a widely shared

belief in the region that *Vaidya Ratnam* P S Varrier, the founder of Kottakkal Arya Vaidya Shala has the *kai-punyam* with blessing of Pookkoya *Thangal* of Panakkad.

However, private clinics have increased as most of the households can now afford the fees in the private clinics. Some of them also mentioned the negative aspects of the government hospitals lead them away like the misbehaviour of some doctors and staff towards the patients and the hospitality of private hospitals pulls them. The classification of illnesses and selection of consultation centres is done after their own observations and analysis. We get this from a young in-patient's words in Thirurangadi Taluk Hospital:

> We visit the government hospitals in the case of fever. Generally, we go to Samad doctor, a famous private practitioner in our locality. Always there is a long queue here. Here in government hospital, they will not examine correctly, but in private clinics, they examine us for a long time. Doctors in government hospitals will not check our previous files, and write it quickly, and they will not write enough medicines.

Another patient Beeran, a daily wage worker observed like this:

> When my younger brother's leg was wounded, the doctor here wrote the medicines looking at his face! He did not touch his leg, did not examine, and he did not put his stethoscope there. The doctor completed his 'writing' the moment my brother told his problem. They are 'writing very quickly, that is the problem', there is another one, and he is a good doctor because he 'writes medicines well.

Some of them mentioned the status attached to the habit of going to private hospitals, especially for the delivery. According to the community wise data, the proportion of childbirth occurred in private hospital is 78 percent among Muslims whereas it is 59 percent among Hindus. Preferring the private hospitals for childbirth in Malappuram is as high as 84 percent, which is highest of all districts[85]. Selection of an 'expensive' hospital for delivering the child is the symbol of status and pride for the husband in front of his in laws. Laila's private hospital in Chemmad is the favourite hospital specialised for delivery cases in the region, followed by MKH hospital and there are many who look for more expensive packages outside Thirurangadi such as MIMS (Malabar Institute of Medical Sciences) and ALMAS hospitals in Kottakkal. Some of them like the poor migrant

[85] Zacharia and Irudaya Rajan, 2008: 51

Muhammad always start with the government hospital except for delivery for which he said 'in government hospital, '*nottam'* (lit. sight, means medical observation) is very less. We also see the transformation of delivery from home to the hospitals, and then now to the private hospitals. Afsal, an elected ward member in Thirurangadi observes the trend:

> There is a mentality of shame if one chose government hospital for delivery. People will ask 'where was the delivery?, if it is MKH then it is okay, and if it was in MIMS he will get good status. Actually it is free in government hospital where it costs around six to seven thousand in MKH and sixty to seventy thousand in MIMS. But people here won't mind it. Even I will not admit my family in government hospital because it is shame for me before my wife's family. Another reason is the economic growth in the community. There are a few who go to private hospital for delivery taking a loan or on debt. The 'status' attached to the lavish spending affects all spheres: marriage, food pattern, mode of celebrating the festivals. I know some persons have taken loan from Thennala Bank to have delivery in big hospitals or to conduct post-natal ritual very luxuriously; I have given them the recommendation as a ward member.

As Bunton (1997: 236) observes, health products have taken an expressive as well as an instrumental function. Just as rationally calculating their need, considering the expressive quality and identity of the products determine the choice of therapies. Bourdieu considered it as integral to a system of classification and social distinction (1984), and thus, part of the *habitus* of a class or social group. He says the health related patterns of consumption could be analyzed for their social meaning, as 'new cultural intermediaries' (Bourdieu 1984, quoted in Bunton, 1997: 236).

Going to the private clinics and hospitals and admitting the children in private English medium schools have become a status symbol. My informants said those who are reluctant to stand in queue at government taluk hospital are ready to wait for a long time at MKH. There can be seen a generational shift in choosing the educational institutions based on their assessment of quality irrespective of the cost in the economic improvement. A young activist said:

> We all were educated from government schools, but our children are studying in private English medium schools, as we believe they will get more care from there. However, if the government schools have that quality we prefer them. For instance,

> Government Higher Secondary School in Thirurangadi has the impressive pass percentage and it is very difficult to get an admission there due to huge rush. People are turning towards government schools if they improved their quality.

Authorities of the MKH hospital also testified to the change in the health behaviour of Muslims in the area thanks to the general change in the occupation and income level. MKH administrator Hamsa observes that the medical expenditure in the Malabar region has gone up and that it is not because of the increasing level of diseases, rather because the community here is becoming increasingly alert of health problems. They provided me a simple economic 'theory' to understand the change:

> As the purchasing capacity increases, then there would be demand of high quality services that we are offering. Generally, people here do not have the tendency to invest and they are ready to spend without bargaining, this general tendency of demand and supply is also effective to the health. While some patients are coming here to avail the comforts of a private hospital for moderate expenses, there are some, especially the delivery cases, who are reluctant to be admitted here because of the low cost, they look for the hospitals with high fees. All new private hospitals are getting huge crowd of patients who are ready to spend; now they need specialist for every diseases.

Dr. Abdu Rahman the senior doctor in the general medicine department at MIMS responds to this trend of reading the rise of private hospitals in the area through different perspective:

> It is true that all big private hospitals in the area are dependent on Muslims' money. However, the area does not have enough hospitals and specialities in proportion to the population here. It is only the private hospitals which are updated according to the new advancements in the methodology of medical sciences to which the government hospitals respond slowly. The private hospitals have these advantages and customers are ready to spend money for the proper care. For instance, they have introduced new methods to cope with the diseases like paralysis and heart diseases like angioplasty and new ventilators began to be used for lungs which help prevent sudden death. Therefore, we should understand that due to these investors we could reduce the

mortality by extending the possibility of death[86] even if they are making huge returns out of it.

Ayurveda: Other Therapeutic Option

In the medical history of Muslims, transformation from the Ayurvedic *thangals* and *ustads* to the contemporary situation where the allopathy dominates as a medical system can be seen. In the contemporary situation, Ayurvedic medicines have also become expensive. Many of my informants noted the preference for certain Ayurvedic treatments for body pain, fractures, and muscle pains. They do throng the outpatient block at Kottakkal Aryavaidya Shala[87] seeking treatment for various illnesses such as digestive problems, skin problems, psoriases, paediatric diseases, and other general ailments like fever, headache. We could also meet some patients who came to try Ayurveda to avoid the risk of surgeries prescribed by the allopathic doctors like knee replacement.

Facilities and the method of consultation at Kottakkal OP unit seemed to me just like the modern allopathic hospital. However, as the patients explained, even if the consultation is free the medicines prescribed by the Ayurvedic physicians and purchased from any of the Kottakkal Aryavaidyshala shops are very costly. Therefore, most of the regular visitors are those who can afford the medicines and the general economic transformation of the community has facilitated the resort to Ayurveda. A free cancer palliative and healing centre has also been running there for last 10 years.

Along with the outpatient block, the in-patient facilities at the Aryavaidya Shala attract a big number of Ayurveda seekers from Arab countries as well. Responding to the high demand for Ayurvedic treatment from rich Arabs, many other private Ayurvedic hospitals were also started in Kottakkal with luxury facilities to attract more Arabs. Alikkutty Ayurvedic hospital, Almas Ayurvedic hospital, and Green Wally in Kottakkal are the known names in the private Ayurveda market. Inflow of Arabs into the region's Ayurvedic hospitals for a long duration has also resulted in the emergence of restaurants

[86] Ivan Illich (1982) has called this phenomena 'medical soteriology' which means the concept of extending the time of death to maximum extent inherent to the philosophy of modern medical science. It means the idea of enhancing and prolonging the life with the help of newest technological developments even if the cure is not ensured.

[87] Arya Vaidya Shala at Kottakkal near to Thirurangadi is the brand name for the group of Ayurvedic hospitals, colleges, and the pharmaceutical products founded by well-known *vaidyar* P. S Varier. The tremendous influence of these institutions has made the name 'Kottakkal' synonymous with Ayurveda in modern Kerala (see Abraham, 2012).

with a wide variety of Arab foods in Kottakkal and other adjacent areas for the Arab families and the locals who are well acquainted with those items. We can see such 'Arab restaurants' with Arabic name boards and menu cards on the both sides of the main road between Thirurangadi and Kottakkal.

The presence of Aryavaidya Shala in Kottakal and the prominence of the share of Ayurveda in the health behaviour of Muslims in the region made them aware of the different possibilities of Ayurveda for multiple diseases even for fever. Free consultation for outpatients at Aryavaidya Shala which is generally considered as costly treatment but cheaper when compared to private clinics; also make them prefer Ayurveda. Unnikkrishnan, the administrator of Kottakkal Aryavaidya Shala strongly claimed that aryavaidya is 'totally accepted by Muslims' and lists the majority patients in the Aryavaidya Shala are Muslims. He also pointed to the raising morbidity among Muslims in the region and the reason, according to him, was the massive change in the food habits.

The Muslim preference for Ayurveda was also testified by some of the *thangal* healers in the region who also prescribed the Ayurvedic medicines, one of them said:

> Unani medicines are very rarely purchased and sold from here; the predominant healing system among the Muslims in Kerala was Ayurveda. The historical reason behind such prominence could be the Urdu and Persian languages in which the Unani medical texts were written and practiced. Urdu language and their meteria medica were tougher and 'alien' to the Muslim practitioners here than the *Sanskrit* and Ayurveda and it got the popularity as well. My mother and her father were well versed in *Sanskrit* and she used to recite the medical *slokas* (verses) after memorising it. Here the Ayurveda for Muslims was just like the Unani for the north Indian Muslims.

We do not see here, even in post-colonial period, the process called by Quaiser (2012: 131) 'medical communalism' perpetrated by the Ayurveda and the state which produced the binaries of 'Hindu Ayurveda' and 'Unani Muslim subject'. Rather, the history and the contemporary state of medical systems point to a unique process of 'Muslim Ayurveda subject' in theory and practice. It is mainly because of the historical absence of Unani among Muslims and in Kerala and the rich Muslim tradition in Ayurveda amidst the widespread communalisation of indigenous medical systems in other parts of India.

In addition to these peculiarities in the case of Unani among Kerala Muslims, in general, as Abraham (2012) observed, comparing to other regions in India, Kerala has some unique features in the practice of Ayurveda. Important among them is the presence of a universalistic, democratic, and secular Ayurvedic culture in Kerala with the participation of various communities and castes in Ayurvedic training and practice, not restricted to specific castes or to Hindus, even though there have been tensions. There were well-known Muslim and Christian families of *vaidyans*, well versed in *Sanskrit* texts, because gaining proficiency in Sanskrit was integral to the learning of Ayurveda in Kerala (Abraham, 2012: 190). The peculiar ways in which Muslims in Kerala are connected to the Unani and Ayurveda is an important dimension to understand their health behaviour.

There are reputed Muslim practitioners of Ayurveda in the region. Dr. Alikkutty, the founder of D. P Alikkutty's Kottakkal Ayurveda and Modern Hospital in Kottakkal is one among them. Of the nine practitioners in the Ayurveda department of the hospital, six including the chief physician, are Muslims with a BAMS (Bachelor of Ayurvedic Medicine and Surgery) degree. The patient records at Alikkutty hospital point to the fact that 90 percent of the in-patients are Arabs from the Gulf countries. Shameer, the Public Relations Officer at the hospital explains the reason which shows how the private Ayurvedic centres in the region respond to the rising market for Ayurveda in the Middle East where the Muslim practitioners have some advantages:

> I got job here because I have proficiency in both Arabic and English. Arabs who suffer from body ailments and old-age diseases prefer to come here. The Arabs prefer Muslim Ayurvedic practitioners to others because they can communicate with them through Arabic language and they trust Muslims. We have centres in Gulf countries to connect with Arabs. We have to prepare medical letter for them in Arabic so that they can take medical leave from their companies.

The community endorsement and preference for Ayurveda can also be seen in the Muslim students' choice for BAMS as their career option. For instance, of 50 total students enrolled for BAMS in 2017 at 'Vaidyaratnam P.S. Varrier' Ayurveda College' in Kottakkal, 15 are Muslim students.

We see the acceptance of Ayurveda and learning of Sanskrit as the channel to the medical knowledge in the narratives of traditional Muslim Vaidya families who still practice

Ayurveda in the unorganized sector as '*thangal*' or 'ustad' along with Islamic *mantram*. For instance, Thalappra *thangal* who practice *mantram* and Ayurveda says:

> We are traditionally *vaidyas* as well, my mother had learnt *sankrit* and her father was '*maha vaidyar'*. To make their healing better received, some of the *thangal* families started to learn Ayurveda which was the mainline local health system in those times and still practicing it along with *mantram*. I learned Ayurveda along with my formal religious education through apprenticeship with a famous *vaidyar* in Kozhikode; I used to sit with him in his shop and drug-making house. Before having the formal knowledge of Ayurveda, some of the *thangals* used to prescribe some medicinal plants as they come to their mind as *ilham* (divine consciousness) like 'you may drink hot water with neem'. Administering them will have the effect of both: the medicinal plant and the word of *thangal*.

Homeopathy

Apart from the government Homeo dispensary at Karumbil, we could see the mushrooming of private Homeo clinics in every nook and corner of Thirurangadi region, which has been assessed by its practitioners. One of the reasons, as Dr. Shameem who has also started his new Homeo clinic in Thalappara opines, is the phenomenal rise of Homeopathic physicians among the Muslim community in Malabar area. Apart from the medical colleges in Kerala, most of the medical students in the private medical colleges in Tamil Nadu, Karnataka, and Maharashtra are from the same area and the graduates are coming back to their home region. He says nowadays it is very difficult to find a place to start a clinic; Thalappara which is 'his area' has already two Homeo doctors. However, all the doctors seem to be getting patients.

Dr. Shameem and Dr. Thasneem, another young woman Homeo doctor in Karumbil, explained that there are types of Homeo seekers in the area. Some of them try Homeo after the failure of other systems while some come after becoming conscious of the features of Homeo medicine such as permanent cure or fewer side effects, and there is separate group who rely on Homeo only for children's diseases. Most of the cases reported in their clinic are skin diseases, and especially the paediatric diseases that include periodic cough, gastric complaints, and congenital deformities.

Along with this disease pattern, they also get the 'share' of what Shameem called 'sedentary lifestyle diseases' of the region, the result of occupational hazards and change in the food pattern. Homeo doctors count them as diabetes, abnormal blood pressure, depression, hypertension, kidney stones, infertility, gastric ulcers, and haemorrhoids diagnosed even in early twenties; earlier many of them were considered as old age diseases.

There are many like Basheer who always prefers the Homeo medicine under the assumption that they have no side effects. Even the private practitioners of allopathy in the area have testified the preference of the Homeo doctors for paediatric diseases. The accounts of the practitioners and patients regarding the relationship between the allopathy and Homeopathy denote the coexistence except on vaccinations where both of them were seen having conflicting views. Health officials in the region (all of them are from Allopathy) allege that some Homeopathic and Ayurvedic practitioners in the region were also part of the campaign against the vaccination.

Acupuncture and Hijama: New Therapies and Religious Affiliation

It was interesting for me to notice the emergent therapeutic methods in the region in recent times. One of them was the mushrooming of healing centres of acupuncture (healing with needle) and *hijama* (cup healing) throughout the main roads and lanes of Thirurangadi area. When I approached to enter inside the Shifa healing centre at Thirurangadi, the big flex boards put outside kindled my curiosity. The boards list the *hadiths* (prophetic sayings) about the necessity of *hijama* and the details of the religious rewards one would get if he undergoes the *hijama* healing. The strategy was to state not only an alternative option to cure the ailments, but to find the religious recommendation for these types of healing. The structure and the appearance of the building of the clinic give an Islamic religious ambience. At the same time, an acupuncture healing centre in Kozhikkode city which was not a Muslim area was painted in red, apparently to suit the feature 'Chinese healing'.

Before I was called inside for the interview at the acupuncture clinic, the lady receptionist had already given me the brochures extolling the dangers in having medicines, especially the allopathic medicines, and the exploitations by the vested interested drug mafias. Seated

inside the consulting room I could find a little girl sitting in the patient's chair with a needle pierced into her heel. The healer was asking the assistant to bring her 'medical file' which contains the records of her previous details that we see in the allopathic hospital. Another man in the room was the *imam* (employee in the mosque who leads the daily congregational prayer) of the Thirurangadi main mosque administered by AP Sunni group. Connection with the *imam* and his regular visits expected to add more authentication to the form of therapy claimed to be prophetic and religiously recommended.

The main healer introduced himself as 'acu-Pr' which means acupuncture practitioner started his clinic after completing the one year training course from Shuaib Riyalu, the main 'acu-Pr' in the region. He presented the philosophy of the therapy as *'one needle can cure more than ten thousand diseases*' which means they provide 'cure' for all kinds of diseases. They prick with needle on any of the 361 acu points in the body which is assumed to set the imbalances in the vital life energy in the body. They say acupuncture has no relation with the religion, rather it originated from China.

Whereas they consider the healing of *hijma* as part of the Islamic tradition recommended and practiced by the Prophet. It is practiced by making a small wound on the vein and putting different cups on the wound to extract the 'waste blood' believed to be collected in the spinal cord. They say, it is 'waste elimination therapy' through which the ailments are cured. He explained how to practice *hijama* through the recommended ways (*sunnath*) mentioned in the *hadith*: the practitioner has to make *niyyath* (intention) like before every religious ritual, perform *vuzu* (ablution, the compulsory ritual before daily *namaz*), pray to God, recite some selected chapters from Quran such as *fatiha*, and *ayah-kursi,* and the patient also has to practice some rituals. A board with the names of the martyrs of Badr battle[88] was also put in the entrance to the clinic who are believed to intervene in his help. Being an active supporter of AP Sunni organization, he resorts to some practices authenticated by Sunnis such as intercession while performing *hijama* even if his instructor Shuaib Rialu rejects them since he belongs to Jamaate-Islami.

[88] Celebrated battle of *Badr* was the first war fought between Prophet Muhammad and his opponents of Makah wherein 70 Muslim soldiers became martyrs and the Makah was defeated. *Badr* martyrs are among the most sought after holy men for the intercession by the Sunnis of Kerala. Prayers are made making them intermediaries for the protection of all kinds, especially when the community face menaces like outbreak of contagious diseases.

However, from our observation of the ailments reported in the centre and the healer's response it was clear that the new therapies respond to the rising market of combating with the lifestyle diseases which can be identified as one of the main characteristics of the disease pattern in the region. Another interesting fact observed in these therapies was the staunch opposition from the practitioners towards the biomedicine and its practices which have repercussion on the heated anti-vaccination campaigns in the area that we will deal extensively in next chapter. Abdu Razak and Sudhir the two practitioners at the Shifa acupuncture *hijama* centre said:

> We do not prescribe medicines to have inside; our therapy is on the external parts of the body, so there are no side effects, no chemical imbalance due to medicines which make complication to our healing. There is nothing called 'virus', 'infection', or 'epidemic', 'pathogen'; these all are just constructions of IMA (Indian Medical Association) to sell medicines. The very first step of our prescription is to suggest to the patients to immediately stop the medicines they are having so far such as the prescribed daily medicines for diabetes. We see lot of diabetes patients daily, and some of them are under the threat of cutting off their arms or legs; they are coming here for the last resort being fed up with the medicines. We have around 600-700 patients.
>
> We also suggest to our patients to not go for inoculations and vaccinations that will make our next generation morbid. After coming to this field, I do not allow any of our relatives to have tablets or medicines. These are all part of 'hidden agenda' to target the third world countries, especially the Muslims.

These newly emerged therapies presented in the region through religious colour caters to the high demand to control the rising lifestyle diseases and they are getting more patients than any other ordinary doctors even if the treatment is very expensive. They charge 750 rupees for *hijama* and 500 for acupuncture which is higher than the fees given to specialist doctors in the area. Unlike Ayurveda and Homeo, the practitioners of acupuncture and *hijama* reject the theory of curing diseases by consuming medicines. At the same times, they join the former in the anti-vaccination drive which makes significant impact in the vaccination coverage of the area.

Notions of 'Rational' and Other Health Practices

The classification of therapeutic methods is in complex ways, differently explained according to the ideological and personal lines. One is the classification between rational and irrational practices. The term 'doctor' represents the 'authentic' 'rational' health practices, having no room for the religious controversy or the question of belief. This category includes the allopathic, Ayurvedic, Homeo, and psychiatric treatment that are assumed working through cause and effect relation. One informant said:

> I used to do these practices (laughing). However, after learning about them 'deeply' I stopped. However, my family relatives are doing them. For me, if any problem persists I consult a 'doctor'. We should not encourage 'these' practices; most of them are 'fake' and exploiters and it is very difficult to classify into 'right' and 'wrong'. I oppose everything that is un-Islamic.

Among these 'rational' methods, biomedicine which is known as 'modern medicine' is generally considered to be the major option. As we noted, the term 'alternative' is relative to each patient; some consulted Homeo as first option, others tried Ayurveda as their first priority. It is also relative to the illnesses, for instance, some of them consulted *thangals* and *ustads* early for shivering fever and Homeo doctors are consulted first for paediatric diseases. There are some healing systems widely present in the area like *hijama* and acupuncture which can be posited in this category but involves the question of efficacy.

The belief in the power of sacred words, invisible beings is seen as something beyond cause-effect relation. Another pattern of classification is between doctors and valid religious healing which are understood as 'rational' and other religiously prohibited practices understood as 'irrational'. It is common belief among all Muslims that there is a valid healing according to Quran and authentic hadith which is understood as 'rational' and the rest of them as irrational. As we said in the case of *Jinn*s, our entire Muslim doctor informants including the ones in Thirurangadi government hospital unanimously stated that the idea called '*mantram'* exists as it is approved by Quran and Hadith. They said, it is permitted and it is good to have a protection from the devils that increases the patients' confidence.

A senior doctor who affiliates himself to the Madavoor group of Mujahid explained the 'ideal health behaviour':

> All health care systems cured by the medicine like allopathy, Ayurveda, Homeo are the valid health care systems. Cure without medicine is there which is 'prayer'; but the patient has to pray for himself or for his relatives or friends; other types of *mantram* are un-Islamic and not efficacious. Sometimes whims and surmises like being panic might be cured by his belief; sometimes he needs a 'reassurance'. One of my patients, an adolescent girl had this problem; her father called me up and asked me to tell her that she does not have any problem. I just told her to take some lab tests and looking at them gratuitously, I told her that she is okay, that word from a doctor cured her. Does it mean I possess superhuman abilities or *ghaibi* (invisible) skills? Nothing will happen beyond the sensory organs that we have.

These classificatory scheme of Muslim subjects based on multiple criteria defy simple binaries such as belief and empirical knowledge (cf. Good 1994). From the accounts of the sufferers and the Muslim medical practitioners, we got the impression that the ideas of 'rationality' and 'irrationality' are understood and produced in distinct ways. In the next section, we see the compatibility and coexistence of different therapeutic methods are also subject to the individuals' ideological position within the religious community that may add to the frameworks given by the medical anthropologists like Khare (1996)[89].

Coexistence and Conflicts between Therapeutic Methods

We see the coexistence of the 'rational' and 'irrational' methods among health seekers. They drink the water washed in the sacred letters written on the ceramic plate before delivery. I also saw another case in which a paper written with sacred letters and magical table hung upon an ailing child in the hospital ward when the newborn baby girl refused to drink mother's milk. After the successful delivery with the specialist doctor, they approached an *ustad* when they noticed the baby's reluctance to breastfeed. The mother and her relatives who were AP Sunnis claimed that the baby began to have milk when the paper is hung above her and she stops drinking milk when it was removed.

The coexistence is evident between the 'explanatory models' of the patients influenced by their own *vishwasam* and the 'clinical realities' of the medical doctors. It is not a

[89] See for instance, Khare, R. S. (1996). Dava, Daktar, and Dua: Anthropology of Practiced Medicine in India. *Social Science and Medicine, 43*(5), 837-848.

'dialectical tension between two reciprocally related orientations; the clinical perspective and cultural perspective' as Kleinman (1980: ix) has understood it, rather; a mutually coexisting multiple systems of cure and care. However, we have noticed that the ideological orientations of the Muslim doctors, not the blanket term of modern medicine or Western medicine, differently define their explanatory models based on the belief, not the empirical knowledge.

Not just patients, Muslim doctors' beliefs and ideological positions will also add to our analysis of coexistence and conflict. Dr. Muthukkoya, a Mujahid doctor converted from Sunni explained his position. The very moment when I entered his consulting room, I could find many Mujahid magazines kept on the table for the waiting patients to read. He always recites the '*bismi'* before every surgery he performs. *Bismi* is the recommended Quranic verse in Islam to be recited before starting anything that reads 'I start in the name of God most gracious and most merciful'. Nonetheless, he classifies the connections and cleavages between religion and health:

> I strongly oppose the practices of amulet or *mantram*, I did not do these when I was Sunni, and now opposing them when I became a Mujahid. I do not believe in it, and there is no need of it. I also believe in the effect of evil eye and sorcery because *Hadith* has said that and even prophet was once suffered from sorcery. For these kinds of diseases, only Quran is the healing.

We should also note, as we have been arguing throughout the chapter, the differences of belief among the Muslim patients on sectarian lines that also affect the ways in which the religious remedies and the treatment methods coexist. It is not a 'shared cultural behaviour'. Two Sunni women we cited above followed the prescriptions of *ustad* along with the medical treatments and they believed that the *ustads* or *musliyars* were 'right' and that their methods would 'work'. They also believed that *ustad's* prescriptions are also necessary along with the medical treatment they were undergoing for it to be 'successful' and effective, and for such illnesses, surgery, or medicine is the solution; *ustad's* methods are not enough.

We have another case, Yousuf who kept on 'reforming' his ideas and practices through his new learning and interactions. He said he has 'his own' positions and ideas on Islamic beliefs and practices, so he did not believe in *ustads*, *thangals*, and *beevis* and their

treatment. When he had a severe stroke and was admitted to a hospital in Thirurangadi, he recited only *swalats*[90] along with the treatment. Reciting *swalat* is understood as a 'common' practice recognised by all religious groups and it is not a 'controversial' practice. He thinks his reliance on reciting *swalats* was crucial in bringing him back to life from the critical battle between life and death. Whereas his family members, especially his wife and mother, longing for his life, followed their old Sunni line of practices, had made a vow to contribute (*nercha*) to a *maqam* if he is saved from death, which was un-Islamic in his view. Basheer, another 'reformed' informant, said he had offered special prayers at mosque and prayed while his wife was undergoing a surgery. For these informants, they practiced the 'authentic' and 'rational' practices while facing critical situations, unlike their 'ignorant' Sunni relatives who followed 'un-reasonable' methods for cure.

The doctors in MKH admitted that some patients bring the cans of the sacred water called *zamzam* or the normal water blown with *mantram* along with them to the hospital wards and drink them except in case of the surgeries which forbid drinking water. They say even the Mujahid doctors allow them and take it as part of their individual *viswasam* or belief. However, there are instances of conflict observed by the 'rationalist' Muslim doctors towards the healers like *thangals* and *ustads*. A Mujahid doctor explains such an incident:

> When I was working in the primary health centre at Thirur in 1980s, I had the experience of conflicting with the patients' worldview and classification of illnesses. Thirur at that time was one of the areas where the light of 'renaissance' did not enter. One patient, a 20-year-old boy, was diagnosed of meningitis (infection to the brain covering) and the relatives taken him to an *ustad* even if I tried my best to convince them about the curability of the treatment. Then their reply was 'for this illness you can do nothing'. Later we came to know that the patient was dead. They understood it as *apasmaram* (convulsion). These types of beliefs were prevalent among both Hindus and Muslims and the difference was it was rampant among Muslims; they took it as part of their religion.

Apart from the vaccinations and inoculations, we also see the conflicts between the different therapeutic systems in the area on various issues. In the area, there are anti-biomedicine groups such as the practitioners of *prakrithi chikilsa* (naturopathy) and

[90] *Swalat* is the prescribed sacred words by which Muslims pray to God to shower blessings and peace upon their Prophet, the Prophet Muhammad. Telling different versions of *swalat* has been considered as one of the most recommended practices which can cure many of the illnesses.

acupuncture who question the very concepts of modern medicine such as infection, fever, virus, bacteria, prevention, and campaign against having the allopathic medicines. They allege that the allopathic medicines will destroy the 'vital force' in the body that is the central feature of the health. Correcting the imbalances in the circulation of this vital force throughout the body is one of the main elements of their healing system. The acu-healers gifted me a book titled, "Why Medicine to Cure?" which questions the failure of allopathy to cure diseases and the contents of its medicine; its prime target of criticism is allopathy, not other medicine giving health systems. Unlike the modern medicine, their explanations of many of the common diseases like diabetes, obesity, and mental diseases locate the reason on the functions of liver and kidney[91]. As interview with DMO (District Medical Officer) of Malappuram, a Muslim woman doctor, exposed the concerns of district health administration about the rising anti-medicine alternatives in the district.

Conclusion

The chapter explored Muslim's health behaviour through the macro contexts of economy and the state health institutions. We found that the contextual determinants of health other than religion, most importantly the occupational change, the new trends in the economy of the region, the resultant changes in the dietary habits, and the regional specificities in the lifestyle, shape their health status. The emergence of the 'migration induced diseases' that come recurrent in the discussions can be cited as an example.

The enquiry into the choice of public and private health care facilities pointed to the fact that the choice is depended on the observations made by the patients on the health facilities and the economic conditions of the different classes within Muslims. Social status attached with admitting the delivery cases in the private hospitals is an exception. Another fact to be noted here is even though the establishment of MKH private hospital in Thirurangadi and mushrooming of private hospitals are widely acclaimed as the result of 'progress', 'change of health practices' and 'religious reform' by the reformist organizations, we see the economic growth and the market demands of the new capable consumers help the rapid growth of modern private hospitals in the area. We see the

[91] Kleinman (1982) notes this trend of considering the kidney as the source many of illnesses in Chinese medical systems.

subjective motives, choices, and preferences are also conditioned by the factors of class, status, and the market.

Related to the health seeking behaviour, the classification of illnesses and selection of remedies is the share of Ayurveda which is not alternative, rather; considered as the mainstream for some diseases. We saw both Ayurveda and Homeopathy are well responding to the emerging pattern of diseases we found earlier. Another such emerging therapy prevalent in the area is the healing of *fasd* (needle healing) and *hijama* (cup healing) introduced in the area through the religious affiliation which also targets the high *market* demand of the measures to combat the rising number of lifestyle diseases, criticizing the modern medical practices. In the end, we saw there is a categorisation of all therapeutic systems into 'rational' and 'irrational' specifically understood by Muslims which also depends on the religious validity of the therapy as well. Different systems coexist with each other according to the pattern of health seeking behaviour we presented earlier and there are conflicts as well especially on the idea of immunization, inoculations and vaccinations. In the next chapter, we draw all the strands hitherto presented to examine if we can suggest talking of a 'Muslim Medical Subject' in the light of foregoing discussions.

Chapter 6

Religious Discourses, State Health Policy and Formation of Muslim Medical Subject

Introduction

In this chapter, we examine the formation of what we refer to as a 'Muslim medical subject' in Kerala in the background of the religious and state discourses. We try to understand the transmission of religious ideology and the specific positions on health practices that it engenders. In other words, we seek to understand how the ideological debates produce classificatory schemes of practices that shape the health behaviour of individuals in the Muslim community through the institution of *mahallu* and its apparatuses of indoctrination.

The chapter touches upon the doctrinal discourses 'from below' (interpretations by the subjects), regulation of the authority and authenticating discourses by the subjects through the institution of *mahallu.* We will also give the accounts of the everyday sites of the interactions and the formation of religious positions at different levels of authority, namely, the *mahallu*, households, and the individuals. In the end, we will try to investigate the question of Muslim community's attitude towards immunizations and family planning program of the state that will help us understand the formation of religious subject in the domain of health.

Reformist Doctrine and Spirit of Biomedicine

> It was the Mujahid leaders like MK Haji in Thirurangadi who led the people from the blind beliefs of healing practices to the 'right' path; they established modern hospitals and showed to the community how to behave properly when one falls ill, the way into the modern medicine.

In these words given by Dr. Mahboob, an activist of Madavoor group of Mujahids, we see an appropriation of modern medicine achieved as the result of their religious reform movement. In conversations and publications of Mujahids, we see how modern medicine is understood as 'light', 'progress', and 'renaissance' and how community is seen as needful of reform in order to be religiously correct and socially progressive. The blending of religious reform with the adoption of modern medicine was observed commonly in the accounts given by all Mujahid informants. The supremo of Madavoor group Dr. Husain Madavoor proclaims their project, a kind of sectarianism inspired campaign for science as he says, 'the Mujahid movement is about religion, education, science and progress' (Quated in Osella and Osella, 2013: 146).

Many of the *Mahallu* residents including the *beevi* in Chullippara have spoken about the common denominator among the medical doctors in the region, that most of them are Mujahid sympathisers. *Mahallu* president Hamsaji once said:

> Most of the renowned medical doctors in the area are from Mujahid background like Mustafa doctor and MC Abdurahman doctor in the MKH. Once, when I went to Mustafa doctor to seek treatment for my grandchild, he became angry seeing a sacred thread whispered with '*mantram'* tied with my child's hand.

Beevi of Chullippara said:

> Sometimes I send my 'patients' to Dr. Kabeer in Kottakkal. Even if he is a Mujahid lenient, I keep a close relation with him. Most of the doctors are from Mujahid background, right?

The older Mujahids in the area recollect the memory of their ancestors who migrated to Thirurangadi. When the institutions like PSMO College, Oriental higher secondary school, and MK Haji private orphanage hospital were established in Thirurangadi, there was a flow of schoolteachers, college lecturers, engineers, and doctors into the region and majority of them were Mujahid activists. Another important feature common to most of them was they came from Areekode, the Mujahid epicentre in southern Malabar, which is considered as the first full literate area of Malabar. Dr. Abdu Rahman narrated his journey of becoming a medical doctor, signalling his community's history of progressive transformation. Later, he became the member of the Mujahid State Committee:

> Areekode is a place where the Mujahid 'revolution' happened; the Mujhaid scholars preached in the mosque about the necessity of modern education, the need of going to school and college, very in early in 1930s and 40s. They even made night visits to each household to enquire about our studies. '*Illness has to be treated'* was an important motto of that educational revolution. A medical doctor called Dr. Usman Sahib, graduated from Madras Medical College had started a charity service centre that prompted me into the medical field. I completed MBBS in 1973 from Calicut medical college and secured PG from Lady Harding Medical College in Delhi, in 1976 when it was only a few among the Muslims who can be a medical graduate. In a single *mahallu* of Areekode alone, there were around 300-400 doctors, and now there are two DMs (Doctor of Medicine) in Cardiology alone in MIMS, a rare area of specialisation; all of them are from Areekode.

His career graph is the representation of a 'reformed region' that endorses 'rational' health practices. Modern medicine has epitomized that striving for both the religiously correct and progressive therapeutic method and the entry of reformist Muslims into the biomedical profession could be seen as the remarkable result of the religious reform movements in the region, in the Webarian sense.

Dr. Aboobacker, another senior doctor who chose medicine as his profession inspired by the 'wave of renaissance' in Areekode, and later shifted to Thirurangadi, also has a similar story to say. In the course of our conversation, he advised me on the proper health practices a Muslim should adopt. He pointed out that it is not necessary that one should always rely on allopathic doctors; other methods such as homeopathy and Ayurveda are also acceptable. Nevertheless, going to healers, making intercession, and chants are prohibited. He also opposed the trend of calling allopathy as 'English medicine' or 'Western medicine', arguing that the basic corpus of knowledge of modern medicine was the contribution by Muslim Arabs like Avicenna and Ibnu-Haitham. The point he wants to promulgate is the fact that Muslims should appropriate allopathic medicine. We have to note the noticeable shift in the position towards 'English medicine' from that of colonial period that we elaborated in second chapter.

With sufficient number of doctors very early in the growth of organization, the Mujahids started an association for the Muslim doctors named IMB (Islamic Medical Brotherhood) in 1987 registered under KNM (Kerala Nadwathul Mujahideen), the apex organization of

Mujahid scholars. They worked to provide medical services in the area like palliative services, circumcision camps and distribution of medicines free of cost. Its first president was Dr. Aboobacker who was the first doctor to come to Thirurangadi from Areekode, his hometown. At the same time, he was the president of KNM West Malappuram district committee. He says:

> Mujahid leaders established schools and colleges when Muslims were educationally backward. Mujahid leader Abussabah Maulavi started Farook arts and Science College in Feroke in 1968 along with the Arabic College. After passing out from Farook College, I went to Calicut Medical College. Later, after the graduation, I came to Thirurangadi and started to work with Thirurangadi orphanage; I was the first medical officer appointed in MKH. Thirurangadi was one of the areas where the Mujahid leaders established educational and health care institutions. I was the first Muslim doctor in this area in 1960s; now there are thousands of them in Thirurangadi alone.

The narratives of these two veteran doctors show the ways in which the religious discourses on the 'proper health practices' produced the conception of 'progress' based on the modern medical education which was seen by them as 'religiously correct, progressive, and rational medicine'. Thus, the Mujahid religious movement also contained a movement from 'healing' of illness to the 'treatment', in medical anthropological sense. We see later that the senior doctors like Abdul Rahman and Aboobacker, the early products of the organizational endorsement of modern medicine, lead the health wings of their organization, an effective way to connect to the lives of the religious subjects. In contemporary times, we see, the health related services and activities are increasingly understood by religious organizations as offering the entry into the domain that lies beyond religious and organizational differences. Such an image would help widen their support base among the Muslims and popularity among the wider Malayali public.

What makes us interested in the accounts given above is the affinity of certain religious sectarian beliefs with specific health practices deemed as 'rational'. Such beliefs work as the vocabularies of motive for meaningful social action. This reminds us of Weber's thesis (Turner B, 1974: 11-12) on the historical connection between the meaning and social action, namely the rational, this-worldly ascetic ethic of puritan Calvinism and the rational economic practices rooted in modern capitalism. What we see is the Mujahid ethic of true religious conduct includes the motives of striving for the health practices supposedly

'rational'. The religious ideology that opposes the practices considered 'blind beliefs' (health practices that work through beyond cause-effect relationship[92]) necessarily included the call for the rational and valid practices, and biomedicine was considered as the predominant form of rational medicine.

This has to be read along with the dominant theme in the history of Islamic reform which stated that Islam in its original form was a plausible socio-political ethic that was compatible with the modern scientific notions (cf. Geertz 1968; Turner 1974; Rasanayagam 2006; Hajj 2009). In a similar manner, Francis Robinson (2008) has opined that the reformism heightened the ideas of human instrumentality in the world, emphasised on the idea of a Muslim as a man of action and thus empowered Muslims on 'earth' or thisworld. Based on the study among the Mujahid reformists in Kerala, Osellas (2013: 161) note the association of reformism with a self-consciously 'modern' outlook, 'systematic life' with a concomitant association of others as 'backward' and 'un-modern' practices. However, we do not see the dichotomous categories of ascetic, this-worldly, active reformists and the mystic, otherworldly, stagnant Sufis or 'traditionalists'. Rather, though there is an inherent affinity between Mujahid ideology and modern medical practices, all organizations including the Sunni-Sufi groups, now increasingly focus on the 'this-worldly' social activities and welfare measures for organizational growth. Here we see a gap between the abstract religious ideology and organizational activism on the ground that demands the popular support at grass root level. Now we turn to this point, the uniqueness of health in the religious organizational activities in Kerala.

Health Activism of Religious Organizations

It is interesting to note that all religious organizations are competing with each other to provide social services exclusively at the modern health care sites irrespective of their denominational differences. Through dispensaries, hospitals and welfare schemes, the organizations spend much more time in engaging with the 'society' within the framework of market. As we mentioned in the second chapter, this is also a historical shift in the

[92] Mujahids oppose the practices like asking help of saints buried in shrines, seeking the help of *Jinns* and angels which, they say, are based on the means beyond cause and effect relationship and immaterial way that will be regarded as *ibadat* (worship) and thus as *shirk*. At the same time, asking the help of doctors and seeking their treatment is the action that work through cause-effect relation and material ways which is not *ibadat* and *shirk,* and thus, the valid method of health seeking (for details of Sunni-Mujahid debates on health practices, see Zirajudeen, 2013, Unpublished PhD thesis, JNU).

response of contemporary religious scholars and organizational bodies towards the modern medicine brought by the British.

Health officials in Thirurangadi Thaluk hospital and Pookkipparambu PHC also testified that a phone call was enough to get donations to the hospital in the form of chairs, bed, insulin, drinking water and food. We could find the chairs and benches in the general OP ward at Thirurangadi Thaluk hospital inscribed with the donor organization's name. The health wing of AP Sunni faction, known to be the hard-line defenders of the practices like *mantram* and the strong opponents of Mujahids also have donated to allopathic facilities rather than to healing centres. The organizations provide food for the hospital inmates especially during *Ramzan* month during which all Muslim hotels will remain closed in the region. However, it is to be noted that some groups that are enthusiastic to donate to allopathic hospitals, however, actively oppose the immunization and vaccination scheme implemented by state. We would take up this point in the later section of this chapter.

Every religious organization among the Muslims has its own separate wing for health related social services and relief activities. AP Sunni faction has their own health wing in the name of *santhwanam* (solace), EK faction has *sahachari* (close associate) and Mujahid groups have their own wings with different names such as 'Medical Aid', 'IMB' (Islamic Medical Brotherhood). These wings provide free medicines, food, and sometimes donate medical equipments and other paraphernalia to the hospitals and the bystanders if required, and the distribution of breakfast, lunch and dinner for the hospitalised. I could see a vehicle painted with '*santhwanam'* visited once in every week with necessary medicines to the small hut of an old lady patient in Chullippara *mahallu* who was left alone with no relatives. When she died, the AP faction to whom the *santhwanam* squad was affiliated, conducted her death rituals according to their organizational style in a *mahallu* dominated by the EK faction.

Irrespective of their stand supporting the healing practices, Sunni organizations also competed with Mujahids in providing social service in allopathic hospitals, not so much in Ayurveda, Homeopathy or healing practices which they otherwise promote. One of the activists provided his own logic for this irony:

> We fight to defend the practices like amulet, *mantram*, or healing with *Jinn*, but when it comes in the area of social services, we provide what exactly the society needs which is

> allopathy. There, the objective is to popularise the name of organization by getting into the domain that people need most, the health, and the allopathic health care.

Rubina Jasani (2013) has given account of the growing influence of Islamic organizations in the social services via reconstruction and resettlement among the riot-affected Muslims in Ahmadabad during 2002 and 2004. She shows the way Islamic organizations make inroads into the religious life by providing the facilities they need the most especially among the post-terror societies (Jasani, 2013: 258). These societies are exposed to experiencing the new 'organizational life' following the disordering of their normal organizational structure due to riot and resettlement. However, the interesting fact she notes is that even if the survivors of the displaced Muslim communities had but to avail the resettlement facilities provided by the organizations, they negotiated with their relationship with them through tactics and diplomacy (Ibid,. 261).

However, in contrast to Jasani's findings, we also have some inputs from the leaders who keep their organizational interests away from the health related activities such as providing palliative care. As an area which people need the most and as need of urgency, it is a common norm not to consider the ideological and religious differences in providing the services. Thus, the hospital as the site of medical care is considered something which cutcross all other differences. There are many charity and relief committees based in the Gulf countries that provide the main source of income for the health wings run by the organizations. Ismail, the secretary of such a relief committee said, they would not consider the organizational differences in providing medical aid. He says:

> Personally, I am a Mujahid follower, but our relief committee reaches out to the persons with different ideological backgrounds because this is a platform to help provide the basic needs irrespective of organizational differences. I participate in the public activities keeping my religious ideology firm in my mind. We consider our relief activities, especially helping the poor in need, will help us with reward in the life after death.

Thus, in contrast to Flueckieger's (2006) idea of 'religious crossroads' inherent to the religious healing in Islam, we place the health-squads of modern medicine of religious organizations at the 'religious and organizational cross roads', whereas they face off on the validity of healing practices. She calls the healing practices of a Muslim female in Hyderabad as 'religious crossroads' and 'vernacular Islam'.

Just as the pragmatic need of increasing the 'social base' of religious organizations, the social works also meet other side of the *dawa* (Islamic practice of summoning others to live in accordance with the divine prescriptions) activities. As Haniffa (2013: 179) noted, in the case of *al-muslimat* organization in Sri Lanka, the motive is to experience improving society through social service activities along with the stated goal of increasing the personal piety. The dichotomous categories in anthropology (cf. Turner, 1974: 146-150) that sees the religious reformists through 'asceticism', 'activism', 'this-worldly' and 'social responsibility' against the 'passivity', 'stagnation', and 'otherworldliness' of Sufis do not help us here to understand the ideology behind the motives.

Learning Practices and Indoctrination of Discourses

The discursive practices lie with the technical processes, in institutions, in transmission and diffusion, and in pedagogical forms produced in order to shape the subjects in a particular manner. The sites of learning can be the key for the production of particular form of Islamic subjectivity. We explore here the process of indoctrination of the religious discourses on health through the educational institutions of *mahallu*.

Inspired by Asad's framework, there is a growing body of scholarship on the ways in which the learning help reshape the activists' conceptions of self, practices of religiosity within and across class, national and gender boundaries through rhetoric that deploys specific notions of religiosity, culture, and state (for example, Mahmood 2005; Hirschkind 2001; Zaman 1999; Robinson 1993; Haq 2013). Hirschkind (2006) in his analysis of emergent Islamic public sphere in contemporary Egypt has argued that the particular form of Islamic socialization is not singularly hegemonic. Rather, it is a practice in the context of shared moral space which is integral to the cultivation of an everyday form of religiosity conforming to the orthodox Islamic norms. However, these works attend centrally to the discussions and practices of Islamic actors and their reformist socialization. We will take up this point raised by Hirschkind, namely, the 'shared moral space', in the coming sections by analyzing the operation of authority in *mahallu* through a dialogue between authority and subjects.

Here we look into the ways in which the ideological positions on the health behaviour, which was debated with the opponent organizations, are reproduced in the religious

community through religious learning centres. Our focus is to show how the religious discourses are served to the members and how do they negotiate with the form of authority in the context of *mahallu*. The primary site at which this knowledge is gained is *madrasa* (religious school from elementary to higher secondary level) where jurisprudence studies (*fqh*), theological beliefs (*aqida*), commentaries on the Quran and hadith, historical chronology of Islam from Prophet to the respective organization are at the core of curriculum. However, in educating Muslim pupils, the powerful alternative institution is the modern public school regulated by the state.

As we have seen in introduction, Chullippara *madrasa* is registered under SKIMVB, the 'educational' board of EK Sunni faction, the largest religious organization among Muslims in Kerala. There is another parallel *madrasa* run by the AP Sunni faction not far away from the EK *madrasa*. The EK *madaras* has 12 levels starting from the primary, upper primary to the higher secondary level. Whereas the primary classes are mainly tought the liturgies of the basic rituals and the basic beliefs in Islam, ideological positions on controversial practices such as 'healing' are included in the curriculum of higher classes. Even the textbooks on the liturgies and the pattern of the basic rituals such as ablution before the prayer, fasting, giving alms, and performing *hajj* are prepared as per the *samastha's* ideological positions on them. For instance, the text for *akhlaq* (behaviour Studies) in the XIth class of EK Sunni madrasa questions the validity of *kahanath* (prophesy and palmistry) and lists the authentic *hadiths* to classify it as *kufr* (idolatry). The chapter says approaching the soothsayers (like *panickers*) and foretellers for one's desires and wishes is *haram* (forbidden practice).

At the same time, there is a separate chapter on *ain* (evil eye) wherein it affirms to the students that evil eye is a reality which is confirmed by the authentic legal sources. The book says the evil eye has its effect which occurs with Allah's intention. In addition, it suggests an authentic *ruqya* (*mantram*) for the protection from it. In another chapter, '*ruqya'* is defined as the 'act of protecting with the sacred names of Allah, with Quran, and other words which do not consist the elements of *shirk* in it'. There is a separate chapter on *nadhr* (making vow), recognizing the effect of the practice and classifies it as *sunnath* (recommended practice) such as making vow to donate to the Mamburam *maqam* in order to fulfil the desires. The texts say, these all are accepted and recognised by the

scholars of *ahlu-sunnathi-wal-jamaa*[93], believed to be the only true and valid group among Muslims. Therefore, there is no harm in following them.

According to the pedagogical system of *madrasa,* the students have to memorise important prayers and *dhikrs* such as the healing *dhkirs* that are useful to gain protection from the evil eye and sorcery and these portions appear in examinations. As we can see, dissemination of ideological positions and classificatory schemes of healing practices starts from childhood even if they are not actively part of the religious discourses. There is also a requirement for the teachers to have a registration number in the organization so as to avoid any member of opponent organization being appointed in the *mahallu* affiliated to it. This system will make sure that the teachers in the *madrasa* will be the propagators of its own ideology by following, teaching, indoctrinating, and implementing the organizational decisions in the *mahallu* where he is posted.

Despite of early socialization and conditioning in the religious educational institutions in the *mahallu*, the behaviour of the *mahallu* residents indicate that considerations other than religion play a role in the formation of Muslim subject. In the case of *madarasa,* the primary agency of other considerations is the school which has been made compulsory by the state for every parents to provide basic formal school education for their children. As we have noted earlier, the *madrasa* system has always undergone the changes according to the demands from its own community to accommodate the necessities of regular school. Numerous English medium community schools under the private managements have sprung up in the area and *samastha* had to start a new curriculum according to the school academic calendar and also shift madrasa timings to suit the school hours.

However, even though the *madrasas* had to inculcate changes in the context of increasing surge for the school education, parents in the *mahallu* consider formal religious education in *madrasas* as an essential part of their children's growing process. Most of them hence prefer the community schools with the facility of *madrasa* education. In order to attract

[93] The term '*sunnat'* means the prophetic tradition, and '*jamaa'* refers to the great companions of Prophet who lived in the first centuries of Islam. Islam, as understood and perceived by those who participate in the religious discourses in Kerala, has this single and true ideology, that is, *ahlu-sunnati-wal-jamaa'.* The Prophet had predicted that his community would divide into several groups and only one group of believers would remain steadfast and not succumb to any false beliefs or misguided leaders and stay true to his message that eventually prevail (Commins, 2006: 16). Most of the authentic *hadith* commentators have interpreted these prophetic words by identifying this steadfast group as '*ahlu-sunnati-wal-jamaa*', that is, the men of tradition and the ideal community. Each religious group who actively participate in the religious discourses claim they are the real *ahlu-sunnah*.

more applications, most of the private schools in the area highlight the facility of *madrasa* education in their schools as 'both educations under same roof'. In the private community schools, religious education is not generally considered important since it has little bearing on the career. Those who can afford, mainly the rich 'Gulf households' and the rich bakery merchants in Chullippara, send their children to the Kundoor Markaz English Medium School which adopts Islamic discipline along with English medium Kerala state syllabus and the *madrasa* with the SKIMVB syllabus regulated by *Samastha*. By sending to these schools, parents are thus relieved of providing religious education.

Arabic colleges are the higher learning centres where those who are interested in the specialisation in religious studies take admission. Those colleges have now adapted well to modern educational needs and offer mixed education (religious and modern education). In contrast, *palli dars* (seminary in the mosque) in the traditional system of higher education gives prominence to the religious education. Unlike the general character of students in *madrasa,* the *mutha'llims* (students in *dars*) scrutinize strictly and select the *dars* and *mudarris* of their own organizational background carefully before enrolling themselves. Hence, *dars* seems an organizational platform for the consolidation of the organizational ideology already initiated in the *madrasa*. Here we are getting into the experiences of two *mutaa'llims* enrolled in the *dars* run by the AP Sunni faction in their own mosque in Thirurangadi, the splinter Sunni group known as comparatively 'strong Sunnis' in the nomenclature of Muslim organizations in Kerala.

I met two *mutaa'llims* from the general OP ward in the government Thaluk hospital; they have come here to seek treatment for fever and they have been referred to MKH for serious cases. One of them introduced himself as *sayyid*, who belongs to *thangal* family and the other was from an ordinary Muslim family. Even if they study in same class, the latter ordinary student seemed respecting and serving his *sayyid* classmate who is believed to possess the *barakath*[94] a highly preferable ascribed qualification to be a religious leader of Sunnis and a healer in future. *Mutaa'llims* said:

> We are the men of AP *ustad* (AP Abubacker Musliyar, the founder of AP faction); he is our authority, we are sure that he is infallible, and this is 'our' mosque (pointing towards

[94] Clifford Geertz has given his definition of *barakah* as 'a kind of spiritual electricity or magical power by which the sacred appeared more as a benefaction, a special ability of particular individuals' (Geertz, 1968: 48).

their mosque where they stay and study). We are the 'real' Sunnis and we hate Mujahids the most because they disrespect the Prophet and the holy men. We regularly read '*Siraj'* the daily newspaper published by our organization and we regularly attend all our conferences of SBS (Sunni Bala Sangham, the children's wing), SSF (Sunni Students Federation, for students), and SYS (Sunni Yuvajana Sangham, for youth). We listen only to the orations of AP scholars.

We have been taught about the belief in the *mahanmar* (holy men), their history, and their *karamath* (superhuman qualities) such as Muhyuddeen Sheikh and Mamburam *thangal*. We are here in the hospital because *Mahanmar* have advised to go to hospitals and consult the doctors in case of illness. We have *samajams* (assembly) conducted fortnightly on every Thursdays and Mondays where we are trained to speak on the topics like Mamburam *thangal*, Ajmer Sheikh, and the specificities of each month in Islamic calendar. Apart from the personal orations, our *ustad* makes us into two teams, as AP versus Mujahids, to debate between us on the controversial issues. We will debate with Mujahids in the future.

After *madrasa* education, classes are conducted by the *mahallu* committee for its adult members, separately for males and females and some congregational prayers, attended by both. Conducting religious classes for women by the women scholars is a recent phenomenon where they get the training on the beliefs and practices of the religious ideology such as learning and practicing of authentic *dhikrs* and *swlats* useful for the everyday needs. Aminumma is one of the regular attendees of such *vanitha* classes (class only for women) conducted in *madrasa*:

I did not have much formal education; I did not get the opportunities for learning. However, now there are so many options for learning, especially for the women who did not get enough opportunities for religious learning. We have weekly women classes in this *mahallu* on each topic in religion and I prefer the women scholars to listen so that we can ask our questions openly. We have the opportunity to ask our doubts and queries in religion especially to get the opinion on the 'true' and 'right' opinions on every issue. We also participate in the *dhikrs* and *swalats* conducted for women.

Migration and Ideological Changes

Individuals keep on acquiring religious ideological aspect from the various places they travel. The changes brought about by migration on the religious behaviour of the local

society has been the concern of many anthropologists such as Geertz (1968), Simpson (2003, 2008), and Osellas (2011). Clifford Geertz (1968) found that the annual travel to Mecca made by the Indonesian Muslims for *hajj* pilgrimage has the social consequence of a movement toward 'scriptural Islam' that they experience in Saudi Arabia. Whereas, Edward Simpson (2003, 2008) shows how material transactions and economic exchanges through the migrations in the West coast India make Islamic reform effective among Mandvi Muslims of southern shores of Kachchh in the Western Gujarat. Osellas' (2011) looked at it through different angle. Exploring the relationship between the religious and economic practices in Kozhikode, a medium-sized port city in Kerala, they focused on economic practices as the production and articulation of specific morality and affect facilitated by the Islamic reform in Gulf and Kerala.

They observe different kinds of religious behaviour where they travel and reflect on their own existing beliefs and practices. An elder resident said:

> Some people change their organization and practice after they leave for Gulf wherein they befriend with the people with those ideologies. Most of the Mujahid youth in Chullippara are 'converted' from Sunni through a friend in Gulf or the video clips or speeches sent by him from Gulf. There was a young boy who was an active member of SKSSF (student wing of EK Sunni faction) and very much regular to the mosque and *madrasa*. However, after he went to the Gulf and came back, he stopped coming and 'changed' to Mujahid. Some of them are 'changing' to *tablige-e-jamaat*, especially those who work and run business in other states in the country.

Muhammad Nasser's case who became Mujahid in the wake of long years in Gulf is a clear account of the migration and the change of religious opinion it entails. His transformation has been slow, but not imperceptible, which is increasingly at variance to those of his family members in Kerala. This change was reflected in his more assiduous observation of prayers and his disavowal of some rituals after the return, most notable of which was his rejection of 'fake' healers. He says about the changes happened to him after migration:

> Lot of changes happened to me after migrating to Gulf. It is not because most of the Gulf countries are following the *salafi* line. Because most of the Dubai population follow the Sunni practices that we have here whereas Sharjah is a *salafi* city. Moreover, it is because we are getting comparatively more freedom in Gulf than here. We can interact

> with different type of people with different ideologies and we get different experiences. I used to meet different people when we assembled for the daily congregational prayer in the mosque where we see different versions of practices.

Attiya Ahmad (2013: 422) sees this as the development of cosmopolitan forms of Islamic practice shaped by their everyday diasporic experience. They juxtapose the new frameworks with what they have been doing at home. Through their interactions and discussions with Muslims of different ethno-national backgrounds and different traditions of Islam, the migrants develop new understanding of what constitutes proper Islamic practice. We found that the exposure to the Muslim life in the Gulf and the change of ideas is dependent on the area and sector one is employed in Gulf.

We have said in the last chapter that many of the residents of Thirurangadi have made their life by migrating to the cities of other states as workers and establishing bakeries, restaurants, hotels, and cool bars. Safeer, a young dropout from *madrasa* said he changed his ideas after his migration to Chennai where he is working in a cool bar. Shabab and Riyas the two brothers in Chullippara are running a bakery in Hyderabad. They say about the changes happened to them from Hyderabad:

> We had lot of changes in our beliefs and practices after we migrated to Hyderabad. We could not see many of the practices we have here. Then we started learning about them and began to hear the speeches and clips we got through social networking sites and gradually we stopped many of the practices we used to do.
>
> Apart from listening to the video and audio clips, we read the Malayalam translations of Quran and hadith. Unlike our home, we get enough time to read books in Hyderabad. Interaction and engagement with the groups like *Thabighe-e-jamaat* from Hyderabad made us rethink our practices which may not be possible if we are in Dubai, which is full of entertainment and luxury.

Religious Organizations and Formation of Ideological Positioning

Now we consider the modalities of the formation of position on health practices among the members of the *mahallu*, the micro unit of religious authority. We need to attend to the question of how the religious organizations bring in the 'sectarian mindedness' or

'sectarian consciousness[95]' among the believers. There are active members of the religious organizations who changed their position according to new resolutions taken by their organizations. Whenever asked about *mantram,* the Mujahid sympathisers did not reject it but said, "*Yes, there is authentic mantram called as ruqya shariyaa which is validated by Quran and Hadith, and the rest are to be rejected"*. The reproduction of discourses in the field can be seen among the full-time activists like Dr. Mehboob (Wisdom group of Mujahid) or the AP *dars* Students (AP Sunnis) and the regular listeners and readers of the debates like Abdul Nasser (Newly convert to Mujahid) who are always updated of fresh discourses and latest versions of classifications. This is the instance where we see the active followers make continuous ethical self-fashioning[96] according to the organizational positions which is very dynamic in nature. One of the activists said:

> We need to 'think deeply' and study those practices before we practice them, we should learn Quran deeply before anything else; I hate all of them even though there are genuine *thangals* and *ustads*, but most of them are exploiters. It is only very recently that I got this opinion after I joined the organization. I could learn much about religion after participating in the programs of all organizations and especially in our party classes. We should be 'convinced' beforehand that it is not a fake practice.

His position is the result of his 'thought' and 'learning' the things that helps him to go for the practices which are 'convincing' for him. Even if he says about his personal takes, we see his personal positions are that of his organization.

Riyas Khan mentioned his change of position on the healing practices, the formation of which is a dynamic process, changing over time according to the personal responses to the authenticating discourses, a continuing process of learning and inhabiting. He is a Sunni activist even though his takes on health practices may seem apparently that of Mujahids. In other words, it is the formation of individual position within the interpretative possibilities offered by the denominations. We see the formation of multiple positions at different times on a single topic:

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[95] Clifford Geertz (1968) argues that the reformist movements in Indonesia and Morocco that he calls 'scripturalist movements' brought in 'religious mindedness' or 'religious consciousness', a new form of religiosity where the text replaced the magical experience. Here, we prefer to call 'sectarian consciousness' that is what actually happens in the context of scriptural debates.

[96] Sabha Mahmood (2005) uses the term 'self-fashioning' to denote the cultivation and articulation of piety among the women participants in the Egyptian mosque movement.

Riyas Khan says:

> When I deeply learned about these kinds of practices, some changes happened to me unlike my family who continues to persist on the same practices. I learned that we should not depend on others for the healing matters, then I stopped going to them. Now, if any problem persists, I would go to the doctors only. I oppose everything which is 'un-Islamic'.

Riyas, along with his daily work as the regional reporter is exposed to the organizational debates in the form of books and speeches. Though he claims he 'personally supports and rejects', we see that his continuous learning does not go much beyond the spectrum created by the organizations. Instead, it is the dynamic aspect of learning and taking position within the organizational structure. In a same manner, Gafoor Mash, from a Sunni family background said that he takes a 'midway position'. The 'neutrality', 'un-biased' attitude, and the 'midway position' between the extremes of organizations that he claimed were in fact taking the possibilities offered by the multiple denominations. He claimed:

> My thought and knowledge is formed through my habit of reading the organizational publications. However, mine is a 'midway' position; I support everyone who does good and oppose all those who are 'extreme' like the disrespect of Mujahids towards the prophet and their discouraging of wearing the top on the head. I do not support the Sunni's celebration of prophet's birthday as well.

We see in these two cases, Riyas and Gafoor Mash, the organizations produce the discourses and classifications and the individuals take a position that they think is better. However, none of them seemed going beyond the ideas of organizations on the practices in question.

Here, the individual choice does not follow the commonly recognized patterns such as rural and urban differences, education, age group and class differences (cf. Osellas, 2013: 145). In our *mahallu*, there are educated men and women in all organizations; among the different groups within Sunnis and Mujahids. The argument that majority of followers in 'reformist' organizations are educated also does not fit into the reality. All young men in Chullippara *mahallu* who 'reformed' their beliefs and practices at home or at other states and Gulf countries, are dropouts from school and *madrasa*, educated up to lower or upper primary level only. To understand the formation of religious subjects and the pattern of

changes in their beliefs and practices we need to think beyond the categories such as educated/uneducated, literate/illiterate, and the old/new which have shaped many of the authors in this regard[97].

Here is the 'strategic' position taken by Nasser, the reformed Sunni after migration:

> I do not go for the practices being debated; if the practices were recommended (*sunnah*) as Sunnis say, I do not want that reward since it is not compulsory. But, imagine if they would be the practices of 'shirk' like visiting the shrines as Mujahids allege, then all of our works go in vain, and we will be treated as polytheists. Therefore, it is always better to keep away from these practices and concentrate on the practices whose classification is 'confirmed', not in question.

The Sunni young men in Chullippara who are very active respondents in the religious debates on online media have now stopped engaging in 'controversial' practices they were previously performing. They used to tie the 'special' amulets in the shops for the improvement in their business but not now. Now, after hearing some reformist speeches they feel 'fearful' to continue these practices. The fear is the thought as to whether it is 'right' to do or not. One of them, Kamar who is very active in online groups, stopped going for Thursday weekly *swalat* program conducted in Mamburam *maqam* which he used to attend regularly. He was convinced of its 'un-Islamic' elements through his constant exposure to the Islamic doctrines through the video clips he has been receiving and his own observations on 'what is really going on' there in the *maqam*.

Technology and Authorization by Subjects

As many anthropologists have noted (cf. Eickeleman and Anderson 1999), the expansion of religious learning through new types of media has broadened the spectrum; people are increasingly becoming able and willing to participate in Islamic debates. While some scholars emphasize how media technologies facilitate the fragmentation of religious authority (for example Robinson 2008), others show their disciplinary power in the

[97] See for instance the works of Osella P and Osella K such as Osella and Osella (2008). Islamism and Social Reformism in Kerala, South India. *Modern Asian Studies, 43*(2/3), 317-346, Osella, P., & Osella, C. (2013). Introduction. In Osella, P., & Osella, *Islamic Reform in South Asia* (pp. xii-xxviii). Delhi: Cambridge University Press. They take education as the main variable to understand the social composition of reformist organizations and their followers.

Muslim majority societies (cf. Hirschkind 2006). Islamic ethical and pedagogical literature in aural and printed form is available to ordinary men that have served to further stimulate the interest in religious discourses. These materials include scholarly arguments and canonical sources combined with vernacular commentaries.

Dale. F Eickeleman (1982, 1998, and 2000) says the shift in technology of intellectual reproduction had a major impact upon the belief and practice throughout the Islamic world. He says, the growth of higher education, increasing level of travel, and proliferation of means of communication augment the expansion of new public sphere. He says there is a critical mass of educated people who are able to read and think for themselves, without relying on religious authorities (Eickeleman, 2000). What concerns him is the question of how universal elements of Islam are communicated and how the emerging modes of communication affect the religious 'universals' in return. This is an interesting aspect that we are attending here, the technology and regulation of discourses by subjects. We also want to enquire whether the 'open access' to the canonical sources could diminish the religious authority.

We see the emergence of such 'Whatsapp and Facebook learners' (as they are known in the region) in the field repeatedly raising questions and doubts about their current form of religiosity. We have also noted the new habit of visiting Islamic WebPages with the content of debates as some of them enjoy and are 'interested' in watching and reading the debates. These kinds of 'virtual spaces' are also working as the 'learning practices' through listening, watching, seeing, interpreting, and accepting or rejecting. As we mentioned about the impact of Gulf migration on the religious ideology of subjects, the universality of the networked web content point to the Asad's (1986) argument that there exist some translocal criteria defining orthodoxy in Islam even if he doesn't theorize this relationship between the translocal and local orthodoxies. In somewhat same manner, John Voll (1994) in his article "Islam as a special World-System" captures the translocal dimensions and interactions of Muslim world. He finds, the features inherent to the Immanuel Wallerstein's world system theory, such as boundaries, rules of legitimation, and coherence apply to the Islamic world. With the modern means of communications and transportation, the worldwide dimension of Islamic discourses has become more prevalent, a discourse-based world system. Our informants always cited the Muslim practices they

watch through online and compare with theirs, especially the 'exemplary' practices in the holy cities of Islamic heartlands like Makah, Medina, and Jerusalem.

The 'democratization' inside *mahallu,* the local structure of religious authority facilitates the regulation of religious discourses by the subjects. In contrast to Asad (1993), this can be identified as the peculiarity of authorization in Islam which is different from Christianity. As Turner (1974) and Das (1984) noted, such 'democratization' of religious power and authority misses in Christianity because of the exigencies of power within the organized ecclesiastical hierarchy which can suppress the micro interpretations and practices.

In the *mahallu*, we can see a constant shift in the mode of the participation, and the demand of particular issues to be debated as it is regulated by the subjects not by the organizations. Thus, we need to investigate how the Muslim subjects influence, regulate, and define the organizations and discourses not only the other way round. Our informant, the secretary of the *mahallu* tells the changes happened to him:

> Earlier I used to attend the debates and speeches wherever it happened. Now I stopped because I do not like to watch the program cursing others which is against Islam. Now I want to hear only those speeches I can learn something which are 'beneficial' for my improvement in piety whereas my son attends almost all programs here and nearby areas, especially the debates and speeches. He says, we need to hear what 'others' have to say, not only our organization's programs. For that, we should hear from them directly, not from what others say about them.

We see here a kind of conscious position on the part of individual listeners. There are discussions among individual in the micro setting of *mahallu,* and if the issue is controversial, it may be taken up by the higher authority of *ulema* who gives *fatwa* (opinion) on the matter. The decision taken by any organization, for instance the *samastha*, can be questioned and challenged by other organizations such as Mujahids' KNM or AP faction's scholars but they have to prove it in the light of doctrines. Sometimes, other organization may challenge for a debate and if it is accepted, it leads to the religious debate between two organizations. Defending the decision taken in the light of authentic sources of doctrines is essential to maintain the credibility and reputation of the organization to remain as the 'authentic religious authority' among the religious

community. This is how a practice becomes debated by the scholars and lived by the followers which is seen in the history of religious debates among Muslims in Kerala[98].

We see the subjects, being the financial donors of the organizational system in the micro setting of *mahallu* and the active participants of the discourse, actually regulate the authority as well. In similar terms, Magnus Mardsen (2013), based on her study in a small town in Pakistan, finds that the Muslim women engage in active debates and discussion with the trained religious authority through negotiations and interactions and they play an active role in the discursive process of religion (Mardsen, 2013: 243-244). We see here the need, action, observation, thought, participation, and acceptance from the part of the individual believers in regulating the discourses. The new forms of media and mass education did not cause the 'fragmentation of religious authority' as Robinson (1993) and Eickeleman and Piscatori (1996) argued. Rather, the new media forms have facilitated the public participation in authorization process.

Here we see a more active notion of subjectivity, a reflexive subjectivity inside the 'Islamic discursive tradition', not the passive bodies, who actively speak, interpret and shape the discourses. Individual interpretation of religion who live inside the religious institution of *mahallu* seems to lead to the notion of a subject who is both autonomous and disciplined, both actively self-forming and passively self-constructed[99]. The 'governmentality' inherent to the nature of power operates in the *mahallu* allows the subjects to decide on their own body and soul, thought, conduct and action.

Local Theological Discourses on Healing

As we explained earlier, Veena Das (1984) suggests to recognize the active role of community of believers in sustaining the ideals of Islam, which she calls as 'folk theology' and 'theological anthropology'. She says, sociology of Islam must investigate into the folk theologies on one hand, and meanings and use of scripture in everyday life of Muslim on the other which can be seen as complimentary to formal theology. It is through the mutual dialogue between institutional theology of *ulema* and that of folk that the answer to the

[98] For a detailed account of the history of religious debates among Muslims in Kerala see Hussain K (1997) *Social and Cultural life of Mappila Muslims of Malabar* (1800-1921), Unpublished PhD thesis, Department of History: University of Calicut.

[99] Michael Foucault's works help us explain the mode of subjectivity in this manner, for the studies on medicine and health inspired by Foucault's notion of subjectivity, see Bunton and Peterson (1997).

question of what constitutes Islam may be found. In a same manner, Steven Caton in an essay on 'what is an authorizing discourse', in response to Talal Asad, proposes that there is an 'official ideology' and an everyday 'un-official ideology'. It is the everyday behavioural ideology that authorizes the official one and vice versa; two are in a dialectical relation to each other. Thus, the interaction works through dialogue (Caton, 2006: 51). We see the institution of *mahallu* facilitates this interaction and dialogue between organization and individuals. However, we do not see a clear-cut difference between the 'official' and 'un-official' interpretations, and 'folk' and 'formal' theologies of Veena Das (1984), rather; we see the reproduction of organizational ideology in the everyday life with adaptation. We also see an extensive theological interpretation on healing practices on part of the common members of the *mahalllu*.

Muhammad's neighbour Basheer, a rickshaw driver regularly reads the Malayalam translation of the Quran and Hadith. His theological interpretation was:

> There is no problem in visiting the shrine. Whenever I visit the shrines, I pray for them and never tell my wishes and desires to them. If I do that, there will be something wrong in my relation with *padachon* (the creator).
>
> I have read Malayalam translation of Quran when I joined organization. In the first chapter itself, does it say '*You alone do we worship, You alone do we ask for help"*? Then why do we ask others? Is it right to elevate the graveyards? We see many *anacharam* (amoralities) there like the Kundoor *maqam* nearby to us. I personally do not support the ideology and practice which sacralise men beyond Almighty Allah and his messenger. I used to clear my doubts from the 'non-partisan' scholars. However, it is not good to denounce the *awliya* (saints) as Mujahids do.

Dr. Muthukkoya's theology was different; but touches the core ideas produced by his patron organization:

> I never visited even Mamburam shrine which is very near from here. Isn't it enough if you pray to Allah? Do you think Allah is not enough to respond to your calls? Didn't Allah say that there are only three mosques in the world Muslims should travel to, seeking the reward? They are Haram mosque in Makah, Prophet's mosque in Medina, and Al-Aqsa mosque in Israel; there is nothing fruitful in visiting any other shrines.

There are Sunni common people in the *mahallu* as well who substantiate their beliefs and practices in the light of theological point of view. Muhammad, a daily wage worker in a tyre workshop who didn't have formal religious education, gives his theological interpretation:

> I have seen that the Mujahids and Jamaa'tis who oppose the *thangals*, *ustads*, and *beevis* consulting them for their problems but they go very secretly. They will also go when they are in emergency. A Mujahid activist asked me once, why sheikh muhyuddeen you often ask for help could not prevent the destruction of Baghdad, his own city including the Quran, and you are seeking his help? I replied to him, Quran is Allah's words, and why he could not protect it. This was the strategy I used to defeat him.

This was the logic used by Muhammad, a Sunni old man to dispel the logical question by his ideological opponent. Even if he is known as a Sunni because he did not join any other organization, he was not an active presence in the organizational activities. Therefore, he did not quote any doctrinal verses to support his arguments in any of our conversations, but he was firm in the validity and efficacy of his practices.

Mustafa, a daily wage worker, shared his Sunni theological interpretation:

> Mujahids say that we should make supplication only to Allah and others do not have the powers to respond to our requests. However, Allah has said that 'I have made some human beings superior to others, what it means? Some selected human beings have special abilities blessed by Allah. The very fact that our prophet had revelations from the God shows that he was not an ordinary man; instead, he was an extraordinary human being. Mujahids can be convinced of these things if they think with common sense.

His theological interpretation was in support of going to the special souls for healing; yet he also gives the idea about prohibited practices:

> One should not practice *sihr* (sorcery) and not approach the Hindu healers because Quran has said that we should not seek their help. But, if there is no other option to cure, sometimes we may have to consult them. While doing so we will lose our *iman* (belief). In the *maqam,* we should not say to them 'please save us', instead, we should say 'please help us from the powers Allah has given you'.

'Losing *iman'* is the local term many Sunnis used to denote instead of *shirk* (associating partner with Allah) which is the common term used in Sunni-Mujahid debates. Apart from

doctrinal support, his observation of what actually Mujahids in his vicinity do when they are in need of emergency cure substantiates his position:

> 'Even a leopard will eat grass if it is in need' (a Malayalam proverb for 'desperate times call for desperate measures'). I have seen my neighbour, he is a Mujahid, went to a Panicker when he was in need of cure. Even he conducted *homam* (Hindu ritual of *pooja*) at his home. We cannot say 'I don't believe' if we do not know about them. There are many *kitabs* (texts) written on the healing practices that the scholars know. Mujahids have started to accept the healing with *Jinn*. Now they are also recognising our practices.

Mustafa's belief in the special powers of holy men was confirmed through his own experience of their help in emergency. One of the visible '*habitus'* observed differently among the Sunnis and Mujahids is the question of whom they spontaneously call for help in accidents and emergencies. Only Sunnis call '*yaa badreengale'* (martyrs in the holy battle of *badr*), or Muhyuddeen Sheikh, or Mamburam *thangal*, who are also the common intermediaries in the supplications of the area. For Mujahids, calling the holy men or making them intermediaries except Allah is a great sin of *shirk*. Mustafa once spontaneously called them; it was his reflexive action:

> When I was cutting a tree, suddenly it fell down on me and I called '*badreengale'*(means, Oh, the martyrs of *badr*, please save me) and I fallen down and became unconscious. When taken to hospital it was found that my rib was broken. I am sure that it was because of the intervention of *badr* martyrs that I was saved with minor injuries.

All adult Sunni males in the *mahallu* congregate and meet for Friday *jumua* prayer in the big Sunni mosque of Chullippara wherein the official *mahallu* announcements are made which affect all member households. Some of the 'official' announcements are mandatory like clearing the *mahallu* fee while some are voluntary like the call for immunizing the offsprings. In the informal group discussion, it was observed that the persons from big *taravadu* (family), rich households, and those who possess any position in the political or religious organizations dominate over the common people. Still all of them could express their own opinion on emergent issues. The focus of every discussion was to elicit religious opinion on the issues considering all other practical sides such as the local necessities. If it is a religious question such as whether the sermon in Malayalam can be given before the Friday sermon, then the religious scholar will have a say whereas in

local issues, such as the family disputes, the local residents know them best and to solve them.

Ideological 'others' in New Contexts

Rather than the fixed certainties given by textual discourses, there are uncertainties, ambiguities, and inconsistencies central to the social life of Muslims conditioned by the socio-political developments. Amidst the differences and conflicts of opinions from the part of organizations on what constitute a 'true' Muslim on the basis of 'authentic' health practices, there are many who see 'rightness' in the very fact of being a Muslim. Their position is to see doctrinal differences within religion as 'personal choices' which are out of their concern. Their explanations like that of Basheer point to the 'common enemy' out there against Islam and Muslims and they demand to think beyond the 'enemy within' (Alam A, 2008)[100]. Basheer says:

> In my opinion, we should abstain from doing anything detrimental to other fellow Muslims. If we have problem with any practice, it is better to keep away from it personally, not hate those who practice it. 'We' should not curse or keep distance from other Muslims for this matter.

In the context of Kerala, EK Sunnis and Mujahids take different positions on religious affairs and politics. While they keep on opposing each other on the validity of controversial practices, when election comes, both of them work and vote for the candidates of Muslim League. This dual position has been reflected in the political positions of the Sunni and Mujahid activists as well. Sometimes, the ideological frictions between these two organizations pose challenges for the League party during election period, especially if the candidate is a strong Mujahid in Sunni majority constituencies. Nevertheless, it can be taken as an example to show the considerations beyond ideological differences conditioned by socio-political factors.

Such shifts were observed as more visible in the ideological conflicts during the time of global politics of *Islamophobia* and anti-Muslim politics in contemporary India. One of

[100] Alam, A. (2008). Enemy Within: Madrasa and Muslim Identity in North India. *Modern Asian Studies, 42*, 605-627

the ideological publications of Mujahids, a monthly magazine that has been spending its pages to propagate 'true Islam' among Muslims now declares its position in new conditions:

> *Muslims in Kerala with abundance of organizations have to identify their 'common enemy'; the enemies of Islam and to find ways to mend the fences between different sects. In the current situations of concerted rampages against Islam, the organizations have to overcome the sectarian exclusivity which is deep-rooted in the community and to unite for common interests.* (*AL-Islah*, January, 2017: 5)

The magazine urges the Mujahid activists to work against the anti-Islamic practices among Muslims and to approach the followers of those practices with 'compassion' and 'sympathy' not enmity. In similar terms, Edward Simpson (2008) finds a marked shift among Gujarathi Kucch Muslims after the riots of 2002 where people search for idioms of unity rather than division; the spectres of violence and catastrophe brought rival Muslim organizations into dialogue with each other. In Kerala which keeps a better record of communal harmony where there is no direct confrontation with the 'common enemy' of Muslims, an ideological consensus among the organizations on the controversial practices is yet to be found. However, increasing cases of doctrinal differences becoming 'personal' and 'insignificant' tend to foster a larger sense of unity among Muslims.

Rubina Jasani (2013: 259) also talks about blurring of boundaries between different Muslim *jamaats* (organizations) after 2002 riots in Ahmadabad. In similar way, Farzana Haniffa (2013: 175) also notes, among the contemporary Sri Lankan Muslims, religiosity and religious identity works on the register of larger political context, namely the ethnicity. She says, in this particular political context, religion has come to override all other forms of collective identity for Muslims even those of language and region. This kind of analysis, shifting of analytical interest into the larger context in which the pious self is desired and the transformation of self it entails, as that of Haniffa (2013), is a critique of Mahmood's (2005) sole focus on intentions.

Dealing with Affliction: Between Percepts and Practices

If we ask if ill health could lead to a suspension of religious rules, at least, temporarily, the reply from the Sunnis in the *mahallu* is that '*every option is permitted in the case of*

asukham (illness)'. This is what one of the *ustads* in Sunni *madrasa* of *mahallu* advised 'reformist' lenient youngsters: '*If there is no any option to cure the illness, if all other ways closed, it is not wrong in consulting even panickers* (the Hindu healers).

Such negotiations with religious commands take place more when the afflicted family deals with chronic and acute illnesses. We see such negotiations in the case of Muhammad who employed all means to cure his daughter's mental illness who has already undergone to traumatic experiences of a poor and un-fair widow. Muhammad, the regular visitor of mosque and part time *muezzin* (those who make call for five-time prayer) Muhammad said:

> I visit many of them, *thangals*, *musliyars*, and *beevis*. I even took my daughter who has been suffering from mental problems after marriage to a *panicker* which is not 'right'. However, sometimes we may have to go to someone like him for *chikilsa* (healing). There is no sin in it. We are permitted to drink alcohol for the medical purposes. Therefore, this is also permitted. We should not do anything un-Islamic like *pooja* (worship) even if they prescribe it. There is not sin in approaching them, but we should not do whatever is prohibited for us.

The respondent cited 'concessions' given by the religion for the sake of medication though it is *haram* (tabooed) under normal condition like drinking alcohol or drinking the urine of cow. Health and medicine thus offer a realm of exception from religious taboos but the flexibility is firmly located within the 'discursive religious tradition' of conscious interpretation by its followers. Such strategic responses on the part of health seeker is mostly approved by the religious scholars working in *mahallu.* The situation of believers in emergency presents us the domain of health as most interpretative topic inside the tradition, yet not coming out of it. Thus, we do not see the health representing 'vernacular Islam' or 'religious cross roads' as identified by Flueckiger (2006). Rather; as our informants did, we locate the health practices inside the mainstream religious tradition.

Veena Das has worked on the ways in which the urban poor households in Delhi deal with the hardships of *Affliction* (2015) that may sometimes affect familial and kin relationships. Das (2015) conceptualises the affliction as 'critical moments' especially among the lower income households. She argues that the experience of illness creates incoherence in families that may cause different actions by individuals. She explores the borderlines

between normality and pathology distinctively understood among different classes. In her view, the illness experience moves between the registers of ordinary and extraordinary especially, the cases viewed as failures of social relations with the kinship and neighbourhood understood as the result of magical manipulations. Lexical terms like *taklif* used by the people covered all kinds of 'discomforts' (Das, 2015: 33).

Young journalist Riyas Khan could not do anything when his mother approached main *ustad* in mosque to 'write' in ceramic plate to give it to his wife undergoing delivery in Lailas hospital even if he has stopped doing them after 'learning its pitfalls'. The important aspect to be noted here is, the case of his children's health demands 'negotiation' on his 'position' whereas he could restrain from other controversial practices that he opposes like participating in the ritual celebration of Prophet Muhammad's birthday.

Nassser, a Sunni middle-aged man 'reformed' after Gulf migration also took a pledge that he would not repeat the grave mistake he committed once, even if he faces critical condition:

> I used to consult them when we had critical conditions, but now onwards, I would endure even the critical conditions and pray to Allah only. If still not solved, I would consider it as my *qazaa'* (fate) but will not visit these healers.

Nevertheless, his wife and children continued with their old beliefs and practices with which he could not do anything except arguing and debating with them. He could avoid the rituals such as *maulid* and *ratib* with which he has problems from being conducted in his house and abstain from participating in the rituals conducted in the mosque of the *mahallu* or other households in the *mahallu* or relatives. However, when his wife complained of chronic headache uncured by the physicians and decided to test an *ustad,* he could only say 'if you have firm *viswavasam* (belief) you can go' and did not want to restrict the options risking her health. The *mahallu* secretary who is 'neutral' on these practices but keeps distance from many of the Sunni practices had to accompany his wife while going to a *musliyar* for his son in law; they had to help out their son in law who was desperately looking for a good job visa in Gulf[101]. In these two cases, we see the deviation

[101] It was observed that for the problems in the Gulf countries, the solution was sought from the 'credible' healers at home. As Abraham (2012) noted in the case of Malayali Ayurveda practitioners in Mumbai who

from the ideology in the case of illness for the close relations while keeping the *swabr* (endurance) on the illnesses of one's own body.

Disciplining Authority: Organization and *Mahallu*

Inability to access the religious views directly from texts on every practice make the individual believers depend upon *ulema* (learned men) and the collective body of *ulema* gets more authority than the individual *alim* (singular of *ulema*). Their decisions and their effect on practices can be observed in the life of *mahallu* residents and their concept of 'authority'. One of the office bearers of the *mahallu* said:

> My religious life is according to the ethos and decisions of *Samastha* Kerala *Jamiathul Ulema* (EK faction) because I cannot get the religious opinion directly from the religious texts. Rather, we need to follow the scholars. Therefore, for me, EK faction *Samastha* is the authority.

His selection of the organization as his religious authority shows the will and participation in the structure of religious authority. As we have seen, the *mahallu* facilitates this 'willed submission' or 'willing obedience'[102] to the form of authority that they finance and sustain. *Mahallu* appears to be an open space of authority, a 'democratic' institution where anyone interested can be the authority unlike the hierarchical structure identified by Eickelmen (2000) and Robinson (2009). And the emergence of new media forms and technology have not resulted in the collapse of the notion and existence of religious authority as Eickeleman (2000) claims. Rather, he is right in saying that such emerging media feeds into the new senses of public space that is discursive, performative, and participative, not confined to the formal institutions.

However, authority is neither fixed nor certain. Every *mahallu* in the region has specificities. In the case of *mahallu* institution, there are some *mahallus* with stringent inter-organizational and *mahallu* committee-household conflicts which depends on the specific history of the *mahallu* and the range of organizational affiliation of the households. As we mentioned in the second chapter, in the Chullippara *mahallu* with equal

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were preferred by the Keralites, the credibility and quality is accorded to the healers at home in Kerala than others.

[102] Seeing the relation with *mahallu* as part of inner binding, an internal part of shaping of self by the self owes to the framework given by Asad (cf. Asad, 2006: 273) which keeps away from purely symbolic approach to the religion and its institutions.

share of households for both Sunni factions with a minority of 'reformists', the posts in the *mahallu* committee are equally distributed between these two factions. Here, there has not been major incidents of conflicts except some expulsions of scholars and the verbal disputes especially during the election period when the strength of all factions become exposed and instrumental for the political parties. Regarding the 'ideological minorities', they recollect the memories of the frictions and tensions happened when the Jamaatis in the *mahallu* brought the orators from outside who made personal abuses at Sunnis. Frictions also happened when they openly cursed the practices Sunnis have been doing. Whereas, as it has been reported in the Malayalam news papers on daily basis, there have been cases of denial for burying dead bodies in the common graveyard due to the organizational or political issues. In some *mahallus*, the government and police had to intervene to conduct election to its committee in peaceful manner and there have been the cases of some mosques being shut down following the court intervention. There are also regional specificities in the pattern of ceremonies and rituals within the Muslims. The Kondotty *nercha* with its specific rituals involved such as the use of elephants similar to the temple festivals has been opposed by *samastha* as un-Islamic.

The complaints from *mahallu*, if not solved within *mahallu*, are referred to *waqaf* board[103], the statutory body appointed by the state government to look in to the issues regarding the *waqf* properties. Some of the disputes are referred to the *waqaf* tribunal. As the representatives of the state and judiciary, these kinds of bodies have to act beyond the organizational considerations. Still, there are complaints against the partisan positions of the *waqaf* board according to the government of the time and the religious organization that supports them.

If there are large number of individuals enough to be the majority in the *mahallu,* they can change the *mahallu* committee and implement new ways of practices according to new ideology. All organizations have the 'freedom of speech and propagation' to spread their own ideology even if there are some frictions to capture the *mahallu* administration. If that freedom is violated then the police and local administrative bodies are called in for

[103] *Waqaf* board is the government body to administer the *waqaf* endowments. *Waqaf* means the property endowed by the individual or a trust in the path of Allah. According to the Islamic jurisprudence, these properties cannot be sold or bought; they have to be used for the religious affairs. Scholars like Talal Asad have written a piece on *waqf* to consider the concept of a property in Islam which can be seen neither public nor private.

intervention, the institutions of the state, which is the agency of authority other than religion.

Individuals and household members struggling to cope with the illnesses of its members, it seemed quite difficult that the *mahallu* authority could regulate the practices related with health whereas it could intervene and bring changes on many other practices such as the rites of passage[104]. There were confusions among the community when the government requested to the *mahallu* committee to announce immunisation and vaccination schedules from the main mosque on Friday. It was publicly announced in the mosque that vaccination be given to their children and the immunization camp was inaugurated by Panakkad Shihab *Thangal* in order to get public support. However, when enquired, one of the residents responded:

> Even if they endorse taking vaccination, we are not sure that the *thangal* and the leaders of *mahallu* give vaccinations to their own children, we respect *thangal* and we follow the *mahallu* authority since it is our religious duty, but not in the case of our children's health. Do the *thangals* and rich committee leaders take immunising medicine to their own children?

We see the cases of 'fragmented subject positions' (the term was used by Schielke 2009) among the households to decide upon the health of their members, capable of intervening and negotiating with the forms of religious authority. They take multiple and shifting positions on different issues, on conforming to the *mahallu* guidelines in religious matters and a different position on taking vaccination for their children.

State and Health Practices

As Irfan Ahmad has rightly pointed out, Interrogation of the authorization process becomes certainly significant in the case of Muslims in India with their distinctiveness as makers and participants in a polity which is secular democracy. Many Islamic practices which are intervened by the state such as forcing of veiling in Iran and Saudi Arabia and forbidding it in Turkey, are volitional to the Indian citizens (Ahmad, 2013: 319).They are distinctive from the Muslim-majority societies of the imagined 'Islamic heartland' of the

[104] Faisal KP (2011) has worked extensively on the changes and transformations to the rites of passage among Muslims in Kerala through the process he called 'textualisation'. See 'Rites of Passage among Muslims in Kerala: Sociological Study of Text and Practice', Unpublished PhD thesis submitted to Jawaharlal Nehru University, New Delhi.

Middle East. Ethnographic account of the process of authorization in a micro-religious setting in India becomes significant as they may offer different perspective, different from the sites of the scholars like Geertz (1968), Asad (1993), Eickeleman (1986), Bowen (1996), Mahmood (2005), Hirschkind (2006), Woodward (1988), Gellner (1993), Schielke (2010). In addition, we need to add much to the frameworks given by the scholars who worked in Indian contexts such as Ahmad and Reifield (1983).

In the case of health, the state is the disciplining authority which legitimizes the conditions under which the subjects can be administered and governed to maintain health status. Health has become increasingly important politically as a major point of contact between government and population. State represents another form of authority with the legitimacy of intervention in the life of its subjects and regulation of the bodies. Unlike religious authority, as Max Weber pointed out, the use of force on any type of social organization would be considered legitimate only if it was permitted or prescribed by the state with its character of compulsory jurisdiction and rule of law (Weber, 1978: 54-56). The production of a bio-political body is the *originary* activity of the sovereign power of the state, the bio-political state, in other words, it raises the questions of the relationship between sovereignty and bio power (Das and Poole, 2004: 10). The relationship between the sovereign state and the social body is characterised in such a way, Veena Das says, that the state has instituted itself with the 'bio-political rationality' while the people are seen as credulous and irrational (Das, 2004: 248).

Our focus here is not to study the state, but to investigate the everyday health practices in the micro setting, enacted and implemented by the state in order to understand how the disciplining authority of state and its authorizations discourses are responded and contested by the Muslim religious subjects. The approach of this owes to the framework provided by the anthropological quests to see what counts as the study of the state in anthropology like Sharma and Gupta (2006) and Das and Poole (2004). Much of this anthropological literature focuses on the precise ways in which the state is experienced by different segments of society in everyday dealing.

Antonio Gramsci (1971: 77-79), the Marxist thinker, discusses the ethical/cultural state in forming and transforming the individuals and groups, educating the consent to the particular regime of domination. He says, in order to create such a collective of its own

and to eliminate certain customs and attitudes and to disseminate to others, the law is the instrument together with other institutions such as the school. For him, the state must be conceived as an 'educator' to create a new type or level of civilization; it is an instrument of 'rationalization', not exclusively as mere 'politico-juridical' organization. There will be a change of phase from an 'interventionist state' to a phase where it reduces its authoritarian and forcible interventions[105].

Louis Althusser, another Marxist thinker, in his search of the role of ideology and ideological state apparatus argues that social structures such as school, media, church, family, and political parties are connected to the state which are, for him, the *ideological state apparatuses*. Ideological state apparatuses which function by ideology are different from the 'repressive state' (2006: 92)[106]. The school or other state institutions like church ensure the subjection to the ruling *ideology* which is necessary for the reproduction of the labor classes and in order to perform their tasks 'conscientiously' (Ibid. 88). They ensure not only the political hegemony but the ideological hegemony also which is indispensable to the reproduction of capitalist relations of production. Ideology is a reality with its effective presence. Aligning with the Marx's theory of state, he says the state power and state apparatus must be distinguished. Church was once the dominant ideological state apparatus (religious ideological state apparatus) in the pre-capitalist period which had religious and educational functions and the struggles of the time were anti-cleric and anti-religious struggles (Ibid. 96). Another important dominant one is the educational state apparatus which has replaced the church in its functions, i.e., the school-family dyad has replaced the church-family couple.

Althusser says the ideas of human subject exist in his actions and practices defined by the ideological apparatus from which derive the ideas of that subject (Ibid. 103), the 'ideological subjects'. Ideology acts and functions to 'recruit' or transform the individuals into subjects. He says any social formation which did not reproduce the condition of production at the same time it produces would not last a year; and the ultimate condition

[105] From Selections from the Prison Notebooks of Antonio Gramsci, ed. and trans. Q. Hoare and G. Nowell Smith, pp. 228–70, In. Sharma and Gupta (2006) *Anthropology of State*.

[106] From Lenin and Philosophy and Other Essays, trans. B. Brewster, pp. 127–86. New York and London: Monthly Review Press, 1971. In. Gupta and Sharma (2006)

of production is the reproduction of the conditions of production (this may be 'simple' reproducing exactly the previous conditions of production or expanding them) (Ibid. 86).

Philip Abrams describes the state idea as the ideological project that legitimates the subjection, and claim to domination with ideological, moral, and regulatory dimensions. He asks to focus on the political processes and practices which legitimate the subjection and shape the existing social institutions. He says political sociology including Marxism, springs from the separation of 'political' especially the state from the social. It aims to give the social account of state which is envisaged as concrete political agency or structure, distinct from the agencies or structures of society (Abrams, 1988). He argues that we should seriously take the remark of Engels "*the state presents itself to us as the first ideological power over man*" and "*the most important characteristics of state is that it constitutes the illusory common interests of a society*". He says the studies of political sociology have concluded to a common point that 'state is the powerful agent of *legitimation*' and the 'axial principle of polity is legitimacy'. These studies also pin point the fact that state is an *ideological* thing in terms of which the *subjection* is legitimated.

In our case, the attention has been paid to the grass-roots processes of polity, the subjects of the state, and their relation to the governmental institutions. These frameworks help us to see the state and its institutions representing the 'legitimate subjection'. For them, the state is an institution with ideological power of authentication and subjection. State is 'institutionalized political power', as 'the cohesive factor in a determinate social formation, and the nodal point of its transformations'. However, they also argue the attribution of the functions-legitimation and social cohesion- only to institutionalized political power is plainly inadequate, and, other forces such as religion have to be taken to account.

Nikolas Rose gives theoretical framework to conceptualize the medical subjects in the context of state mandates on the social bodies regarding the 'social diseases'. In his view (Rose 2006: 148-158), the state involves the forces, techniques, and devices that promise to regulate the decisions and actions of individuals, groups, and organizations in relation to the authoritative criteria. It seeks ways of exercising authority over persons, places, and activities in specific locals and practices. The state programs such as statistical enquiries, census, enhancement or curtailment of the rate of reproduction, minimization of illness,

and promotion of health can be seen as 'bio-political strategies' of state that operate differently in 'liberal democracies' (Ibid. 149).

Disturbances and frictions such as epidemics and disease are deemed as 'social problems' that have consequences for national well-being and thus call for remedial authoritative attention and state intervention. In the advanced liberal democracies, welfare is considered to be the rationality of rule: expert conceptions of health transcribed into the objectives of political government. The subjects are considered as customers, the consumers of health services as active individuals seeking to enterprise themselves through acts of choice according to their life and meaning. Individuals and those to whom they owe allegiance are made responsible for their individual choices as 'private obligation' (Rose 2006: 158).

Michael Foucault (1976, 2006) reiterates to include the micro settings such as family, personal relations, and the religious authority to the sociological analysis of state and power. He is critical of theories which consider power as 'sovereign', a unitary and centralised construct, repressive and coercive in nature. In the study of state and its power, it is a shift of focus from the macro agencies to the everyday settings. In contrast to the Marxist conceptualisation, as we mentioned about Althusser, Foucault's ideas help us to shift the focus to the localised, dispersed, diffused form of power operating at micro level (Turner B S, 1997: xi) such as the *mahallu* in our case and the micro institutions of state operating there. He says power is embodied in the day-to-day practices of the medical profession within the clinic, through the activities of social workers, and the mundane decisions of the legal officers (Ibid: xii).

He reconceptualises the state, pointing towards the shift from the territorial jurisdiction to the management of life, thus attributing the adjectives such as 'the hygienic state', the 'immunizing state', the 'therapeutic state', and the different modalities of managing life. Through the concept of 'bio-power', Foucault refers to the mechanisms employed to manage the population and discipline individuals. For him, biological life is a political event; reproduction and disease are central to economic processes and are subject to political control. However, if we turn our attention to the heterogeneous categories of citizens such as the Muslims who are also subjected to the guidelines provided by the religious authority on health practices, we have to address different forms of bio politics,

in other words, Islamic health seekers are subject to dual form of authority, namely, the state and religion.

Foucault examines the practices and processes of governance and rule in the social realms beyond the state. For him, state is but one modality of governance, not the only source of power. He discusses the role of scientists, political scientists, and hygienists in the working of *governmentality,* which he described as the contact point between technologies of domination (including the discourse) and technologies of the self. There are several forms of government internal to the state; it is within the state that a father rules the family, a superior the convent etc. Thus, we find, there is plurality of forms of government and their immanence to the state the activities of which distinguishes them from the transcendent singularity of state (Foucault, 2006: 134)[107]. He says the body is the principal target of the medical gaze and governmentality (Turner, 1997: xv). The concept of governmentality helps us understand the micro-negotiations of the relations of power as we see in the *mahallu*.

Foucault's approach (1980) draws attention to the techniques used for managing populations or the 'social body'. He saw the emergence of the perception of illness as a collective social and political problem to be addressed by political intervention where hospital worked as an institution. Therefore, the history of medicine in Europe was the history of political and administrative arrangements for the clinical interventions in the everyday life of the social body and regulating and monitoring the health behaviour of citizens through surveillance. Health care functions were divided between health officers and doctors for the prevention of diseases necessary for the formation of 'able' citizens and prosperous nation state.

Nevertheless, modern public and political life cannot be said to be solely based on reason and rationality as we have seen in the previous section. Indian political discourse and public life can be seen as the amalgamation of religious beliefs, 'superstitions', and of course, the modern, secular forms of political rationality (Chakrabarty 2008)[108]. Veena Das puts it differently, the mode in which the state is present in the life of community is the state is suspended and oscillate between a rational bureaucratic entity and a magical

[107] Foucault, M.(2006). Governmentality. In Sharma and Gupta ed. *Anthropology of State*

[108] Dipesh Chakrabarty (2008) has written a paper on how superstitions play in public life in India. Devika (2008) has also noted how the religious beliefs and rationality went hand in hand on the discourses on family planning in Kerala public sphere.

one. It exists as rational entity in the structure of rules and regulations and there are community customs in the shadow of these rules. The community derives its own existence from their particular reading of the state (Das, 2004: 230).

The state in India (colonial and post-colonial) continues to frame the practices and experiences of people related to health and illness and produce new forms of medical subject according to its political ideology in each time periods (Alavi 2007, Devika 2008, Sujatha 2014). As theorists of public sphere have come to recognize, regulation of health practices is of eminent political concern for the state that reorganizes the people's ethical sensibilities. Moreover, on the other hand, the state intervention in the provision of health was not opposed even by the Liberals (Kethineni 1991). The colonial state, unlike the previous political regimes, created a situation in which the state subscribed to one official system of medicine and produced a discourse about its subjects and their knowledge system along with the state interventions and policymaking (Sujatha and Abraham, 2012: 6). The state in India bears the lineage of its pre-independence era policy of public health with 'scientific superiority' of modern system over traditional knowledge systems (Priya, 2012: 104). Recommendations of all government appointed committees on public health reflect this lineage, the supremacy of bio-medicine due to the required 'scientificity' for the medical systems enacted by the state for its vision of 'modern development' (Ibid). The post-colonial notions of developmental state were a nationalist reworking of British ideas of colonial state; indeed, there was an element of continuity. The role that science played in this political imaginary was significant. The 'scientific empire' depended heavily on science for legitimizing the power in management of life in post-colonial societies. Therefore, the reliance on scientific knowledge and expertise due to its intrinsic superiority to local knowledge was central to the notion of developmental state and the same was reflected in the ideas of Islamic reformists (Iqtidar, 2013: 490).

The language of public health is the language of state and the 'official' system; which is modern medicine. It is the language that the residents are habituated about their region except some of the aspects. For instance, the ideas of pure water, healthy food, and public hygiene, contagion are those provided by the government agencies such as the health department. The title of 'doctor' is the symbol of the perception of that 'officialdom'. As we know, though the region has several systems of medicine, the state-sponsored health care since the twentieth century has been based on biomedicine which is the trend not only

in India but elsewhere as well including Europe and North America. Therefore, there has been incompatibility between the public demand and state efforts in providing the standardised systems of health care (Sujatha and Abraham, 2012:1).

Nandy and Visvanathan (1990) think the 'development' as a reason of state, as a legitimizer of regimes, has now claimed to power over human body which is seen as a domain of social knowledge and intervention. Therefore, medicine-modern medicine- is a crucial theme in the discourses of development and the language of modern medicine has aptly corresponded to the language of development. Modern medicine came to be the harbinger of 'true healthy' individual and society and eventually a 'developed' society (Ibid. 145-146). Medicine, as the legitimizing principle, has allowed state to inspect, survey, and classify people which they call as 'mundane politics of everyday life' (Ibid. 167).

Specificities of Community Response

Talking from the context of Kerala, which is always taken as the 'model' for development in health and social sector, the discourses on 'social development' and 'social reform' have always been coeval with the production of knowledge and certain discourses by the state and state apparatuses which endorse some practices and reject some. These discourses have shaped the very concept of 'illness' within which the choices are made by the subjects. So, the state (in the context of Kerala, its form can be understood as princely state (Travancore-cochin), provincial state (Malabar) in the colonial period and the communist and non-communist governments in the postcolonial period), has been crucial in the formation and re-formation of medical subjects. This has been evident from the historical accounts of Kerala as Devika puts it:

> *One of the common threads that run through all varieties of reformist discourse under colonialism and after-the colonial official's, the missionary's, the newly-educated local elites', the post-colonial developmental activists'-is the strident differentiation of 'progress' from 'ignorance/superstition' and the faith that the latter may be alleviated by rooting out the material, social, and ideological conditions in which it thrives. Thus, far from 'liberating' subjects into a neutral term of 'choices', such reformist projects sought, to eliminate the basic nurturing conditions of 'un-desirable traits…the public sphere, then, may be viewed as a space in which modern power operates, with disruption,*

> *subversion, and contestation, precisely through the construction of ostensibly 'free' and 'autonomous' subjectivities* (Devika, 2008: 6-7).

However, it has to be stressed that different social groups in Kerala responded to these discourses in distinct ways. Along with state's development and reform projects, there were also community development projects and community reform movements initiated by different religious and caste groups. In the case of Muslims in Kerala, the discussions of 'social development', 'socio-religious reform and revival', 'enlightened consciousness', 'Muslim renaissance', and 'progress' are also associated with Islamic religious discourses, which are ideological, organizational and theological in nature. As we have mentioned above, these religious discourses define, redefine, authorize and classify the knowledge and practices within the religious tradition which endorse certain health practices and reject some. In contrast to Hindus, discourses on rites and practices among Muslims in Kerala have always been religious in nature rather than social or political. For instance, as Lindberg (2009) noted, public discourses on *marumakkathayam* (matriliny) among Hindus were centred on 'political correctness' and 'modernity' whereas it was religious in nature among Muslims pointing to the 'un-Islamic' nature of matriliny[109].

Kerala model in the health sector has been emphasised and its health indicators is understood to be at par with Western world, especially, in terms of its low infant and maternal mortality, and its highest life expectancy in the country (Health, Kerala State Planning Board, 2011: 3). The credit for its success has been given to the investment in the primary health care system and the increasing share of private health care sector and the increasing dependence on the private sector. The impending problems the state's health sector faces enumerated as the high level of morbidity, increasing suicide rate, and the mental health problems (Ibid)

Kerala has a strong Panchayat Raj Institution system (PRIs) with 999 Grama Panchayats and 152 Block Panchayats and 14 District Panchayats. The role of PRIs in the Public Health Care System and Public Health Delivery System has been widely studied[110]. Each

[109] The modernization movements among the north Indian Muslims were also deeply informed by the religious discourses. For instance, Sir Sayyid Ahmad Khan's Aligarh movement which was influential throughout south Asia was coeval with the project of *tahzib-ul-akhlaq* or refinement of morals. It was an effort to modernize Muslim lives by rejecting 'superstition' and inculcating Western education (See Devji 2013: 3-4)

[110] See for instance, *A study on Effectiveness of Panchayati Raj Institutions in Health Care System in the State of Kerala*, Kerala Development Society, 2012, Planning Commission, Government of India.

grama panchayat has a Hospital Management Committee (HMC) under the leadership of elected head of concerned local government and the medical officer is the convenor. Subsequent to the enactment of Panchayati Raj act, various public health institutions were transferred to three tier Panchayats in Kerala in February 1996. Generally, a Panchayat has dispensaries, Primary Health Centres (PHC), sub centres, maternal and child welfare centres, immunization and other preventive measures, family welfare programs, and sanitation programs. However, PRIs have limited control over the health officials because they are the employees of State government under the Directorate of Health Service or Indian System of Medicine Department or Directorate of Homeopathy etc.

Primary health centres (PHC) and Community health centres are considered as the building blocks of the health sector in Kerala. Public health officials understand them as the pillars of health service delivery system and public health activities[111]. They function under the authority of both state government and the three tier local self-government institutions. Administered by the state government, majority of the health programs are run through the local self-government bodies of District *panchayat*, block *panchayat,* and *grama panchayat* (village *panchayath*). The officials have to conduct immunisation programs, vaccinations, and health awareness programs, implement the state and central government schemes, exercise the funds through LSG bodies, and to submit reports and projects and implement them. It is Kerala's experiment with the participatory democracy that the Government of Kerala introduced 'decentralized planning' in 1996. Important planning and budgetary functions that were previously done by the state level agencies were now transferred into urban municipalities and rural self-government bodies (Corbridge & Williams & Srivastava & Veron, 2005: 229).

In Pookkipparambu PHC at Thirurangadi, there are total 16 staff; along with the doctors and nurses there is 1 health inspector, 5 Junior Health Inspectors (JHI), 7 field staffs, and the nurse staffs with special responsibility of looking into the health of expectant mothers. They are entrusted with the duties of immunization programs and other projects submitted to and passed by the Panchayat. Along with the Panchayat projects, there are many state and national health projects and missions that they have to implement connecting with each household in the region. Even if the salary of the staffs is given by the state health

[111] Dr. U Nandakumar (2016) '*What happens in our health centres*' (*Mathrbhoomi*, August, 31)

department, they are meant to implement the projects given by the respective panchayats. The local health officials like them are very much connected with the micro aspect of the health of the region.

State, Muslims and Health

The history of state welfare measures in the three political units later united to form the state of Kerala- the British Indian district of Malabar, and the princely states of Cochin and Travancore- shows significant contrast between the regions where Malabar with its specific political experience has always been lagging far behind. In Travancore, the modern welfare state took shape quite early in nineteenth century under colonial power. Welfare policies, especially in education and health, were implemented in Travancore and Cochin from the late nineteenth century which underwent dramatic expansion between the 1860s and early 1940s. Meanwhile, Malabar district of northern Kerala, as part of Madras presidency, remained much behind in education and health until after independence to catch up with the other two regions (Devika, 2008: 18). The death rate in Malabar was double that of Travancore and Cochin in the mid- '50s with the outbreaks of different contagions like the cholera epidemic (Ibid. 20). Thus, we have to keep in mind that these regional variations in the public health machinery where state was variously 'present' have great impact upon the response of the contemporary Muslims in the region towards the state mandatory enactments on public health.

However, unlike many Muslim areas in north India, which struggle to make the daily survival due to the precarious conditions in the social and economic development (cf. Basant and Shariff 2010; Jeffry & Jeffry & Jeffry 2013), Muslim majority district of Malappuram has success stories in all social indicators of development especially the education and the participation in the governance. History of anti-state rebellions during British period is forgotten and the new history of utmost participation in the politics and utilization of state benefits has been cited with pride and honour. This Muslim majority district shows healthy trend in the indicators of public health. Maternal Mortality Ratio in Malappuram is as low as 31 in 2013-14 against the high percentage in other districts such as Alappuzha which shows 45[112]. Infant Mortality rate among Muslims is lowest in Kerala

[112] Health Information Cell, Directorate of Health Services (DHS), Government of Kerala, 2014: 19-21. We are aware of the fact that the southern and Western regions in India have the lowest infant and maternal

with 19 (per 1000 live births) against the overall rate of 21 in the state. Under five mortality is 26 against 26 in the state which is 28 among Hindus[113].This has to be read along with the fact that in Kerala, pregnancy is highest among Muslim community which is 9.7 percent compared to Christians (5.0), and Hindus (6.1), and the fertility rate is highest in Malappuram[114]. Total Fertility Rate (TFR) among Muslims is 2.5 against Hindus (1.6), Christians (1.9), and the national average of 3.6[115].

As is well known, the position in the health indicators such as infant mortality is influenced by biological and socio-economic variables, such as child's sex and birth order, mother's schooling, household economic status, and access to the infrastructure such as electricity, drinking water, and sanitation. We see a favourable condition of all these variables among the Muslims in the region that we see in the table below.

Here are some vital statistical facts about the health status of Muslims in Malappuram:

Households with improved drinking water source	93.8
Households with good sanitation facility	98.7
Mothers who had anti-natal checkups	96.9
Protected against neo-natal tetanus	96.6
Registered pregnancies for mother and child protection	74.9
Mothers received post-natal care from Doctor/nurse	93.8
Those who availed the financial assistance for delivery	16.8
Institutional births	99.6
Birth assisted by Doc/Nurse/LHV/ANM/Others	100

District Fact Sheet-Malappuram, National Family Health Survey, 2015-2016

Albeit these high performance in the health indicators, the reasons behind the poor percentage of coverage in the immunization vaccinations among Muslims in Malappuram is a point of discussion. It is an analytical conundrum to see the highly performing Muslim

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mortality rate against the high percentage in the central region. Obviously, position of Muslims in the south and West is even better than other regions. For instance, in the South, infant mortality rate among Muslims is as low as 29 per 1000 live births lower than the rate of 52 among upper-caste Hindus (Deolalikar 2010: 74).

[113] Indian Institute of Population Studies (Quated in Kulkarnim 2010: 121).

[114] Zacharia and Irudaya Rajan. (2008). *Costs of Basic Services in Kerala-2007: Education, Health, Child birth, and Finance.* Working Paper-406, Trivandrum: CDS

[115] If we go to the all India level data, Muslims have the second loWest infant and under-five mortality rate. This is a puzzle, somewhat surprising given the economically disadvantaged position of Muslims (Deolalikar, 2010: 72).

majority district in all social indicators like public health delivery, education, and infrastructure goes far behind in the state measures to combat public diseases. The table give below sheds light on this aspect:

Children between 12 to 23 months fully immunized (BCG, Measles, 3 doses of Polio and DPT)	Urban (61.1)	rural (80.2)	Total (70.6)
BCG	94.2	96.0	95.1
3 doses of Polio vaccine (OPV)	70.0	84.3	77.1
3 doses of DPT vaccine (Diphtheria-Tetanus-Pertussis)	73.4	88.3	80.8
Measles vaccine	73.5	84.2	78.8
3 doses of Hepatitis B vaccine	70.0	84.3	77.1
Children received vaccination in public health facilities			79.9
Received from private health facilities			20.1

District Fact Sheet-Malappuram, National Family Health Survey, 2015-16

A close look at the figures in the table shows that Muslims in Malappuram are not averse to take vaccinations per se; rather the reluctance is towards some selected vaccinations like polio, measles, and Hepatitis B. We also see while the rural people favourably responding to the vaccination drive, the urban Muslims who are considered educated are comparatively averse to some vaccines which needs a further exploration into the topic.

Immunization in Malappuram District: Public Health and Muslim Subject

We are to look into the theoretical complexities inherent to the Muslim health behaviour through two important areas strongly enforced by the state and widely discussed as specific to the Muslim community: immunization and contraception. The health administration from the state secretariat to the three tier panchayat systems are in full swing to produce the 'desirable' changes in the Muslim health behaviour especially in the immunization drive where they are generally considered as 'deviant'. The campaigns and health education drives never have been coercive, rather, as Foucault said 'through constructive power of state' such as discussions and campaigns through *mahallus*.

Analysis of immunisation programs under the state institutions such as vaccinations and inoculations can be taken as an example to understand the health behaviour of the Muslim community in relation to the state and their religious belief. In the case of Muslims in

Kerala, this relation is widely discussed especially the health behaviour of Muslims in Malappuram district. The response to the immunizations specific to a religious community is subject to the discussions under the public health logic that 'a person not immunized against the infectious diseases risks not only his health but also that of others' (Kethineni 1991). Such a response in specific ways is addressed in the background of Kerala's general achievement in the health indicators of its population, an 'odd' community in otherwise 'good', 'healthy' society.

Hence, in the cases like these, where a person's health behaviour directly affects others' well-being, the state's intervention is considered as legitimate. Such intervention is termed as 'paternalistic intervention' which implies that the individuals cannot make choices that are rational for them whereas the experts can legitimately intervene in modifying the health behaviour according to the goals set by the criterion that determines what would be good for the individuals as members of the social body (Das, 2015: 201). As Bryan S Turner says, the notion of 'generalised risk' may lead to the greater surveillance and control through the preventive medicine. It creates a political climate within which the intervention and control are seen to be both necessary and benign where the individuals need to be self-regulating and self-forming (Turner 1997: xix). What concerns us here is to explore the health behaviour of Muslims regarding the 'public diseases' the control of which is the core agenda of the state in order to ensure the bio-security of its citizens unlike the other private choices that may risk only the individuals. The issues pertaining to vaccinations are closely tied with the questions of political rights, civil disobedience, rights of subjects versus citizens, and the nature of consent (Das 1999).

The discussions against anti-vaccine campaigners and the state-wide alert on the outbreak of diphtheria and cholera were in the wake of two children diagnosed with diphtheria died in the Muslim dominated Malappuram district in September 2015. According to the local health department officials, the reason was the presence of non-immunized and partially immunized children in the area, who were unprotected from virus. They specifically point to 'some Muslim pockets' with a strong anti-immunisation ideology; some areas have100 percent of the population not immunized their children who are exposed to high risk diseases such as Tetanus. In the context of Kerala which has the reputation of high coverage like Gujarat, the blame is attached either to the local health workers or to the communities when the local-level epidemics occur. Here, the blame is for the Muslim

community in the Malappuram district unlike the Muslims in other districts that demands a closer look into their health behaviour in the context of state's mandates on public diseases.

Responding to this trend, the left government decided to take strict actions against the anti-medicine campaigners and to make vaccinations compulsory for every child for school admission[116]. It was also decided to collect data on immunity of children in the state and categorise those who did not take immunity medicines at all, not completed yet, and those who do not know about medicines. School head teachers were given the charge to collect the details and submit the report to the government through local self-government bodies. The government order came in the context of rising state-wide campaigns against the immunization programs and the declining rate of immunization coverage. The emergence of vaccine preventable diseases like diphtheria that were once eradicated was attributed to the reluctance of Muslims towards immunizing their children as the result of anti-vaccination campaigns. Along with the state health department, the organizations such as Indian Academy of Paediatrics, Indian Medical Association, and Indian Medical Forum have decided to move legally against the anti-vaccine campaigners in Malappuram[117]. In the wake of news on the spreading diseases, the district health machineries have started intensive vaccination drive in the district.

The health officials in the region like Abul Raheem in Thirurangadi Taluk hospital and health inspector at Venniyoor explained the process of the health delivery and their experiences of the community response. In order to educate the people, there is a group of field workers in the health campaigns known as Accredited Social Health Activists (ASHA) recruited under the government of India flagship program of National Rural Health Mission (NRHM). They visit every household to make them aware of the available health services, and the main task is to spread awareness about the prevention and control of communicable and non-communicable diseases, and palliative care. They are also entrusted to provide health services such as pre-natal care, birth registration, immunization, and to analyse the health issues in the area and to work to find solutions.

The health workers talk about the responses they get from the region:

[116] *mathrbhoomi* (June 16, 2016)
[117] The Hindu (July 22, 2016)

> There are a few, especially some religious scholars (in fact, they are not scholars) who shut their doors before the campaigners like the ASHA workers. They have misled the community into misconceptions about immunisation such as the fallacy of American agenda to target the Muslims. If we ask them further, they would make us 'other group'. In order to dispel these misunderstandings, once we invited Panakkad Shihab *Thangal* to inaugurate the polio immunisation program and it yielded the result for a certain extent; we could reduce the rate of resistance.

They say when their earlier campaign on the basis of IEC (Information, Education, and Communication) didn't succeed well among the Muslim community, they have embarked upon a new project of 'behavioural change' of Muslims in health. It is aimed at changing the health behaviour by finding out the root-causes of the person who is not willing to take vaccinations and to counter the reasons he raises with proofs. It is just like the strategy of the 'alcoholic de-addiction' centres. They also claim the result:

> Earlier, they were not taking preventive medicines for elephantiasis, now they come here asking for the tablets, they have also started asking for the contraceptive methods, testing for AIDS, and attending the counselling classes. These are remarkable change considering the characteristics of this area when compared to their behaviour in the past.

Muslim health inspector in the area Naseer talks about his working experiences in the area compared to other areas:

> As per the report, the last polio patient was identified in Kondotty, Malappuram district following which two staffs in the health department was suspended. This is the condition in this district; there are some families that never come forward for the immunization. When I was working in Thrissur, the neighbour district to Malappuram, the Christian community go to their church on Sundays and directly come to the sub centres to take vaccinations for their babies. Here, some groups with hidden agenda are propagating the false assumptions against the immunizations and they are exploiting the illiteracy of the people here, the campaign is that vaccination would make the babies infertile when they become adults. Allegation of infertility is stronger against Rubella vaccine for girls.

This statement by Naseer, the health inspector in the area indicates the concerns among the health authorities, other local government bodies, and among the community regarding the immunization programs. The report about a polio patient in Malappuram was seen as a case that may jeopardize the global program of polio eradication by the year 2000. He also

mentioned the behaviour of Muslims in other parts of Kerala such as Muslims of Guruvayoor where he worked; they come forward for the vaccinations 'enthusiastically', the statement calls for the need to add the specificities of the region while we study religion or behaviour of religious community.

The local health authorities complained of some anti-vaccination groups, some of them are inspired by the religious ideology who would say, 'what is the problem with you if anything happens to our children; if they die we will bury them'. They also point to the religious organizations like AP Sunni groups, *Thabligh-e-jamaat* who shut their doors before the public health officials. Other anti-vaccination group includes Homeopath doctors, the practitioners of naturopathy and acupuncture. According to the health officials of the region, the groups identified by them as '*mantravadis'* (we called them the religious healers of *thangals*, *musliyars* and *beevis*) were never ready to hear what they say. Instead, they are unleashing widespread campaigns throughout the district citing the 'scientific studies' on the health hazards of the immunization and make allegation of concerted efforts to target Muslim community by reducing their numbers through vaccines.

Apart from the anti-vaccination campaigns Dr. Sakeena, the DMO (District Medical Officer) of Malappuram district mentioned the affection of mothers in this region towards their babies in peculiar ways could have prevented them from immunization and the tendency is helped by the anti-immunisation campaigns. Some inoculations like Polio drops will result the three days fever for the babies that the mothers and the household members generally don't like. She also points to the result of the community reluctance towards the immunization: all patients diagnosed and admitted in the special cell of the Kozhikode medical college for vaccine preventable diseases are Muslims and the reason is they have not taken the immunisation. Since many of them are air-borne diseases the private hospitals deny the admission to protect other patients.

> We had made mosques and madrasas as the epicentres of our campaigns to motivate the community to take immunisation medicine, but the result is not satisfactory because of the resistance of a small minority. We were always grilled by the health minister and secretaries in the monthly conferences held at the state health directorate at Trivandrum and we, the health officials from Malappuram, were called as 'back benchers'. I tried to convince them about the necessity to deal the issue through the state level programs

> instead of health department. At last, DHS (Director of Health Services) recognised our helplessness in this issue.

This is from the service experiences of Dr. Sureshan, the retired Deputy DMO of Malappuram which tells about the dilemma the state health department faces regarding the response of the Muslim community in the region towards the state guidelines. However, his experience of 15 years as a doctor in Thirurangadi Taluk hospital tells about the specific ways in which the immunisation medicines and vaccines are approached by the community in the region:

> People here have craze towards the modern medicine and it is the dominant health system in the area. Some them go to the homeopathy for a while but they again come back here. The only problem is the wide reluctance towards the immunization which is, I think, to be understood as the 'general impression' historically exists among the community in the area. However, comparing to the previous levels, the situation has changed a lot thanks to the educational mobility, but comparing to other districts the contemporary level is too low.
>
> The first question I ask to the patients here is 'whether they are immunised or not'. In this area, there was one tetanus death, three diphtheria cases were reported, and they were sent back to the medical college, later I came to know that one of them died. Last year there was a case of H1N1 in this area.

Immunization and its Local Critiques

I could observe the anti-vaccine and anti-allopathic campaigns were very active in Malappuram when the government ordered for the first batch of vaccines for diphtheria. Marches, *dharnas*, public meetings in schools and colleges were conducted, pamphlets distributed and messages spread through social media against the vaccinations. The main issue of campaigners was the vaccinations were the state and central government agenda to control Muslim population growth in Malappuram.

The content of the campaigns involved the citations of both the scientific reasons against the immunizations and the global political developments against Muslim community. The method was door-to-door campaign to every household soon after the health officials come and leave from there. Even though each therapy of acupuncture, *hijama*, homeopathy, naturopathy has its own association, all of them were united against the

vaccinations and hold combined campaigns in the region. The association has its own advocate to appear for the cases related with the vaccination issues. One acupuncture practitioner says:

> They are not disclosing the ingredients of the vaccins. They want 90 percent of the population vaccinated and the remaining 10 percent are the privileged class in the society. Why the doctors and the rich people are not giving vaccines to their own children? What is the use if I have medicines for your disease? These are all the hidden agendas of imperialism and drug companies to exploit and destroy India and target Muslims. We do not want to throw our babies to the hands of drug mafias to make them permanently morbid; their health is our prime concern.

The campaigns are on against pulse polio immunisation program, vaccinations for small pox, diphtheria and missiles, tetanus and Rubella medicine for the girls. The campaign is 'should we hand over our girls to the hands of drug mafia to make them infertile?

The campaigners have its activist in each locality; Musthafa in Chullippara was one of them, who works as the acupuncture healer in the area. During my stay in the *mahallu,* he was always trying to convince me about the problems of immunization and invited me to participate in their classes. The health inspector says that only 30 percent of the schoolchildren attend their classes on vaccinations, which means the anti-vaccination drive could make an impact. There are some in the area who even harass and curse the field officials. Abdul Raheem the administrator of government Taluk hospital, Thirurangadi says:

> Only the Muslim community is the most hesitant to the immunisation medicines; Christians and Hindus will not do that. Here, there are sugar patients who don't have medicines and pregnant women who never consult the doctor, what shall we say to them? Lack of education is the main problem. Only the awareness campaigns can bring any change

> Recently I heard a religious scholar preaching that Muslims women should prefer the Muslim lady doctors first, then the non-Muslim lady doctor, Muslim male doctor next, and the non-Muslim male doctor. What is this? The same scholars had opposed the female education and becoming the female doctors.

Avoiding modern medicines for diabetes and pregnancy also shocks him and he views it as the product of illiteracy. However, contrary to what he said, Thirurangadi which is one of the highly educated areas in the Malappuram district is assessed as the lowest in the rate of immunisation coverage. The case of Thirurangadi which is also one of the epicentres of the religious reform movement and the resultant 'progress' in the education and modern health, demands to look for a different approach to study the response to the state and religious guidelines.

Immunization and the Muslim Dilemma

There are discussions in the public media around the health behaviour of some communities especially the Muslims in Malappuram for weakening the public health system by not letting their children to have vaccination for diphtheria, tetanus, measles, Hepatitis B, and Polio. Discussions point to the defying mentality and the organized denial of vaccinations by the Muslims in Malappuram[118]. Health experts including doctors and public health officials blame the decreasing immunity of Muslim society. The health department, and almost all dailies and channels endorse and promote the early vaccinations and see the reluctance and anti-vaccination arguments as 'unscientific'. It was reported in Malappuram alone 233357 children under 16 were not taken vaccinations for any of the listed communicable diseases. Some of the public health officials blame the social and political conditions of Muslim society that led them to the communicable diseases.

There are many factors we need to attend here. One is all discussions in public media and government agencies such as the district health department point to the relation between religious faith and participation in vaccination drive. For instance the then health minister V S Shivakumar claimed the lack of immunisation in Malappuram was due to the anti-vaccination campaigns of some religious organizations. Some of the news reports[119] identified it is the religious organizations of AP Sunni faction and Jamaate-islami are the strong anti-vaccine campaigners.

[118] For instance, see the article in Malayalam daily titled 'social lesson of Diphtheria' (*Mathrbhoomi*, July, 22, 2016)
[119] Hindustan Times (October 21, 2015)

As it was observed, the field accounts of the common people, irrespective of the ideological differences shared the concerns and doubts on immunization programs. These concerns stem from doubts about efficacy of immunization which is a medical concern, and fear and anticipation related to 'targeting the Muslim community', a political question, and thirdly the religious question of taking medicines without diagnosing any disease simply by anticipating an outbreak. In short, the Muslim subjects were not keen to buy the notion of 'risk' which is so central to immunization as a preventive measure.

However, the main individual respondents in the household on the immunization were women who are the 'decision makers' on the children's health but guided by the family and husbands often prefer to play it safe. An elder woman who is also the mother of the ward member said:

> We are giving vaccinations and inoculations for our children because the doctors in all hospitals ask for it, so, we are following the guidelines because they are mandatory. We the mothers are going for all immunization programs.

There were some who raised confusions from religious point of view. Muhammad Nasser, a middle aged Gulf returnee who 'updated' his beliefs and practices after his exposure from Gulf and wide reading of religious debates and speeches tried to respond to every queries from religious point of view:

> Government says it is good for our health, but I have doubts on whether it is allowed in Islam. I have heard somewhere that we should not take medicines expecting the possibility of a disease to come, but I am not sure.

The question of immunization also raised the issue of priority and ranking in conforming to the mandates of religion and state if they are in conflict with each other. Along with the immunization, the family planning programs had also the same conflict of interest in allegiance. Some of them explained their stand through their interpretations:

> I do not follow the government laws if they are at odds with Islam. However, I have heard about a *hadith* which says that we (the Muslims) are beholden to abide by the laws enacted by the government of the locality we live.

The health authorities in the region like the health inspectors and the DMO also mentioned about some households reluctant to take immunization vaccinations because of their

religious ideology. Municipal councillor in the Chullippara ward took pride in the appreciative achievement of his ward in the turnout in the percentage of vaccination except 'some households' such as those who are affiliated with *Thabligh-e-jamaat* who stopped taking immunization medicines after 'converting' to a new organization.

In return, the local health authorities said, they would selectively deny the government services to the noticeably arrogant anti-vaccination supporters or compel them to take vaccines in order to avail the signatures of the health officials such as the issuing of birth certificates for the home deliveries. Sometimes, they impose heavy fines after raiding their shops in a 'strict manner'. They report slight change in the attitude when it was publicly announced in the presence of MLAs and other representatives of the area that those who did not take the immunisation cannot avail the government services. All of our informants among the health officials of the Malappuram district such as the directors of health services and health inspectors, especially the Muslim officials felt ashamed of their community, religion, and region when they are stood accountable in front of the state and national health authorities due to the low per cent in the coverage.

However, there are many Muslim religious scholars, religious organizations and households endorse the vaccination programs. Some of them use their houses and *madrasas* in the *mahallu* as vaccination camps. All religious organizations have responded to the ongoing public discourses on the necessity and problems of immunisation programs, most of them were endorsing the vaccinations and the effectiveness of the modern medicine. These issues were included in the Islamic magazines for the families, published by all religious organizations. '*Aramam'* magazine of Jamaate-Islami refutes the arguments of 'anti-modern medicine' campaigners[120]. It says the organizations like WHO and UNICEF cannot act with 'hidden' agendas and modern medicine has its own mechanism to curb the anti-people elements in the vaccinations. It also rejects the campaigns that the vaccinations were used as contraceptive measures.

In the wake of the death of two children in Malappuram and many more admitted in the Kozhikode medical college, Dr. Rizwi, the Assistant Professor at paediatrics department wrote an article in *Probodhanam* weekly blaming Muslims in Malappuram district for their alleged reluctance in taking immunization for their children. Through this magazine

[120] Aramam, July, 2016, p.6-7

published by *Jamaate-Islami*, he rejected the campaigns and ideologies against the immunization and reiterated the fact that science, especially the medical science was the tradition of Muslims which should not be opposed.

At the same time *Santhusta Kudumbam* ('happy family') a weekly published by the EK Sunni faction for the Sunni households asks the heath authorities to dispel the confusions and concerns that exist regarding the immunisation vaccines through the campaigns. It also opposed the discussions targeting the Muslim community and Malappuram district. There are individual viewpoints such as that of Musthafa:

> Personally, I am against the immunisations because we need to fire at leopard when it actually comes, not before it. However, my wife gets the vaccinations for my children done without my knowledge; she is influenced by the campaigns of some doctors. She is afraid of the consequences they list. My neighbour has not taken any vaccinations; still all their children are living healthily? All these vaccination and inoculation medicines are coming from America and I really doubt that they would target the regulation of Muslim population; I am afraid of them.

The rumour and suspicion about having the taking vaccinations is more akin to the communities in the 'margins' especially about the state's intentions while forging policies that involve the body, sexuality and reproduction of 'other' communities or areas with 'special jurisdiction'. This is somewhat similar to the Ashforth's (2004) finding that the measures to control HIV transmission were interpreted by the Black subjects of South Africa as the concerted effort to regulate the Black reproduction among the coloured population which was the product of the specific local history of the politics of apartheid (Quoted in Das and Poole, 2004).

Obedient Citizen and Pious Muslim: Disputing Contraception

As we said earlier, the queries about the response to the state guidelines of the family planning programs also arrived at the replies with doctrinal sources. It was a health official in the region who made 'religious interpretation' like this:

> Our religion urges us to marry fertile women and it also condemns the killing of children (foeticide) fearing the poverty. But the family planning campaigns are at low ebb now

> because of the decreasing birth rate and aging population of Kerala. The birth rate is also coming down in Malappuram district as well.

This point raises some discussions regarding the family planning and Muslims which also touches upon the foundational aspects of Muslim health behaviour, the Islamic discourses on sex, pleasure and reproduction and the response in the field. Overwhelming majority of the Muslim *ulema* either prohibits or discourages the family planning measures such as tubectomy. For instance, Irfan Ahmad (2013) gives account of Maududi's stands, one of the influential Islamic thinkers in south Asia, on sexual pleasure, reproduction, and Islam. Maududi says human's goal is neither simple self-perpetuation nor pursuit of pleasure; the pleasure-oriented sex is subversion of the divine and thus illegitimate. Sex's only intent was to procreate. He widely condemned the contraceptives and birth control as suicide which were against his vision of 'pious civilization' (Ahmad, 2013: 323).

The religious teachings on birth control usually quote a verse from Quran which commands Muslims not to slay their children out of the fear of poverty and remind the great of sin of infanticide in Islam. However, according to Islamic jurisprudence, as Maulana Ashraf Ali Thanawi's *fatwa* says, the use of contraception is permissible only if there is legitimate excuse such as the illness due to the repeated childbearing. Even if there is interpretative flexibility when there is *zaroorat* (constraint) or *majboori* (health emergency), he considers that the contraception is generally not permissible.

In same manner, one Islamic magazine named *santhushta kudumbam* (happy family) in Kerala published by the EK Sunni religious organization for Muslim women, advises that contraception and stopping childbirth without sufficient reasons such as illness as *haram (santhushta kudumbam,* March 2016:40). The situations of *majboori* also appear when there is government enforcement of the compulsory family planning programs where Muslims would have to obey. However, the ethnographic accounts of the ways in which these discourses are interpreted and accepted in the field give a diverse and complex picture of the relationship between Islamic teachings and the ground realities of Muslim fertility behaviour.

Any fieldwork on Muslim fertility, registers this aspect of religion that using contraceptive techniques, especially sterilization (tube closing) is contrary to Islam, especially the reformist Islam (cf. Jeffery & Jeffery& Jeffery 2013: 383-5). Recent surveys in India also

indicate that 9 percent of currently married Muslim women against only 1 percent of Hindu and Christian women say that the reason behind not using contraception is, 'it is against their religion' (Ibid. 384). Responding to this wide trend, Jeffery & Jeffery & Jeffery (2013) who conducted fieldwork on the fertility behaviour of rural Muslims in UP at north India, argue that we must situate the fertility behaviour of rural Muslims, in the wider social, political and economic contexts within which they are struggling to make their life. They say the 'Islamic doctrine' provides a poor basis for the interpretation of Muslim fertility behaviour in contemporary India. Nevertheless, such simple conclusion does not adequately give account of their fertility behaviour in the context of religion. Rather, we need to attend the ways in which such doctrinal discourses are interpreted in the field. Broader socio-historical processes that shaped such an interpretations have to be explored while we analyze the acceptance of contraception among Muslims.

Moreover, we see the resistance to and subversions of state's projects of family planning among other communities and regions as well. The demographic figures foreground the acceptance of birth control in Kerala as rational choice under given circumstances. However, critical studies (such as Devika 2008) into the popular acceptance of birth control measures in Kerala, especially in its southern regions, expose the significant complexities inherent to the family planning methods. She says the fertility behaviour is connected to the changing forms of power that binds the state, the political rationality of government, and society within which the rhetoric of 'option' and 'choice' have to be explored (Devika, 2008: 5).

Critically looking at the commonsensical notion about the un-coerced acceptance of family planning in Kerala that generalize the Malayali response, she sees how the family planning propaganda in Kerala proved appealing differently to various social, economic, and geographical situations. Even if there was a general agreement that population had to be controlled, the disagreement was over questions of 'how to'. In contrast to the artificial contraception, natural birth control through sexual self-control was hailed as ideal for the sexually disciplined subject inherent to the idea of modern monogamous conjugality in the Malayali public sphere. We have to note here the fact that Islamic tradition also endorses the sexual control and permits the natural birth controlling measures. However, foremost is to see how the Muslims respond to the state's mandates in different socio-political contexts.

We want to conclude the discussion by citing a response towards my question on family planning programs that points to our argument that the focus has to be on the ways in which doctrines are taken in the field by not only by those who live with religious tradition but also as the subjects of the state. Musthafa, one of our informants, said:

> Birth control laws are now becoming like compulsory. We have to abide by the laws. Does a hadith say that we have to follow the rules of the land we live?

Summary

We attended to the discussion of how the religious discourses on the health practices and the endorsement of specific practices, which work through 'cause and effect', are reproduced in the field. We also saw all religious organizations, overwhelmingly thrown into the social services and squads exclusively in the sites of the modern medical institutions in order to reach out to the wider public. Health is understood to be the most fundamental social need where the organizations can intervene and provide services in order to have a wider social acceptance and legitimacy in the new social contexts. It also showed the discrepancies between what the religious organizations say and do in the field, adapting to the new social demands. So, unlike religious healing, modern health care is an area in which religious and organizational boundaries are not considered in providing aid and service which stands at the religious and organizational 'cross-road' with flexibilities .

We discussed various organizational positions and their classificatory schemes of health practices that get disseminated through the religious educational institutions in the *mahallu*. We also saw the formation of personal opinion within the religious tradition through selecting the appropriate positions of organizations, as and when individuals are 'convinced'. The opinions and religious positions such as the identity of a 'true Muslim' based on the practices are influenced by the political and economic conditions of the time and space.

The doctrinal discourses and interpretations of the subjects showed that they also regulate, influence, and define the organizations and discourses in multiple ways. Individual believers listen, analyse and interpret based on practical necessities, and then choose, and organize their practices accordingly. Hence at times we found a discrepancy between

ideological position and practice adopted(between what they 'argue' and what actually do) in the case of illnessWhile mahallu residents thronged the hospitals for curative services, they were hesitant to avail particular preventive services and this kind of reservation only about vaccinations have a long history (Sujatha 2014). Our observations in the area point to three main concerns regarding the immunization drive which demand to think beyond the religious cause. Firstly and primarily, the medical concerns on the necessity and efficacy of immunization, and secondly the political concerns of 'Muslim community being targeted', and thirdly, the religious question of whether a medicine can be taken before diagnosing the disease, and the interpretations of some religious organizations that reject the immunization.

Health behaviour has long been a subject of interest to medical anthropologists. It has also been known how the value system and cultural predispositions influence health seeking by any social group (Kleinman 1980; Good 1994; and Lock 2010). Such studies on health and culture have largely touched upon civilizational differences between the East and the West and also often draw upon binaries between 'tradition' and 'modernity'. In this chapter, however, we have tried to argue through the case of Muslims in Kerala that health behaviour and ideas are shaped by different and often conflicting components of a society. Islamic discourses of emergent religious organizations itself present a contentious space urging the health seeking subject to think and choose between ideological positions. Many of these religious discourses endorse and recommend modern developments in medicine.State policies and interventions represent another set of factors impinging on the options before the Muslim health seeker. By suggesting the idea of a 'Muslim medical subject', this chapter draws attention to the dynamics by which religious authorities condition and enable the Muslim health seeker to respond to her/his own health requirements and to relate to state policy under actual and lived conditions. This process of negotiation and decision making by Muslim health seekers goes beyond simple theories of cultural conditioning of health behaviour and also defies binaries such as the rational and irrational, science and religion. Unlike health seekers from other religious communities, the Muslims in Kerala do have an inescapable framework and strong explanatory model given by the religious organization that they are affiliated to when it comes to health practices, in a way that distinguishes them from the other groups inhabiting the same region. Asad's theoretical premise also urges us to see the Muslims

subjects through an aternative approach, different from other communities, because they inhabit the moral frame of Islamic orthodoxy.

Conclusion

We started our discussion in the background of important writings in sociology and social anthropology of religion with specific reference to Islam and Muslim societies. Clifford Geertz's (1968) study of Islam as cultural system ruling out the doctrines and foregrounding the symbols in the making of religious meaning set the ground for the study of Islam in the anthropology of religion. El-Zain (1978), one of the early post-Geertzian anthropologist, sought to look for multiple versions of local Islams that help make meaning in mutliple, dynamic, and constant mode, unlike Geertz's homogenous feature of symbols and meaning. Dale Eickeleman (1982), responding to discussios initiated by Geertz and El-Zain, took a middle ground between the normative texts of Islam and the contextual determinants such as class which are, for him, critical in understanding Islam in local contexts. Mark Woodward's (1988) classificatory scheme of Islamic rituals also contributed to the anthropological dilemma with text and context in Islamic societies but with exclusive catagories such as local and universal. Akbar Ahmad (1987) and Richard Tapper's (1995) attempt to Islamize social scientific methods fails to provide an alternative methodological framework to study Islam and Muslim societies.

A radical shift was brought about by the intervention of Talal Asad (1993) in the sociology of religion which upacked many of the existing notions of religion. He questioned the very concept of religion in the anthropological defenitions that rule out the power of doctrines, laws and sanctios, and the role of disciplining authority in the production of religious truth, meaning, and knowledge. He showed how power is inherent to Christian and Islamic traditions in the production of religious truth, symbols, and meaning.

Asad's (1986) essay on anthropology of Islam marked a major turning point in the academic works on Islam. He argued there is the idea of a correct form of practices in Islam as it is understood by its followers, an Islamic orthodoxy that defines the Islamic and un-Islamic practices. Drawing on Scottish philosopher Alasdair MacIntyre, Asad argued Islam should be approched as a 'discursive tradition', neither a 'blueprint' of Gellner nor the 'cultural system' of Geertz. Inspired by the great openings made by Asad in anthropology of Islam, many works like, John Bowen (1996), Sabha Mahmood (2005), Charles Hirschkind (2006), and Samulie Schilke (2009) tried to understand the modes of

ethical self-fashioning among Muslims in the background of powerful disciplining authority. Using the tool of ethnography, these works move away from the conventional binaries of resistence and subordination which are unhelpful to understand the nuances of Muslim subjects.

However, taking these theoretical frameworks as our points of departure, the thesis tried to engage with the question of how the religious discourses and authority operate in the field in the domain of health where there is a possibility of Islamic orthodoxy being negotiated by the imperatives of ailing subjects. The studies considered to be the major benchmarks in the study of Muslim societies are based on Muslim majority countries like Middle East, North Africa, and Far Eastern country of Indonesia. The framework based on Muslims in South Asian countries like Pakistan and Bengladesh also shares similar concern (cf. Werbner 2013 on Pakistan; Haq 2013 on Bengladesh) where the Islamic orthodoxy and authority have greater power in the public life and the state (cf. Zubaida 2001, for the role of Islam on state and civil society in Egypt). Hence, it was pertient to look into the formation of Muslim subjects in the Indian context taking into account the differences within Muslims such as the orientations of social locations that were glossed over in the major works.

In Indian sociology however, we are faced with the lack of comprehensive method to deal with the concerns shared by Geertz, El-Zein, Eickeleman, and Woodward, namely, the relationship between text and actual field (cf. Ahmad 1981 and the contributors to his volume). The studies tend to take Hindus as the reference groups because, for them, the practices of Muslims in India are syncretic. Even if Veena Das (1984) has provided a useful approach of 'anthropology of folk theology' that urges us to focus on the complex interpretations from the common believers, she did not see the existence of a universal orthodox Islam that we see even in the local interpretations. Even though historians on Indian Islam like Barbara Metcalf (1982) and Francis Robinson (1993) have focused on the aspect of authority which was ruled out by Das (1984), the lacune of ethnographic representation in thier works prevent helping us comprehensively understand the complex ways in which power of Islamic orthdoxy operates in the field defining the subjectivity of the faithful.

It is towards this theoretical point that the thesis wanted to respond, because, in the context of Kerala, concepts and practices of health and illness are the key topics of debate between the religious organizations based on which many new groups have come into being. Our attention towards the state as the form of legitimate authority on health practices makes the thesis different from the studies we cited above. Hence, the objective was to investigate the formation of Muslim medical subjects placing them inside the power and authority of religious tradition and the state.

To operationalize the study, we selected a particular *mahallu,* a unique form of religious life of Muslims in Kerala. *Mahallu* appeared to be the institution of power and discipline in the micro domain of religious life where the religious tradition is sought to be lived in the field. However, instead of the orientalist notion of hegemony of authority over subjects, we saw that *mahallu* system worked as a form of 'democratic' space which facilitated the dialogical interaction between the authority and subjects.

The historical account of the Muslim response towards religious authority and state showed that as Eickelmen (1982) pointed out, the contextual factors defined religious position but it was subject to authorization of religious subjects as well. In particular socio-economic, and political situations of colonial period, religious authority has always been in conflict with the state power. The discourses of the disciplinary authority of *ulema* have been subject to the acceptance and approval on the ground which was defined by the specificity of the economic life in the region. The troubled class relations and the anti-tenant land-ownership policies of the colonial government led Muslims in southern Malabar, primarily an agrarian society into the frontier against the British state. Such an existential context influenced the Muslim community to take position in favour of the anti-British *ulema* and against the pro-British religious scholars.

Turbulant relation between the state and the community in the region created a huge chasm in the health and educational infrastructural development compared to Travancore and Cochin regions (cf. Devika 2008). In return, British retaliations against the revolts and the violent repression made the people in the region averse to everything which is British, the English language and modern medicine, espicially, against the vaccinations for Cholera. Health needs were met by traditional *vaidyars* and Muslim *ustads* who were *vaidyars* and religious healers as well. However, more importantly, we see a radical shift

in this position in later periods, from the agrarian community to the remittance economy, from the anti-state rebels to the state beneficiaries. Plural medical systems came in full bloom in the public health scenario in Kerala.

Another important development within Muslims in Kerala was the emergence of religious organizations in the leadership of *ulema* (religious shcolars) with distinct ideological positions on correct religious behaviour that defined the true model in the health practices. The organizations communicated to the larger community through preaches, public debates, publications, and wide use of latest technological means. The positions were produced to the everyday religious life via controlling the micro religious institution of *mahallu* and indoctrination through its educational institutions.

One of our primary objectives was to investigate the formation of concepts, ideas, experiences, and practices of health among the members of the *mahallu* in the background of religious discourses that tended to define the correct model of practices. New theoretical frameworks in medical anthropology such as those of Good (1994) and Kleinman (1980) against the existing dichotomy of belief and knolwledge of objective reality helped us to understand the concepts and practices of health within the religious tradition.

With the objective to give account of the health behaviour of Muslims, we cited some specific cocepts and practices, namely *adab* (etiquettes of hygiene) and circumcision through which the Muslim bodies were subject to the religious discipline that lie beyond the ideological lines. However, circumcision and childbirth, the key rites of passage conducted inside home has been subject to the medicalisation process. We also mentioned about the locally embedded medical lore, knowledge and practices of medicinal preperation and home remedies inherently linked to the local Malayalam calander and ecology.

The chapter showed that classification of illness and remedy seeking is conditioned by the sectarian beliefs. Distinct concepts and practices of body, illness, and healing were defined by the existing differences on the sources of knowledge in religion. Instead of a single Islamic orthodoxy that Asad (1986) conceptualized, we see the local orthodoxies sustain such beliefs and practices. For instance, Sunni households in the *mahallu* practiced thier own religious remedial measures for protection even from the outbreak of epidemics and

contagious diseases, severe droughts, and the emerging lifestyle diseases like cancer and kidney failures. Local Sunni Islamic orthodoxy validated and sustained their religious correctness and efficacy which always respond to the emerging diseases among the community.

Such conditioning was stronly observed in the beliefs and positions on the invisible beings of *Jinn*s and their contact with the human world which has been the most controversial topic in the debates at inter and intra group levels among Muslim organisations in Kerala. Muslim doctors in bio-medicine, Ayurveda, Homeopath, and the Muslim health officials in the region from District Medical Officer to health inspectors believed in the existence of *Jinn*s. Such beliefs tells us to think beyond the concepts that compartmentalise between 'belief' and 'rational' medical knowledge.

However, the ideas of true health practices were also the outcome of the authentication process among the community of believers who watch, observe, and classify the practices. In this process, not just efficacy but piety of the healer and his credibility worked together which depended on the succussful interplay of *mantram* (powerful healing words), *thanthram* (strategy of healer), and *yanthram* (correct presription of medicine). In the use of medicine, Ayurveda with its diverse practices played an important role in the the process of acceptance. It points to the complex ways in which the Islamic orthodoxy operates in the field in the domain of health.

In addition to the understanding of concepts and experiences in the context of religious discourses, we also attempted to discuss the health behaviour of Muslims in the context of economic life, occupational change, food pattern, and the changes it brought about in the social situation, consumption pattern, health market, and religious activism. The changes in occupation, livelihood and income played an important role in the changing health status of the Muslims in the region. It was a transformation from the agricultural economy to a remittance economy with a significant share of commersialisation. Migration and remittance income redefined the class structure and lifestyle of Muslims which in turn helped the rise of a medical market. Moreover, new social arenas of organizational activities rather than the sole focus on moral conduct, like establishement of educational institutions, hospitals, and welfare activities verily depended on the Gulf remittance. The

food habits also responded to the assimilation through migration along with its inherent connection with the religion and regional culture.

Though new source of income has influenced the choice of private health care centres, the public health system in the region has been on the remarkable progression with the significant participation of Muslims in the governance and state health schemes, a historical shift from the colonial past. Alternative medical systems like Ayurveda, Homeopath, and *fasd-hijama* therapies not only respond to the emerging lifestyle diseases but also actively participate in the anti-vaccination campaigns in the region. Thus, we noted the specific ways in which different therapeutic systems coexist and conflict with each other and with the religion.

Apart from the organizational indoctrination, migration and travel bring in the ideological changes at home. The increased global connections through the historical relations via trade, pilgrimage and circulation of scholars and the enormous circulation of working classes through migration showed the existence of something called a universal Islamic orthdoxy. Such trans-national imaginaries increasingly emerged through movement of multitudes for livlihood has always been taken as frame of reference for the idea of 'right' practices which has been considered in contrast with the indoctrination at the local orthodoxy of *mahallu*.

However, irrespective of their ideological differences on the validity of healing practices, all religious organizations actively worked in the allapathic and public health sites, a new arena of social activism which thrived on the remittance income from the Gulf. We called this new surge 'health activism' of religious organizations adding a new dimension to the concept of *da'wa* which is a shift from the sole foucs on ideological affairs. Thus, modern medical institution, not the religious healing sites, worked as the 'organizational crossroads' where the ideological boundaries become permeable. Following various ethnographic studies like Jasani (2013) and Haniffa (2013), we have argued that the larger socio-political, and economic contexts define the ways in which ideological boundaries operate in the community where the considerations of class, ethnicity, and gender may come into play, particularly in Indian context.

As the discourses and disciplining authority regulate the actions, we also see the active subjects participating in the discourses through new means of communication technology

by which they regulate the discourses in return. The institution of *mahallu* facilitates this interaction between the authority and subjects. We have also noted the problems in holding on to ideological position when family members face critical moments. However, we cited some examples that showed the interpretative possibilities offered the space for doing the things otherwise prohibited. Thus, they placed thier transgressions in health seeking inside the Islamic tradition.

Adopting the theoretical framework given by the thinkers on state like Max Weber, Antonio Gramsci, Lois Althusser, Philip Abrams, Nikolas Rose, Michael Foucault, and Veena Das, we saw how the state is a disciplinary authority with the legitimacy of intervention in life of subjects, and the regulation of bodies. We took the Muslim reservations against immunization and family planning programs of the state to see how they engage with the bio-political strategies of the state.

Except for the reluctance to adopt vaccination and contraception, the region performs well in all health indicators and in fact, witnesses an active participation in all other health schemes.. There is a significant difference between Muslims in rural and urban area in the percentage of immunisation coverage. Conflict of opinion between the health officials in the region and the local critiques of immunization was also noticed. The Homeo doctors, practitioners of *fasd* and *hijama* and the naturopathy are in the forefront of the campaign against immunization which pointed to the health hazards of immunization. There are some religious groups like *Tabligh-jamaat* which appears as reluctant to participate in the drive. Thus, rather than the monocausal approach that pinpoint on religious affiliation, multiple factors, namely the political concerns of Muslim minority, medical concerns raised by campaigners, and the religious reservations make impact in the low level of coverage of some vaccines like Polio and Hepatitis B. We also saw even if all religious organizations endorsed and campaigned in favour of vaccines, the decision to vaccinate thier children was taken by the individuals who are exposed to mulitiple discourses other than religious.

Thus, the immunization and contraception among Muslims showed how they are connected with the legitimate bio-political authority of state and its injunctions which may, sometimes, come at odds with that of religion. Our ethnographic study shows that even though the religious positions on immunization and contraception make impact upon

the behaviour, how the discourses are accepted in the field is another crucial aspect to consider. Such an effort would show us a complex picture; a group of individuals shape their health behaviour according to the religion along with many individuals and groups with multiple opinions. Socio-economic, political, and regional factors make an impact upon the formation of these nuances and multiplicities. Therefore, while studying Muslim society in the context like India, attention should be paid to the political processes and discourses which produce 'Muslim civil society' in which the state is deeply imbricated. Engagement with the state mandates on immunization and contraception vividly shows this. Thus, our thesis showed the specific ways in which the concept that we suggest 'Muslim medical subject' are formed through the religious and state discourses, but it is differently articulated.

The thesis showed that religious discourses have a significant role in shaping the way Muslims feel, experience, think, and behave in the domain of health practices. Concepts and ideas, and practices of health differed according to denominational background. It produced a vocabulary of motive among followers that endorsed some health practices and rejected some. In addition to religious discourses, we saw that there are particular historical and socio-economic features inherent to Kerala Muslims that defined their health status in unique ways. We argue such an analysis of particular socio-economic contexts is important while studying authorization and religious subjects among Muslims. The chapters also highlighted different ways in which various occupational and class groups among Muslims behaved differently in health seeking rather than considering Muslims as a homogenous group.

Moreover, foregrounding the responses of Muslims of *mahallu* towards religious discourses, the final chapter showed the complex ways of authorization process of health practices in field. It also showed the un-negotiable bio-political power of state in defining the health behaviour which was clear in our analysis of Muslim engagement with state policies of health. We also saw some instances of conflict between state and religious community such as the issues of immunization and family planning programs as it is widely written. However, our enquiry showed the way other factors, namely, social health, political status of Muslims, and the economic reasons become more prominent than religious concerns on immunisation and family planning. Thus, authorization practices and authorization discourses among Muslims are significant imperatives to understand Muslim

subjects but the focus has to be turned towards how they are accepted and practiced by different actors in community who live in a particular socio-economic conditions. We argue the existing frameworks in sociology and social anthropology on Islam and Muslims developed in the context of Islamic societies are limited to understand the specific modes of Muslim subjectivity in health, in the context like India.

Aimed to explore into the specific ways in which Muslim medical subjects are formed in the context of religious and state discourses, we only selected the Muslim informants who have any kind of connection with *mahallu* authority. Most of them were activists or have any kind of affiliation with different Mujahid organizations and two Sunni organizations who are the major active participants in the religious debates on 'proper' health practices. These groups represented the majority individuals and households in the *mahallu*. However, we could not include other versions of Muslims, namely those who do not have any organizational connection, counter-organizational groups, marginal Muslim groups, Muslim atheists, and Muslim communists and so on who might have different stories to tell. Unwillingness of women informants to talk with a stranger researcher for a long time in the religious ambit of *mahallu* has limited their number as informants comparing to males. However, we have included elder women members of *mahallu* who were ready and 'allowed' to talk with me. Such features of our sample of informants, occurred as selective and accidental limitations of the thesis. As we noticed during our study, a further research into 'Muslim women medical subjects' in Kerala, in the context of religious authority and state has a significant scope for another thesis that would certainly add much to Mahmood's (2005) celebrated monograph on Muslim women's agency.

We owe much to the theoretical frameworks propounded Talal Asad and post-Asadian studies which delved deep into the specificities of Muslim subjects in different contexts. As our thesis attempts to contribute to the existing theoretical tradition in sociology and social anthropology on Islam and Muslim societies, we also focused on Muslim subjects and tried to discuss their specificities in a particular socio-political situation. However, if non-Muslim subjects were part of the ambit, taking accounts of health behaviour among a few Hindu households who stay in *mahallu*, the thesis could have given a comparative analysis, which could be another limitation of the present work. Such a research endeavour looking into the aspect of authority, discipline, and religious subjects, comparing different

religious communities would be another contribution to sociology of religion and could be the theme of future research.

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