Producing “science/fictions” about the rural and urban poor: Community-based learning at a medical college in South India

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Dedication

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Abstract

This dissertation is an ethnographic case study of a community-based teaching program (CBTP) in public health at a medical college in South India that explored how the CBTP produced particular ways of seeing and understanding rural and urban poor communities. Drawing from critical, feminist, and postcolonial scholars, I suggest that the knowledge produced in the CBTP can be understood as "science/fictions", that is, as cultural texts shaped by transnational development discourses as well as medical teachers' and students' sociospatial imaginations of the rural and urban poor. I explored how these science/fictions mediated medical students' performative actions and interactions with a rural and an urban poor community in the context of the CBTP. At the same time, I also examined how knowledge produced in students' encounters with these communities disrupted their naturalized understandings about these communities, and how it was taken up to renarrativize science/fictions anew.

Data collection and analyses procedures were informed by critical ethnographic and critical discourse analysis approaches. Data sources includes field notes constructed from observations of the CBTP, interviews with medical teachers and students, and curricular texts including the standardized national textbook of public health.

The findings of this study illustrate how the CBTP staged the government and technology as central actors in the production of healthy bodies, communities, and environments, and implicitly positioned medical teachers and students as productive citizens of a modern nation while rural and urban poor communities were characterized sometimes as empowered, and at other times as not-yet-modern and in need of reform.

However, the community also constituted an alternate pedagogical site of engagement in that students' encounters with community members disrupted students' assumptions about these communities to an extent. Nevertheless, institutionalized practices of assessment, and epistemological and ontological understandings of the nature of science tended to privilege the standardized curriculum and popular cultural stereotypes as scientific knowledge thereby excluding the place-based narratives of local communities, medical students, and teachers. This study, therefore, argues that interactions with local communities in community-based education and development programs cannot democratize knowledge production in medical education without a simultaneous engagement with post-foundational epistemologies in the social sciences and humanities.

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Chapter I. Introducing the Problem: Sociospatial Orientations of Knowledge

I began this dissertation with an interest in exploring how knowledge produced about rural and urban poor communities in higher education institutions (HEIs) in India is shaped by the sociospatial orientations of historical and contemporary academics towards them, and how such orientations might be transformed through community-based educational programs. Specifically, I sought to explore how this knowledge was imagined and sociospatially situated even in the 'scientific' discipline of public health, and even when produced through 'direct' pedagogical interactions with rural and urban poor communities. Implicitly, I sought to question conventional understandings of science in science education as an objective and universally valid body of knowledge across different historical and geographical contexts, and of scientific or empirical processes of knowledge production as being unmediated by culture. I coined the term "science/fictions" therefore, to provoke a consideration of scientific knowledge as fictional, that is, imagined and created, yet also mediated by the sociospatial realities of knowledge producers in relation to their objects of study (Haraway, 1989; 1991; Said, 1978). In sum, this study explored how a community-based teaching program (CBTP) conducted by the department of public health at a medical college in South India produced science/fictions about rural and urban poor communities.

Science fiction, as a literary genre, has always been centrally concerned with fear or awe towards an alien 'other' that the human race has had to contend with and subjugate for its own survival. I have also found therefore, the term "science/fictions" as an analytically productive metaphor for discourses on development. Like popular science

fictions, development discourses often imagine apocalyptic futures for humanity and the environment, and place much importance on the role of science and technology in the salvation of the entire human race from these futures (Haraway, 1991; Redfield, 2002). Like many science fictions, development discourses while being produced in specific locations travel globally to also shape people's cultural imaginations of and desires for a futuristic, technologically-produced, modern, and humanistic world shared by all.

Unlike science fictions, however, development discourses inform policies and programs in different parts of the world often making 'scientific' arguments to restructure their material and cultural realities in incredibly powerful ways, although scholars have shown how these discourses have been shaped by historically specific cultural and political processes (Cohn, 1996; Cooper & Packard, 1997; Escobar, 1995; Tsing, 2005). Such claims have been possible because of the deep complicity with the state and markets of academics and practitioners working from within various disciplines in the production of colonial and postcolonial development discourses about the colonized world, and later the 'Third World' (Cooper & Packard, 1997; Kaplan & Grewal, 2002; Lal, 2008; Parker, Samantrai & Romero, 2012). The disciplinary histories of anthropology and economics and of interdisciplinary fields such as area studies and development studies in the U.S context particularly illustrate their powerful roles in shaping the development landscape worldwide by virtue of their relationships with the state and the markets.

In the case of public health that this study focuses on, historical studies using postcolonial and feminist perspectives have argued that racial and gendered concepts and categories as well as concepts of health and disease were shaped by colonial conditions.

For instance, notions of therapeutic landscapes, or the "tropics" were largely Eurocentric inventions shaped by the anxieties and fears of European bodies interacting with "new", "strange" and "exotic" environments and diseases in the colonies that prompted the establishment and development of new fields of study like 'tropical' medicine and medical geography primarily to protect European bodies (Arnold, 1993; 1996). Further, in the Indian context, the colonial state's inconsistent public health policies for local natives such as coercive quarantines to control epidemics were shaped by political contingencies to avoid uprisings on the one hand, and to ensure smooth colonial trade marred by diseases like cholera on the other (Harrison, 1992).

Many of the health concepts and policies developed in the colonial period continue to be dominant in contemporary discourses in developing countries. At the same time, however, anti-colonial, nationalist, and feminist projects have challenged some aspects of these discourses, and taken up others in new ways. For instance, concepts in eugenics and reproductive health along with domestic science were taken up in anti-colonial and feminist projects towards the biological and cultural production of modern Indian families, and in turn the nation (Hodges, 1999; Ahluwalia, 2008). While such practices allowed some women to take on new citizenship identities and make reproductive choices, motherhood also became closely tied to the development of the nation so that contemporary public health policies in India target mothers for the development of their children's and families' welfare. Perversely, the state's population control policies, again developed in the late colonial period, have also facilitated families to conduct sex-selective abortions (Gupta, 2006). Similarly, while assisted reproductive

technologies fulfill the desires of infertile heterosexual and homosexual couples, and of single people to have children, fertility clinics also profit through the creation and kindling of these desires by privileging notions of biological kinship and purity, and thereby reinforce women's reproductive roles and statuses as mothers contributing to their financial and mental trauma in the name of offering reproductive choices to women (Madge, 2011).

Contemporary educational processes within public health in medical education, however, have not been subjected to similar scrutiny in postcolonial contexts. Hence, little is known about the persistences, disruptions, and transformations of hegemonic discourses in the discipline's curriculum and its pedagogical practices. Community engagement programs, as part of higher educational institutions including medical colleges, are particularly well-suited to exploring how teachers and student interpret and remake knowledge in hegemonic and counterhegemonic ways. Taking a community-based teaching program (CBTP) in the discipline of public health or Preventive and Social Medicine (PSM) at a medical college in Bangalore, India as a case study, I explored how the class[1] and gender 'orientations' of PSM educators, that is, the predisposed ways in which they have learnt to think, know and teach about the rural and urban poor in India shaped their interpretive and knowledge-making practices. In other words, I explored how their sociospatial imaginations of rural and urban poor shaped how they interpreted and translated historically produced global development discourses to produce science/fictions.

[1] Since the relations between caste, religion and class are extremely complex, the study privileges a class analysis in general.

Situating the Project in Medical Education in India

Since the 1990s, medical colleges have been proliferating in India, particularly in the state of Karnataka where this study was conducted (Nair & Webster, 2010; Sood, 2008; Supe & Burdick, 2006). The increasing trend of specialization in hospital-based and treatment-oriented disciplines tends to serve more elite sections of society located in urban and international locations (Qadeer & Nayar, 2005; Sood, 2008; Supe & Burdick; 2006). As health disparities particularly rural/urban differences in nutrition, maternal mortality, and communicable diseases in the country continue to increase, there is a growing urgency for medical education and practice in India to address the needs of local, particularly marginalized communities (Qadeer & Nayar, 2005).

The above trend of specialization in urban hospital-based clinical disciplines, however, is not new and has been recognized since the 1970s by the World Health Organization (WHO) and the Medical Council of India (MCI), the regulatory body of medical education in India. These national and international health organizations have made oft-repeated calls to "re-orient" medical education to a community-based public health model in order to serve the needs of marginalized communities (Dongre, Deshpande, Gupta & Garg, 2010; Majumder, D'Souza & Rahman, 2004; Supe & Burdick, 2006). While WHO's Reorientation of Medical Education (ROME) was successful in establishing community field visits and internships as integral components of the curriculum in medical colleges in India (WHO, 1991), after nearly forty years of community-based teaching they appear to be tokenistic practices as students tend to prepare for postgraduate examinations in order to study further in specialized fields more

lucrative than PSM (Bansal, 2004; Prinja & Verma, 2006). In sum, despite service learning programs such as field visits and internships, dominant trends of specialization have not been subverted, and medical education continues to be removed from the needs of marginalized communities.

In analyzing this grim picture of medical education in India, I take a cue from Apple (2004) who, almost counter-intuitively, responded to laments about the failure of schools in the US to argue that they, in an odd way, work to reproduce inequalities. In this study, therefore, I ask how community-based pedagogies in medical education might be working to re/produce orientations towards communities from privileged class and gender positionings.

Medical education has historically held promise for upward social mobility that continues to be true in postcolonial India. Middle to upper class Indian men and women as well as European women were grudgingly allowed to enter the largely white and male medical 'fraternity' in colonial India (Harrison, 1994; Hassan, 2011; Kumar, 1998; Forbes, 1994; Lal, 1994). Their participation in medical education, it has been argued, was made possible in part by claiming gendered and/or raced advantages in serving the wretched lives of native women and their communities (Forbes, 2005; Hassan; 2011). Thus, medical education has always been simultaneously associated with upward social mobility and community service. This paradoxical relationship raises questions of whether and how community field visits might be re/producing classed, raced, and gendered orientations towards communities, answers to which will be crucial in understanding why community-based pedagogies have not been able to change dominant

trends in medical education in the past thirty to forty years of their implementation. More importantly, a failure to explore these orientations will serve to perpetuate practices within medical education that at best do not serve the needs of marginalized communities, and worse are harmful to them through the distribution of trivialized and essentialized understandings of their cultural and health practices (Gregg & Saha, 2006; Kumagai & Lypson, 2009; Schiller, 1992; Wear, 2003).

This study, therefore, sought to explore the 'orientations' that community-based teaching practices and programs produced towards the marginalized communities with whom medical colleges worked. Specifically, I sought to understand how the CBTP at one particular medical college mediated particular ways of seeing and understanding certain communities from particular social positionings. Rather than terming such knowledge as 'science', I have found it useful to understand it as science/fictions with the '/' urging us to consider how the knowledge produced is objective, that is, produced from a distance, yet also subjective, that is, from particular social positionings or sociospatial orientations.

My orientations towards the study. In many ways this study can be understood as autoethnographic as in studying medical teachers' and students' orientations towards rural and urban poor communities in India, I examine a social group with whom I share more or less similar social, cultural, symbolic, and economic capital. Although I did not study medicine, I attended a medical college to pursue graduate studies in pharmacology and interacted with undergraduate and postgraduate medical students as peers. I later taught South Asian medical students at medical colleges in India and China. I thus

interacted with medical students and teachers from diverse sociocultural backgrounds and places with different normative understandings around gender propriety. Yet, I can make a tentative generalization that we largely came from the upper to middle-class sections of society in South Asia. Hence, this project says as much about my own subjective formation in medical colleges as it does of my participants' subjectivities.

At a personal level, I belong to an upper caste *Brahmin* Konkani-speaking community from the western coast of India, a community that dispersed from Goa during Portuguese rule to the south in the states of Karnataka and Kerela and to the north in the state of Maharashtra. Despite this dispersal, my ancestors took with them important cultural capital that predisposed them to access and learn the local languages to gain positions in administrative and other services in the Adilshahi kingdom in Karnataka, and later in the colonial government through literacy in the English language (Bourdieu, 1986). Migration became an important practice within my community to build further cultural capital as many families moved from the relatively 'underdeveloped' coastal areas to Bombay, Bangalore, and Madras during the colonial period for education and jobs. Consequently, education and fluency in the dominant working languages constitutes an important source of symbolic capital in my community with most having different levels of fluency in Hindi, Marathi, Kannada, and English in addition to Konkani depending on the particular regions they grew up in and their schooling. English education has thus been important within my family for at least three generations with my grandmother and her sister being teachers in Montessori schools in Bombay.

It is not surprising therefore that I too was educated in an English-medium school with Hindi, the national language as my second language, and have moved in social circles where English was often the dominant medium of communication in addition to Hindi, Marathi and Kannada. My interactions with rurality have been through annual visits to 'native' places in Goa and coastal Karnataka, and most significantly through Hindi, Marathi, and Kannada cinema, although I have interacted with migrant youth who have come from rural places for domestic work in my home or other kinds of work.

My interactions with the urban poor have largely been transactional. I do not remember 'noticing' urban slums in my everyday life having being sensitized perhaps to ignoring their presence. Rather, my knowledge of urban slum life is largely informed by Hindi cinema which Nandy (1998) has characterized as a "slum's eye view of politics." Middle-class conversations about the rural and urban poor have been another source of knowledge, and have significantly shaped my naturalized assumptions about them. Hence, this study is shaped by how conversations about the rural and urban poor in the context of a community-based learning program strike *me* as familiar or surprising based on the discourses I have encountered in my life largely through popular culture and middle-class conversations. Below, I briefly preview the academic discourses I have engaged with that inform the framing of this study.

Theoretical Framework

Drawing from critical, feminist, and postcolonial scholars from a variety of disciplines, I use the term 'science/fictions' to play with the multiple meanings of the words 'science' and 'fiction', and to explore the relationships between them. I attempt to

disrupt the oppositional relationship between ‘science’ and ‘fiction’ by understanding the scientific curriculum as cultural texts, or discourses, produced by particular groups of people. In its Foucauldian usage, discourse can be understood as a set of statements produced by and circulated within social groups that frames the way that they think and act (Mills, 2004). Inspired by Said’s work on orientalism where he has suggested that knowledge about the ‘Orient’ is a “created body of theory and practice” and “not an inert fact of nature” (1978, p. 4), the scientific curriculum can be also understood as fiction, not in the sense of being false, but in the sense of being a product of creative work shaped as much by the producers’ experiences as by their imaginations of, and sociospatial orientations or relations towards particular people and places. Donna Haraway (1989) has suggested that the opposition of ‘fact’ and ‘fiction’ is an incorrect one as both are accounts of human action that depend upon direct experiences, testimonies, and interrogations. Whereas ‘facts’ are already proven and therefore separated from the practices that produced them, she suggests that the term ‘fiction’ reminds us that ‘facts’ were fashioned into being through creative and imaginative actions. Thus, by treating the scientific curriculum as fictions or cultural narratives, I explore the traces of the actors who created them, and situate them in the social world (Haraway, 1988). The first body of literature thus challenges the notion of objectivity by looking at how the sociospatial relations between the historical actors involved in the production of public health discourses and their objects of study, that is the communities they sought to understand, describe, and reform, shaped their knowledge about them.

The concept of fiction as mentioned above also stresses upon the very act of creating a narrative. Hence, in the second body of literature I draw from Norris & Jones' (2005) mediated discourse analysis (MDA) to articulate the theory of practice employed in this study. Focusing specifically on community service learning as a pedagogical practice, I conceptualize the 'community' not merely as a site where learning happens but as a cultural space, a 'contact zone' or a pedagogical 'site of engagement' where diverse sociocultural histories of differently situated actors and their social practices converge to open up a window for mediated action to occur (Norris & Jones, 2005; Pratt, 1998). Unlike deterministic theories of social and cultural reproduction in education, this theory of practice highlights that the unpredictability of actors' performative actions and interactions in specific moments of time and points in space can create possibilities where naturalized assumptions embedded within dominant discourses can be reinforced or disrupted (Bourdieu, 1990; Fabian, 2001). Here, the term 'science/fiction' is used to consider how students and teachers deploy scientific ideas and technologies as cultural tools in their encounters with local places and people.

In the third body of literature, I look at how the complex relationships between universities and the political economy have historically shaped the organization of knowledge into separate disciplinary domains as well as the separation of the sciences from the social sciences and the humanities. Here, the term 'science/fictions' is a reminder that the separation of the realm of science from the realm of fiction is a naturalized effect of institutionalized power (Yanagisako & Delaney, 1995). Particular disciplines have had stronger influences over others in shaping development discourses

so that although most disciplines and interdisciplinary fields have global connections they tend to travel along the lines of separation naturalized in the Western academy (Appadurai, 2000; Cooper & Packard, 1997; Tsing, 2005; Lal, 2008; Parker et al., 2012). However, universities are also embedded within civil society (Lal, 2008). The emergence of new interdisciplinary fields such as women's studies, postcolonial studies, environmental studies and others have reconstituted the relationships of universities with civil society (Parker et al., 2012). Drawing from Nancy Fraser's (1989; 1990) understanding of civil society or the public sphere, universities and even specific disciplines could be understood as constituted by multiple publics, that is, discursive spaces with differential relationships with the state and the market, and counterpublics which are marginal discursive spaces articulating oppositional interpretations to discourses produced by dominant public(s). Thus, from a social justice perspective, it would be crucial to look not only at how disciplines engage with local communities as counterpublics but also with academic counterpublics such as women's studies, cultural studies, and others employing post-foundational epistemological perspectives.

The overarching research questions I ask in this study therefore, are: What 'science/fictions' about rural and urban poor communities did a community-based teaching program (CBTP) in PSM at a medical college in Bangalore, India produce. And how were these science/fictions shaped by globally produced development discourses on the one hand, and the situated knowledges of PSM teachers and students about these communities on the other? More specific heuristic questions guiding the study include:

1. How did these ‘science/fictions’ mediate medical students’ performative actions and interactions with the residents living in an urban slum and a village?
2. How did these communities constitute counterpublics or alternative pedagogical sites of engagement to disrupt these science/fictions?
3. How was knowledge produced through encounters with communities used to renarrativize universalizing science/fictions?

Methodology

This study is a single-sited case study informed by critical ethnographic and critical discourse analysis approaches. The ethnographic site was a medical college in the state of Karnataka, a region where there has been a rapid proliferation of medical colleges in the last two decades (Sood, 2008). The medical college that I chose for this study claimed to be one among five colleges in India to have a well-established community-based teaching program (CBTP) in the country. I was in the ‘field’ for a period of six months from December 2012 to June 2013 during which time I observed the program that lasted for about three weeks during the months of December 2012 and January 2013, interacted with post-graduate students in the PSM department, and interviewed PSM teachers and medical students all of whom participated in the program in different capacities. My primary participants were six PSM educators: three males and females each, and eleven undergraduate medical students from different sociocultural backgrounds and spatial locations to understand their experiences and interpretations of the pedagogical activities in the CBTP.

This ethnographic study was motivated by a desire to study "up", that is the powerful (Nader, 1969; Demerath, 2009; Ortner, 2010), and "sideways", that is, to study those in different cultural domains but with whom I share more or less similar cultural and material resources (Ortner, 2010; Yanagasiko & Delaney, 1995). By studying up and sideways, I wished to problematize that which is familiar, naturalized, and sacred as effects of power.

Data sources included field notes and reflexive memos from observations of the CBTP for 3 weeks, interview transcripts from audio-recordings of two rounds of interviews with PSM educators and one round of interviews with medical students, and curricular texts such as the standardized textbook followed nationwide, the CBTP manual, and other information sheets created by PSM educators for the conduct of the CBTP that year.

Data analysis included coding procedures to develop themes across the data as well as discourse analytic strategies to situate these themes within a historical and discursive context (Fairclough, 2001; Gee, 2011; Norris & Jones, 2005). I used critical discourse analysis of curricular texts and micro-level interactions during the CBTP to relate local understandings to global discourses as they travel in time as well as across levels of the local, national, and international (Tsing, 2005; Vavrus & Bartlett, 2006). I also paid attention to statements that were extremely familiar to me, seemed natural and obvious or where claims to the "real" were made, and to ethnographic surprises, contradictions, and crises where naturalized assumptions were being challenged. These strategies enabled me to situate local understandings within particular cultural

backgrounds which I shared with my participants as well as to explore how they might be appropriating global discourses in creative ways (Sutton & Levinson, 2001).

Organization of the dissertation. The dissertation is organized into seven chapters including this introduction. In chapter two, I discuss the theoretical framework informing this study. I have attempted to retain to a large extent the content and organization in this chapter as I had written it prior to data collection in order to give a sense of how the findings were shaped by the initial frameworks I began with. However, I have revised it in order to shed those elements from the chapter that were related to goals that I did not eventually pursue. Hence, I have sought to maintain a balance between providing a sense of temporal change in understanding, and in constructing coherence in the overall story for better readability and intelligibility. I have done this by reframing the chapter from one focused on exploring the 'orientations' produced in public health and community-based pedagogies towards marginalized communities, in general, to one where the connections of concepts such as 'science/fiction' and 'site of engagement' that drive my research questions are made more explicit. I include the research questions as of November 2012 in the appendices as a way for readers to compare the shift in my thinking and framing of the dissertation.

In chapter three, I elaborate upon the connections between my goals, the theoretical framework, and the methodology I used to answer my research questions. I both describe and justify the use of particular methods and strategies to collect and analyze data. This chapter thus informs the reader of the choices I made in the construction of the findings.

The findings of this study are organized in chapters four, five, and six. In chapter four, drawing primarily from curricular texts and observations of the CBTP, I show how pedagogical activities tended to stage the government and scientific technology as central actors in making healthy places and bodies that implicitly positioned PSM teachers and students as agents of change and progress while characterizing marginalized communities whom they served as non-agentic or deviant. I also show how these pedagogical activities were informed by dominant discourses of modernization and neoliberalism embedded in the PSM curriculum. As mentioned earlier, I have termed these globally produced discourses of development as "science/fictions".

In chapter five, drawing primarily from observations of the CBTP but also from interviews with medical students and PSM educators, I discuss how the 'community' constituted an alternative pedagogical 'site of engagement' as compared to the classroom and the hospital where medical students' imaginations of urban and rural poor informed by the PSM curriculum, popular culture, and their place-based knowledge came into contact with the sociocultural resources of the men and women living in a rural and an urban slum community. Although these encounters created certain frictional moments where dominant science/fictions were destabilized, if only temporarily, the voices of community members and their place-based knowledge were either interpreted to fit in with dominant science/fictions, dismissed, or not taken up for further public dialogue and debate pedagogically in large part because institutional structures of assessment tended to privilege curricular texts.

In chapter six, I discuss my encounters with PSM teachers- the primary participants of this study- where I shared my early interpretations of the CBTP with them using interview data with PSM teachers. I illustrate how my theorizations changed through these encounters as well as provide their clarifications and justifications around why they designed pedagogical activities in the ways that they did. This chapter illustrates the contextual challenges that they faced and will possibly continue to face that provide insight into their pedagogical choices.

In the seventh chapter, I discuss the implications of these findings to practice and policy that I preview briefly below.

Significance of the Study

Community service learning as a pedagogy in higher educational contexts has increasingly been gaining popularity for the opportunities it provides students for learning experientially (Cashman & Seifer, 2008; Furco, 1996), to develop intercultural sensitivity in a multicultural society (Boyle-Baise, 2006; Rhoads, 1998), and to enact their social responsibilities as citizens towards marginalized communities (Kahne & Sporte, 2008; Rhoads, 1998). Service learning pedagogies also allow universities including medical educational institutions to combine their goals of enhancing teaching/learning for students while performing their social justice goals of community development (Bringle & Hatcher, 2000; Seifer, 1998). Most studies on service learning have tended to focus on the effectiveness of service learning pedagogies in achieving pre-determined skills without an interrogation of the kind of knowledge produced through these processes (Butin, 2003). This study contributes to education through an

interrogation of the 'community' as not merely a site that fosters experiential learning, multicultural and/or citizenship education but as a cultural space implicated in the production of class and gender orientations towards communities.

Although some scholars have begun to reflect upon the cultural politics of service learning by problematizing the power relations between universities and communities and the knowledge produced thereof (Boyle-Baise, 2006; Butin, 2003; Coogan, 2005; Himley, 2004; Kahne & Westheimer, 1998), much of their research has been limited to the social sciences and the humanities within western contexts. This study, however, goes beyond 'filling a gap' in the geographical or disciplinary terrain. Rather, it suggests that disciplinary and geographical contexts profoundly shape service learning pedagogies not only in terms of teaching practices but also in terms of the discipline's social relations with communities, and the knowledge produced thereof. For instance, PSM educators' understandings of marginalized communities have an institutional and discursive history specific to public health and development in India which influences their teaching practices. Indeed, it is debatable whether such community-based educational programs could be referred to as service learning programs as recognized in the U.S. context. Nevertheless, using the term 'service learning' to describe the CBTP highlights how national and disciplinary contexts shape HEI-community engagements desirous of including elements of student learning and community service (or community development, as the case may be in developing countries), and calls for transnational understandings of service learning programs. A transnational and transdisciplinary approach illustrates how the internationalization of disciplinary knowledge and practices

has moved along global vectors to shape in particular ways the local, regional, and national policyscapes as well as landscapes in postcolonial India (Appadurai, 1990; Carney, 2009; Tsing, 2005).

While these insights will be most relevant to medical education in geographical contexts that have similar postcolonial histories, medical educators in countries such as the US advocating for more critical socio-cultural understandings of internal health disparities will also find the study's findings useful at an epistemological and methodological level. The study will also be meaningful for other helping professions and development organizations in enabling them to critically reflect upon their practices in light of the historical relations they have built with communities.

Finally, this study is crucial as it examines dominant sites of cultural production such as medical educational institutions. The knowledge produced in these sites has powerful effects in shaping the cultural imagination of a society, particularly since it makes scientific truth claims of objectivity. At the same time, the findings of this study hopes to harness the force of imagination in arguing for new ways to reconstitute medical institutions' relationships with international civil society through research and pedagogy where they engage with critical, postcolonial and feminist perspectives in the social sciences and humanities as well as with local rural and urban poor communities (Appadurai, 2000). Such engagements with counterpublics will be necessary steps in democratizing public health discourses and transforming practice.

Limitations and Scope of the Study

This study was largely exploratory in nature. While it has raised certain important questions and areas for further inquiry, it must also be kept in mind that the story presented in this dissertation is an incomplete one. The purpose of the study and the research questions directed the study to explore the hegemonic persistences and disruptions of historical public health discourses in the curriculum and pedagogy at one site. Consequently, the study does not claim to evaluate the efficacy of the CBTP nor is it meant to be an indictment of the institution, the teachers, or the program itself. As the teacher participants often reminded me, the CBTP that I observed has evolved since it began and will continue to do so as they revise and improvise it. Further, the CBTP is only a small part of the entire undergraduate medical program. Some of the issues raised in this study might very well be addressed in later parts of the undergraduate curriculum that I did not examine. What the study does is to draw attention to certain issues by exploring the particularities of this case. In situating the case in its historical and disciplinary context, I suggest that the issues I have raised may not be limited to the individual case itself, and argue for future empirical studies examining similar phenomena in other contexts.

Although the study could have benefited from exploring the connections between different sites where public health discourses are produced and circulated, it nevertheless contributes to comparative knowledge on medical education as it goes beyond the individual institution, program, and my interlocuters to look at the ways in which the broader historical and discursive context has shaped the specific situations that I examine

(Vavrus & Bartlett, 2006). Hence, the findings could be applicable to the rest of the country and in other contexts, although I leave it to the readers to identify the specific aspects of the study that are comparable and transferable to their contexts (Maxwell, 2005).

Another limitation of the study is that I did not engage with community members' interpretations of the program that could have significantly influenced the kinds of arguments I have made and their strength. This was in part because I sought to confront my own naturalized assumptions about marginalized communities, and compare them with middle-class and scientific understandings. Secondly, my research questions were not focused on specific health issues but looked broadly at how the CBTP, and medical teachers in particular, framed certain health issues and characterized communities in the process. Thus, exploring community perspectives regarding these multitudinous issues would constitute multiple research projects in their own right. What this study achieved, however, was to raise concrete questions regarding these health issues through an engagement with critical and feminist perspectives in the social sciences and humanities to drive future research projects at this site and/or in others.

Similarly, I engaged only to a limited extent with students' consumption of the CBTP and their learning processes. While I did alter the study from its initial focus on the cultural production of science/fictions to include students' interpretations in a limited way, I hope to conduct future studies exploring students' and community members' interpretations of community service learning programs at this site and others.

The broad focus of this study, however, enabled me to identify specific problems in public health teaching such as the production and distribution of deficit understandings of marginalized communities from privileged class perspectives, and conceptualizations of their 'cultures' in static, homogenous, and essentialized ways that either ignore gender differences or understand them from middle-class perspectives. Since I did not engage with the perspectives of different community members myself, I could not juxtapose the findings produced from my method with theirs. This was strategic as I did not wish to confuse the intent of the study which is to understand the epistemological assumptions underlying their methods, and the knowledge produced thereof. As a result, I am able to convincingly argue that direct visual and physical interactions and experiences are no less mediated ways of seeing and knowing marginalized communities than imaginative and textual ways of knowing. What matters, I argue, is an interrogation of the social relations shaping knowledge production.

Clarification of Terms

While I have attempted to define terms as and when they crop up, here I clarify the usage of a couple of terms that I have used prolifically throughout. I use the term preventive and social medicine (PSM) as an institutionalized form of the field of public health in medical colleges in India. PSM teachers are medical doctors who have specialized in PSM or community medicine (CM), terms used interchangeably to describe this discipline in medical colleges in India. I refer to the discipline as public health to refer to the broader history of the discipline rather than institutionalized form of

PSM, although I use the latter to identify teachers. I use medical teachers and PSM teachers interchangeably to refer to the teacher participants in this study.

In this study, I have used the term ‘community’ in its singular form as an analytic rather than a particular group. When I refer to ‘communities’ or ‘local communities’, I refer to social groups who are typically objects of development in developing countries, and when specified, to the social groups with whom PSM teachers interact with in the context of the CBTP.

Chapter II. Framing the Study: Science Studies, Pedagogy, and Development

In this chapter, I discuss the theoretical framework informing this dissertation project. The chapter is organized into three sections exploring three different but related bodies of literature. The first body of literature draws from science studies, development studies, and the history of medicine and public health, particularly in India. In this section, I dwell on the relationship between scientific knowledge and objectivity, and consider how ideologies of governance constitute public health discourses. In the second body of literature, I continue this conversation around objectivity in the context of education. Here, starting from the assumption that curricula are sites of ideological struggle, I explore how mediated discourse analysis offers conceptual strategies to understand the cultural politics that plays out in the classroom. Rather than assuming that the ideological curriculum mediates pedagogical practices and learning in deterministic ways, I consider how scholars of service learning have conceptualized the 'community' as a site of engagement that opens up counterhegemonic possibilities such as by engaging with local communities, and their place-based narratives about their lives. While I focus on pedagogical practices here, in the third body of literature I focus on the relationships between higher educational institutions (HEIs) with the political economy and the civil society in an attempt to situate pedagogical practices and classroom discourses within their larger contexts. However, my goal is to also explore how the internationalization of interdisciplinary fields have been understood as reconstituting disciplinary relationships with civil society in global, national, and local contexts in counterhegemonic ways or not.

To use the metaphor of 'science/fictions', I explore first the ambiguous relationships of development and public health knowledge to science historically followed by a consideration of how the cultural politics of education shapes the production, circulation, and transformation of this knowledge in the micro-level context of the classroom as well as in the macro-level context of globalization of public health knowledge and other disciplines. I conclude this chapter with a reflection on my personal imaginations of the rural and urban poor written in April 2012 in light of the theoretical framework I had constructed prior to my entry into the field.

Historicizing the Production of Science/fictions in Public Health and Development

In this section, I briefly introduce some historical debates within anthropology of science, history and philosophy of science, and science studies that question the relationships of science with nature and culture. Proceeding with the assumption that scientific practices are shaped by sociocultural and historical conditions, and that they produce cultural knowledge, I explore from postcolonial and feminist perspectives how public health has constructed its object – the population or communities it serves, as fixed, homogenous, stable identities based on class, race, and gender differences in relation to modern notions of what it means to be a healthy person.

The purpose of this section is to argue that understanding science, and particularly public health, as a culturally specific way of knowing is crucial to explore the cultural injustices that it might produce through its "social patterns of representation, interpretation, and communication" when applied to understanding certain groups or communities (Fraser, 1996, p. 7). Hence, constructions of classed and gendered health

behaviors manifest as acts of cultural domination, nonrecognition, and/or disrespect (Fraser, 1996). Cultural domination occurs when public health practitioners impose their interpretations upon particular social groups. Nonrecognition occurs when the authoritative representational, communicative, and interpretative practices of the dominant culture, in this case that of medical authorities, render social groups invisible while disrespect occurs when they are routinely described in unflattering ways (Fraser, 1996). Drawing from Said (1978), Linda Tuhiwai Smith (1999) terms such acts as colonizing practices when medical authorities do not reinforce the values, and identities of the communities they work with, exclude their experiences and knowledge while speaking about them in universalizing ways, and/or write untrue or negative and insensitive things about them. Thus, this section critiques the claim that public health discourses and its practices represent the needs of the communities as I suggest that their interpretations and representations of the community have historically been colonizing in nature.

Debates around the nature of science (NOS). Although the field of science studies is new, historians and philosophers of science such as Popper, the logical empiricists of the Vienna circle, Lakatos, Feyeraband, Kuhn, Merton, and others have long debated around the nature of science (NOS), that is, the "epistemology of science, science as a way of knowing, or the values and beliefs inherent to the development of scientific knowledge." (Abd-El-Khalick & Lederman, 2000, p. 666; Kuhn, 1962). Pre-Kuhnian philosophers of science were interested in "developing a normative logical account to justify scientific claims rather than a descriptive account of how science

actually works", and employed an 'internalist' approach to the history of science that excluded the contexts within which scientific practice took place (Abd-El-Khalick & Lederman, 2000, p. 666). While Robert Merton's work was concerned with studying the social structure of science, Kuhn's work marked a shift by looking at the context of discovery, and considering how those factors understood by logical empiricists as irrational or external to science influenced scientific knowledge production (Abd-El-Khalick & Lederman, 2000; Franklin, 1995). Kuhn's externalist approach to the history of science set the stage for the emergence of the Edinburgh school of science studies and the rise of the sociology of scientific knowledge (SSK) in the 1970s that explicitly relativized science as a form of inquiry (Franklin, 1995). Science studies scholars thus began to produce sociological and descriptive accounts of scientific knowledge production, compare them with scientists' discourses around science, and situate scientific practices and discourses within their social and cultural contexts (Franklin, 1995; Abd-El-Khalick & Lederman, 2000; Latour & Woolgar, 1986; Longino, 1990; Shapin, 1996).

Feminist scholars were among the earliest to politicize the "cultures of science" (Franklin, 1995). According to feminist standpoint theorists such as Sandra Harding and Evelyn-Fox Keller, the domain of science and technology, or technoscience, was characterized as a 'masculine' culture as professional practices tended to exclude women implicitly or explicitly (Weber, 2006). Further, since technoscience was associated with 'Big Science', that is, science and technology projects sponsored by powerful institutions such as the government, the military, and transnational corporations that subordinated

and regulated the bodies and lives of women and indigenous people as well as the natural environment, ecofeminists such as Vandana Shiva influenced the essentialist characterization of technoscience as 'Western' and 'masculine' in opposition to 'nature', indigenous and Third World people, and women (Anderson, 2002; Franklin, 1995; Weber, 2006; Robbins, 2012).

Feminist anthropologists of science such as Strathern, Yanagisako, and Delaney have since problematized this separation between 'nature' and 'culture', and the taken-for-granted 'natural' or 'biological' facts in gender and kinship studies (Strathern, 1995; Yanagisako & Delaney, 1995). Strathern, for instance, has argued that Darwin's theory of natural selection was shaped by notions of genealogy in early nineteenth century Britain which was then "read back" to naturalize genealogy so that notions of blood and kinship were cultural 'facts' rather than biological ones (as cited in Franklin, 1995). Haraway and Martin have similarly looked at the constitutive role of metaphor, analogy, and narrative in the formation of scientific facts, again disrupting the binary between nature and culture (Haraway, 1989; Franklin, 1995; Martin, 1991). The naturalization of certain cultural facts, however, established social domains as they became the basis for a host of different practices, especially scientific practices that claimed for itself the domain of the 'natural'. The claiming of the 'natural' by science thus made it a sacred domain that could not be read in relation to other cultural domains (Yanagisako & Delaney, 1995).

With globalization, science studies scholars have extended their focus from ethnographies of the lab to multi-sited ethnography as they look at the embeddedness of local scientific cultures in transnational institutions and discursive networks (Franklin,

1995). Latour's (1995) actor-network theory has been particularly influential in understanding how technologies and practices travel to different places, and how they are translated and stabilized to shape their ecologies, landscapes, and cultures in distinctly local ways while nevertheless being recognizable across different points in the network. However, multi-sited ethnographies have often not made connections between the contours shaped by colonial travels of ideas and technologies with those shaped by contemporary globalization. (Anderson, 2009). Although Latour urged scholars to understand how science traveled in the colonies, his earlier work cast colonial relations in simple forms of dominance and submission, and resembled diffusionist theories of modernization in denying local agency (Anderson, 2009). On the other hand, Sandra Harding's (1998) call to develop a multicultural science, and to include indigenous 'ethnoscience' into Western science challenged the "triumphalism and exceptionalism of modern science." (as cited in Anderson, 2009, p. 393). However, her engagement with postcolonial scholars and their critiques too were notably minimal.

Postcolonial studies of science or postcolonial technoscience, however, can offer an understanding of how categories of the 'natural' and the 'biological' were shaped by colonial contexts of knowledge production, and how they have been stabilized into enduring structures and practices in contemporary contexts as well as how they have been taken up differently by local agents for particular purposes in different geographical and historical contexts. Thus, the 'postcolonial' does not mean the end of colonialism but asks us to understand contemporary social phenomena in the world as effects of European imperialism on former colonies and on their colonizers (Anderson, 2002).

Postcolonial analyses can both reveal and complicate persistent binaries such as "global/local, first-world/third-world, western/indigenous, modern/traditional, developed/underdeveloped, big science/small science," and so on (Anderson, 2002, p. 644). However, these binaries continue to be in operation, particularly in development discourses. Indeed, the exalted position of science and technology, and other technologies of the state employed in colonialism as a modernist project shaped subsequent Cold War discourses on development, particularly theories of modernization (Crewe & Harrison, 1998; Cohn, 1996; Prakash, 1999; Escobar; 1995)

Edward Said's (1978) *Orientalism* is often noted as a starting point in postcolonialism, although Fanon's psychoanalysis of the colonized personality has been been hugely influential as well, most notably in Homi Bhabha's work (Anderson, 2002). Said has drawn from Foucault's notion of discourse to argue that notions of the 'West' and the 'East' are cultural inventions that served to define the European subject in relation to a colonized 'other'. The 'Western' academy thus while apparently producing objective knowledge about the 'Orient' was not only shaped by the colonial context but was also inadvertently complicit in shaping colonial projects. Said's work frames this study most directly as I look at a kind of internal orientalism in terms of how middle-class medical professionals employ colonial categories of difference to construct the rural and urban poor whom they work with. Said's critique of the objectivity of western knowledge becomes especially relevant as I look at knowledge production in the biomedical sciences. Critiques of *Orientalism*, however, are that in asserting the authority of western knowledge, the binary relationships of west/east, and colonizer/colonized are

maintained and essentialized thus reinforcing their power. Bhabha (1984) and Spivak (1988) have extended Said's work and addressed this binary relationship. While Bhabha has suggested that the colonizer/colonized relationship is characterized by ambivalence and hybridity, Spivak has argued that an academic focus on the hegemony of colonial discourses inadvertently contributes to an epistemic violence by failing to retrieve subaltern voices and alternative local knowledges that continue to persist. The term science/fictions is useful in exploring how hybrid knowledge is produced about communities through encounters with them.

Thus, employing postcolonial perspectives, I attempt to historicize public health in the rest of this section in order to understand how discursive meanings of the 'community' came about as part of specific historical formations in Enlightenment Britain and colonial India, and how they have travelled over time and space, not necessarily without disruptions in meaning, but in ways that continue to linger in the consciousness of PSM teachers in India.

Population health and the strength of the state. According to the political philosophy of mercantilism that prevailed until the late eighteenth century in Europe, a large population was perceived as wealthy and therefore, as a measure of the strength of the state (Foucault, 1978; Porter, 1999). This philosophy fuelled imperialistic goals of discovering new areas for more wealth both in terms of material resources and in terms of new populations to be conquered (Peet & Hartwick, 2009). Reverend Thomas Malthus, an English cleric, however, proposed that food supply would never be able to keep up with increasing birth rates and that death due to epidemics, poverty, and starvation would

always limit the rise in population sizes (Porter, 1999; Simon-Kumar, 2007). These statements had profound implications for the rise of fields of knowledge such as public health, demography, and population sciences in the nineteenth century as the measurement of birth rates and death rates and other statistical measurements became important ideological tools for the measurement of the health and sizes of populations (Ahluwalia, 2008; Porter, 1999; Robbins, 2012).

The study of health and disease was perceived as indicative of the state of society. Biological concepts of the normal and pathological were extended to understanding the state of the society where 'normal' denoted both a generality, and an ideal or prescriptive state (Canguilhem, 1989; Porter, 1999). Social statistics made it possible to study social pathologies and allowed for the scientific management of society by determining the pathological in terms of its deviation from the normal (Porter, 1999). This evaluative notion of the 'normal' however, tended to reflect the cultural and gendered values of the upper and middle classes so that the lives of working class populations were de facto deemed pathological. Public health practices have played a crucial role in the discursive construction of deviant health behaviors as features of class, race, and gender differences, which I elaborate upon below.

Public health and the social control of the poor in Britain. Industrialization in nineteenth century Britain had resulted in massive migrations of people to urban areas for work that had led to overcrowding in the city, accumulating waste and filth, and poor housing making living conditions for the poor particularly unhealthy. The poor became easy targets for epidemics such as typhus and cholera (Porter, 1999). Edwin Chadwick

introduced the principle of 'less eligibility' in the New Poor Law of 1834 (Porter, 1999; Stallybrass & White, 1986). This principle, derived from Benthamite notions of keeping the poor in a place where they could be monitored and surveyed, ensured that the conditions for the workhouses for the poor were worse than the lowest job offered outside to discourage the poor, especially the able-bodied ones, from using this option (Porter, 1999). In addition, Chadwick's 'sanitary idea' of 1842, generally thought of as separate from the poor laws, coincided with the principle of less eligibility as he perceived poverty to be an effect of disease rather than as a predisposing factor, and that filth as the only cause of disease (Porter, 1999). Thus, the removal of filth became the single-minded focus of public health measures, and not necessarily the improvement of the living conditions of the poor (Porter, 1999; Stallybrass & White, 1986). Thus, political and economic considerations intertwined with sanitary reforms and legitimated an increasingly interventionist, bureaucratic state.

Public health in Britain and the constitution of the bourgeois subject. Literary theorists such as Stallybrass and White (1986) and Gilbert (2004) suggest that public health reforms did more than just facilitate state practices of social control. Drawing from Bakhtin and Kristeva, Stallybrass and White suggest that reforms also discursively mapped the social order on the bourgeois body and constructed it as an antithesis of the grotesque body represented by the poor. The poor became objects of fear and disgust but this disgust was inseparable from refinement as "it designated the 'depraved' domain of the poor, while it simultaneously established the purified domain of the bourgeoisie" (Stallybrass & White, 1986, p. 140). Chadwick's law ensured the spatial distancing of

the poor by housing them separately from the respectable classes but simultaneously rendered their invisibility visible so that they could be under the constant surveillance by central authorities and under the benign, reforming gaze of the bourgeoisie (Foucault, 1979; Stallybrass & White, 1986).

As urban topography got mapped out based on principles of cleanliness to separate the slum from the suburb, the bourgeois nevertheless were forced to encounter the underclasses in public spaces, such as roads, markets, and railway stations (Stallybrass & White, 1986; Gilbert, 2004). The regulation of the lower classes in geographical space also resulted in the regulation of the bourgeois body. The fear of encountering unhealthy bodies of the poor in public spaces was encoded in terms of the fear of being touched (Stallybrass & White, 1986). Thus, along with quarantining, theories of contagion and contamination ensured the regulation of touch that enabled the distancing of the bourgeois from the poor. Similarly, smell was also used as an agent of class differentiation and a sign of civility. Later, with bacteriological advances, the morbidity of stenches got replaced by a theory of germs and the dire consequences of filth derived from direct physical contact rather than through smell from a distance, although the discursive meanings associated with smell were not necessarily lost (Anderson, 2006). Thus, these practices of public health came into being to constrain the 'revolting' poor, revolting in the sense of rioting in masses against the rich but also in the sense of producing disgust in the bourgeois subject.

Amongst the poor, the prostitutes and the nomads had particular important functions in constructing the bourgeois subject. While the poor classes in general were

perceived to be immoral and depraved, the prostitute was a particular source of contamination, both moral and as carriers of venereal disease, because they could penetrate and pollute the bourgeois bedroom (Stallybrass & White, 1986). Similarly, the wandering nomad became the immoral and unpredictable carrier of diseases as well as the antithesis of the domestic, stable household (Porter, 1999; Stallybrass & White, 1986). Thus, Bakhtin's notion of the grotesque body described as filthy, squalid, smelly, sexually promiscuous, reproducing in multitudes and living in overcrowded spaces is an antithesis of the refined, regulated, and faithfully monogamous bourgeois body that was constructed and legitimated as much by discourses of 'high' culture as it was by 'scientific' notions of public health (Stallybrass & White, 1986). Couched in the language of reform, public health practices facilitated social control of the poor with their consent while also positioning bourgeois reformers as benign rather than as exploiters of the poor. These hegemonic practices purported to remoralize them in the image of the dominant class (Porter, 1999; Stallybrass & White, 1986). In this way, the lower classes became an object of disgust and fascination for the bourgeois as they sought to reform them in their image through education and health practices while simultaneously constructing themselves as representative of a 'higher' culture.

Colonialism and public health in India. Public health policies in Britain did not get implemented in similar and straightforward ways in the colonies (Harrison, 1994). Although policies on sanitary reform and cholera were in dialogue with insular Britain, they followed a different trajectory in India (Gilbert, 2004; Harrison, 1994). Gilbert (2004) suggests that the different historical trajectory of public health in India "embodies

a differential understanding of space between metropole and the colony, a different way of both perceiving and conceiving that space, and therefore of representing it" (p. 141). India was, she suggests, the barbaric double of London, a reservoir of epidemic diseases especially of cholera that had ravaged Europe repeatedly.

Colonial conditions shaped European understandings of the relationship between health, and place. The tropical climate was an influential trope in colonial discourses of health and was characterized as being harsh and unsuitable for the European constitution that made long-term colonization practically and politically unviable (Arnold, 1996; Harrison, 1994; Kumar, 1998). Arnold (1996) suggests that the tropics must be considered a conceptual space rather than a geographical one in the sense that "it was a Western way of defining something culturally and politically alien, as well as environmentally distinctive, from Europe and other parts of the temperate zone" (p. 6). Initial optimistic accounts of travelers referred to the tropics as a paradise and only gradually did the more negative, pestilential and alarming characterization of the tropics emerge (Arnold, 1996). This pessimism was supported by statistical accounts of persistently high mortality rates, particularly among British women and children (Harrison, 1994). The climatological deterministic approach of the late eighteenth century in Britain suggested that being uprooted from their environment that had shaped their frame and character made acclimatization challenging (Arnold, 1996; Harrison, 1994). The assumption that bad climates bred bad character was prevalent although the resistance of certain natives to British political and economic goals also played a role in the negative characterizations of those groups (Harrison, 1994). Later bacteriological

advances facilitated a discursive shift from the construction of native environments such as *bazaars* (markets) as reservoirs of dirt and filth to the construction of the insides of the native body as a reservoir of germs (Anderson, 2006; Harrison, 1994). While statistical and epidemiological methods rendered native practices as deviant, bacteriological methods rendered the germs of the natives visible (Anderson, 2006).

The historical trajectory of public health in India was greatly influenced by the Sepoy Mutiny in 1857 (Harrison, 1994). After the scare of the mutiny, the colonial government was reluctant to use coercive measures such as quarantines and cordon sanitaires based on contagion theories, for both financial and practical reasons of implementation and political ones as they did not want to incite rebellion of the masses (Harrison, 1994; Qadeer & Nayar, 2005). The reluctance to implement maritime quarantine was also because it hampered colonial trade significantly. However, a failure to adopt these practices threatened political relations internationally as well as internally with the native elites demanding appropriate sanitary practices (Harrison, 1994). Thus, the enactment of sanitary practices in India got restricted within the military with little attention paid to the indigenous populations as it was fraught with political dilemmas (Kumar, 1998; Harrison, 1994; Qadeer & Nayar, 2005). Government policies tended toward general sanitary measures rather than specific ones and their enactment was devolved to local and municipal bodies with much of public health work taken up by voluntary organizations.

Public health, race, and the civilizing impulse. Harrison (1994) mentions that sanitary reforms undertaken by missionaries and philanthropists were motivated largely

by ‘the civilizing impulse’, and proselytizing goals. For instance, the Countess of Dufferin fund was founded in 1885 to extend medical relief to Indian women who had not benefited from western medicine. The seclusion norms of upper class Indian women prevented male doctors from examining them. So long as the women remained secluded and followed indigenous practices of hygiene, it was perceived that Indians could not be considered civilized. Thus, public health discourses, irrespective of the mechanisms of social control used (quarantining, policing or popular education), were implicated not only in the construction of the civilized British subject but also of the civilized medical authority, be it an Indian woman or British man, as the antithesis of the uncivilized and ignorant native. As Anderson (2006) suggests, “experiencing hygiene could also be a means of experiencing empire and race” so that the image of the conqueror shifted from the soldier and got transformed into the ‘crusading’ sanitary reformer (p. 2).

Anderson’s (2006) book on tropical medicine and hygiene, and the construction of race in Phillipines makes an important critique of historians of colonial medicine. He suggests that they do not explicitly point out the significance of their analyses beyond the colonial period, so that historians of international health and development begin their narratives after the 1940s and the creation of independent states. For instance, he suggests that David Arnold insightfully asserts that biomedical ideas and practices in 1914 began to shape the identities and relationships of Western-educated Indian middle class with the larger public but limits the significance of his analysis to that time period. Anderson’s aim, therefore, is to trace the continuities between the late-colonial civilizing processes and international development projects. He suggests that the adult Filipino was

constructed by American hygienists as "both a menace and mimic", "half devil and half child", and as "an immature, contaminating type, but also as a potentially reformable one if subject to the right techniques of the body" (p. 4). This is similar to Stallybrass and White's (1986) argument where the underclass was constructed as potentially reformable and hence, an object of fascination, yet also emerged from the disgust that separates them from the bourgeois. Anderson's (2006) study suggests that while the discursive meanings associated with the object of public health may be different, there are continuities in the way it is constructed as an object of fear and disgust that distances it from the public health authority at the same time that it represents an evolutionary form that can be reformed into the image of the dominant. Hence, the object – the community to be served - in public health was constructed on the basis of unequal class relations although the relations between the metropole and the colony were also racialized and gendered in different ways than it was in Britain.

Public health, motherhood, and the nation. Two projects in feminist historiography are important to this study in historicizing public health in India that are different from the works by Harrison (1994) and Arnold (1996) above in that they lay out the discursive terrain of public health rather than focus on formal and institutional historical events. Moreover, they include Indian middle-class feminists as active social actors in this terrain rather than as victims.

Rai (2008) has noted that while nationalist politics opened up spaces for a feminist agenda, it also restricted these agendas. The engagement of anti-colonial struggles with modernity created a vision of the nation that was gendered and set the

terms for development agendas that marginalized women's concerns. However, Ahluwalia (2008) critiques these notions that Indian feminist agendas were appropriated by nationalist ones and suggests that middle-class women entered the public space in a quest for political power as much as they did for women's rights. She suggests that their advocacy was shaped by their elite subject positions rather than through a sustained dialogue with subaltern women so that their feminist agendas excluded the majority of the women. She argues that the notion of women as 'mothers of the nation' were not necessarily constructed by men alone but also by middle class women in their quest for power.

Ahluwalia (2008) notes that the engagement of Indian middle-class feminists with nationalist, eugenicist, and public health discourses in the early 20th century did not occur in isolation within India but were products of their engagement with international feminists like Margaret Sanger, Maria Stopes, and How-Martyn, who also approached the issue of birth-control from an upper class or middle-class perspective. Porter (1999) too has earlier pointed that middle-class feminists in Europe had made arguments for citizenship based on their roles as mothers of imperial children. They mobilized themselves to participate politically in the public space by articulating their specialized knowledge of child-rearing and managing the family economy (Porter, 1999). Middle class women were important in the formation of domestic science as a field and in the administration of social welfare in Britain whereby they could teach 'ignorant' women the scientific practice of managing the household (Hodges, 1999; Porter, 1999). Health

concerns such as maternal and infant mortality were constructed as problems that needed to be addressed for the national good (Hodges, 1999; Porter, 1999).

A combination of bourgeois nationalist, public health, middle-class feminist, and eugenics discourses in the early 20th century shaped the construction of the modern family that facilitated a naturalized understanding of the relationship between reproductive practices and national progress (Ahluwalia, 2008; Hodges, 1999). Using Foucault's notion of governmentality, Hodges (1999) suggests that while the family became an important tool for governance in the modern period in general, in colonial India the conjugal family served not only as a tool but also as a model for governance. This is because the modern family was positioned in opposition to the Indian joint family that was characterized as traditional, timeless and a site of pleasure and affect as well as a sign of degeneration that was inefficient and outmoded in modern times (Hodges, 1999).

The promotion of women's education also relied on and created the conjugal couple as a basic unit of the modern family (Hodges, 1999). Women's education became the site of political engagement for middle-class feminists through the promotion of domestic science. While the mother-in-law was the traditional disciplining force and the person to go to for advice, domestic science claimed to not only teach women hygiene, housewifery, mothercraft, first-aid, home nursing, and eugenics, amongst other skills in a scientific way but also disciplined them to become independent from the joint family (Hodges, 1999). Thus, women's education was important for constructing the new 'Indian' woman who was not only a suitable companion for her husband in a modern family but also an independent mother who was in charge of the scientific and moral

rearing of her children and thereby, an active participant in the national struggle as producers of future nationalists. Hence, public health, nationalist, and feminist discourses intersected and produced the modern family as a norm and prerequisite for development in distinctly bourgeois terms.

The discursive shift in the concept of population. The concept of the population as a national index of wealth in the nineteenth century shifted to 'Third-World' populations as a global threat in the twentieth century. Hodges (1999, 2004) suggests that American-led overpopulation discourse characterized 'Third-World' populations as too large, in its effort to consolidate power in a new world order after WW II. While the population in India was not considered to be a cause of its own decline but rather as an effect of poverty in the 19th and early 20th century, it got reframed as "always already overpopulated" (Hodges, 2004, p. 1162). Overpopulation discourse posited both a problem and a technological solution, the reduction of fertility, simultaneously. This relationship between fertility and 'Third-World' development, however, was not a naturalized assumption but contested amongst eugenicists, birth control advocates, nationalists, and feminists as their rationales for the usage of birth control (or not) varied (Ahluwalia, 2008; Hodges, 1999). Overpopulation discourse, however, became a converging point for discourses that legitimated birth control advocacy, eugenics, women's health, and conjugality as a model for modern family life so that the relationship between fertility and progress became naturalized (Hodges, 2004). More importantly, while these discourses were racialized and gendered, they did not get consolidated without the complicity of bourgeois Indian nationalists and feminists as the

targets of overpopulation discourse were identified by class differences within 'Third-World' populations.

The trope of the 'community' in international development discourses. As the referent of the population shifted from 'Third-World' nations to particular social groups perceived to be a threat to national progress, the trope of the 'community' appears to have populated international development discourses. Liepins (2000), a scholar in rural studies, asserts that the word 'community' has gradually been inserted in discourses that signifies a social space or arena and a set of diverse and changing cultural meanings and practices that has significance for rural people but is not limited to them. Crooke's (2007) review of the term, particularly in the field of public policy, is of relevance as she suggests that "community is not principally about pre-modern, village, or rural-based societies; instead, for many today community is about developing new power relationships and sustainability" (p. 29). However, it is the association of 'communities' with a pre-modern and marginal space that concerns this study. This symbolic association of communities as premodern and developing disrupts the First world/Third world and West/East binaries which tend to locate developed, modern countries in the West and developing, underdeveloped countries in the East.

Within public health, the 'culture' that characterizes a community tends to be constructed in fixed, homogeneous ways that has not yet been integrated into modern society and is treated as an object that can be studied in terms of its *difference* with the dominant culture and accordingly changed (Schiller, 1992). The culture of a community is constructed as an antithesis to modern structures of which medical institutions and the

state government are representatives. Thus, the 'community' as the object of public health can be thought of as a euphemism that carries the various discursive meanings associated with 'low' culture such as the poor, the rural, the native, while avoiding an explicit reference to specific social groups (Fairclough, 2001).

In this section, I have attempted to historicize public health discourses with the goals of questioning assumptions of objectivity around the nature and production of public health discourses. I have also explored how the sociospatial relations between producers of public health discourses, and their object of study, local communities, might shape characterizations of the 'cultures' of marginalized social groups and spaces . In the next section, I look at how critical educators theorize the possibilities that contemporary community-based pedagogies can open up to include voices of diverse communities, disrupt historical discourses, and produce alternative knowledges.

Negotiating Science/fictions: Cultural Politics of Service Learning Pedagogies

While in the previous section I have attempted to historicize public health discourses, and have suggested that the sociospatial relations between public health as a discipline with its communities shapes cultural knowledge about them, in this section I consider how community-based or service learning pedagogies are understood as capable of altering these relationships, and thereby the knowledge produced. I employ concepts from mediated discourse analysis (MDA) to theorize how the 'community' might constitute a pedagogical 'site of engagement' where historical relations, discourses, and practices are negotiated in unpredictable ways to open up both hegemonic and counterhegemonic possibilities (Norris & Jones, 2005). I begin first with a discussion of

concepts in MDA followed by an overview of the different approaches employed in community service learning pedagogies.

MDA as described by Norris and Jones (2005) is concerned with exploring the relationship between discourse and action. While drawing from other approaches such as ethnography of communication, interactional linguistics, conversation analysis, and critical discourse analysis (CDA), MDA differs from them in that it looks at how discourse is a matter of social action through the analytical lens of the action itself in which discourse is one of several tools employed by people. This analytical maneuver broadens the focus from verbal and textual tools to include how "objects, gestures, non-verbal sounds, and built environments" interact in a nexus of social practices involving multiple actors (p. 9). With this brief introduction to MDA, I discuss some of the central concepts that inform this study.

Mediated action. MDA understands action not as a matter of individual agency but as mediated, that is, a "a product of the 'tension' between the agenda of the individual and the mediational means made available in the sociocultural setting and appropriated into the individual's *habitus* as components of social practices" (Norris & Jones, 2005, p. 169). The notion of mediational means insists that all social actions are mediated by cultural tools such as discourses, and practices historically associated with social groups or institutions.

Cultural tools or mediational means. Norris and Jones' (2005) framework of MDA posits that all human actions are carried out through cultural tools which include technical tools, such as objects, as well as psychological tools, such as language, counting

systems, writing, diagrams, schemes, and other signs. All cultural tools are material and psychological in that psychological tools are made material through texts, utterances, practices, and identities, and material tools are integrated into psychological representations of social practices in the user's *habitus* (Norris & Jones, 2005; Voloshinov, 1973). Further, cultural tools are carriers of social structures, histories, and ideologies (Norris & Jones, 2005; Voloshinov, 1973). Hence, public health discourses and related practices using tools such as surveys, and medical interviews, for instance, have been produced historically by various social groups and carry their ideologies with them.

Practice. According to Bourdieu (1990), social practices are actions with a history (as cited in Norris & Jones, 2005). Practice can be understood as a historical accumulation of material experiences within the *habitus*, or socially constituted disposition, of the social actor over a lifetime. As they move within their social worlds, individuals appropriate social practices and the cultural tools embedded within these practices in their *habitus*. However, practices are also mediated actions carried out historically within a particular group of social actors so that individual actions are recognized within the social group as the same practice (Norris & Jones, 2005). This suggests that individual actions are not only socially constructed but that these constructions have been constituted through historical practice recognizable within particular social groups. For example, when an individual doctor asks pertinent personal questions regarding a patient's health behavior over a period of time, it is recognized as the practice of history-taking by other doctors when it is carried out in a prescribed,

ordered, and structured manner with the explicit purpose of identifying the medical problem and making a diagnosis (Fairclough, 2001).

Sites of engagement. Sites of engagement have been defined as "those moments in time and points in space where social practices converge to open a window for mediated action to occur" (Norris & Jones, 2005, p. 141). I understand and employ this concept in ways similar to Pratt's (1998) notion of the 'contact zone', or anthropologists' understanding of 'encounter' (Asad, 1973; Fabian, 2001; Escobar, 1995) as productive, yet also violent moments in time, where the unpredictability of interactions between differently situated actors, their sociocultural histories, and practices can create both hegemonic and counterhegemonic possibilities. Sites of engagement as conceptualized in MDA, however, is particularly useful as it pays attention to the orientations towards time and space that people bring to situations thus facilitating an analysis of built environments, social practices, and the *habitus* of individuals (Norris & Jones, 2005; Voloshinov, 1973).

Agency. When considering moment-by-moment actions, agency is easier to attribute to individuals. However, when actions are situated within larger social practices, identity constructions, and discourses, agency can be understood as "distributed among human actors, mediational means and the various discourses that circulate through them" (Norris & Jones, 2005, p. 170-171). In Bakhtinian terms, the utterances of individuals can be understood as having multiple voices, pointing out the distributed nature of agency in the production of discourses (Fairclough, 2001; Gee, 2011; Norris & Jones, 2005). For example, while one might confer agency and motives to individual PSM educators or

medical students, if one considers the historical nature of practices, their actions can be understood as being distributed to global social actors involved in the production of public health and biomedical discourses since the colonial period (Norris & Jones, 2005). However, the purpose of discussing the ideological bases and hegemonic effects of public health discourses is not to suggest that individuals perform culturally given roles, and enact scripts in deterministic ways, but to point out the limits within which individual actions must be understood.

Interdiscursivity, dialogicality, and performativity. The dialogical nature of discourse enables one to explore how individuals might in practice be engaging with multiple discourses so that their actions are not entirely unconscious, and would be better understood as strategic performances. Although PSM educators' and medical students' experiences and knowledge may be more similar than different owing to their training, and possibly similar class backgrounds that can certainly allow for the distillation of a common culture shared and reproduced in medical education (Qadeer, 2006; Zaidi, 1986), they may have access to other discourses that are specific to their sociocultural histories so that their interpretations of public health discourses may not be identical (Norris & Jones, 2005). Further, these different discourses may not necessarily be compatible with each other, and can be said to be in dialogue, even in confrontation with each other (Fabian, 2001; Fairclough, 2001; Voloshinov, 1973). The dialogical nature of discourse suggests not only the inherently communicative and social aspects of language but also that language is both the site and the stake in ideological debates (Fairclough, 2001). These different discourses and the ideologies embedded within them are

incorporated within the *habitus* of individuals, who may not necessarily have achieved coherence amongst these discourses through an internal dialogue despite their efforts to do so. Instead, their actions may suggest an 'interdiscursivity' or the coexistence of a mix of discourses that may even be contradictory. These instances of interdiscursivity suggest a dialogicality whose exploration can indicate the contested nature of the concept at hand (Norris & Jones, 2005). Interdiscursivity in individuals' utterances in the same and/or different contexts could be understood as instances of learning (Lewis & Ketter, 2004), or as strategic identity-making performances (Butler, 1988).

The above concepts, thus, equip me to look at how teachers' and students' performative actions and interactions in the 'community' as a pedagogical site of engagement disrupt and refashion historically produced dominant discourses. Although medical colleges in India do not term their community-based teaching practices as service learning programs and pedagogies, a term largely used in countries such as the U.S. and the U.K., I look at this literature to understand how scholars of service learning have conceptualized and categorized community service learning practices with the goal of examining the horizons of possibilities that they have created. These approaches also illustrate the cultural politics of service learning thus enabling me to situate the CBTP in this broad and diverse terrain.

Community service learning - multiple conceptualizations. The rubric of service learning in higher education includes a wide variety of service programs. These include programs that emphasize the service component and the served such as volunteer activities and community service as well as those which focus on the learning and the

provider of services such as internships and field-based education (Butin, 2003). Community field visits and internships in medical education belong to the latter category that tend to focus more on the learning than on service and largely from the perspective of the provider and less from the perspective of the served, although calls for 'reorientation' in the medical education curriculum argue for a greater shift in focus to the service component and the served.

Instrumental approaches to service learning. Butin (2003) suggests that technical and cultural approaches to service learning are both instrumental approaches in that the former uses the experience of working in the community as a means to develop technical knowledge of students, while the latter allows students to develop a cultural understanding of the community for personal growth.

Technical approach to service learning. This perspective focuses on the characteristics and components of service learning and its implementation as a technology. Questions of efficacy, quality, efficiency, and sustainability of the process and the outcomes of service learning are privileged (Butin, 2003). From the technical perspective, service learning is shown to enhance students' cognitive outcomes, critical thinking skills apart from other technical skills, personal efficacy and confidence in implementation of skills in actual practice, and the development of social, cultural and moral attitudes. Strategies to improve service learning from this perspective consider the quality of the placement, the frequency and length of contact hours, the perceived impact of the service, and students' exposure to and interaction with individuals and community groups of diverse backgrounds (Butin, 2003).

Three empirical studies in community-based medical education illustrate a technical orientation to service learning. In India, in an evaluation of the 'Reorientation of Medical Education' camp, it was found that students were positive about the camp in terms of their knowledge of primary health care centers and the direct interaction with village-level service providers (Dongre et al., 2010). However, they did not feel equipped to understand the socioeconomic factors determining health and to diagnose health problems in these settings. Thus, in this study the evaluation of the service learning program focused on the knowledge gained by students of health care provision and of 'knowing' the community in technical ways. A quantitative study of a community-based program conducted by Howe and Ives (2001) examined the impact on the career preferences and attitudes of 260 students in their third and fourth years of medical school in Sheffield, United Kingdom after a year's exposure to the community. This study showed that women tended to prefer community-based work while men continued to prefer hospital-based careers. Further, they also suggest that early exposure to the community may alter attitudes towards doctor-patient relationships and community-based work, based on differences in third and fourth year students on these parameters. Thus, in this study, although the focus was less on the learning, the impact of the program on student attitudes was judged by technical criteria, such as time spent in the community, early exposure, and gender.

Another study based in Japan (Okayama & Eiji, 2011) sought to examine the association between community-based learning and students' attitudes towards community health care with the objective of solving the shortage of primary care

physicians in the community, especially in rural areas. The medical educators were trained to carry out 11 learning tasks in different aspects of community health work, and students evaluated these learning activities based on the confidence they gained in doing these activities and on their perception of the learning activities being worthwhile. The authors concluded that improved confidence in these tasks will increase motivation to practice community health care.

A common feature of all of these studies is that the socialization processes within hospitals were assumed to alienate students away from the community. Yet, they did not question the formal content of the curriculum and assumed that by using the community as a different site of learning, students would automatically be socialized in a way that would 'orient' them towards the community. Hence, in these studies the community was a site of experiential learning where the focus remained on the improvement of skills or development of attitudes. Although each of these studies assumed that education must be responsive to community needs, the community tended to take a secondary role with the development of students' skills and attitudes taking precedence.

Cultural perspective on service learning. This approach focuses on the meaning-making of participants within and through the context of the program. From this perspective, service learning is seen as a means to know more about 'ourselves' by engaging with those who are different from us. The diversity of the site is therefore crucial for students to understand, respect, and engage with a culturally diverse society. Service learning is also perceived to mediate between individual self-knowledge and societal responsibility (Butin, 2003). Hence, technical and cultural perspectives in service

learning are often linked together with a focus on both academic and civic learning. DeJaeghere (2009) suggests, however, that intercultural experiential learning should go beyond learning about the 'other' or respecting 'others' for the purposes of personal growth. Rather, such experiential learning requires a deeper understanding of the different values, beliefs, and constructions of meaning in different social and cultural groups and local engagement with the purpose of creating justice for those with whom we live.

A study in Vietnam from a cultural perspective evaluated a program that aimed to increase collaboration between the university and local communities (Hoat & Wright, 2008). The program aimed to develop students' ability to integrate their theoretical knowledge in practical situations by learning about the doctor-patient relationship, decision-making processes, and the changing health care environment in real life contexts as well as to involve the perspectives of community members and local health staff in health care practices (Hoat & Wright, 2008). The evaluation included interviews of students, community members, and local health staff to learn about their different perspectives on the program. The findings suggested that the program enhanced the motivation of health care staff through their involvement in the training of future doctors while allowing them to upgrade their own knowledge and skills. Students felt that they understood more about rural life and communities and learned from the experiences of local health staff. The community members felt that the students' behavior towards them was respectful and improved from previous encounters and appreciated the contributions of teachers, students, and local health staff in the improvement of health care in the

community. Thus, this study indicated not only improved civic engagement on the part of students but also the development of a sustainable partnership between the institution and the community. DeJaeghere (2009) has argued from a critical perspective on civic engagement that evaluations of experiential learning need to examine specifically how students' intercultural understanding and engagement is enhanced or not and is "grounded in a purpose of creating justice", rather than merely learning about or respecting "others" for personal growth (p. 230). Thus, while Hoat and Wright show enhanced knowledge on the part of the students and an engagement that was valued by the community, the questions asked in the study were limited to the sharing of knowledge, skills, and attitudes between the university and the community and did not explore the depth of understanding gained by students regarding the cultural values, beliefs, and meanings in the community related to health care.

Critical approaches to service learning. From a political or critical perspective, service learning as a pedagogical innovation is examined and challenged on normative, ethical, epistemological, and ontological grounds (Butin, 2003). Rather than thinking of communities as resources that students can exploit for personal growth and enhanced learning, scholars argue that community service learning programs must be driven by the needs of the community as they see them (Coogan, 2005; Welch, 2002). Service learning from this perspective is potentially transformative to the extent that it aims to disrupt the authoritative and hierarchical structures within service learning towards more democratic and collaborative ventures between students and teachers where knowledge is co-constructed through mutual understanding (Butin, 2003).

Scholars using critical approaches often fluctuate between offering pessimistic accounts and cautiously optimistic recommendations regarding the possibilities of social change through service learning. MDA is a useful approach to examine service learning from critical approaches as it requires the researcher to be open to the unpredictability of encounters between differently situated actors while being cognizant of theoretical understandings of power relations between these actors. Hence, I consider below the issues raised by critical scholars regarding the limits and possibilities of service learning while noting that service learning encounters are too complex to be predicted through theoretical deliberation, and doing so would undermine the agency of the different participants, particularly of communities, in shaping these encounters,.

Problematizing the social justice claims of service learning. Although service learning can be potentially transformative, a critical perspective examines the foundations of service learning and is skeptical of its progressive and ameliorative assumptions. For instance, Boyle-Baise (2006) conducted an interpretive case study of a community service learning program which aimed to understand how prospective teachers of multicultural education developed a critical stance towards equality. She found that while teachers had developed greater understandings of cultural diversity and equality, some of them also shifted the blame from the 'deficient' youth to 'poor' parenting. Further, while the program increased the tolerance of pre-service teachers to work with youth from culturally diverse backgrounds or those living in poverty, it did not foster a structural critique of the situations in which they lived (Boyle-Baise, 2006). Hence, a critical perspective suggests that there is not only limited empirical evidence on the substantive,

meaningful, and long-term solutions for the communities that it claims to help but that these programs may actually be perpetuating and reinforcing dominant deficit perspectives of 'others' (Apple, 2004; Boyle-Baise, 2006; Butin, 2003). Rather than overcoming community and university boundaries, service learning becomes yet another means to reinforce the superior position of the university as a benefactor with knowledge, expertise, and resources in the guise of benevolent volunteerism (Butin, 2003; Himley, 2004).

Problematizing the nature of service learning based on charity. Scholars within this approach to service learning have questioned the nature of the relationship between those serving and those served and argued for service learning to be grounded in an ethic of social justice rather than charity (Himley, 2004; Kahne & Westheimer, 1998). Service learning based on charity socializes students into valuing altruism, volunteerism and compassion for the less fortunate and stresses the importance of civic duty and the need to be socially responsive citizens. Scholars have pointed out that service has roots in the volunteerism of white middle and upper class women in the US, UK, as well as in India where volunteers sought to improve the material and moral lives of the less fortunate (Himley, 2004). These volunteers attempted to "re-script" the lives of the less fortunate within discourses and values from upper or middle class perspectives that were also raced and gendered (p. 420). Through service projects, these women expanded their political participation in the public sphere and were able to construct themselves as citizens contributing to the growth of the nation. Service learning, thus, reinforces conservative

assumptions that caring individuals can overcome societal problems and frames solutions from the providers' perspectives, which are invariably assimilationist in nature.

Reframing service learning. In considering these critiques, some scholars insist on reframing service learning from a pedagogical innovation to social praxis or movement-building where they seek to politicize community needs rather than institutionalize them by problematizing the relationship between HEIs and communities (Coogan, 2005; Cushman, 2002; Swords & Kiely, 2010; Welch; 2002). Thus, a social justice approach would pay attention to the ideological underpinnings of institutional discourses and the power relations that shape the interactions between educators and students with local communities. This calls for a shift in the focus of reflection from self-discovery, student learning and student identity development to examining how relations of power, ideology, institutional arrangement, and social structures influence the understanding of social problems in the community and collective problem solving (Swords & Kiely; 2010).

Kahne and Westheimer (1998), in their earlier work, insisted that pedagogies focused on change rather than charity need to foster critical reflection of social policies and conditions rather than understanding them as given, and the acquisition of skills for political participation amongst students. DeJaeghere (2009) draws from critical pedagogy and critical multicultural education to suggest that a critical citizenship education must involve collaborative mobilization and collective problem solving by groups of people around an issue through democratic processes. Such processes involve reflexive practices where students learn about power, alterity, positionality, ethnocentrism, and deeply-held

assumptions about difference before entering the field (Coogan, 2005; Keene & Colligan, 2004; Swords & Kiely, 2010; Welch, 2002).

Reflexivity as a practice requires an examination of one's privilege, priorities, and positionality in terms of how power is enacted in relationships with community members. Rhoads (1997) has earlier argued that action and reflection are interactive components of liberatory educational practices, and community service is unlikely to foster social change without reflexive practices that challenge students' understanding of social inequities. Instead of thinking of medical educators and students as separate from the communities with whom they work, reflexive practices encourage an examination of the differential impact of social structures on their lives and on the lives of community members (Keene & Colligan, 2004; Rhoads, 1997). A back-and-forth play between insider and outsider perspectives that looks at both connections and separations is a more responsible and responsive construction of mutuality which avoids an exoticization of difference on the one hand, and the dissolution of differences, on the other (Welch, 2002). Assuming mutuality either as a consequence of deep engagements with the community or based on the sharing of a common identity can be particularly insidious as important differences are ignored (Mohanty, 2003; Welch, 2002). Rather, mutuality needs to be forged as part of an ongoing struggle based on common goals, and not on common experiences or identities (Mohanty, 2003). Thus, unlike service learning from a cultural approach, reflexive practices enable a problematization of personal experience, of the experiences of the other, and of cultural difference.

Reflexivity includes an examination of not only communicative and interpretive practices but also representational practices. Fabian (1983) suggests that ethnographic writing practices tend to deny the subjectivities and coevalness of their participants. Coevalness occurs when participants are recognized as contemporaneous with the researcher and not characterized as belonging to a pre-modern or an older evolutionary stage in time. Although anthropologists engage with participants in the field in ways that do not objectify them, they use the 'ethnographic present' in their descriptions and interpretations of the community that essentializes communities and represents them as homogenous and unchanging. These writing practices which fail to acknowledge the heterogeneity of 'third-world' populations, are acts of colonization, as discursive representations of the 'other' in essentializing and disparaging ways have material consequences that are exploitative in nature (Mohanty, 2003; Tuhiwai Smith, 1999). These discursive representations are legitimized by educational institutions or dominant social groups as objective knowledge about the 'other.' The concept of coevalness, therefore, has implications for me as a researcher as well, in the way that I write about these educators and represent their interpretations of communities.

In this section, I have looked at the potential of community-based pedagogies such as service learning in producing counter-hegemonic possibilities, and considered how encounters between students, teachers, and communities may or may not democratize processes of knowledge production. In the next section, I shift my focus from the pedagogical interactions and performances to explore how interdisciplinarity has traveled globally to shape dialogue across disciplines, reconstitute relationships with

international civil society, and alter the development landscape in different local contexts. This analytical movement enables me to address my third subquestion around how local, place-based knowledge produced through pedagogical interactions with communities is engaged with to renarrativize dominant knowledge forms or science/fictions.

Reconstituting Disciplines, Science/fictions, Publics and Counterpublics

In this section, I argue that while science/fictions in different disciplines have travelled globally as universals so have institutional divisions that maintain science and culture as separate domains, each having differential relationships with the political economy and civil society. Interdisciplinary dialogues across these domains would therefore be necessary to reconstitute disciplinary relationships with communities, and the science/fictions they produce. This raises questions around how interdisciplinarity as a phenomenon has been internationalized, and thereby differentially reconstituted HEIs, their relationships with the state, markets, and civil society in different contexts, and the development ideoscapes and policyscapes in those contexts (Appadurai, 1990; Carney, 2009).

Higher education institutions (HEIs): Their publics and counterpublics.

Nancy Fraser (1990) extended Habermas' concept of the public sphere to understand the civil society as constituted of multiple publics and counterpublics with differential linkages with the state and markets. She defines the public sphere as "a theater in modern societies in which political participation is enacted through the medium of talk. It is the space in which citizens deliberate about common affairs, hence an institutionalized arena of discursive interaction" (p. 57). The public sphere, thus, can be thought of as a

discursive space that mediates between civil society and the state. Hence, civil society organizations constitute, in part, the public sphere. I say 'in part' because Fraser (1990) argues that the public sphere conceptualized in the singular tends to represent a bourgeois masculinist space that excludes subordinated groups like minorities, working classes, and women from all classes. She suggests, instead, that the public sphere must be thought of as multiple publics whose different positionings in relation to the state and the market shape the dominant nature of these discursive spaces. Subaltern counterpublics are discursive spaces for marginalized social groups where oppositional interpretations of their identities, needs, and interests are articulated in relation to the dominant public(s) and serve as a base for politicizing these discourses through their dissemination into wider arenas (Fraser, 1990).

HEIs can be thought of as one dominant public where discourses around the needs and interests of communities are articulated and disseminated as knowledge. However, different ideological positions exist within higher educational institutions as well. Each discipline constitutes a public while being constituted in the tensions among its multiple publics. In the case of medical educational institutions for example, while biomedical discourses have greater currency by virtue of their ideological consensus and connections with the medical industry globally, public health discourses offer oppositional interpretations of health and illness by broadening the focus from the body to the social and environmental contexts within which people live (Krieger, 1998; 2000; Qadeer & Nayar, 2005). The departments of community medicine within private medical colleges, thus, occupy a unique position in the public sphere in that while having direct interactions

with local communities and claiming to serve their health needs, they are located within institutions that strive to produce knowledge and knowledge products relevant to the global economy as well as seek to train students to implement national development schemes according to state stipulations. Thus, these departments are sites where discourses articulating community needs, interests, and identities are shaped as much by the political economy as by 'expert' disciplinary knowledge.

Discourses that claim to articulate community needs and provide solutions, however, are shaped by the power relations between multiple publics as I have illustrated earlier in the case of public health (Fraser, 1989). Fraser has argued that the satisfaction of needs within development or welfare activities has tended to focus on the assessment of needs, the formulation of solutions, and their implementation ignoring an important intermediate step involving the interpretation of politicized needs by social actors in the public arena, particularly those who have the power to enforce implementation. She suggests that politicized needs get framed by 'expert' social science discourses of specialized publics before they become objects of potential state intervention (Fraser, 1989). For instance, expert-need discourses include development discourses in NGOs, disciplinary discourses within HEIs and journals, legal discourses with judicial institutions, administrative discourses in agencies of state institutions, and therapeutic discourses in medical and public health institutions (Fraser, 1989). Expert-needs discourses, however, often make appeals to scientific knowledge and universalism even though they are produced in specific local contexts. They travel beyond their sites of production to engage with local contexts in different places on the basis of the

universalism they espouse and seek. Expert-needs discourses in different disciplines and fields of knowledge can therefore be understood as universals or universalizing science/fictions (Tsing, 2005).

The formation and universalization of disciplines. Tsing's (2005) concept of 'engaged universals' elegantly articulates the contradiction that claims to the 'universal' made by scientists, social justice advocates, and activists need to engage with the 'particular' in order to become universal. She further suggests that friction is inevitable when 'universals' or globally travelling knowledge encounter cultural difference in 'local' spaces just as say, between two sticks in producing sparks, or when the rubber meets the road to produce motion. It is this friction, she asserts, that makes global power effective since only through the encounter of universalist discourses with local cultural difference that it gets the necessary "grip" to be taken up within local contexts. At the same time, it is this friction that belies the notion that global power operates smoothly like a "well-oiled machine". Yes, friction can be the "fly in the elephant's nose" but it cannot be understood as a "synonym of resistance", she says, because "hegemony is made as well as unmade with friction" (p. 6). The occurrence of friction, therefore, could be a point of entry into understanding the power relations between different groups, how interventions and schemes are interpreted by them differently, and how winning and losing happens contingently and differentially in such encounters. I employ this concept as I discuss below the historical formation and universalization of disciplines.

Disciplinarity, interdisciplinarity, and development - hegemonic publics. Postcolonial studies have asserted that colonial relations shaped knowledge production in

different disciplines. Tsing's (2005) concept of friction would ask us to look at how those forms of knowledge were universalized differently through an engagement with the particularities of different contexts. Cohn's (1996) work on the different forms of colonial knowledge suggests that the development of investigative modalities such as enumeration, surveys, museology, observation/travel, historiography and others that have become established research methodologies within various disciplines today occurred in engagement with local people and their specialized knowledge. For instance, he describes how in order to establish control over India, the colonial state sought texts- grammars, dictionaries, and teaching aids- to help them learn languages that led to the objectification of vernacular languages and their systematic study. Their engagement with local philologists made it possible for them to convert an Indian form of knowledge to a European one. Thus, Cohn shows how apparently 'European' forms of knowledge came to be through an engagement with native interlocuters and their knowledge systems. The knowledge produced, however, was shaped by colonial power relations, as was the naming of that knowledge and its universalization in different parts of the world. While Cohn's influential account suggests a violent appropriation of local knowledge, Prakash (1999) stressed the frustrations that colonizers faced in universalizing science. He describes how scientists and museum curators during the colonial period, in their attempts to universalize science, had to engage with native Indian elites and the poor, and include them in the new category of 'humans' claiming a shared biology. Although colonizers distanced themselves from the colonized using racial categorizations, again on the basis of claimed biological difference, the universalizing categories of 'human' and

'science' opened up an ambivalent space for the colonized elite where they could disrupt the binary relationship between colonizers and the colonized. While the colonized elite's aspirations and practices could be understood as mimicry, that is, like the 'white male colonizer' but never quite the same, the ambivalence in this difference also opened up possibilities for the colonized elite to refashion and indigenize the universal of science (Bhabha, 1984; Prakash, 1999).

Disciplines such as anthropology, history, and sociology have similarly reflected upon their complicity in knowledge production in the colonial period, and their roles in shaping contemporary development landscapes in different developing countries (Cooper & Packard, 1997). Anthropology, as a discipline, for instance has reflected upon how its 'scientific' study of the 'cultures' of primitive groups was shaped by the colonial context within which such research took place (Asad, 1973; Cohn, 1996). Its constitution and legitimation as a discipline was shaped by its contribution to colonial projects, and later to the notion of development and its practice (Cohn, 1996; Cooper & Packard, 1997; Crewe & Harrison, 1998). Similarly, area studies and development studies came into being as new interdisciplinary fields in the American academy in the context of the Cold War to produce practical knowledge about newly independent nations that would inform U.S. foreign policy in a quest for political and economic power (Cohn, 1996; Kaplan & Grewal, 2002; Parker et al., 2012; Lal, 2008). Hence, interdisciplinary fields, like disciplinary ones, have not been isolated from the influence of the state and the markets, although university research is often assumed to be so. Indeed, academic fields with stronger claims to scientific research have enjoyed intimate and influential relationships

with power. The discipline of economics within the social sciences, for instance, influences powerful institutions such as the World Bank and the International Monetary Fund (IMF) located in the Global North more than disciplines such as anthropology on the basis of the scientific claims they can make.

Disciplinarity, interdisciplinarity, and development- counterhegemonic publics. Universities are also deeply embedded within civil society (Lal, 2008). New interdisciplinary fields of academic study have also been created through the momentum generated by social movements such as American studies, black studies, women's studies, gender studies, postcolonial studies, and others (Parker et al., 2012; Klein, 1996). These fields of studies challenged disciplinary claims of political neutrality and objectivity, and sought to counter the inequalities naturalized by such claims, and reclaimed ownership of objects of knowledge such as the political from political science and the body from the monopoly of biologists by broadening "the notion of the political to include the personal, the body, and the quotidian" (Parker et al., 2012, p. 8). The social movements that have propelled the reorganization of the academy are not limited to the global North. As Appadurai (2000) has argued, globalization has provided traction to social movements as well, with new forms of international civil society being constituted, such as non-governmental organizations (NGOs), through "grassroots globalization." The internationalization of feminism and human rights discourses, for instance, has occurred quite rapidly (Wotipka & Ramirez, 2008; Ramirez, Suarez & Meyer, 2007). While institutional theorists downplay the role of power in the global diffusion of certain discourses as compared to others, maintaining an agnostic as well as a 'distant' point of

view, ethnographic and micro-level studies on the academic institutionalization of social movements, such as feminism and human rights discourses in developing countries illustrate how the friction of engaging with local realities shapes the particular institutional forms created, and their publics and counterpublics (Bajaj, 2011; Chen, 2004). Importantly, Tsing (2005) has pointed out the global connections of different 'local' and conflicting forms of environmental activism with middle class students and academics on the one hand, and forest-dwellers on the other, each having different visions of the rainforest in Indonesia. In doing so, she counters simplistic binaries made when counterhegemonic social movements are associated with the 'local' through words such as grassroots and indigenous, and hegemonic discourses are associated with 'global', and 'Western', and suggests that both hegemonic and counterhegemonic discourses and practices have global connections and constitute different publics and counterpublics. While Appadurai (2000) has distinguished between 'weak' and 'strong' forms of internationalization, Tsing uses the concept of friction to suggest that travelling discourses gain traction differently as they engage with local networks of power. This inevitable engagement of universals with local contexts shapes the particular forms that they will take.

Taking the example of the institutionalization of feminism, scholars have shown how feminist NGOs have interacted with forces of professionalization to produce "hybrid" ones constituting complex relationships with the counterpublics they seek to represent on the one hand, and with aid agencies and the state, on the other (Alvarez, 1999; 2009; Merry, 2006; Ong, 2011; Thayer, 2010). In the case of women's studies

(WS), an academic form of feminism, Peiying Chen (2004) has provided insight into how intellectual activists in two Taiwan universities, as she calls them, have juggled their identities as relatively privileged women committed to the cause of lesser privileged women, and as marginalized academics in male-dominated institutions professing knowledge of lesser value in the economy. Miske (1995) has shown in her study on the 'Thai' way of doing women's studies that WS is enacted as WID (Women in Development) i.e focuses on achieving gender equality by increasing access for women in different spheres. She suggests that in developing countries, activism in WS is intricately linked to economic development. Similarly, WS in India too, has focused its activities on documentation, research and extension work outside the university with only a small part of its work focused on establishing teaching programs (Anandhi & Swaminathan, 2006; Howe, 1997; Jain & Rajput, 2003; Pappu, 2008). University WS centers, thus, have tended to replicate the work of NGOs and centers outside the university. Further, disciplinary knowledge production in postcolonial countries has been intricately linked with nationalist projects as a form of decolonization that has served well for the politicization of certain issues but foreclosed others (Lal, 2008; Parpart, Rai & Staudt, 2003). For instance, disciplines such as economics and history have dominated the rationale for politicizing gender issues but have not considered how national culture has been constructed on women's bodies (John, 2001). When questions have been asked that threaten nationalist identities, Third-World feminists have been critiqued as elitist and 'westernized' (Narayan, 2013). Although feminist activists have negotiated with the state to achieve their goals, including the institutionalization of WS centers in

universities, the traction that they have got in its encounters with aid agencies, academic standards, the state, and with activists around particular issues has shaped the contours of academic activism, the knowledge they have produced, and their publics and counterpublics.

Lal (2008), taking the example of sociology, has further argued that since decolonizing academic projects in postcolonial nations have tended to work with rather than against the state, the notion of a singular "indigenous professional sociology" in opposition to "American-as-universal" sociology forecloses the notion of multiple public sociologies within postcolonial nations. Hence, she argues that a study of different configurations of disciplines in particular nation-states becomes crucial to distinguish between how they differentially constitute hegemonic and counterhegemonic publics.

Public health: hegemonic or counterhegemonic? In the case of public health, Qadeer and Nayar (2005) suggest that the institutionalization of public health into the medical curriculum in India as community medicine or family medicine or PSM depoliticized the field by reframing these discourses within the biomedical model so that the field got reduced to concerns on sanitation and hygiene and a narrow focus on quantitative approaches to epidemiology. They, therefore, argue for a return to the fundamental principles in public health and epidemiology which focused on the social environments of communities. From this perspective, a critical engagement with public health discourses holds the potential for creating a public sphere that places the community at the center of the activities of medical practitioners (Hammarstrom, 1999; 2008; Krieger, 1998; 2000; Potvin et al., 2005; Qadeer & Nayar, 2005). Hence, although

public health discourses are produced within a space populated by 'experts,' their insistence on interaction with local communities as multiple counterpublics holds the promise for the politicization of community needs. Whether and how these interactions with its counterpublics indeed democratize and transform institutional discourses is questionable when public health knowledge is historicized, and unpredictable as argued earlier, and therefore must be subjected to empirical study- a task I take on in this study.

Although the above scholars have considered public health as a counterpublic in relation to biomedical discourses, its academic engagement with oppositional discourses such as feminist and postcolonial perspectives has been understudied in India with the exception of a few who have noted gender biases in the medical curriculum including the PSM curriculum (Gaitonde, 2005; Iyengar, 2005; Nagral, 2005). Scholars, however, have employed feminist perspectives to understand and critique public health policies and practice. For instance, differences in women's access to health resources, in reporting health issues, making decisions regarding their health, and their children's health have been noted, and have pointed out a lack of engagement with or an appropriation of feminist perspectives (Fochsen, Deshpande & Thorson, 2006; Bandewar, 2003; Qadeer, 1998; Simon-Kumar, 2007).

Simon-Kumar's (2007) study on the public health officials' interpretations of the Reproductive and Child Health (RCH) policy illustrates how public health has engaged with the oppositional discourse of women's reproductive rights. She has shown how officials perceive women as making rational choices when they seek to reduce their family size in accordance with earlier discourses on family planning. When women's

reproductive goals deviate from national ones, however, they are perceived to be 'irrational'. Further, she suggests that the notion of reproductive rights is understood less in terms of women's rights to control their own bodies but in terms of their rights as consumers to avail quality services. Thus, despite the policy's incorporation of the oppositional discourse of women's rights, the prevailing discourses of population control and neoliberalism dominate the policy documents so that the implementation depoliticizes women's needs by reframing the discourse with conservative meanings. Neoliberal discourses thus, in this case, can be viewed as 'reprivatization' discourses which argue that politicized needs, such as gendered needs like reproductive rights are not important enough for state intervention and are private matters (Simon-Kumar, 2007; Fraser, 1989). Alternatively, ideological words that have much traction are appropriated to take on new meaning suitable to conservative interests. Neoliberal discourses, for instance, have appropriated the notion of 'empowerment' from feminist language to focus on individual capacities and choices of the poor (Kamat, 2004; Simon-Kumar, 2007). Rather than understanding poverty as a consequence of structural inequalities, this new meaning of 'empowerment' reinforces the idea that individuals are both the causes of their own poverty, and the solution (Kamat, 2004; Sharma, 2008; Simon-Kumar, 2007).

Thus, public health as a discipline cannot be labeled either as hegemonic or counterhegemonic in singular ways but must be understood in relation to how it engages in specific local contexts with its publics- the state and the political economy as well as with other disciplinary discourses and with its communities, each of which are constituted by publics and counterpublics with differential relationships to power.

Imagining the Rural and Urban Poor

In this section, I re-present my reflections on how I imagine(d) the rural and urban poor in light of the theoretical framework I had developed in April 2012 prior to my entry into the field for data collection.

My imaginations of rural and urban poor men and women have been mediated by everyday interactions with individual migrant (from rural areas) and local workers and through representations in literature, movies and other kinds of cultural media that I have come into contact with living in urban India. I have rarely interacted with people from poor 'communities' in the sense of living or interacting with them in their neighborhoods or villages. Yet, this study is my interpretations of what PSM educators think and teach about these communities. This raises the question of where my 'knowledge' of the poor or the rural come from and what legitimacy it has. In this section, therefore, I discuss briefly the discourses that I have encountered to illustrate my class and gender positionings in relation to the rural and urban poor in India that are relevant to understanding my interpretations in this study. This is a reflective exercise on my part to remember the social relations between me and my family with the young men and women who worked for us; the goal being primarily to situate the development of my aesthetic sense as classed and gendered such as when one thinks about the disgust associated with dirt and filth, and its dependence upon the domestic and public work of sanitation and hygiene done by the lower classes in India, particularly by young girls and women.

Middle-class values I learnt, not least from the soap operas and movies my family watched, was about saving money and managing within what one has. Stressing the trials and tribulations of the middle-class helped universalize these experiences as intrinsic to the human condition and to hide the historical privileges that I had. I was raised with the privilege of not having to work for my food or living until my Master's degree. Even more so, I had the privilege of having my clothes washed, the bathrooms and toilets cleaned, and residing in my own personal space in a neat and well-maintained house. This meant that I had sufficient time to devote for my education, leisure, health, and fitness as well as for cultivating an aesthetic sense and taste about 'high' and 'low' culture.

I was raised with what one can call 'male' privilege as my primary duty was not the historically gendered work of learning house management but to complete schooling and graduation. That this privilege depended upon my mother's and grandmothers' caring work as much as it depended upon my father's earning abilities became apparent to me only when I had to share in the caring work when my grandmothers became old and sick. My privilege most immediately depended upon the numerous domestic servants, many of them young girls, who did the work of sweeping, cleaning, clearing the garbage amongst other 'sanitation and hygiene' work as well as their nursing work. Since caring and cleaning work done by middle-class women in private domestic spaces and by lower class men and women in both private and public spaces, is rarely acknowledged as productive labor in the economy, the privilege arising from it was normalized for me.

My experiences of relative material scarcity in the U.S. and an introduction to critical and feminist perspectives, particularly by black and postcolonial feminist scholars pushed me to reinterpret my past and present experiences, and to reposition and reconstruct my identity in relation to the world. Significantly, these experiences influenced the development of this research project as I sought to disrupt the homogeneity of the category of 'Indian woman' while focusing on how class significantly shapes gender norms and privileges. For instance, bell hooks' critique of the 'innocence' of white middle-class women jolted me to think about the development of my 'personality' as dependent upon the class relations with numerous workers that were also gendered (hooks, 1994; Fisher, 2000). I interrogated my memories of friendships with the girls who stayed and worked at my place. In my mind, the problematic relationship between my family and the young girls and women who worked for us lay in traditional caste-based practices that my grandmother, for instance, was complicit in and not me. For instance, she insisted that the child of the woman who swept our house sat on the floor and did not touch the sofa, lest it get dirtied. Separate plates and cheaper soaps were provided to them, lest they pollute our dishes and our Brahminical bodies. I resisted these caste-based discourses and practices of differentiation based on notions of dirt and forged friendships with them. I thought my opposition to these traditional practices as a modern woman rendered my relation with domestic servants equal either as fellow citizens or as women. It was possible for me to think of a modern India not shackled by traditional discriminatory practices. Framing modernity in progressive terms served to hide the social distance in my relations with historically disadvantaged groups and to

romanticize them so that the underlying power relations maintaining their disadvantage remained unexamined. It was in moments of crises when they were found to be at fault such as when things went missing or when they were ‘rude’ and ‘arrogant’ in their display of insurgence that romanticized notions of my ‘friendships’ with them were disrupted. These moments of crises were further used as evidence within my family to reinforce the essential character of lower class men and women.

My complicity in maintaining unequal social relations lay not in direct personal misbehavior but in assuming that my relations with them was based on some universalizing principle such as humanity, national citizenship, or sisterhood, and therefore equal. By assuming this equality, I failed to recognize that their work is not merely functional that can be converted into a monetary value but as shaping the material lives of middle-class families in deeply profound ways (Rose, 1977). More importantly, by virtue of the time and labor that they put in to make middle-class lives livable, their material conditions become unlivable. Thus, while the disparaging representations of the living conditions of poor workers such as being dirty, crowded, and infested with germs may be true, their explanations are falsely located within the sociocultural environments in which they live and not traced back to the unequal social relations between their communities and the rest of Indian society (Bourdieu, 1990; Rose, 1977; Said, 1978). The failure of poor women to raise children disease-free and to educate them is often attributed to ignorance and reluctance to change their conditions without accounting for the burden of both economic and caring work that they do in exchange for little material gain.

The above account is more relevant in understanding my imaginations of the urban poor in whose case the dependence of the middle classes is more direct. My imagination of rural India is even more romanticized not least because the essence of their labor is commodified and made unrecognizable (Rose, 1977). It is romanticized also because of postcolonial anxieties among the Indian middle-class about their vanishing culture and authenticity. These anxieties are easily alleviated by engaging in spectacles offered by Bollywood songs, movies, and books that hail rural and traditional ways of life or by periodic visits to rural places which represent one's native roots and origins, although such visits are also important commemorative practices for migrant groups such as mine to remember their linkages with particular places, and the specific cultural histories of their migrations.

On the other hand, rurality is also depicted in the media as primitive, illiterate and backward that have yet to be integrated in modern India. These constructions of the primitive suggest that while the educated Indian middle-class has managed to distil the problematic aspects of the cultural and religious beliefs including the patriarchal nature of these beliefs, rural and traditional communities remain in their underdeveloped state because of their uncritical acceptance of these cultural beliefs. Thus, while certain politicized gender issues such as widow immolation, female feticide, domestic violence are located within rural or traditional communities that sections of the educated middle-class claim to have surmounted, the politicization of other gendered cultural values, such as domestic work, sexual and reproductive behaviors and others have been difficult as they challenge assumptions about authenticity.

These imaginations of rural and urban poor that I have articulated above framed my observations and experiences during the research process, and were also interrogated, as I identified and remembered familiar discourses when I engaged with the strangeness of participating in community field visits.

Summary

In this chapter, I have attempted to situate the study in the intersections of science studies, development studies, postcolonial and feminist studies, higher education, curriculum and instruction, and interdisciplinary studies. In the first body of literature, I set the stage for understanding scientific knowledge as cultural texts or fictions which helps address my first research question. In the second body of literature, I conceptualized the curriculum as a site of ideological struggle, and the community as a pedagogical site of engagement where students, teachers, and community members negotiate diverse sociocultural resources. This section helps me address the questions of how students' interactions with local communities disrupt the science/fictions that mediate their actions. In the third body of literature, I discussed the complex relationships of disciplines and their knowledge-making practices with the global political economy and international civil society, their reconstitution through interdisciplinarity, and their differential contributions to development ideoscapes and policyscapes in different contexts. Arguing for an exploration of how disciplines constitute hegemonic and counterhegemonic publics in particular contexts, I take public health as a case study to understand how it engages with local communities and social science disciplines that act as its counterpublics in the production and renarrativization of science/fictions.

Chapter III. Ethnographic Case Study Research: Studying "Up"; Studying "Sideways"

Ethnographic Case Study Research Design

This research project is a single-sited case study informed by critical ethnographic and critical discourse analysis inquiry approaches. Case study methods can be employed to examine a "contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context may not be clearly evident" (Yin, 2014, p. 16). Case study research can be distinguished from other methodologies by its interest in conducting "in-depth description and analysis of a bounded system", that is, "a single entity, a unit around which there boundaries" (p. 40). According to this definition, I examine in this study the spatially and temporally bounded phenomenon of a community-service learning program that was enacted at a medical college in South India over three weeks spanning the months of December, 2012 and January, 2013 (Merriam, 2014). The case study, Merriam argues however, needs to be understood as a methodological choice, and not merely a matter of determining the unit of study. While she does not dwell much on the epistemological and political-ethical bases for making such choices, she argues that the knowledge of the 'particular' is valuable in providing deep insight into phenomena and their contexts especially when they cannot be easily separated from each other- an epistemological position, and that the "force of a single example is underestimated."- a political or rhetorical argument (p. 53).

Vavrus and Bartlett (2006; 2009), however, discuss and develop an epistemological case for case study methodologies, and in doing so problematize the

central concept defining case study methodologies, the notion of a "bounded system". They suggest that while ethnographic case studies argue for 'ecological validity', that is, describing how phenomena are shaped by their contexts so that simplistic generalizations and predictions are not made in other contexts, case studies too often get caught up in analysis at one level, usually at the micro-level, without making comparisons both horizontally and vertically beyond the 'bounded system', usually defined in demographic or geographical terms. Although Vavrus and Bartlett do not say so explicitly, the 'bounded system' often used to define the boundaries of the phenomenon under examination in ethnographic case studies is related to how culture is conceptualized: phenomenological and ethnomethodological approaches focus more on how meanings are made in bounded localities, while critical approaches understand these local meanings and practices as shaped by larger power structures, and recent poststructural approaches explore the local/global nexus through more complicated understandings of culture (Anderson-Levitt, 2012). How I conceptualize culture in this ethnographic case study thus informs how I define the boundaries of the individual case and explore its vertical and horizontal relationships with other levels and domains.

Conceptualizing Culture. The concept of culture, although central to the definition of anthropology as a discipline, is a contested one. Abu-Lughod (1991) has even suggested that it be abandoned altogether because of its tendency to overemphasize coherence through notions of holism so that communities are perceived as bounded and discrete entities. Further, she argues that although the concept of culture was meant to remove "difference from the realm of the natural and the innate", it tends to fix

differences in such rigid ways that "they might as well be considered innate" with the result that communities are perceived to be different and separate from one's own (p. 470). Instead, she suggests that Bourdieu's (1990) concept of practice might be more appropriate as it focuses on "contradiction, misunderstanding, and misrecognition, and favours strategies, interests, and improvisations over the more static and homogenizing cultural tropes of rules, models, and texts." (Abu-Lughod, 1991, p. 472). Similarly, Foucauldian notions of "discursive formations, apparatuses, and technologies" allows for considering the possibility of the "play of multiple, shifting, and competing statements with practical effects" within a social group (Abu-Lughod, 1991, p. 472). Both these concepts of discourse and practice along with a deliberate focus on examining the connections, both contemporary and historical, between a community and an anthropologist including the world that she comes from that enables her to study this particular community, are important in troubling the assumption of boundedness that the concept of culture engenders (Abu-Lughod, 1991).

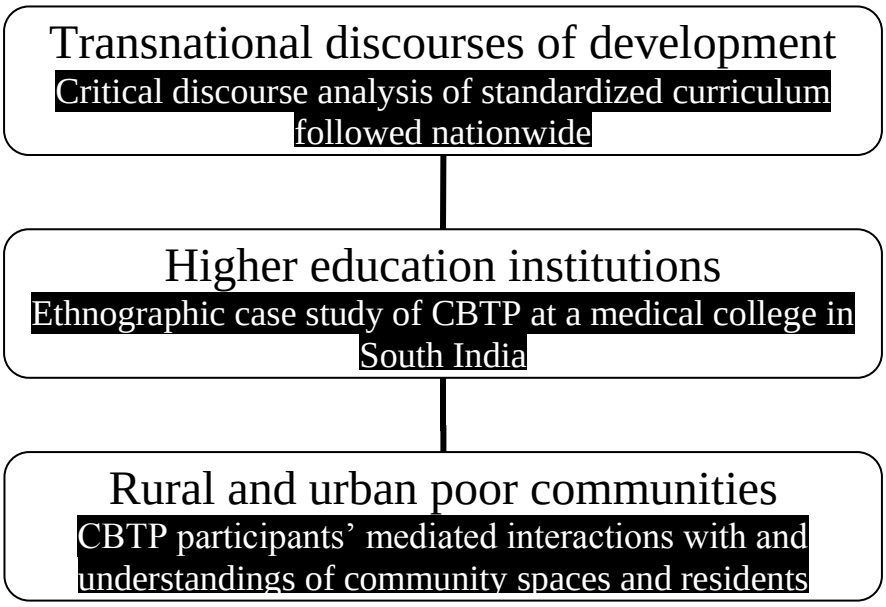
Yanagisako and Delaney (1995) defend the concept of culture and suggest that it can be "a productive site for discussion and debate about difference and similarity" as well as for a "continual assessment of the coherence among a society's discourses and practices. (p. 19). The productiveness is lost when the "heuristic tension is resolved in the favor of either side of the opposition" between fragmentation and coherence, similarity and difference across discourses, domains, and institutions. The issue, they argue, is that while cultural anthropologists have routinely read across other people's cultural domains, discourses and social institutions to construct coherence, "cultural domains in our

supposedly more functionally and institutionally differentiated society, on the other hand, could not be read across so cavalierly." (p. 14). In particular, they point out that one is prohibited from reading across liberal humanists' sacred domain- science, to explore its relationships with economic and political systems or to gender or racial hierarchies. Thus, they suggest it is important to explore "how culture makes the boundaries of domains seem natural" as well as to "make compelling claims for connections between supposedly distinct discourses." (p. 19). Reading across the sacred domains in one's own societies would therefore be crucial in exploring how each of these domains make claims to universality by naturalizing power, that is, by ascribing identities and relationships to nonhuman basis, whether in nature, biology, or god thereby removing them from the realm of human social agency. In this ethnographic case study, therefore, I study "up" or vertically in the sense of studying the powerful (Nader, 1969), in this case the sacred domain of science, specifically the discipline of public health, and explore how it naturalizes power through its discourses and practices, and how they relate with historical and contemporary discourses of development produced by national and transnational actors. Studying "up" can also be understood as studying "sideways" (Ortner, 2010) as research participants are often not "up" relative to the ethnographers, but often occupy more or less the same social space, habitus, similar kinds of material or cultural capital, and working in similar cultural domains of knowledge production- the knowledge class or the professional managerial class (PMC) as I do. Hence, I read sideways across the cultural domain of science to look for similarities and differences in other cultural domains such as social science disciplines, and our shared habitus of participating in

middle-class to upper-class sociocultural and citizenship activities such as schooling, higher education, national politics, entertainment. Studying sideways, however, alters research relationships significantly, and raises political and ethical issues around access, the selection and conduct of research methods, and the representation of participants.

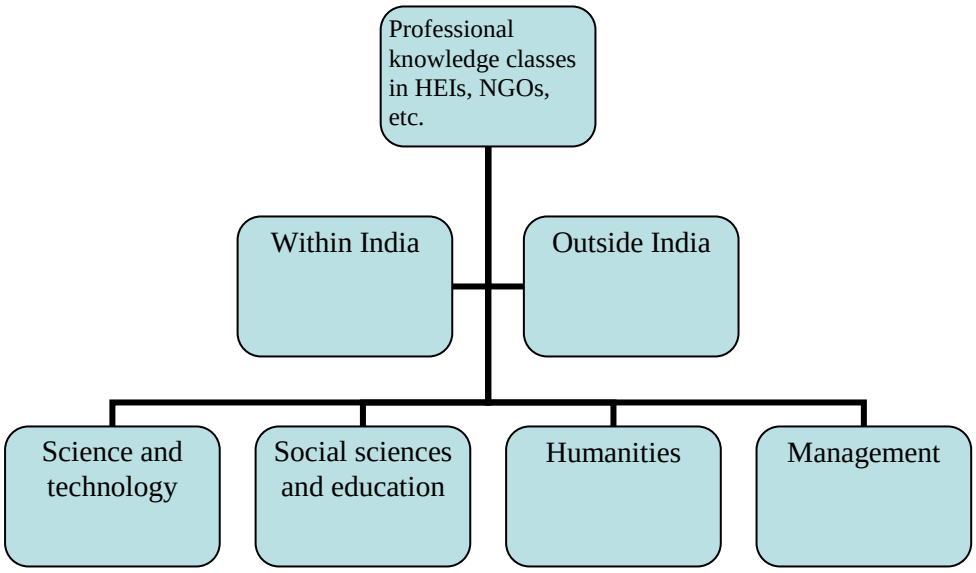
Figure 1 below attempts to represent the methodology of studying "up" that I have employed to explore ways of seeing and understanding rural and urban poor communities from the sociospatial orientations of PSM teachers and medical students participating in the CBTP at a medical college in South India. This includes an examination of transnational discourses of development informing the standardized curriculum followed nationwide using critical discourse analysis. Through ethnographic observations of the CBTP and interviews with CBTP participants, I explored their interpretations and appropriations of the curriculum at one particular site. Using mediated discourse analysis, I explored how encounters with community spaces and residents disrupted transnational discourses of health and development and their situated knowledges mediating their understandings of the rural and urban poor. In sum, I examine the sociospatial orientations that shape dominant articulations of rural and urban poor.

Figure 1: Studying "up"



In Figure 2 below, I attempt to illustrate my sociospatial relationships with my research participants with whom I share more or less similar social, cultural, and symbolic capital as members of professional knowledge classes within the Indian context. My constructions of participants' articulations of rural and urban poor are also shaped by my differential mobility across disciplinary and national boundaries that afford me access to certain discursive networks more than others as well as by the control I have in the research and writing process. Studying "sideways", thus, involves an exploration of how my sociospatial orientations and motives intersect with and depart from those of my participants as I construct their understandings of the rural and urban poor.

Figure 2: Studying "sideways"



Ethnographic site and participants. Studying "up", particularly institutions with distinctive programs and practices brings with it issues of maintaining anonymity particularly when the geographical context is part of the analysis rather than merely the stage where events happen. A comparative study of at least two programs at two different medical colleges would have made the issue of protecting the anonymity of the institution to some extent. However, getting access to institutions was time-consuming and fraught with unpredictability, and I was able to study only one program at one medical college. This meant that I had to decide whether I keep the name of the city itself anonymous, a difficult choice, as the city's participation in the global economy, its particular environmental and linguistic characteristics, and the institution's location within a regional university system are not only crucial to the analysis but also distinctive enough to make anonymity difficult. On the other hand, excluding these distinctive aspects from the analysis would mean a complicity in the sense of failing to speak truth to power

(Ortner, 2010). It would also implicitly suggest that the institution's uniqueness is unrelated to the geographical context in which it is positioned. Hence, I made the difficult choice of naming the city which increases the probability of identifying the institution to an extent. To reduce this probability, however, I use a pseudonym for the institution and exclude certain distinctive characteristics of the institution itself that while intellectually and politically salient, I reserve them for stories in the future with more substance than I have presently. I also use pseudonyms for participants and shuffle their statements around so that it is not possible to attribute them to one or the other. Finally, I stress throughout, for both intellectual and ethical reasons, the historical, political, cultural, and geographical situatedness of the institution and the research participants so that their utterances and practices while their own in many ways can also be distributed to actors beyond them (Jones, 2005).

Ethnographic site selection. The ethnographic site is a medical college in the state of Karnataka, a region where there has been a rapid proliferation of medical colleges in the last two decades (Sood, 2008). Medical colleges currently in this state amount to 41 of which 37 have been incorporated within a broader umbrella called Rajiv Gandhi University of Health Sciences (RGUHS) established in 1996 in order to standardize the curriculum and regularize examinations that are further aligned with the guidelines set by the Medical Council of India. Since RGUHS students who complete their Bachelor of Medicine and Bachelor of Surgery (M.B.B.S.) degrees need to compete in the future in postgraduate Doctor of Medicine (M.D.) or Doctor of Surgery (M.S.) examinations, the standards structuring the curriculum and assessments are more or less in line with those

set by the national regulatory body in medical education, the Medical Council of India (MCI). Although there might be nuanced or even significant differences between these standards between RGUHS as a university system with other universities as well as among the institutions within the RGUHS system, I err on the side of exploring the homogenizing effects of these standards rather on the differences and reserve a focus on the latter for future studies.

Within the RGUHS system, I limited my study to the city of Bangalore, which itself has 9 colleges and is the most urbanized so that the communities within reach might be relatively distinct from other places in Karnataka. Another important reason to focus on Bangalore is that many students from different parts of the country prefer to study in the city so that PSM educators might face greater diversity in the student body that may affect their teaching practices. Out of the 16 colleges that have recently opened up in Karnataka since the 1990s, most of them are dispersed around the state with four of them located in Bangalore. Thus, this city, apart from a few other colleges in other parts of the state, houses some of the older colleges with longer institutional and disciplinary histories that might inform a deeper understanding of the practice of community field visits. Table 1 shows the list of medical colleges in Bangalore under the RGUHS university system.

Table 1: List of medical colleges in Bangalore under RGUHS

Established since 1990s	4
Established between 1970s and 1980s	3
Established between 1950s and 1960s	2

Source: Medical Council of India (MCI)[2]

Sampling decisions. I initially planned to conduct informal inquiries with each of these institutions to get a broader sense of the terrain with regards to how community field visits are structured. I also had a more instrumental goal of narrowing down the selection of the institutions based on certain inclusion criteria. The colleges of interest were the ones which would have a substantial history with institutional records of having conducted community field visits and who would have established relationships with rural and urban health practice areas as well as PSM educators with substantive experience in having conducted these field visits. I sought to limit my study to at most two colleges as I intended to study in depth PSM educators' strategies, interests, and improvisations as they designed field visits, and to explore the similarities and differences in how field visits played out in different institutional contexts. Similarly, I planned to spread my net widely in the initial stage of the study and speak to all PSM educators in these two sites and then to eventually focus on those educators who were most deeply involved in the design and implementation of field visits. I also anticipated that the selection of the sites and participants would depend in large part upon their willingness to spend time with me, approximately six months intermittently, in the

[2] Retrieved from http://www.mciindia.org/InformationDesk/CollegesCoursesSearch.aspx

discussion of the curriculum and the field visits. Thus, my sampling plan was largely purposive or information-oriented that sought "to maximize the utility of information from small samples and single cases." (Flyvbjerg, 2006, p. 230).

Contacts and connections. Studying up is largely a matter of having "contacts" inside institutions (Ortner, 2010). Hence, although I sent emails to different institutions, I heard back only from one three months later. I also attempted to call and visit some institutions but their gatekeepers: the secretaries of deans and principals filter out those whom they perceive to be less urgent or important. Generating "interest" in terms of having something substantial to offer or in terms of curiosity was what I found most challenging in getting access- an issue that is particularly challenging while studying up (Ortner, 2010). Ultimately, I managed to gain access into the institution I studied, let's call it Jeevan Daan Medical College (JDMC). Yet, the process itself was important as it set the stage for how I would position myself in relation to the institution and my participants, perform and underplay insider and outsider identities depending on the context as I negotiated with institutional gatekeepers. It provides insight into the interconnections I have with this group that influenced how I came to study it.

Some of my connections were social; my father's doctor was a respected and recognized cardiologist at one of the medical colleges. This connection not only provided me information about the program that I sought to study but also served as a potential entry point into the college. Further, we share the connection of living in the same neighborhood recognized as being upper middle class to upper class in composition. Other connections that made it possible for me to study this particular group, and to claim

'insider' status was that I had studied at a medical college and worked as a medical teacher for four years. Despite this professional connection, I was aware that I was nevertheless outside of a 'deeper inside' occupied by PSM teachers who were also trained to be medical doctors (Ortner, 2010). Hence, in order to generate interest in my project, I enhanced my symbolic capital by claiming 'expertise' in the field of education, and thus claimed an 'outsider' identity. While I stressed upon this expertise strategically for the instrumental purpose of gaining entry to complete a project that will lead to my own career advancement, I also hoped to contribute to PSM educators' pedagogical practices and the institution through the research process itself (Lather, 1986). My status as a student of a U.S.-based university also contributed to my symbolic and psychological capital (Demerath, 2009), yet it also complicated my identity as an Indian national, and the claims I could make to local contextual knowledge as compared to a Non-Resident Indian or foreign nationals of Indian origin. Thus, although I am not a fluent Kannada speaker, I stressed upon my 'insider' identity as a Bangalorean, and as a Konkani speaker from coastal Karnataka with a working knowledge of the Kannada language. Thus, I strategically performed certain identities for the instrumental purpose of gaining entry.

Getting access into JDMC. On inquiring about my contact's knowledge of community field visits at this particular college, I learned that they had a comprehensive program that I refer to as the community-based teaching program (CBTP). The doctor spoke very proudly about it, and also stated that it is one of the five colleges in the entire country to have such a program. This college therefore not only met my inclusion criteria for an information-oriented selection of my research site but also would constitute an

extreme or unusual case that would enable me to make certain assertions in more compelling ways (Flyvbjerg, 2006). To elaborate, I could make assertions about how and why such a program is understood to be exemplary by the community of PSM teachers, and to achieve what political and material ends. It also constitutes, in Flyvbjerg's terms, a "critical case" in the sense that although it may very well be an exemplary pedagogical case, it nevertheless raises prickly issues regarding the relationships between institutions and communities relevant to other institutions at the same time that it can offer them creative pedagogical strategies. I learned later, however, that another college in Bangalore too had an elaborate program such as the CBTP, and although I officially gained entry into that college following a review by its own institutional review board, I decided to defer a comparative study of that college due to logistical reasons. Interestingly, certain faculty members have worked or have had and continue to have relationships with the PSM departments in both these colleges at different periods of their lives, thus highlighting the discursive network between the two. Nevertheless, this social connection altered the framing of my study from one that sought to be more 'representative' of the broader terrain in Bangalore city to one that highlighted the uniqueness of a particular case while also situating it within the larger discursive context.

While mentioning this doctor's name was useful in beginning a conversation with higher level administrators as well as with my participants, it also took a lot of patience, persuasion, and strategizing to get access into this particular medical college. I sat outside the principal's office for several hours on consecutive days before I got to speak to her. Although the head of the department (HOD) of PSM at the time asserted his support to

my project, it was subject to me getting permission from the institutional head, and provided I would name and acknowledge the college and the department for their support in it. When I did get to speak to the principal, I realized that there was a misunderstanding regarding the nature of my project and my positioning in relation to the institution. She acknowledged that I was making an unfamiliar request and had to clarify institutional precedents regarding my request. On clarification, she suggested I could proceed by paying the fees equivalent to a *foreign national* to attend the CBTP as a student observer as well as monthly fees for the time I would spend after the CBTP. My initial reaction was anger and frustration that they sought profit because I was studying in the U.S. However, when I spoke with the HOD, I realized that while I perceived myself as their colleague, albeit a junior one, they responded to me as a student even though I had stressed in my letter that I had taught in medical colleges before, and that I was pursuing my Ph.D. degree in education rather than in public health. They further assumed that I wanted a certificate of completion from them as part of my Ph.D. requirements. This misunderstanding prompted me to reposition myself as their colleague in more assertive ways as well as an Indian national. Further, I stressed upon the potential value that I could bring through my 'outside' expertise as an educationist and as a researcher that we could negotiate subsequently. I also clarified that I could not name the institution, despite the exemplary nature of their program, to maintain the anonymity of the participants (see appendices for letters of correspondence). Following several failed attempts of meeting her because of her extremely busy schedule, as a desperate attempt I waited outside the college examination hall, and got a chance to speak with her during the

lunch break. She was again very respectful and clarified to me that they did not have an institutional precedent such as the one I had requested, and therefore asked me to meet the director of the Foundation that administered the educational programs of the medical college amongst others. The director apologized to me and clarified that they had understood me to be a student, and had used a policy that international medical institutions use for Indian students when they request short term internships. He asked me more about my project, showed genuine interest in it, and continued to be extremely supportive till the end.

The above process of getting access into this college reiterates some of the commonly cited issues in studying sideways: the issue that gatekeepers to institutions are both busy and powerful so that access to them can be difficult. Mere persistence, however, may or may not have been enough as it also required the deployment of symbolic capital to be heard as well as to generate interest in my project. Finally, my own access to material resources also shaped the nature of the project. Paying a monthly fee as a student-observer would have not only shortened the study to one or two months, it would have also significantly altered my relationship with the teachers, and the institution. Secondly, since the study was funded from personal resources, I intended to complete data collection by July or August, 2013, and return to the U.S. for data analysis, and dissertation writing. Hence, my relentless persistence was shaped by my knowledge that the CBTP would begin in the last week of December in JDMC. Getting access after the CBTP would have little meaning for me as I would not be able to observe it as it happened, and could not wait another year to observe it. Also, at that time I hadn't heard

back from the other colleges that I had contacted. When I did hear back positively from another medical college which had a program similar to the CBTP both in structure and prestige, I learned that their program too was held over two to three weeks in December, 2012, and January, 2013. Even though I did not do a comparative study with this college, a significant difference in this latter college was that they approached me, albeit in March. They also had an established institutional process for external researchers and required me to submit an official application to their institutional review board in which I had to name one of their faculty members as a co-Principal Investigator who would assist me through the entire process of data collection. Although I found this relationship more suitable in its participatory and collaborative nature, I got approval to begin this research only in June, 2013 with permission to observe their CBTP in December, 2013 and January, 2014 which would have delayed the timeline of my project significantly. Hence, I decided to defer this latter project to a future, undecided time, and limit my study to JDMC.

Research participants. I got permission to conduct research at JDMC one day before the CBTP began. Hence, I was unable to conduct interviews with PSM teachers prior to the CBTP, although I had informally been introduced to some of them during my negotiations to gain entry over a month. One of the teachers introduced me to the 200 students seated in the large classroom when I informed them about my project, and took group consent from them after stressing their protection of privacy and maintaining the confidentiality of our interactions during the CBTP. I also told them that they were free to not interact with me if they chose not to. Later, after the completion of the CBTP, I

recruited students for interviews. I described my intent, the time they would have to spend for this purpose, the voluntary nature of the action, and stressed again that the interviews would be private and confidential. I sought to invite students from different places, languages, and religions. I was looking for at least 16 students, four from each category with two male and female students in each category- Kannada/Telugu speaking; North Indian; international students, and non-Hindu students. Hence, I mentioned these categories of interest in my recruitment speech (see appendix for recruitment notices). Of the fourteen students who approached me, I interviewed eleven students who challenged some of my assumptions that informed my categorization strategies. Table 2 provides details about the students in terms of the categories that I sought to describe them with.

Table 2: Student participants and characteristics

Place	Language	Sex	Religion
Karnataka- 4	Multilingual including Kannada/Telugu- 3 Non-Kannada/Telugu speaker- 1	4 females	Hindus- 4
North India- 3	Hindi/Urdu- 3	2 males, 1 female	Muslim- 1, Hindus-2
International students of Indian origin- 4	Kannada/Telugu- 2 Hindi/Urdu- 1 English- 1	2 males, 2 females	Muslim- 1, Hindus- 2, parents of different religions- 1 (Hindu and Christian)

Of the four international students, two of them were Hindu and Kannada/Telugu speakers (one male and one female), and one of them was a Muslim, Urdu-speaking female student, and one of them was a binational and biracial male student who spoke primarily English. Of the four 'local' students, all female and Hindu, two of them had stayed in other countries during their childhoods, and asserted their multicultural and multilingual identities; one of them was from a small town in coastal Karnataka and spoke Kannada and Konkani- the local language in that region- and clarified that her dialect of Kannada was different from areas around Bangalore; and the fourth had lived most of her life in Bangalore, was a native Konkani speaker but clarified that while she could understand Kannada, she did not speak it. Recruiting Kannada/Telugu speaking male students turned out to be challenging. However, I did note a few informal conversations I had had with them during the CBTP. Finally, the three North Indian students included two Hindu male students and one Muslim female student, all of them Hindi/Urdu speakers. I sought this diversity among students to explore how their different linguistic, religious, and place-based backgrounds might shape their experiences and interpretations of pedagogical activities. While language shaped their participation significantly because of the communicative nature of these activities, I was curious to know how non-Hindu students interpreted their interactions with communities that were largely Hindu, and finally how students from other parts of the country and the world interacted with these local places, and the meanings they made of them through these interactions.

During the CBTP, I acquainted myself with postgraduate tutors who largely facilitated most of the activities as well as with a few of the PSM teachers. Since I occupied the ambiguous position between a student and a teacher much like the postgraduate students, and because we were mostly unmarried and of a similar age group, I was able to relate with them informally when we got together to chat in groups before the start of the day and at the end of the day, when we went for a couple of treks to the local hills, and when we went to eat locally made snacks. Although they were not my research participants, they spoke to me about their research projects, shared with me the textbooks they referred to, and spoke about their expectations as postgraduate students that gave me insight into how their programs were organized. While most of them were curious about my project, a couple of them were particularly interested in knowing more about qualitative research methods. I shared my resources with one student for his presentation on qualitative research methods, and another student took me to the college library to peruse through their catalogue in PSM or public health. These informal activities were important as I was able to get a broad sense of the research topics that they were pursuing, the textbooks they referred to, and the repertoire of research methods that were accessible to them. I was thus able to situate the discipline's discursive frameworks, and interdisciplinary connections largely within positivist paradigmatic approaches. In general, students and teachers got used to seeing me around, eating along with them during lunch and dinner in the common dining hall, and taking down notes when I observed various activities.

I related with PSM teachers in more formal ways, especially with senior faculty members, and male faculty members. I shared informal moments with a couple of female faculty members when I shared a room with them during the program, and two others who brought along their children with them when we chatted about our personal lives. I interacted with male teachers during activities or when we travelled in the bus from one place to another briefly. During the CBTP, I got acquainted with medical social workers who have close links with field institutions such as the primary health care centers, and community leaders, if any, and also serve as faculty in the PSM department. Teachers also spoke to me about the oral history of the program briefly- who were involved in initiating the program in 2003, and how the activities have changed over the years, and so on. These interactions helped me revise my interview questions as well as inform how I would select my research participants.

Out of 15 faculty members excluding postgraduate tutors, six faculty members were included in this study. Five of the six participants- three men: Dr. Murali, Dr. Chandra, and Dr. Vijay; and two women: Dr. Mangala, and Dr. Sumathi were included because they were involved in the CBTP since its inception in 2003. The sixth participant, a woman- Dr. Vineetha, was the key person in charge of organizing the CBTP that I observed that year. All, except one- a Christian, were Hindus. I shared with them details of the project and gained consent from them in person (see appendices for informed consent sheets).

Dr. Murali- one of the senior professors helped initiate the program in this college with the HOD at the time in 2003 and supported by the vision of the principal at the time,

presently the director of Medical Education. Dr. Murali with approximately 28 years of experience is well-known in his field with strong networks across medical colleges, with the RGUHS, and with several local, national, and international non-governmental organizations over the years. He has been a part of several of the projects that the department has initiated within the hospital and with the rural field practice area. He has travelled extensively and participated in international conferences and served as a consultant and principal investigators in public health projects sponsored by the World Health Organization amongst others. His regional, national, and international networks are reminders that his ideas, values, and practices have both local and global connections. A very inspiring, charismatic, and amiable person, he was keen to hear about my frank thoughts on the CBTP. All other participants were associate professors at the time, and each of them had different interests and contributions to different departmental projects such as the defluoridation plant, the special school, health care waste management, and others with 8 to 10 years of professional experience. Dr. Murali and Dr. Mangala particularly were interested in pedagogical issues and had undergone training from the US-based Foundation for Advancement of International Medical Education and Research (FAIMER) Institute (http://www.faimer.org/education/institute/index.html) again pointing to the department's global discursive connections. All participants were ethnically from South India, spoke Kannada, Telugu or both, and had also studied medicine at both undergraduate and graduate levels in South India. The HOD at the time of the program was excluded primarily because he was very busy, and he expressed the same to me although he was extremely supportive in my endeavor throughout. Other

professors, associate, and assistant professors were excluded largely because I had identified themes and patterns from existing data that I could assemble together to tell coherent stories with crucial divergences.

Research Methods. The ethnographic methods for data collection and analysis that I used in this project were observations of the CBTP, interviews with PSM teachers and medical students and document analysis.

I followed an iterative process between data collection and analysis as well as between the different methods. The table below provides a brief overview of this process. Data collection started with observations of the CBTP recorded in the form of field notes. Based on my observations, I designed an interview questionnaire to understand the rationales behind the organization of the CBTP, and its institutional history and politics. I also conducted a preliminary analysis of the field notes to identify certain areas for further exploration, and directed me to conducted discourse analyses of relevant sections in curricular texts. Curricular texts included the CBTP manual designed by the department faculty as well as the standard textbook followed nationwide, and other relevant texts used during the CBTP such as survey questionnaires. Textual analyses enabled me to move back and forth from the specificities of the CBTP to the discursive context within which PSM educators work. For instance, the intertextual references to international institutions, conferences and national policy statements within the curriculum were useful in broadening my frame of interpretation and in situating PSM educators, their utterances, and practices within the discursive context that they work in (Gee, 2011). Based on this preliminary discourse analysis, and ongoing review of the

literature, I designed a second round of interviews to explore deeper into teachers' interpretations of pedagogical activities in relation to curricular texts. (See Table 3 below and appendices for timeline, and interview questionnaires). Following an analyses of teachers' interviews, I conducted interviews with students to explore their interpretations of pedagogical activities in relation to those of teachers.

Table 3: Iterative process between data collection and analysis

Data collection (December 12, 2012 to June 12, 2013)	**Data analysis (January 13, 2013 to May 8, 2014)**
Noted down reflexive memos on the process of gaining access (December 12, 2012 to December 23, 2012).	Reframed methodology, and repositioned my relationships with institution (December 12, 2013 to December 23, 2013 and ongoing throughout period of data collection).
Conducted observations of CBTP activities (December 24, 2012 to January 12, 2013)	Identified areas, topics, themes for further data collection and analysis; created Phase II interview questionnaires (January 13, 2013 to February 25, 2013).
Revised and finalized questionnaires for Phase I interviews (January 13, 2013 to January 22, 2013); Conducted interviews with PSM educators (Phase	Situating preliminary findings from field observations within institutional context; Analyzed interview data and identified themes and subthemes

I) to explore institutional history and politics of CBTP (January 23, 2013 to March 13, 2013)	(ongoing throughout period of data analysis)
Selected texts from curricular documents based on topics and themes identified from previous analyses (January 13, 2013 to March 12, 2013, and ongoing throughout period of data analysis); Conducted reviews of the literature around these topics and themes (Ongoing from January 13, 2013 throughout period of data collection and analysis)	Did textual analysis of identified areas, topics and themes (January 13, 2013 to March 12, 2013, and ongoing throughout period of data analysis).
Revised Phase II questionnaires and conducted interviews with PSM educators (Phase II) on specific pedagogical activities (March 13, 2013 to April 1, 2013)	Analyzed interview data to identify convergences and divergences across participants, curricular texts and field notes (March 13, 2013 to May 13, 2013, and ongoing throughout period of data analysis) ; revised subsequent interview questionnaires as needed.
Created and finalized questionnaire for student interviews (May 14,	Analyzed interview data to identify convergences and divergences across

2013), and conducted interviews with students (May 29, 2013 to June 5, 2013)	participants, curricular texts and field notes (Ongoing throughout period of data analysis); revised questions for subsequent interviews as needed.

Observations of the CBTP. The CBTP was inaugurated on December 24, 2012 and included a pre-orientation program of three full days and three morning sessions that predominantly used the 'lecture' method of teaching. In the afternoon sessions, students visited sewage treatment plants, urban slums, an urban primary health care center, and the hospital waste management unit. They also practiced the basics of giving first-aid and played a simulation game. The general schedule of the program is described in tables 4 and 5 below.

Table 4: Pre-orientation program and urban component

Day	Lecture topics	Activities
1 (Dec 24, 2012)	Inauguration & pre-evaluation	First Aid
2 (Dec 26)	Communication skills and sociology, urban and rural health issues, substance abuse, health care system in India, health care waste management, sewage treatment plant, solid waste management	
3	Nutritional assessment, family study	
4	Importance of AYUSH for common ailments	Visits to urban slums, sewage treatment plant or hospital visit for health care waste management
5.	Personality development	Visits to urban

		slums, sewage treatment plant or hospital visit for health care waste management
6.	Health examination for children, oral health examination, survey proforma	Visits to urban slums, sewage treatment plant or hospital visit for health care waste management
7 (Jan 1, 2013)	Research methodology, medical ethics, PRA techniques and social mapping, Do's and Don'ts in during rural visit	Chikkanahalli simulation game

Following the urban component of the CBTP, students en masse were transported in large buses to the college's rural field practice area. For the next 8 days, students and teachers stayed in dormitories provided by a local religious institution from where they visited villages on an everyday basis. The CBTP in the rural area was packed with several activities. About 200 students were allocated to seven villages. Below is the itinerary of what students did each day.

Table 5: Rural component of the CBTP and conclusion

Day	Common activities	Activities rotated by village
1 (Jan 2, 2013)	Meeting with Local leaders Briefing on Social Mapping	
2	Geographical / Social mapping (9 am- 1 pm) Review of Family study schedule (5.30-7.30)	PHC visit and Defluoridation plant (2-3 pm) Health camp in village (3 pm onwards) Visit to Milk Chilling Centre (7:30 pm onwards)
3	Family study, Anganawadi Visit (9 am- 1 pm)	PHC visit and Defluoridation plant (2-3 pm)

	Review of School health (5.30-7.30)	Health camp in village (3 pm onwards) Visit to Milk Chilling Centre (7:30 pm onwards)
4	9 am-1pm School health examination 'Healthy lifestyle' Debriefing	PHC visit and Defluoridation plant (2-3 pm) Visit to special school (2-3 pm) Health camp in village (3 pm onwards) Visit to Milk Chilling Centre (7:30 pm onwards)
5	Monsoons simulation game (9 am – 1 pm) Briefing about survey (5:30 pm-7:30 pm)	
6	Survey on Nutrition assessment in the community (9 am – 3 pm) Debriefing on survey Briefing on community health education (5:30 pm – 7:30 pm)	Visit to special school (2-3 pm) Health camp (3 pm onwards)
7	Preparation for community health education Health Camp 5.30 -7.30 pm- Community health education	Visit to special school (2-3 pm) Health camp (3 pm onwards)
8	9 am-1pm *Shramadaan* (service by contributing time and labor through activities such as repairing or providing small things or painting classroom walls in the village school)	Health camp (3 pm onwards)
9	Report preparation	
10 (Jan 12)	Valedictory function-presentations by student groups and post-evaluation	

Because of the way in which the CBTP was organized, I had to make a choice between observing all pedagogical activities and observing all the different student groups. I chose to do the former as my research questions pertain primarily to understanding the design and implementation of the CBTP in its entirety, and less on the diverse iterations and enactments of specific pedagogical activities. Hence, I followed one student group assigned to villages 1 and 2, selected randomly, throughout the CBTP. I made an exception in the case of the health education skits when I observed the student group assigned to village 4 because I had observed the practice sessions of the student group that I was following.

Mediated discourse analysis (MDA). MDA served as both theory and method informing my observations and their analysis. The conceptual tools in MDA lend themselves well to analyze moment-to-moment interactions and to relate them to historical practices beyond the timescale of the interaction.

I recorded my observations in the form of field notes and reflexive memos. In field notes, I described the cultural and material tools employed in various pedagogical activities (Norris & Jones, 2005). For example, I paid attention to how student participants interacted with the built environment of the settings in which pedagogical activities took place as well as how they negotiated what they wore, said, and did in their performative interactions with community members in different sites in the CBTP itinerary such as the homes of community members and primary health care clinics (Emerson, Fretz & Shaw, 2011). In these different sites, I recorded through jottings snippets of informal conversations and discussions among students (Emerson, Fretz &

Shaw, 2011). These conversations helped me understand students' 'attention structures' during the activity, that is, what aspects of the setting and the interaction drew their attention, and how they negotiated meaning amongst each other and with community members during the interaction (Jones, 2005). I noted down in particular moments of contradiction or friction that they encountered in my observations of their interactions and/or that they narrated to each other in conversations. I interpreted these moments as points of convergence between the diverse cultural histories and practices of the participants defined in MDA as 'sites of engagement' (Norris & Jones, 2005). I also noted down their verbal and bodily articulations of their interactions with difference embodied in local men and women, and their environments as such points of convergence. In noting such points of convergence, I sought to explore how students negotiated the ruptures and disjunctures in their discursive frameworks, and how they made sense of them. I hoped to use these stories to enquire more deeply into how PSM teachers understood such contradictions, frictions, and reactions, and how they would respond to these moments pedagogically.

In reflexive memos, I reflected upon why I might be finding some experiences of participating in community field visits familiar, strange, surprising, and so on in an attempt to make explicit the memories, emotions, experiences, and discursive cues that mediated my observations and predisposed me to pay attention to certain actions and utterances more than others (Fabian, 2001; Norris & Jones, 2005). I then attempted to situate those experiences, memories and discourses as part of my gendered class habitus.

Document analysis. The textbook title, 'Textbook of Preventive and Social Medicine' (2010) by Park, K. in its 21st edition, was the primary document as this book is recommended throughout India at the undergraduate level, and for entrance exams for post-graduate admissions. I also used other documents such as the CBTP manual that PSM educators created as a text that students and teachers could refer to during the program. The manual was a summary of different topics that would be covered during the CBTP using primarily Park's textbook as a resource but also other sources. The summary focused on key points that students needed to know for the purpose of the CBTP. The manual also included other valuable resources such as the program's daily schedules, and survey questionnaires that students needed to use for different activities. I use the term 'curricular texts' to refer to Park's textbook and the CBTP manual, and specify the text when referring to only one of them. I use the term 'standard curriculum' or 'standard curricular text' to highlight that the use of Park's textbook is legitimated by institutions nationwide with the effect of naturalizing its statements as substantiated and valid truths. Other documents collected and analyzed for this study included pre- and post- test questionnaires that teachers employed to evaluate students' knowledge before and after the CBTP.

Selecting sections for textual analysis. The entire textbook or CBTP manual was not used for analysis. The research questions of this study guided my selection of sections of texts for data analysis. Field notes from observations also directed me to look at certain sections more than others. These sections tended to be in the borderlands between community medicine or PSM and the social sciences such as sociology, communication,

environment, and so on, and constituted the core in the corpus of data. Examples of such chapters in the textbook are- Man (sic) and Medicine: Towards Health for All, Concept of Health and Disease, Medicine and Social Sciences, Communication for Health Education and so on. Analyses of these sections allowed me to situate the discipline in relation to the biomedical framing of health and disease as well as in relation to paradigmatic perspectives within the social sciences. Within these chapters, I focused on the following themes: the methods recommended for learning about, interacting with, and producing knowledge about the community, characterizations of the community, and the explanations or rationalizations provided to understand such characterizations.

Critical discourse analysis methods: Identifying discourse types. I illustrate below the processes that I follow in undertaking data analysis through an example of an analysis of the chapter titled 'Communication for Health Education'. This chapter is divided into the following headings: The Communication Process, Types of Communication, Health Communication, Principles of Health Education, Practice of Health Education, and Planning and Management. I scanned the vocabulary for ideological words, and classification schemes to understand what discourse types the text draws from and might be in conversation with. Based on my theoretical framework discussed in chapter two, I identified discourse types by examining who was identified as subjects or actors, in what processes and events, and the attributes of these agents in the texts. For instance, I situated the text within the discourse type that theorizes the communication process from functionalist perspectives because the text employed the classification scheme of *sender/receiver* and stressed on efficiency of the process as a value. Thus, classification

schemes, metaphors, and grammatical aspects of language have experiential value in that they are cues to or traces of the ways in which the text producers' experiences, ideologies, knowledge and beliefs of the social world are represented (Fairclough, 2001). I also looked at the vocabulary and grammar for their relational and expressive values as well. For instance, the text may have expressive value in that it is a cue to and trace of the text producers' subjective values and thus, builds an identity for the readers as senders and as possessors of privileged knowledge (Fairclough, 2001; Gee, 2011). The text has relational value in the way that it may build the identities of senders and receivers and the relations between these two groups.

For example, the text below describes *one-way* and *two-way* communication(Park, 2010, p. 794). Two-way communication within this discourse type is hailed for its greater efficacy in influencing behavior than didactic modes of communication:

> The Socratic method is a two-way method of communication in which both the communicator and the audience take part. The audience may raise questions, and add their own information, ideas and opinions to the subject. The process of learning is active and 'democratic'. It is more likely to influence behavior than one-way communication

The involvement of the audience is understood as making the process active and 'democratic', and thus alters the sender/receiver classification scheme to some extent. The value of this two-way communication is, however, primarily to effectively influence the audience's behavior through their active engagement which reiterates the hierarchy between the sender and the receiver in the communication process The communication process is thus democratic to the extent that the audience can 'add their own

information'. However, such a process does not compromise or alter the sender's position as a knower in the sense of possessing knowledge that is largely valid and intact.

This analysis provided me an understanding of the theory or theories of communication employed in PSM largely, and raised questions regarding how these theories mediated pedagogical activities, particularly those involving interactions between students and community members. It also raised questions regarding how contradictions and frictions during interactions were interpreted as failures in the efficiency of the transmission of the message or as cues to problematize and alter the message itself. Similarly, I explored other methods used in the textbook such as surveys, interviews, home visits and so on, in order to understand how knowledge produced about the community might be shaped by the class and gender relations between medical professionals and communities, and helps build professional identities for medical students as primary consumers of this text.

Critical discourse analysis methods: Building cultural worlds of communities. I also looked at how language in the textbook was used to build cultural worlds, or figured worlds of local communities for its readers (Gee, 2011). Figured worlds are "storylines or descriptions of simplified worlds" in which particular actors can be recognized as being typically engaged in certain acts and where significance is built for particular valued outcomes more than others (Gee, 2011, p. 11). This helped me to look at how the text established a relationship with the readers who are future health educators and built their identities in relation to the communities with whom they will interact. For instance, people are undifferentiated in a passage of the text in the same chapter discussed above,

and are characterized as ignorant and lacking awareness about their own needs, as having prejudices and misconceptions regarding health matters, and unwilling to seek the 'right' information. In particular, scientific knowledge is positioned in opposition to the cultural values, beliefs and norms of the people, where the latter act as barriers in the acceptance of health information. This passage helped build the identities of the readers as health providers who possessed the 'right' knowledge and shared responsibility with the government and the media in disseminating this knowledge. Hence, these descriptions suggested a figured world of the Other as constituted of 'people' who lacked that knowledge and clung to cultural and religious beliefs. There may be multiple figured worlds, however, such as between the self and the lower classes, of Indians and the rest of the world, and others whose articulations might be inconsistent and contradictory. For instance, the phrase "Marriage is universal in Indian society" recurred in the textbook frequently. This framed the family as the 'primary social unit' for health interventions on implicitly heterosexual and biological grounds. The statement was also used to classify Indian and particularly rural culture in relation to the West, where the problem of unmarried mothers was stated as a problem in contrast to India. Thus, I explored how the intersection between different cultural worlds created ruptures in how communities were characterized, and what these ruptures meant in the construction of medical students' and teachers' identities.

Finally, the above analytical methods helped me to relate meanings produced during the CBTP or during interviews beyond the timescale of the interaction or the institutional history of JDMC to historical national and transnational actors such as the

Ministry of Health and Family Welfare in the Government of India, the Medical Council of India (MCI), and transnational institutions such as the World Health Organization (WHO) and conferences such as the Alma Ata Health for All Declaration in1991 amongst others (Norris & Jones, 2005). Intertextual references in curricular texts to these actors legitimated certain kinds of knowledge, and certain ways of understanding and knowing particular communities.

At the same time, I also looked for statements that sounded familiar to me or when ontological claims were made. I used these statements to reflect upon how my shared habitus with participants might be shaping these assumptions, and looked for alternative storylines primarily in the literature to frame further interview questions. I also paid attention, however, to contradictions and moments of crises where naturalized assumptions were being challenged. These included moments of surprise, amusement, awe and others. These strategies enabled me to study "sideways", that is, to situate participants' understandings within shared cultural discourses as well as to explore how they might be appropriating them creatively (Sutton & Levinson, 2001).

Interviews with PSM teachers. I employed semi-structured interviews as a method to understand PSM educators' rationalizations for the design of pedagogical activities, and their responses to my interpretations of these activities. I approached the interviewing process as a social practice where knowledge is co-produced collaboratively between the interviewer and the interviewee in the interactional process (Talmy, 2011). This approach recognizes that the interviewee responds to not only my questions but also to the interpretive cues that my bodily presence evokes and provides context to how the

interviewee might respond to me throughout the interviewing process. Therefore, I pay attention to both the content of what the interviewee says and the process by which this content might have been produced (Talmy, 2011). Such an approach pushes against the privileged stance that the researcher takes in extracting knowledge from the interviewee while maintaining a safe distance without exposing herself. My aim in the interview process was, therefore, to note the ways in which we negotiated our various knowledge claims in the process of communication. Hence, I audio-recorded the interviews so that I could analyze the back-and-forth discursive movements, the misunderstandings, surprises and disagreements that occurred during communication (Fabian, 2001). I also noted the changes in my own assumptions over the data collection period, and how such changes were shaped by my encounters with participants. Although I could not note the changes in my participants' assumptions because of the relatively short period of data collection, I have articulated their responses in the past tense to point out that their utterances were specific to the moments in which I asked those questions rather than fixed in time as well as shaped by the institutional context in which they were in. Most of them reiterated to me that the CBTP is an evolving program which they are constantly evaluating and learning from. Hence, the program itself may change as might their responses to similar questions, and these changes may or may not have been prompted by the research process. I discuss the implications of such an approach on the validity of the findings later.

I conducted two rounds of semi-structured interviews with the participants. In the first phase of interviewing, I inquired about PSM educators' personal and professional

backgrounds, the institutional history of the CBTP, the disciplinary politics around organizing it, that is, their goals, the challenges faced in initiating and organizing the program, and finally the evaluation strategies they have used in the past to address issues (see appendices for interview protocol). These interviews were approximately 45 minutes each.

The second phase of interviewing addressed specific aspects regarding certain pedagogical activities and lasted approximately 30 minutes each (see appendices for interview protocol). Since these interview questions were framed based on preliminary analyses of observations and curricular texts, they also constituted my early interpretations of the CBTP. For instance, I had developed some preliminary theories or patterns, if you will, that technology and the government were attributed agency in improving environmental conditions, and therefore the health conditions of communities with little mention of people's roles in making such changes. Hence, I sought to understand how teachers understood the role of people and politics in shaping environmental and health conditions of different places. Similarly, I sought to understand how teachers interpreted and addressed the production of certain stereotypes around rurality in particular pedagogical activities such as the monsoons simulation game, and health education skits. Thus, the second phase of interviews was an opportunity to share my interpretations with PSM teachers, and to engage deeply with them around certain issues that I found pertinent for both intellectual and political-ethical reasons. The sixth chapter, in particular, focuses on these conversations where I have sought to highlight how my own theories changed through my encounters with participants. Further, since I

conducted concurrent analysis with data collection, I tended to revise questionnaires so that there were slight differences in questions between participants. These revisions occurred in response to new knowledge gained through previously collected and analyzed data. Hence, the revisions of questionnaires also represent my learning process to an extent. Although I was unable to record the changes in thinking amongst PSM teachers during the research process due to the short duration of my study, I believe the interview process may have pushed teachers too to think differently about their practices.

Interviews with students. I conducted one round of interviews with students lasting approximately 20-30 minutes each. Unlike the interviews with teachers that took place in their office spaces or in the department lab, I conducted interviews with students in public places in the JDMC campus. All interviews were audio-recorded. Although my initial research design did not include interviews with students, I found it to be necessary as PSM teachers made several assumptions regarding what students learned through interactions. Hence, one of my goals was to complicate these assumptions by listening to students' perspectives; and not so much to triangulate, that is, confirm or disconfirm "evidence" gained from teachers and observations of the CBTP. Another goal of interviewing students was to understand how they might have interpreted pedagogical activities similarly and differently in relation to the discourses informing curricular texts. I was curious to know, as mentioned earlier, how they spoke about their encounters with cultural and material difference, given their different religious, linguistic, and place-based identities, and what discourses they employed to make sense of these differences. These interviews, while constituting a secondary data source, served as useful reminders of the

diversity of students' cultural backgrounds and in their consumption of discourses thus making me pause while making deterministic claims about the homogenizing effects of discourses. In addition to formal interviews with students, I participated in numerous informal conversations with students, particularly those assigned to villages 1 and 2, during the CBTP which I recorded in the form of field notes. I also spent time with students informally in the bus when we played singing games as we travelled from one place to another, at lunch and dinner times in the common hall, and when we went trekking to the nearby hills in the early hours of a few mornings.

Transcription. I conducted audio-recordings of the semi-structured interviews with students and teachers. In situations when knowledge can be gained more through participating than in the form of collecting facts, recording data was postponed. In such situations, I relied upon field notes that I attempted to record as soon as possible after the event (Fabian, 2001). In the case of audio-recordings, I transcribed them personally immediately after conducting the interviews so that I could recall and record nonverbal gestures, facial expressions, and other subtle cues that struck me as relevant using Inqscribe. When transcribing immediately was not possible, I noted down pertinent points in reflexive memos. These practices were useful in constantly thinking about the data, forming early categorizations for analysis, and in identifying areas that needed to be pursued with the same or other participants.

Audio-recordings are often treated as neutral records of a conversation that can be referred to even after an event has occurred. However, the process by which an oral discourse is transposed into a literary form privileges my interpretations of the audio-

recordings as the researcher or the 'knower' (Talmy, 2011). Hence, the transcripts include sounds that may or may not be parts of incompletely articulated words, although it affects the readability of the transcript. I have, however, included punctuation marks such as full stops and commas, and capitalized words at the beginning of sentences to enhance the readability of transcripts. My analyses, however, were based on the raw transcripts that did not include these grammatical changes. While I have not highlighted differences in grammatical usage through the use of identifications such as *sic*, I have used square brackets [ ] to offer my translations of certain indigenous references or to point out portions of the transcripts that were unclear and that involved a degree of 'guesswork' on my part.

Data analysis. As mentioned earlier data analysis was closely intertwined with data collection procedures. I used a combination of Atlas. ti and Evernote for maintaining the database and for qualitative data analysis. Data sources include field notes, reflexive memos, interview transcripts, and documents. I used Evernote to write and organize field notes and reflexive memos. In addition to using MDA where I identified and analyzed certain encounters in depth described earlier, I also identified themes within field notes and reflexive memos from observations, and summarized them in the form of analytical memos in Evernote. As mentioned earlier, interview questionnaires represent my early interpretations of observation data. I also presented my initial thoughts on the program in a public presentation in the medical college at the conclusion of the CBTP which is accessible online (http://prezi.com/qupykuu69ket/?utm_campaign=share&utm_medium=copy&rc=ex0shar

e). Observation data was organized according to specific pedagogical activities, and according to the date that they occurred. Reflexive memos included patterns or themes that cohered across two or more pedagogical activities or events.

In Atlas.ti, I coded interview transcripts- divided into Phase I interviews for teachers, Phase II interviews for teachers, and student interviews. Coding was informed in part by my theoretical framework but also by my preliminary analysis of data gathered from observations. The data was categorized initially based on the pedagogical methods used to learn about the communities visited such as surveys, visits to homes, and so on. I then looked for repeating themes as well as divergences across participants and data sources regarding each method, and then across the different methods used.

Following coding, I created networks of codes that explored relationships between codes, particularly in the case of Phase I interview data. I then wrote analytical memos in Evernote and constantly revised and reorganized the emerging patterns and themes. The Phase II interviews were already categorized according to specific pedagogical activities, and the themes that I sought to explore in further depth. Hence, in these interviews, I coded for quotes where certain assumptions around pedadogical activities were stated clearly. These constituted 'evidence' for my hunches developed through observations, and of cohering patterns across teachers. I also coded for quotes where my assumptions or hunches were challenged, and where there were contradictions in what individual teachers said, and between teachers. Throughout, I attempted to construct narratives of the data that I had analyzed in analytical memos. When I analyzed student interviews, therefore, I focused primarily on differences in interpretation between

students, and between students and teachers, although I also looked for quotes where the homogenizing effects of students' interpretations were apparent.

I created summary memos in writing and in the form of a presentation at the conclusion of the study. I presented the latter to the department, the principal of JDMC, and the director of Medical Education that can be accessed online (http://prezi.com/0rmadppympwr/?utm_campaign=share&utm_medium=copy&rc=ex0share).

I later pulled out quotes from different participants that illustrated particular broad themes, and organized them in an attempt to summarize them into coherent storylines. Repeated attempts to do this created multiple outlines and narratives. The story articulated in this dissertation thus is one that I wanted to tell at this given moment, although it could have been constructed in several different ways to achieve different purposes.

Addressing Validity Threats

Validity threats typically are understood as issues in conducting research that can compromise the truth value and the credibility of the knowledge produced. These may include the possibilities of participants explicitly lying to researchers or telling them what researchers would like to hear. It could mean that the researchers' values and biases may have influenced data collection and analysis so that they only confirmed what they already suspected.

Certain strategies have been developed in the past to address these validity threats, particularly in qualitative studies. These include long-term and intensive

involvement with participants, member-checking participants' statements with them, and triangulation of data collection methods and participants. These strategies, however, assume that there are true stories that can be found in reality and accurately represented in relation to this reality. Further, such true stories can be found if an adequate distance is maintained between the researcher and participants so that the researcher's own biases will not interfere in finding these stories and in representing them. Interpretivist and constructivist researchers, however, justify these practices for ethical reasons as they seek to privilege the constructions of their participants over their own (Guba & Lincoln, 1998). Critical scholars who are also social constructivists, however, seek for alternate criteria that can help them distinguish between constructions that explicate their differential relationships to power, and the material effects they can produce (Fabian, 2001; Lather, 1986; Kincheloe & McLaren, 2000). Postmodern scholars dismiss the very notion of objectivity and insist on rhetorical creativity instead in representing participants' stories persuasively while also problematizing the coherence of their own representations, and their relationships to "the real" (Clifford & Marcus, 1986).

From a constructivist perspective, I maintain that the knowledge produced in this research is constructed rather than an accurate representation of this particular medical college or of the phenomenon of community service learning broadly. This does not mean that it is false. Rather, it means that my motivations and interpretive choices influenced what I observed and noted down as pertinent and how I included and excluded certain texts and quotes in order to tell a coherent story that was compelling to achieve particular ends. Hence, I compared diverse data sources (Maxwell, 2005; Patton, 2002):

the texts produced across different pedagogical activities as well as students, and teachers' perspectives, to look for coherence across them that helped me tell a compelling story, and to answer specific questions about knowledge production. My goal, however, in comparing these different data sources was not to privilege coherence as truths, and divergences as falsehoods but as different interpretations shaped by different interpretive contexts. For instance, the revising of questionnaires from positivist perspectives could be considered sacrilegious because I compromised the internal validity of the study as I did not replicate the same questionnaire or the setting for different participants. Hence, I could not compare the responses from different teachers as responses to my objective questions in a controlled setting. However, I understood the interview data as a co-constructed process, and considered how my positionality might have shaped participants' interactions in the analyses of my data (Talmy, 2011). I also understood my interview questionnaires as early interpretations which allowed me to explore how subjective changes in my own interpretations took place over time through an encounter with participants.

From a critical perspective, I strived to make "subjectivity a condition for objectivity" (Fabian, 2001, p. 5). To clarify, I attempted to describe my presence in this research and how it shaped interpretive processes so that the knowledge produced could be located or situated as coming from a particular place in the world (Haraway, 1989). By locating my subjectivity, that is, specifying my interpretations of the sociospatial distances between myself and my participants, does it become possible to understand how I have constructed my participants and their practices- the 'objects' of my study.

Hence, this story is shaped by the relationships I developed with PSM teachers spending approximately six months intermittently at this college with the symbolic and material resources I had at my disposal. Certainly, other stories could have been told from different social and political locations. In striving for a located objectivity therefore, I have sought to highlight the links between my goals, interpretive frameworks including academic theories as well as personal memories, experiences, and reflections, and objectified texts such as field notes, quotes, and excerpts from documents.

I also based the study on the principle of intersubjectivity whereby the process of knowledge production involves a change in the researcher and the researched further disrupting the notion of a distance between them (Fabian, 2001). I addressed the problem of reactivity, where the researcher's presence might affect participants' reactions and vice versa, by drawing from Patti Lather's (1986) concept of construct validity. In order to show construct validity, I described how my *a priori* preliminary theories of PSM educators' practices have changed by my engagements with them. Although this study does not employ catalytic validity where one would examine how participants' perspectives might have changed in the research process, I noted moments of 'friction' or confrontation between participants' and my own theories of practice that may have triggered changes in their perspectives as well (Bourdieu, 1990; Fabian, 2001; Tsing, 2005). I also shared with postgraduate students and teachers my interpretations through my interviews, and in two public presentations. In the second public presentation, I also shared some research articles that had informed my own interpretations, and that I hoped teachers would find useful in thinking through their own practices from the perspectives

that I had shared with them. Rather than doing a member-check of transcripts with participants, I shared my interpretations with them where they could negotiate their concerns with me privately or publicly which indeed did happen. This decision was motivated partly because they were extremely busy. However, it was also partly pedagogical and shaped by my interests in effecting changes in their approaches from a critical perspective, and partly to 'check' and complicate my interpretations by putting them under the scrutiny of my participants (Lather, 1986).

I also constantly looked for divergences and contradictions in the narratives of single participants and across them. My goal in doing so was informed from a poststructural perspective to highlight the agency of participants in negotiating homogenizing discourses, and to avoid my construction of another metanarrative. This does not by any means downplay the power of the discourses and institutions that I describe in this study but shows how these are negotiated at the micro-level so that their effects cannot be unambiguously predicted.

Finally, the validity of qualitative research is often questioned in terms of the generalizability of the findings to the population being studied, particularly when one or two settings are involved (Maxwell, 2005). This study, however, while limited to a single site in a demographical or geographical sense is not limited conceptually to a single-level analysis. I study 'up' using critical ethnographic and discourse analysis approaches to explore how the sociocultural resources that medical students converge with those of community members in rural and urban field practice areas in interactions between them to produce multivoiced, and therefore multisited meanings about these localities and the

people that inhabit them (Wertsch, 1991; Norris & Jones, 2005; Vavrus & Bartlett, 2009). These meanings are local in that they are context-specific shaped by the configurations of time, space, and the actors involved in the interaction, yet agency in the production of these meanings can also be distributed to actors located in sites and times beyond the specific interaction (Jones, 2005). Importantly, I connect these meanings to global and national institutional actors through intertextual references while also situating these meanings in the disciplinary history of public health in the specific context of postcolonial India (Fairclough, 2001).

As argued earlier, however, the narrative constructed in this study is not meant to be understood as a universally valid truth or a metanarrative. I strive, instead, to describe the conditions that shaped my interpretations and offer conceptual strategies to readers to make sense of similar phenomena in their own contexts. Hence, I leave it to the readers to identify aspects of the study that may be comparable and transferable to their contexts (Lincoln & Guba, 1985).

Chapter IV. Introducing Science/fictions in Public Health

Introduction to the Findings

In this chapter and chapters five and six, I discuss the findings regarding how a community-based teaching program (CBTP) at Jeevan Daan Medical College (JDMC) in Bangalore, India produced "science/fictions" about rural and urban poor communities, and how these science/fictions were shaped by transnational development discourses on one hand, and the situated knowledges of medical teachers and students on the other. As argued earlier, while expert needs discourses make arguments for a redistribution of resources to particular communities, the needs themselves may be framed or interpreted by 'experts' without including community perspectives (Fraser, 1989). This is a form of representational injustice since communities are excluded politically in the reframing of their needs (Fraser, 2005; 1996). Even when included, however, community members may be misrecognized in the sense that their voices are misinterpreted, silenced or considered invalid, thus failing to reframe expert needs discourses. This constitutes a form of recognitional injustice (Fraser, 2005; 1996). The study thus is concerned with how the community, as counterpublics of the dominant public- PSM educators, and students at JDMC (Fraser, 1990), may constitute an alternate pedagogical 'site of engagement' (Norris & Jones, 2005, p. 139), where individuals with diverse social histories and discourses converge in unpredictable ways to produce knowledge that disrupts and renarrativizes expert needs discourses.

In analyzing and writing the findings, I constructed and employed the term 'science/fictions' to talk about expert needs discourses in the context of science education

broadly, and public health in particular. In the fourth chapter, I explore the discursive frameworks informing the CBTP curriculum, that is, the standard textbook used nation-wide, and other texts such as the CBTP manual prepared by the department, and the 'how-to' guidelines for an educational game borrowed from a non-governmental organization (NGO). In this chapter, I explore the oppositional relationship between 'science' and 'fiction' by examining the scientific curriculum as cultural texts produced by particular groups of people. By treating the scientific curriculum as cultural narratives, I explore the traces of the actors who created them, and thus attempt to situate the knowledge produced as coming from 'somewhere' (Haraway, 1988).

Taking the examples of the monsoons simulation game, and visits to a sewage treatment plant in the urban setting, a defluoridation plant in the rural setting, and primary health care centers in both settings, I show how curricular texts mediating these activities are informed by discourses of modernization and neoliberalism. As ideologies of governance, these discourses have particular social and political histories so that the boundaries between science and fiction get blurred. I discuss how each of these pedagogies produce cultural narratives that construct modern identities for the nation as a whole through particular classed, and gendered interpretations of rural spaces and urban slums. However, the characterizations of these rural and urban spaces and the people inhabiting them are not always consistent; they are sometimes contradictory due to an intermingling of different discursive frameworks that do not cohere well together. While the modernizing impulse of public health discourses allow PSM teachers and students to construct themselves as modern, urban, educated professionals in relation to the

communities they seek to reform, residents of villages and urban slums are constructed as part of an empowered nation-state at other times (Stallybrass & White, 1986). At the same time, these contradictions in the characterization of communities create a liminal space wherein lies the potential to destabilize the truthfulness of science/fictions and create new narratives (Bhabha, 1994).

In the fifth chapter, I explore how encounters with local communities may create opportunities to further destabilize the authority of these science/fictions. I continue the conversation initiated in chapter 4 regarding the objectivity of scientific knowledge by exploring the social conditions in which knowledge was produced. To that end, I examined how students negotiated their relationships with communities and meanings about their lives through direct and imagined interactions with them. I suggest that the historically unequal social relations between medical institutions and communities shape how global science/fictions mediate students' ways of seeing, and understanding of local places and people. However, I also discuss how the community, as counterpublics, constituted an alternative pedagogical site of engagement where situated meanings of places converged with travelling discourses to destabilize the authority and universality of science/fictions (Fraser, 1996; Norris & Jones, 2005). However, such disruptive knowledge was unevenly produced and not collectively engaged with to reframe or renarrativize science/fictions.

In the sixth chapter, therefore, I attempt to re-narrativize the science/fictions produced about communities towards alternative understandings. I take specific dialogical 'encounters' with teachers in how we, the teachers and me, differently

understood the relationship between people and places (Fabian, 2001), and discuss the pedagogical implications of politicizing these relationships, particularly when communities are engaged with knowledge production. The crux of my argument in this chapter is to suggest that performative actions and interactions with communities are not by themselves transgressive. The radical potential of a particular pedagogical practice lies not in the method itself but in the dialectical interplay between the practice and the theories that mediate it (Bourdieu, 1990). I suggest that the politicization, that is, examining the social, historical and political influences, of public health texts is necessary for both conceptual and ethical reasons so that pedagogical practices can produce transformative knowledge. Engaging with different disciplinary and paradigmatic perspectives may be one way to renarrativize science/fictions, not as an alternative to engaging with local communities but in order to firstly recognize them as epistemic equals, and secondly to subject public health texts to political interpretation amongst and across its publics and counterpublics (DeJaeghere, 2012; Fraser, 2005; 1989).

Relating findings chapters to research questions. Using data from observations of the CBTP and curricular texts, chapter four addresses the broader question around the nature of science/fictions, and how they are shaped by transnational development discourses. In chapter five, using data from observations primarily but also interviews and curricular texts, I address the subquestions more closely around how the situated knowledges of participants shape the production of science/fictions and mediate students' interactions with community members, and how they may be disrupted or not in the

process. Chapter six addresses the third subquestion around how knowledge produced through encounters with the community in the CBTP was used to renarrativize science/fictions using data from teacher interviews.

How did a community-based teaching program (CBTP) in public health at a medical college in India produce 'science/fictions' about communities living in rural areas and urban slums?

How were these science/fictions shaped by transnational development discourses on one hand, and the situated knowledges of PSM teachers and students about these communities on the other?

1. How did these 'science/fictions' mediate medical students' performative actions and interactions with the residents living in an urban slum and a village?
2. How did these communities constitute counterpublics or alternative pedagogical sites of engagement to disrupt these science/fictions?
3. How was knowledge produced through encounters with the community used to renarrativize universalizing science/fictions?

Actors in Public Health and Development

In this chapter, I explore how various pedagogical activities implicitly attribute agency to human and non-human actors in community development (Fairclough, 2001; Latour, 1996). I draw from Latour's (1996) actor-network theory, and from Anand's (2011) work on urban metabolism to understand the material-semiotic relationships between human and nonhuman actors. I first show how visits to the sewage treatment plant, the milk chilling center, and the defluoridation plant discursively construct

technology as a significant development actor in urban and rural spaces respectively. Although these visits also implicitly position the state as a benevolent development actor, visits to the primary health care center, the anganwadi[3] center, and the government school do so much more explicitly. In all of these various texts, different ideologies of governance and development are deployed that objectify rural and urban slum dwellers in essentialized ways while unfailingly attributing agency to the state, and technology.

The collusion between the state, and science and technology, however, is not new as historically the colonial state deployed science and technology to legitimize its control over the population (Prakash, 1999). In doing so, it constructed particular ways of knowing as legitimate more than others. This legacy has been carried on by the postcolonial nationalist state as well, as medical curricula continue to produce the fiction of a benevolent state despite its decreasing presence in the current neoliberal policyscape (Carney, 2009). The production of this fiction allows the state to take credit for the successes of development, and to justify its complicity with the markets in framing development agendas while ensuring that the failures can only be attributed to its so-called beneficiaries.

Yet, who is the 'state', and how does it function? By examining how the various texts attribute agency in neutral, scientific language, I show how PSM teachers participate in policymaking on the ground as they repeatedly cite discourses of governance while positioning their knowledge practices as neutral and apolitical (Butler, 1988; Fairclough, 2001; Levinson, Sutton & Winstead, 2009).

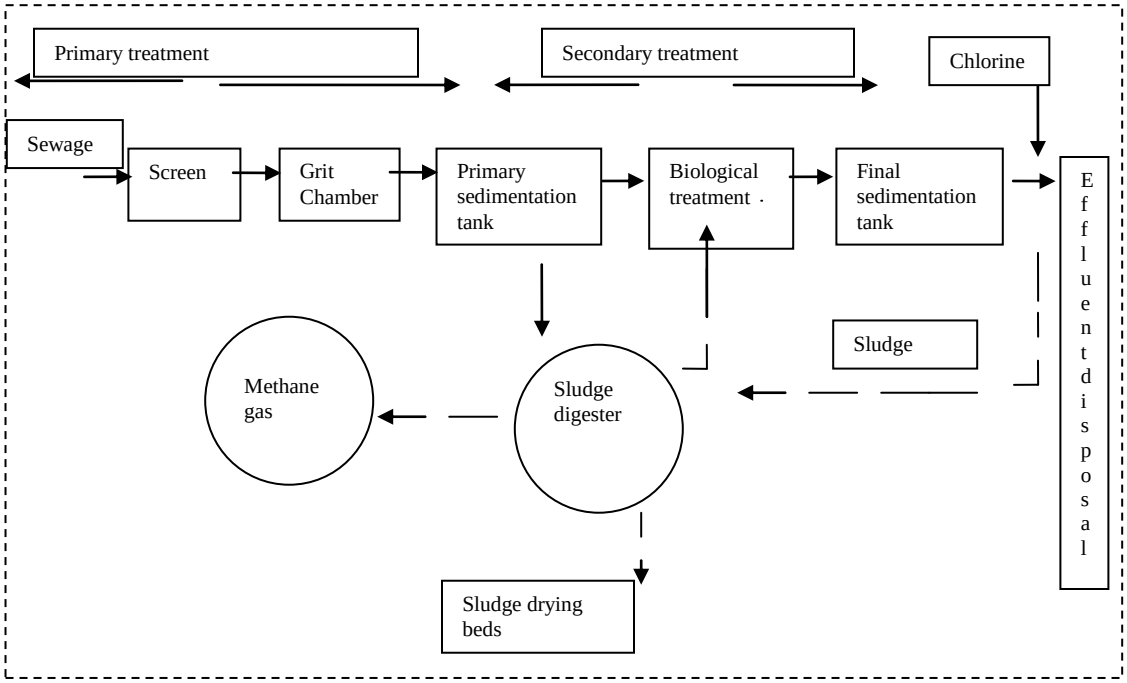
[3] Anganwadi, or 'courtyard shelter' in Hindi, started to promote early childhood basic health care and education in villages as part of the Integrated Child Development Services (ICDS) program in 1975.

Non-human actors in public health and development. In this section, I illustrate how technology was staged as an actor in the pedagogical visits to the sewage treatment plant, the milk chilling center, and the defluoridation plant. The actors involved are components of the physical environment such as sewage, milk, and water that are modified for the benefits of the community at large through the use of scientific technology.

The symbolic economy of sewage. In the text below on the sewage treatment plant retrieved from the CBTP manual, it becomes clear that agency is attached to sewage as it is identified as the perpetrator of diseases through the breeding of flies, mosquitoes, and helminths that can harm the health of communities through the contamination of food, and the environment. Technology embodied by the sewage treatment plant is the other actor that converts the 'nuisance' to a safely disposable effluent, no longer harmful to both nature and humans.

> **Composition of sewage:**
> Sewage *(S)* contains 99.9 % of water. The solids which comprise barely 0.1% are partly organic and partly inorganic; they are partly in suspension and partly in solution. The offensive *(A)* nature of the sewage is mainly due to the organic matter which it contains.
> **Health aspects**
> Unless prompt measures are taken to provide proper means of sewage disposal, the following environmental problems may be created:
> - Creation of nuisance, unsightliness and unpleasant odours.
> - Breading of flies and mosquitoes.
> - Pollution of soil and water supplies.
> - Contamination of food.
> - Increase in the incidence of disease, especially enteric and helminthic diseases.
>
> **Aim of sewage treatment:**
> To stabilize the organic matter so that it can be safely disposed off and to convert the sewage water into an effluent of an acceptable standard of purity which can be disposed of in to land, rivers or sea.
>
> Modern sewage treatment plants are based on biological principles of sewage purification, where the purification is brought about by the action of anaerobic and aerobic bacteria.

Flow diagram of a modern sewage treatment plant



- Excerpt on the sewage treatment plant (Retreived from CBTP manual)

While the language in this text appears technical and neutral, it does enact certain identities and social relations. By making "modern sewage treatment plants" key actors in producing healthy environmental conditions and by taking students to witness these plants in practice, the text asserts the modernity of the nation as a whole. Conversely, sewage by its 'unsightly' presence and 'offensive' odors can act as a signifier of a space that is not modern, particularly to the gaze of an outsider (Stallybrass & White, 1986).

In taking the analysis from the textual level to the social context within which this text was consumed, I'm reminded of when Dr. Murali spoke ruefully of the city's moniker being changed from Garden city to Garbage city in his lecture on the sewage treatment plant. In that lecture, he stressed the aesthetic value of sewage treatment as

much as he did the material effects sewage had on health and the environment, if not more. This stress on enhancing the aesthetic look, however, cannot be interpreted as unrelated to, and separate from the material or economic domain, as it has immense consequences for the city's modern image, given the huge number of international visitors here and its increasing participation in the global economy. Indeed, it is this desire to project a beautiful, clean, wealthy, and modern city to the global traveler that prompted the relocation of several urban slum dwellers during the 2010 Commonwealth Games in New Delhi (Nelson, 2009; Sudworth, 2006). The desire to mimic the aesthetic look of European and North American spaces is particularly apparent in the burgeoning advertisements on hoardings, and newspapers for spacious residential enclaves within and surrounding this city. The following image and text has been retrieved from a

website of a popular construction company in Bangalore.

Inspired by the vibrant culture centers such as London's West end and New York's Broadway, the architecture of this project thoughtfully blends contemporary high rise living with lifestyle choices of Art, Music and Cinema. At Purva Westend, its fine living like nowhere else.

- Retrieved from http://www.puravankara.com/pages/Residential_On-going_Projects

Discursive texts such as these, fuel the desire amongst the aspiring upper and upper middle-classes for luxurious enclaves to spatially separate themselves from the urban poor (Holston, 2008). In this process of capturing and shaping the urban landscape, slum dwellings are pushed to cramped spaces where they cannot be seen, yet where they can be easily sought out for servicing elite spaces. In the description of the flow of sewage from homes to the plant, and eventually the river when it becomes safe for disposal, the glaring absence of humans is similarly significant. Implicitly, the humans behind the technology such as engineers are the ones that are applauded for engendering a discursive and material shift of this postcolonial nation's associations with filth and poverty, with little mention of the scavenging, garbage picking, and sanitary work done by men and women from the margins of urban society. Such a theory offers little scope to disrupt the chains of signification that uncritically links offensive odors and unsightly filth to certain social spaces and groups (Stallybrass & White, 1986). It is not surprising then that the questionnaires medical students take with them to the homes of slum dwellers are structured to assess their sanitary conditions in deterministic and objectifying ways, a phenomenon I explore later.

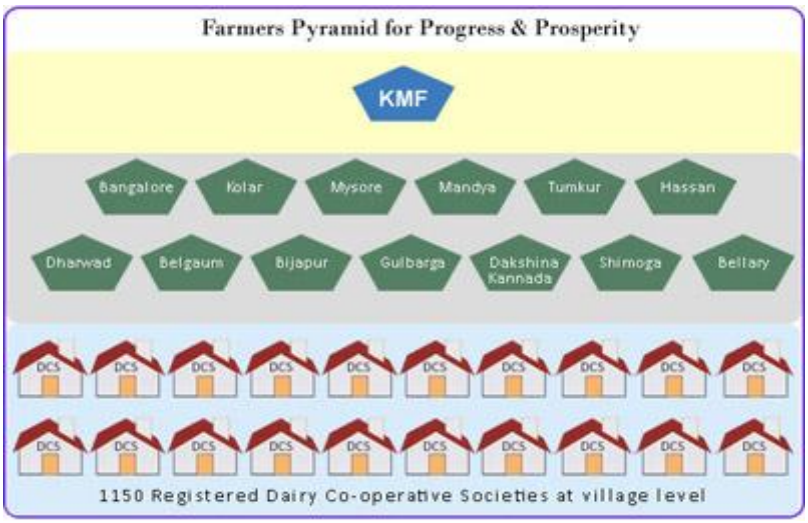
Water, milk, and two discourses of development. While the sewage treatment plant staged the flow of waste and its meanings at a national and global level, the milk chilling center illustrates the complex movement of milk from the udders of cows in rural spaces to international markets (Prakash, 1999; Anand, 2011). The defluoridation plant too makes the distribution of scarce quality water a central actor in the lives of rural communities that urban middle class communities in the same region of water scarcity

might easily take for granted. These visits are different from the visit to the sewage treatment plant in that they make implicit connections to the impact they have on the development of rural communities in particular. However, they are similar in the use of neutral language describing the technical processes involved in ensuring the hygienic and nutritive value of milk, and the optimum level of fluorides in water.

Public health language is used, for instance, to name the different kinds of bacterial diseases that spread through milk. Bacterial contamination of milk can affect entire communities if hygienic standards are not met from production including the breed and health of the milk-yielding cows, the vaccination statuses of the dairy farmers, and the milching processes that they employ to the point of distribution. In this case, the offenders are the microbes that can spread disease, rendered visible through microbiological tests such as the methylene blue reduction test (MBRT). In order to ensure that communities far and wide receive fresh and hygienic milk, the role of technology becomes central. The milk chilling center offers medical students an opportunity to witness the complex and routinized performance of technology coordinating the smooth movement of milk from trucks through various containers under specified cooling temperatures, and procedures such as pasteurization before it reaches the doorstep of the consumer. Although this new site in the CBTP itinerary pushed the boundaries of the syllabus from technological processes such as pasteurization to the organization of dairy farmers' lives through this cooperative institution, the following text from the CBTP manual was consistent in placing technology as a 'revolutionary' actor in the development of farmers.

> The KMF [Karnataka Milk Foundation] is forerunner to introduce this innovative technological initiative for bringing about revolutionary improvement in quality of milk collected in DCSs [District Co-operative Societies]. This system has several advantages such as elimination of mastitis in milch animals and improvement of productivity. **The milk from milking machines, collected through Automatic Computerized Milk Collection Units is chilled directly in Bulk Milk Coolers. This chilled raw milk, untouched and unadulterated by human hands, has very high microbiological quality, comparable to international standards. This high quality milk is being utilized for manufacturing high quality value added milk products, for both domestic as well as international markets** [emphasis in original].
>
> - Retrieved from CBTP manual.

This paragraph illustrates the centrality of technology in the 'revolutionary' improvement in the quality of milk collected through the use of milking machines, and the automatic computerized milk units. Further, the use of technology ensures the complete control over human and microbial contamination by producing milk 'untouched and unadulterated by human hands'. In this way, the milk chilling center through the use of technology becomes an embodiment of modernity and good health at par with international markets. Importantly, the milk chilling center embodies sustainable development that takes along rural dairy farmers in this progress towards modernity. The following excerpt from the CBTP manual shows the organization of the KMF as a democratic and grassroots organization which was stressed upon by the representative to us at the milk chilling center:



The organization is three tiered on Co-operative principles.
A. Dairy Co-operative Societies at grass root level.
B. District Co-operative Milk Unions at single / multi district level.
C. Milk federation at State level.

All above three are governed by democratically elected board from among the milk producers. Under the direction of elected boards, KMF, various functional Units & Unions are performing the assigned tasks to ensure fulfillment of organization objectives.
During the last ten years, the Federation has given greater emphasis on procuring quality milk from DCSs under the concept of "Quality Excellence from Cow to Consumer."

- Retrieved from CBTP manual.

I recognized "dairy co-operative societies", "democratic", and "grass root" as ideological words that position the KMF within 'the white revolution' and grassroots development movement in India (Fairclough, 2001). These words evoked an association for me with 'Amul', the first dairy cooperative in India that spurred the white revolution, a matter of pride for Indians not only because it became the largest milk producer in the world at that point but importantly because it was made possible through the cooperative organization of thousands of rural dairy farmers.

I was reminded of the semi-fictional film made by Shyam Benegal, 'Manthan (The Churning)' in 1976 (co-financed by 500,000 farmers who donated Rs 2 to the

production of the film) regarding the local cultural politics around milk collection and distribution in the context of creating a dairy cooperative (http://www.amul.tv/amultv/viewfeaturedmovie.html). This movie, importantly, did not conclude with the depiction of rural dairy farmers achieving the end-goal of empowerment. Instead, it pointed out the complex class and sexual relationships between rural dairy farmers in a village who were very often women, and an urban, middle class, and educated 'pioneering' group of men headed by a veterinary doctor, who came to this village with the goal of introducing a milk cooperative. The story ended with their frustrated departure from the village after having triggered not progress but a vicious caste politics between the rural dairy farmers and existing controllers of the milk distribution system. Their departure not only signified their privilege to enter and exit at will but also deliberately placed the agency on the rural dairy farmers themselves in the possibility of triggering a social movement. By highlighting the messiness of rural politics in the context of developing a milk cooperative, it pointed out that the empowerment of rural dairy farmers is not inevitable but an ongoing power struggle whose end cannot be predicted.

In contrast, the title of "Farmers' pyramid for progress and prosperity" in the CBTP manual assumes an empowered rural population whose integration into a democratic organizational structure and a Fordist technological assembly line allowed them to participate competitively in international markets, the ultimate marker of economic development. As this commodity acquires a brand name, wiped clean of any traces of microbes and human labor, to take on a life of its own in it cross-border

exchanges, one wonders how and to what extent the profits as well as the health benefits generated through this technology reach the farmers at the bottom of the pyramid (Rose, 1977). Although students need to learn about the international standards of milk quality as measures of health which may appear to be disconnected from the social and political organization of milk and is indeed peripheral to the curricular domain, such characterizations of technology as actors in rural and national development are very much implicated in circulating and legitimizing politically motivated cultural myths. Whether and how the cooperative is indeed economically and socially empowering to the dairy farmers in the case of Amul or in the case of KMF are questions that remain with me as we, the students, the teachers, or myself did not raise them in our conversations or in our subsequent interactions with village residents, to my knowledge. Consistent in other visits such as the defluoridation plant and the primary health care centers was the narrative of progress where the government was also identified as the primary actor in public health reform and development.

Government as actor. Every medical student is expected to learn about the public health care system including anganwadis, and primary health care centers (PHC). This is done through a theoretical description of the system in the community medicine syllabus but also through two month postings in rural and urban PHCs as part of their mandatory internship at the end of their degrees. From a functionalist point of view, this makes sense as medical students need to learn about their roles in relation to other health workers in the system. These curricular policies are also crucial in socializing them into choosing to be primary health care practitioners rather than in private, tertiary health care centers.

However, from a dramaturgical point of view, the visits to anganwadis, the PHCs, and government schools also act as symbolic displays of power (Cohn, 1996; Prakash, 1999). They construct a benevolent state that is deeply concerned with the welfare of the population which is strikingly in contrast to discursive constructions in the popular media as corrupt, self-interested, and apathetic to the concerns of the poor and marginalized. These also depict a rationally planned bureaucratic organizational structure where everybody's roles and functions are clearly defined with very little room for ambiguity. For instance, when we walked into the urban PHC, the postgraduate described to us the mandated structure of a typical PHC and its functions. A typical PHC must have a labor room, and the necessary facilities to conduct deliveries and abortions, the general examination room, a storage room for the pharmacy, a room where immunizations are conducted and vaccines are stored at prescribed temperatures, the Medical Officer's office, a room for other staff members, and toilets. She mentioned to us the typical staffing pattern at a PHC, the population that is usually under its jurisdiction, and the stipends and incentives that the honorary members like the Auxiliary Nurse Midwife (ANM) and Accredited Social Health Activist (ASHA) get for the work they do. The important point to be noted is that the Ministry of Health and Family Welfare has laid down official guidelines regarding these structures and functions that students are expected to know. This implicitly gives the impression that a well-organized and a smoothly functioning public health care system already exists. There were also several posters inside and on the walls of the PHC informing the larger public about the various

health schemes targeting the most marginalized groups such as women, children, and those with BPL (below poverty line) cards.

The anganwadi worker (AWW) in the village anganwadi, and the medical officer at the rural PHC mentioned a list of health schemes implemented in that area and how they benefited the local community. In our visits to the village government schools for a school health examination, and the anganwadis, we also learned from the school teacher about the interconnectedness between these educational institutions, and the PHC doctors who conduct periodic health examinations of children. All of these images, and sounds reinforced the impression that the state had everything in place with regards to taking care of the health and educational issues of the most marginalized.

Human actors in public health and development. In this section, I discuss two distinct social groups positioned as actors in public health and development: PSM teachers and staff, and anganwadi workers (AWW). Both, while part of the civil society, nevertheless acted as agents of governance.

PSM teachers as agents of governance. Unlike the milk chilling center, the defluoridation plant is a homegrown community development intervention. The plant is a testimony to the long-standing work of the community medicine department with the community in the rural field practice area. In the visit to the defluoridation plant, the postgraduate guide described the skeletal and dental problems that high levels of fluorides in water would cause, an endemic health issue in the area. This set the stage for a justification of the plant followed by a description of the various kinds of technological processes involved in defluoridation with an emphasis on reverse osmosis, the method

used at the plant. Here too like in the visit to the sewage treatment plant, and the milk chilling center, we were informed about the flow of water through pipes from different sources of water in the community to undergo reverse osmosis in the plant and its distribution through a tanker to different parts of the village (Anand, 2011). In this case, however, while technology remained a significant actor in community development, the visit also highlighted the central roles of the college management and the department staff in establishing this plant in collaboration with local leaders in the community through the village government (the panchayat), and a national grant giving body- the Council of Scientific and Industrial Research (CSIR). Further, the guide stressed on the importance of community participation, thus assigning community members agency in this intervention as well. However, participation was understood in largely neoliberal terms through the payment of Rs 5/- for 25 liters of water (O'Reilly, 2006). While this price was perceived to be nominal, the guide and the PSM teachers in my conversations justified it on the principle that when something is given for free, community members fail to appreciate the value of the received good.

While this notion of 'community participation' on the surface seemingly constructs the community as actors of development, it disguises the capitalist relations between those that produce and consume technologically available 'natural' water (Fairclough, 2001; Robbins, 2012). The PSM teachers, however, insisted that this was not a capitalist venture in that they were not seeking profits. Rather, they justified the payment on a moral basis as well as to sustain this intervention since the CSIR, a government body, ensured only infrastructural support while the responsibility of running

the plant lay with the college institution and the community itself. The medical institution's actions make sense within the neoliberal policyscape in India (Carney, 2009; O'Reilly, 2006). Within this policyscape, sustainable development means that private actors such as institutions and communities must be involved in the maintenance and continuation of an intervention, thus reducing government expenditure. While their involvement, or 'participation' involves a financial contribution for institutions and communities, this form of governance also involves a discursive regulation that can be understood in terms of Foucault's notion of 'governmentality' (Sharma & Gupta, 2009).

Governmentality involves a form of governance that brings the population's conduct and practices in line with policy through a discursive self-disciplining rather than an overt form of coercion. It is also a form of governance where the state legitimizes itself through a productive concern for the welfare of the population. The professional public health community represented by PSM teachers in this case, although not officially representing the government, repeatedly cited the discourse of neoliberal governmentality, through moral and rational justifications for the payment of defluoridated water (Simon-Kumar, 2007). PSM teachers consistently suggested that while different sections of the community may have different capacities to pay for this water, what is needed is an attitudinal change amongst them. In demanding for a financial contribution, they also sought to teach the community a moral lesson to value the commodities they are getting rather than taking them for granted. Under this guise of environmentalism, they promoted a kind of rationality and mentality that disciplines and homogenizes the community members with the 'right' attitude while discounting and

making secondary the different bodily and material relationships that women and certain caste/ethnic, and class groups have with water. That some of these groups might already appreciate the value of water through bodily experiences of scarcity is not considered as relevant because its value can be appreciated only in a monetized sense (Vavrus, 2003). Instead, PSM teachers without being government employees engage in state practices by citing and translating government policies and discourses on the ground with high fidelity for the consumption of students and the community (Butler, 1993; Levinson, Sutton & Winstead, 2009). In internalizing discourses of governance, they engage in practices to regulate their own bodies and those of others on the grounds of a concern for the welfare of local communities, and of the nation as a whole. Thus, their professional and teaching practices were not merely scientific endeavors but can be understood as cultural practices where PSM teachers performed their citizenship identities as modern, educated Indians contributing to the development of the rural and urban field practice areas, and the nation as a whole.

Anganwadi workers as agents of governance. AWW are even more curious agents of governance as they are simultaneously beneficiaries of the state while doing its regulatory work without being official employees (Gupta, 2001). As women from the local community with basic education specifically recruited to run anganwadis along with other helper staff such as the ANMs and ASHAs, they are beneficiaries of the state. At the same time they do the enumerative and surveillance work of the government by counting the births and deaths in the villages within their jurisdiction, conducting health surveys, monitoring immunization schedules, and the conduct of other health and

development schemes, serving as a child care center, and providing early education and nutritious food for children up to the age of six years while not being official employees of the state.

In many ways, these surveillance practices are similar to the work done by sanitary officers in the colonial period. What is distinct is that they were part of the sanitary police and enforced government policy through the exercise of more overt forms of authority, sometimes involving forced evictions, quarantining, and cordoning of areas (Harrison, 1994). These actions were also justified on the basis of the welfare of a particular population. Prakash (1999) points out this inherent contradiction in the governmentality employed in colonial spaces, that Foucault's Eurocentric conception failed to consider (as cited in Prakash, 1999), was that the colonial state was janus-faced: caring and despotic at the same time. What is new about the governmentality enforced in the postcolonial context of India is that the 'policing' and 'surveillance' work has been feminized not only since the AWWs, ANMs, and ASHAs constitute a female workforce but also in that their regulatory work is masked by their nurturing and caring work. Further, official state employees who are part of the larger ICDS infrastructure monitor and supervise AWWs based on the paperwork they are expected to generate, thus mimicking a patriarchal and colonial structure in a more disguised manner.

In the visits to the urban PHC and the anganwadi, we were shown the 'registers' that documented the enumerative and surveillance work being done in these government institutions. The AWW at the PHC told us that she maintained all the details about the community including the number of births and deaths, the immunization records of each

child, the ages of each family member, and the addresses of every family within the community. If parents did not arrive for the next immunization dose as scheduled, she told us that they would go to their homes, interact with them, and motivate them to get immunized (for free). AWWs also identify 'eligible couples', that is, married couples with one or two children, to counsel them about family planning. AWWs thus, are objects of state surveillance while they are also expected to do the enumerative and surveillance work of the state in the context of implementing health and development schemes targeting women and children. This ambiguous location of the AWWs is suggestive of the diffuseness of power in the working of the 'state' and the regulatory work it does while taking care of the population (Sharma & Gupta, 2009).

More importantly, however, the significance of the 'register' was that it symbolized a functional state. The AWW told us how she maintained 42 registers documenting the implementation of a vast number of schemes, results of surveys, and routine records of height, weight, nutrition, immunization, and so on. In our informal conversations with her, she told us that her supervisors believed she was doing her work only if it was written on paper, and ironically this paperwork took more of her time than actually teaching children and cooking nutritious food.

Despite the AWW's expression of her frustrations with the state's bureaucratic obsession with rules and regulations, she eagerly presented the registers to us which also symbolized the importance of her work in the caring of the population. In this way, she and the curricular texts repeated the fiction of the state as a benevolent actor.

In sum, visits to the different sites discussed above projected the state as modern and benevolent, evidenced by its well-planned organizational structure, and health and development schemes. In this constructed or figured world (Gee, 2011), the poor health statistics of the nation is not due to an apathetic state or the absence of a rational bureaucratic system but by implication due to the failure of those who need them to utilize these facilities appropriately. The poor health and environmental conditions of certain communities can by implication be attributed back to themselves so that sociocultural 'factors' such as their cultural beliefs, illiteracy, low socioeconomic status [SES], and others are not neutral statistical correlations but the causes of their sociologically pathological conditions. Thus, in order for this partial and ideologically motivated narrative to make sense where technology and the government are the driving actors of development and progress, a culturally different 'other' must be simultaneously constructed.

Characterizations of the rural and urban poor. Take the monsoons simulation game, for instance, which constructed the cultural world of an imaginary village in South India by establishing certain social norms according to which medical students were expected to make decisions and behave while role-playing villagers. For instance, the students were divided into families with at least one 'untouchable' or *Dalit* family that located itself at a distance from the other families to simulate the social and spatial distance that such social groups have historically faced in India. The game also mandated daughters' marriages at the end of three years incurring high dowry costs for families as a gender norm. This gender norm meant that families would try to reduce the number of

girls in their family to one (as the game required every family to have at least one daughter). The praying to the village goddess for good monsoons, and therefore productive crop yields was a ritual that families were expected to do before the beginning of every season. The game's points system was such that the random selection of a 'good', 'moderate', and 'poor' monsoons would yield different points for crops such as *ragi,* groundnut, and maize. While the game provided opportunities for students' strategic selection and distribution of crops in the acres of land available to them where they could hedge certain risks associated with a poor monsoon, the points they would gain would largely be influenced by the kind of monsoons they would get and the resources they had to begin with.

The dominance of an economic understanding of development comes across quite strongly in the monsoons game. For instance, farmers' lives were evaluated based on their financial status as calculated through annual expense sheets (see table 6 below).

Table 6: Annual expense sheet (reconstructed from guidelines on the monsoons game

	Fields	**Season**	**Production**
Ragi			
Maize			
Groundnut			
Total			
Loss to crops from diseases, pests, drought, etc.			
Consequences of malnutrition in previous year			
Total food available this year			
Loan repayments, cost of marriage, wells, bunds			
Food eaten by family this year			
Surplus carried forward to next year			

In these calculations, gender and patriarchal social structures contributed to the impoverishment of farmers as did their epistemic failures to harness environmental resources such as water, and to control pests, and diseases. Further, the game also sought to construct farmers as 'rational economic men' through the introduction of certain opportunities. Families then, could make decisions to improve their lives by adopting modern technology such as irrigation facilities, or by utilizing public health services such as vaccinations to prevent diseases. Although the game acknowledged that these decisions were not always easy and involved difficult trade-offs sometimes involving ethical issues, it also implicitly constructed tradition or culture as a barrier to development, and modernity as the path towards development. Moreover, culture was constructed as highly deterministic where farmers had little agency and mechanically enacted cultural rules. This understanding of culture enabled the construction of an 'ideal type' traditional society that was fixed in time and in place with little scope for change. Implicitly, the solution was framed as a cultural shift from a traditional to a modern society facilitated by such actors as the technology, and the state (Harrison, 2005). In such a framing, medical students and teachers were thus positioned as harbingers of good health, and therefore of modernity.

Conclusion

In this chapter, I have attempted to construct how the discipline of public health attributes agency to technology and the government in its theory of development and progress. By treating this theory as a narrative, I stress upon its fictional nature in the way that it is shaped by historical and political ideologies of governance that serves to

legitimize the state's control and utilization of public resources including resources for good health on the one hand while justifying the increasing privatization of its functions on the other. I have also attempted to 'situate' the knowledge produced in the sense of pointing out those who have participated in the production of these narratives: the national and regional governments, international organizations that influence national policymaking, and colonial state practices. Finally, I've shown that this narrative constructs medical students and teachers as modern, urban, and educated in relation to the communities whom they serve that are constructed quite ambiguously, as the abject 'other' sometimes, and as empowered at other times. It is within this ambivalent construction of the communities that public health narratives produce the modernizing impulse within medical students and teachers, and enable them to perform their citizenship identities.

Through this chapter, I set the stage to make the argument that the curriculum and pedagogical practices need to be understood as dialectically shaping each other. Hence, while pedagogical practices may create possibilities for disrupting the production of science/fictions, unless the curriculum is understood as fictional rather than scientific, the knowledge produced from such disruptive pedagogical moments will always be 'managed' or discarded away. Through my engagements with teachers, I theorize certain disruptive moments to renarrativize agency and pedagogy in public health. The goal, I suggest, is not to achieve closer approximations of truth, but to constantly marshal our pedagogies towards an exploration of alternative interpretations that can destabilize the science/fictions we produce.

Chapter V. Producing and Destabilizing Science/fictions

In this chapter, I attempt to reconstruct students' pedagogical interactions and performances with the community as they happened to show how they shaped knowledge production. In other words, while in the previous chapter I argued that expert needs discourses, or as I call them science/fictions, mediated pedagogical activities in hegemonic ways, in this chapter I explore how encounters with the community as counterpublics might have opened up possibilities to alter or interrupt these discourses (Fabian, 2001; Frasier, 1990). In order to do so, I explored how the community constituted an alternative pedagogical 'site of engagement' as compared to the hospital or the classroom in the way that it changed the social conditions of knowledge production. I define 'site of engagement' as "those moments in time and points in space where social practices converge to open a window for mediated action to occur" (Norris & Jones, 2005, p. 141). In this sense, the community constituted a site where individuals with diverse sociocultural histories were brought in contact with the cultural tools mediating pedagogical activities (Norris & Jones, 2005; Voloshinov, 1973). Cultural tools included material objects such as the doctor's coat, survey questionnaires, curricular texts, bodies, and the built environment as well as psychological tools such as language, popular culture, and various discourses; although all tools are simultaneously material and psychological since psychological tools are materialized into objects, and objects are sites of meaning-making (Norris & Jones, 2005). This site of engagement thus, could be an unpredictable 'contact zone' where the mediated action would be shaped by the convergence of different social histories in particular moments of time and points in

space (Pratt, 1998). I argue that although the unpredictability of the encounter(s) with the community held the potential to disrupt the universality of science/fictions to produce alternate meanings of local places and people, these meanings were diffuse, uneven, and not taken up by students and teachers collectively to renarrativize dominant science/fictions.

The Community as an Alternative Pedagogical Site of Engagement

PSM teachers conceptualized the community as an alternative pedagogical site in comparison to the hospital because they believed it fostered students to draw from cultural tools that were significantly different from those accessible in the hospital setting. The cultural tools that students would have to engage with were not limited to the patients' bodies, the instruments used to investigate them, and the built environment of the hospital space but they also extended to the landscape and the built environments of the urban slums and the villages they visited, and the people that inhabited these spaces. Further, the pedagogical activities in the community would also require medical students to use semiotic tools like language, bodily senses like vision, and their imagination in more focused ways than in the classroom or in the hospital. Thus, the setting itself changed the social conditions in which pedagogical activities took place and the cultural tools needed to enact them. PSM teachers theorized that this change in setting could foster not only a change in doctor-patient relationships but also a conceptual shift towards a deeper understanding of the social context of health and disease. I therefore, explore below how the cultural tools employed in the community shaped such changes in doctor-patient relationships, and local, place-based knowledge of health and disease.

Encounters with the community. PSM teachers understood the community as a site that fostered interactions with people that were qualitatively different from the kinds of interactions that were possible in the hospital. According to Dr. Chandra (March 28, 2013), changing the context within which these interactions between doctors and patients took place would produce a different kind of knowledge in part because the hierarchical relationships between them would be altered:

> See, family study is one component where our students get that opportunity to directly interact with the family members in their own environment. Unlike in a hospital setup if you go to other clinical subjects only opportunity where they get to interact with people is in a hospital where they come to hospital or they come to the doctor as a patient okay and there will be certain kind of restrictions when it comes to that communication and it will be usually restricted to only to that particular disease condition what they've come for and students will not get an opportunity to interact with them in an informal setup or in a setup where the person is comfortable. So here in family study we have this kind of an opportunity where the person whom the students are interacting are in their own setup, it's an informal setup. And uh since the student goes visits them so student is what should I say inferior to that person. The role is reversed when it is the hospital because the doctor has an upper when compared to the patient so here the students have to make an effort to learn things or to extract the information.

Dr. Chandra, thus, perceived that taking medical students to the homes of community members was transformative both in content and process. Dr. Chandra's mention of 'other clinical subjects' is a discursive reference to the discipline's historical opposition to these subjects' inordinately narrow focus on the disease condition. In making a comparison to clinical subjects, he problematized the dominant hospital-focused nature of medical practice and teaching because of the limited knowledge it could produce. Dr. Mangala (March 27, 2013) clarified this conceptual limitation of interacting with patients in the hospital as compared to within the community.

> In the hospital they are exposed to already patients. The event or the disease what we call it has already occurred. They've come there for a cure, and they, these

> people, prescribe them some medicines and then they go back. But they do not know what are the reasons for that particular person to fall sick. Is it the physical environment conditions, is it the social environmental conditions or is it something else? So for that reason we take them to their homes the family visit itself to find out certain basic things. So that is where the housing environment plays a major role.

The hospital as a site of engagement was therefore, oriented differently in time and space as compared to the community. As Dr. Mangala puts it, the event has *already* occurred so that the investigative and diagnostic practices are also narrowed spatially to the body. From this perspective, the purpose of medical education and practice is geared towards treatment and cure. On the other hand, public health as a discipline is interested in investigating how people got sick by changing orientations to both time and space. They seek to go to the homes of community members, examine the physical and social environments of the spaces that they inhabit, and investigate into the reasons that they may have fallen sick or identify potential threats so that they can intervene and prevent disease in the *future* for a group of people rather than individuals. Going to the community therefore does not merely change the context in which teaching/learning occurs but alters the very purpose and understanding of medical practice and teaching. I explore how going to the community altered the doctor-patient relationship before I go on to exploring how it altered the knowledge produced itself.

Doctor-patient relationships. As Dr. Chandra suggests, communication practices between doctors and patients are shaped by the hospital context and the condition in which the patient presents himself/herself to the doctor. While in the hospital, the patient is in an unfamiliar place with the doctor taking the position of authority in the formalized interactions within this space. In the homes of community members, however, doctors are

not on their turf and are forced to get out of their comfort zones. Consequently, they need to put in more effort in developing rapport with them. For instance, doctors may allot a limited period of time to each patient in the hospital. In the community, however, doctors would have to be proactive about visiting particular community members and their visits would be subject to their availability. Community members, on their part, may enquire doctors as to the purpose of their visits and may permit access to their homes and bodies on the basis of the trust they have developed with them. In that sense, visiting communities alters the hierarchy of the doctor-patient relationship to an extent by changing the structural context within which such interactions occur. Pedagogically therefore, students would need to learn how to develop rapport with community members in order to complete particular tasks for which they would have to develop some level of fluency in the utilization of certain cultural tools- especially language but more broadly communication skills.

Building rapport. On the inaugural day of the CBTP, the speakers, who were highly ranked college administrators (and doctors), dwelt considerable amount of time talking about being patient listeners, trustworthy, caring, and other such characteristics towards developing more equitable relationships with their patients. They also advised students to never differentiate on the basis of religion or between the rich and the poor. Fairclough (2001) has referred to such approaches to altering the doctor-patient relationship as a kind of 'synthetic personalization' where although the language used during this communicative phenomenon may appear on the face of it to be extremely polite and respectful, the institutional context within which they occur does not

necessarily change. He refers to the institutional context as the power-behind-discourse, that is, the power that enables doctors to occupy positions of authority with patients willingly answering certain intimate questions about their lives and bodies. When doctors go to the community, however, the institutional rules and structures that make such communicative encounters possible and normal are no longer valid. To that extent, community-based teaching is transformative in that it alters the structure of the communicative encounter between doctors and patients with the doctors having to take the onus of building trust in order to interact with community members.

Institutionalized symbolic power. Despite the argument presented above, I would push against the claim that such communicative encounters invert the relationship between doctors and community members. This is in large part because the power-behind-discourse that the institutional context confers onto such encounters is not limited to geographical space (Fairclough, 2001). The cultural capital that doctors accumulate through the institutionalization of the medical profession is both embodied as well as inscribed into material objects such as the stethoscope and the doctor's white coat (Bourdieu, 1986). The doctor's person and these objects thus continue to exert symbolic efficacy beyond the institutional space so that the encounters between doctors and community members while troubling the hierarchical relationship do not necessarily transform the institutionalized relations between them. The PSM teachers were not blind to the symbolic efficacy of the 'white coat'. Although teachers distanced themselves from the symbolic meanings associated with doctors such as the privileged positioning next to God, for instance, they nevertheless advised students, who are not yet doctors, to wear the

coat and gain entry into the homes of community members. Merely wearing the apron thus, was sufficient to enforce community members to enact their roles as compliant patients.

Sociocultural symbolic power. Medical students also entered community spaces as classed and gendered subjects so that the doctor-patient relationship cannot be understood as being governed by the social and institutional conventions sustained by the medical profession alone. Community members, including children, responded to medical students based on their class and gender identifiers as well. While wearing the white coat was desirable to embody authority, having shared linguistic or sociocultural resources was perceived to be crucial in developing rapport with local communities. This desire to come across as insiders perhaps was meant to compensate for the authority that they wielded over communicative processes, another form of synthetic personalization. Speaking Kannada or Telugu in a familiar way, for instance, would fit the rural conversational style. By familiar, I do not mean facility in the language but rather the use of conversational techniques like calling an old man passing by "taata" or grandfather, or a lady as "akka" or sister followed by everyday questions such as "oota aayta?" or "kelasa aayta?" as in "Have you finished your lunch?", or "Have you finished your work?". Such conversational techniques are instances of how linguistic and sociocultural resources are marshaled to build familiarity and rapport with local community members that serve to mask the class differences that both male and female medical students are marked with.

To be sure, language is used to communicate content. But, my argument in the above anecdotes and following ones is that language also acts as a class signifier. This was most apparent to me when local children swarmed around us eagerly trying out various English phrases with us as conversation starters while the non-Kannada and non-Telugu speaking students on their part, tried out Kannada or Telugu phrases that they had learned. These amusing intercultural encounters also highlighted, however, how the children had immediately positioned us as English speakers, and how students and I were anxious to speak back in the local language to them.

Similarly, dress is a site where class and gender relations are negotiated. I was observing young female students preparing for their evening skit minutes before they were going to start in a large open compound in the village. They were excitedly asking each other if they 'looked' the part of rural women as they tried out makeshift saris over their brightly colored and tight fitting pants and short kurtas. Looking the part was important to build rapport with the audience- the community- by creating an illusion of authenticity based on students' imaginations of what rural men and women are like in this context (Ellsworth, 1997). Yet, these notions of authenticity were being troubled by young girls from the village, probably in the age group of 9-12, who were sporting jeans and T-shirts. This is an instance of how dress acted as a site for girls and women to perform their gender identities that were also simultaneously classed (Butler, 1993).

My intention in describing these class and gender signifiers is to suggest that community members position medical students not only by the doctor's coat that they wear but also by their class and gender positionings. Language, dress, and other class and

gender signifiers carry with them a constellation of meanings that are not value-neutral. They shape how the participants in an interaction make assumptions about each other and interpret their utterances based on their own positionalities.

Community as counterpublics: Undoing symbolic power. While I cannot make comparative claims regarding how doctors and patients negotiated conversations in hospitals and communities similarly or differently, I argue that it would be simplistic to assume a smooth operation of power in communities by embodying symbols of authority. Students experienced several moments of frustration when they experienced that the white coat did not necessarily perform its magic. For instance, many houses were empty during the time that we visited as the residents were away for work which meant students would need to visit again, and be proactive about finding out the times that they would be available. In one village we went at a time when mothers were busy getting their children ready for school, and while they answered some questions they were fidgety and not very forthcoming as they were keen to hurry the process along and get back to work.

Others were more direct in refusing to talk to students. I heard a few students mention how certain residents were quite insistent about not wanting to speak with them while others declared their skepticism regarding the purpose of their visits and the purported benefits to them. Students, of course, responded by saying that the surveys they were undertaking were intended to produce information that would be of benefit to their community. Yet, the symbols of previous visits such as hashtags, code numbers, and stickers were visible on the walls and doors of most houses suggesting that being surveyed for information was a routine exercise for them (Ferguson & Gupta, 2002).

Unlike the above instances of overt resistance, community members also employed subtle forms of resistance. For instance, in one of the visits that I accompanied, a student was asking a middle-aged man about his income who chuckled in response and said, "You can put it as 'x' amount" implying that he fell within the 'BPL' or "below poverty line" category. The man employed a 'strategy of trickery' or deception to manipulate the technology of the written word, that is the survey, to his advantage (Glissant, 1992). In doing so, he altered the very nature of the knowledge so that it was impossible to make claims of accuracy and authenticity for the data collected.

Local, place-based knowledge production. In this section, I examine pedagogical activities that included 'direct' and imagined interactions with people living in rural communities and urban slums. I explore how the knowledge produced through such interactions was mediated by cultural tools such as survey questionnaires, the built environment, and students' sociocultural resources about these places (Norris & Jones, 2005).

When the cultural histories of students and community members converged in particular moments in time and points in spaces, opportunities were created where new meanings were produced. In this sense, the community constituted counterpublics- both in terms of actual people living in rural and urban field practice areas, and in terms of students' imaginations or memories of people living in such spaces (Fraser, 1990).

Temporal structures and relations as cultural knowledge. The time of the day that medical students were scheduled to go to the homes of community members was informed by medical social workers' partial knowledge of the everyday practices within

villages and urban slums regarding which houses were locked at a particular time of the day, who would be present to talk, the time available for the person(s) to talk with students, and their relative willingness to talk. My point here is not to suggest that the time when students visited these homes introduced a bias in their understanding of the social context. Rather, my point is that the knowledge on the temporal structuring of the lives of the people whom students visited was a cultural tool that medical educators employed to structure the pedagogical activity, although it was not recorded in the survey questionnaire as knowledge about the social context. Implicitly, this cultural knowledge that shaped the encounter was relegated to the realm of 'field experience' where its importance lay largely in getting things done rather than in theorizing the social context, no doubt in partial ways. Exploring the links of who was present in the home and who was not at the time when students chose to visit could have been generative points of inquiry into family members' linkages with the labor market and other social institutions and how their presence/absence during that time of the day may shape the physical environments and the nutrition of their families which were the guiding research questions of the activity. For instance, how might the presence of women, children and senior citizens in homes during the day be points of inquiry to understand their labor contributions in the production of healthy domestic spaces as well as their linkages with labor markets and social institutions such as schools and anganwadis that may shape the spaces they occupy?

In one particular village that I visited, students were frustrated with the time of the day that they were scheduled to visit the homes since women were busy sending their

children away to private schools. In another village students also interacted with people employed in home-based finance-generating practices, such as sericulture, where they bred cocoons to produce silk that would be sold in the nearby town. Although their interactions yielded rich contextual knowledge regarding the temporal structuring of their lives in relation to different social institutions, and while this knowledge may have contributed to students' interpretive frameworks in different ways, it was not incorporated in a collective theorization of the social context in the way that the knowledge gained through the survey questionnaires was. This privileged positioning of the survey questionnaire thus directed students' attention structures in ways that they paid attention to those moments in the communicative encounter when the knowledge produced could be filled into the questionnaire (Jones, 2005). Similarly, the survey questionnaire directed students' attention to spaces within the community members' homes that were perceived to be relevant in the production of healthy bodies.

Survey questionnaires and the built environment. Survey questionnaires are the tools of a routinized social practice in the discipline of public health and other social science disciplines. Bernard Cohn (1996) has referred to surveys as an important 'investigative modality' in British India since the late eighteenth century, where it was used as a form of exploration of the natural and social landscape. The earliest systematic survey of India was conducted in 1765 but eventually proceeded to document and classify the occupied territory's "zoology, geology, botany, ethnography, economic products, history, and sociology." (p. 9). Underlying these surveys was the notion of space as measurable, classifiable and representable (Bayly, 2000), and that when

conducted properly, surveys would yield accurate and objective representations of reality (Latour & Woolgar, 1986). Hence, surveys are perceived to be tools of knowledge production that are valid across cultural contexts. The survey used in this particular pedagogical activity was one borrowed from the regional university, albeit modified to serve their purposes. However, when examined as a cultural tool the classification schemes employed can be appreciated as being ideological, and situated in the gaze of the raced, classed, and gendered outsider (Fairclough, 2001).

In the survey questionnaire below for instance, there were several items that were descriptive requiring minimum interpretation such as the number of rooms and living rooms present, whether the house has a shared wall or not (attached/detached), presence or absence of cross-ventilation, or a smoke outlet, or a cooking platform. These questions are what one may call 'standard' and objective questions. They are used to direct students' attention towards certain aspects of the domestic space, and not others to produce certain inferred meanings informed by an assumed universal value around how these spaces should be organized. Thus, the presence of a cooking platform is implicitly valued, and I can only guess at its perceived benefits, such as being a facility in which a dedicated area to food-related items could be made clean and hygienic. However, a deficit discourse is also simultaneously produced suggesting that the absence of such a platform is problematic. Indeed, my own attention in the entire survey questionnaire was drawn to the 'cooking platform' because of the chronic back pain my mother was experiencing at the time exacerbated by the many hours she spent in the day standing at this platform. Thus, while the cooking platform may certainly have its health benefits

from a particular viewpoint, it need not be from other perspectives. The classification schemes employed and the values attached to them were, however, understood as being universally relevant and valid.

Other elements in the questionnaire were largely inferential and depended on how students assessed the environments based on their own perceptions and values around space, sanitation, adequacy, and sufficiency. My argument isn't however to point out a methodological flaw that could be corrected by making the survey more 'objective' but to suggest that it is irredeemably subjective.

Table 7: Excerpt of survey questionnaire from family study activity

III. RESIDENTIAL ENVIRONMENT

A) HOUSING

1. ☐ Attached ☐ Detached
2. ☐ Own ☐ Rented
3. Total number of rooms ……
4. Number of living rooms ……
5. **Overcrowding:** Present/Absent

Overcowding	Persons per room	Floor space	sociological
Criteria	Yes/no	Yes/no	Yes/no

6. **Wall:** ☐ Kuccha ☐ Pucca **Roof:** ☐ Kuccha ☐ Pucca **Floor:** ☐ Kuccha ☐ Pucca

Infer House is Kuccha/Semi Kuccha/Semi Pucca/Pucca _____

7. Ventilation: ☐ Adequate ☐ Inadequate **Cross ventilation:** ☐ Yes ☐ No
8. Lighting: ☐ Adequate ☐ Inadequate
9. **Kitchen:**
   a. Ventilation: ☐ Adequate ☐ Inadequate
   b. Lighting: ☐ Adequate ☐ Inadequate
   c. Smoke outlet: ☐ Present ☐ Absent
   d. Floor: _____
   e. Type of fuel used:
   f. Type of stove used:
   g. Cooking platform: ☐ Present ☐ Absent
   h. Storage area for raw food: ☐ Sanitary ☐ Insanitary
   i. Storage area for cooked food: ☐ Sanitary ☐ Insanitary

Kitchen is ☐ Hazardous ☐ Non hazardous area ☐ It does/ does not pose health risk

	Respondents' Inference	Students' Inference
10. **BATHING FACILITIES:**	☐ Adequate ☐ Inadequate	☐ Sufficient ☐ Insufficient
11. **WASHING FACILITIES:**	☐ Adequate ☐ Inadequate	☐ Sufficient ☐ Insufficient

12. **Record if the following are present:**

Heaps of refuse/stagnant water collection/fly breeding places/human excreta/stray dog menace/ Any other

B) WATER SUPPLY:

a) Sources of Drinking Water Supply: Bore well/ Open well/ Sanitary well/ Draw well/ Piped Water Supply
(Infer) Sanitary or Insanitary _____

b) Source of Washing water supply: Bore well/Open well/Sanitary well/ Draw well/ Piped Water Supply
Mini water supply scheme (Infer) Sanitary or Insanitary

c) Method of Drinking Water Collection: (Infer) ☐ Sanitary ☐ Insanitary

d) Method of Drinking Water Transportation: (Infer) ☐ Sanitary ☐ Insanitary

e) Method of Drinking Water Storage in the household: (Infer) ☐ Sanitary ☐ Insanitary

f) Method of Drinking Water Usage: (Infer) ☐ Sanitary ☐ Insanitary

g) Quantum of Drinking Water: ☐ Adequate ☐ Inadequate

h) Total per Capita Water Availability for all purposes: _____ ☐ Sufficient ☐ Insufficient

C) **WASTE MANAGEMENT:**

1) Solid waste management:

a) Type of container used for collection of solid waste: -
_____

b) Frequency of disposal:
_____

c) Place of disposal:
_____

d) Distance of the place of disposal:
_____

e) Comments on waste segregation:
_____

f) Any other remarks:
_____

Solid waste management is ☐ sanitary ☐ Insanitary

By making the survey a thoroughly subjective and cultural tool, I suggest that it privileges particular ways of seeing, knowing, and assessing these domestic spaces, all of which are acts of power legitimized as they are by larger institutions such as the WHO, and government bodies. The use of mathematical language does by no means make these surveys objective but merely makes a limited set of interpretations accessible to a wide variety of audiences. For example, the international housing 'standards' as described in

the textbook are easily observable, measurable, and remarkably precise, presumably to minimize interpretation. The textbook also makes intertextual references to the Environmental Health Criteria made by the WHO thus attributing universality to these standards. Below is an excerpt from the manual that clearly and precisely defines how environmental conditions within the home, and other places such as schools and anganwadi centers should be measured, classified, and evaluated.

Persons per room

Accepted standards	
1 room	2 persons
2 rooms	3 persons
3 rooms	5 persons
4 rooms	7 persons
5 or more rooms	10 persons

Floor space area

Accepted standards	
110 sq ft or more	2 persons
90-100 sq ft	1.5 persons
70-90 sq ft	1 person
50-70 sq ft	0.5 person
Under 50 sq ft	nil

Sex separation –Overcrowding is said to exist if two persons over 9 years of age not husband and wife of opposite sexes are obliged to sleep in the same room

Lighting- is said to be adequate, if a person is able to read the newspaper in the middle of the room in daylight.

Ventilation –is said to be adequate if there is cross ventilation.

Cross ventilation is said to exist if doors and windows face opposite to each other or if the doors and windows are present on the adjacent walls.

- Excerpt from the CBTP manual

The above standards therefore were supposed to inform students' inferences as they classified and assessed the spaces that they examined. The mathematical precision of these standards were meant to preclude ambiguity in interpretation so that they could be comparable across observers and cultural contexts. However, the setting of these standards themselves were neither objective nor arbitrary as they were 'accepted' and

promoted as universally applicable by particular groups based on their own understandings of what is acceptable. Although these standards were contextualized in different contexts, these processes too were informed by those groups who again set standards according to their own perceptions of safety, adequacy, and so on.

Importantly, the setting of these standards privileged these understandings of healthy spaces over other possible understandings that students could have made, and especially those made by the people residing in the homes that they visited. Instead, the survey questionnaires denuded homes of meanings that people made in building livable homes as they were treated as sources of meaning that already existed rather than as meaning-makers in their own right.

This is not to suggest that students did not make other meanings in the encounters with people in their homes or that teachers did not encourage students to explore other directions in their inquiries, and I discuss both of these aspects later. What the survey questionnaire did, at least in my interpretations of the interactions I observed, was to shape students' attention to structures in ways that privileged a particular way of seeing and conceptualizing of the materiality of spaces and its relationship to people, health, and development (Jones, 2005). Such a privileging was in large part because the activities were closely aligned to the official syllabus prescribed by the regional university that was in turn influenced by the Medical Council of India's regulatory guidelines for medical education.

Community as counterpublics: Students' situated meanings of place. Although survey questionnaires structured students' interactions with women and other family

members, I was curious to know how students from different sociocultural backgrounds might have interacted with spatial difference and interpreted its relationship to the people living in these spaces, themselves, and their health.

I had recruited students on the basis of whether they were Kannada or Telugu speaking students or not. As I began conversing with them I realized I had made several assumptions of my own regarding their spatial and linguistic identities, and their understandings of rural areas and urban slums. For instance, I had implicitly assumed that Kannada or Telugu would be the 'mother-tongues' of students who would come forward as 'Kannada-speaking' or 'Telugu-speaking', or that they would have lived in South Indian states for a bulk of their lives. Of the five students who came forward identifying themselves as Kannada-speaking however, two of them had studied Kannada in school, were city-bred, and lived in Karnataka for a significant period of their lives but whose mother-tongues were not Kannada; one was a student from a small town with some lived experience of rurality in coastal Karnataka whose mother-tongue was Kannada but claimed her dialect was significantly different from the local one, and was more used to speaking in Konkani, the dominant language in her geographical area; two others were Non-Resident Indians, that is, students who are permanent residents of countries outside of India, and whose mother-tongues were Kannada and Telugu respectively, of which one of them said he had periodically visited his native village with his father. On the other hand, non-Kannada or non-Telugu speaking students included three Hindi/Urdu speaking students from North India who had some lived experience of rurality; and two local city-bred students with limited lived experiences of rurality, one of whom said she understood

Kannada but could not speak it. My interviews with students thus happily, displaced my assumptions that people with neat linkages between language, identity, and place existed 'out there'. The students I interviewed had moved around so that their identities, and thus, their constructions of themselves and "others" were not clearly linked to one but to multiple places and languages, although their mobility might have been shaped by their class backgrounds.

Similarly, although PSM teachers mentioned that the urban slum community largely included migrants, they nevertheless characterized them as Kannada or Telugu speaking as if the states of Karnataka and Andhra Pradesh were exclusively Kannada-speaking and Telugu-speaking territories when they are not. A huge population of Daccani Urdu-speaking Muslim population exists in both states which got automatically excluded from the realm of 'local languages' because of the organization of states according to dominant languages spoken by upper caste Hindus- the dominant religious group- in these regions. Also, the increasing pervasiveness of English and North Indian Hindi in these regions has also made migrant populations multilingual, often for reasons of survival. Thus, when we went to an urban slum, some North Indian students could converse in Hindi with Urdu-speaking Muslim families or because Hindi was intelligible to even Kannada or Telugu speaking families. My point is to highlight that people's imaginations about places are often linked with languages and identities. These naturalized linkages tend to keep people in fixed places and times despite their increasing mobility. Surprises, therefore, such as the ones produced by ethnographic fieldwork, can disrupt such naturalized linkages (Willis, 1980).

One of the Bangalore-based students (interview, May 29, 2013) described her surprise at what I would call a 'middle-class lifestyle' that she witnessed in one of the domestic spaces at the urban slum.

> Yeah what I found funny there was there was this TV that was playing in there. So I was quite amused. Like they have this room which is really tiny like a 10x10 that was the size of the room but they have like a TV playing and they had about what his income was 110 bucks a day and he would spend all of that. There was no question of saving, and different kinds of food like for the kids things like puffs and stuff, so it's not. That was what I found was pretty similar to us but then it was sad that the actual basic conditions are not that you know up to the mark- the toilet facility inside, the bathing was within that room that they stay in. I found a little disturbing. But the villages I found in contrast were actually much better maintained. The houses there probably had more space also, and was more hygienic I thought at least based on what I saw.

Her amusement came from the unexpected similarities that she saw in their lifestyle with her own, particularly in her use of "like us". The furniture and memorabilia such as the TV in the house or children eating of treats like 'puffs and stuff' signified to her a lifestyle that was not too different from her own, although the physical dimensions of the space and the income of the parents might have signified a low socioeconomic status. Although she interpreted the built environment of the domestic space in ways that the survey questionnaire mediated, she also made other meanings that related to her own sociocultural background (Rapoport, 1982).

Similarly, when I spoke to three students from North India, two male and one female, all of them claimed the villages in the rural field practice area to be more 'developed' than the ones in North India that they were accustomed to. Indeed, one of them even declared, "It's actually not a *pakka* village I feel you know. The houses and all are pretty okay and all the facilities are also there the transport facility is also in the [village] is good." The village thus did not meet her naturalized ideas about what

constitutes a *pakka* or a 'confirmed' or 'solid' village. Her understandings of rurality- the built environment, roads, and other facilities, and connectivities to urban centers- were shaped by her regionally located experiences (Cloke, 2006). Interestingly, a Kannada-speaking student from coastal Karnataka perceived the village she visited as less 'developed' than the ones she had frequented in her lifetime. Students brought with them their location-specific experiences with very different meanings of rurality. They tended to, however, make sense of these different meanings of rurality drawing from the dominant evolutionary discourse of development suggesting its pervasiveness in popular and disciplinary discourses.

Popular culture knowledge. Scholars interested in the use of popular culture in educational practices are generally divided in two groups (Dolby, 2011). There are those who tend to do textual analyses of popular culture to bring to focus the classist, racist and sexist assumptions they implicitly hold that can be uncritically consumed by youth, and therefore argue for the development of students' critical media literacy skills (e.g., Dolby, 2011; Iyer & Luke, 2011). There are others who think of popular culture in more 'celebratory' terms as an alternate "lived" curriculum that youth consume and interpret differently depending on their class, race, and gender positioning (e.g., Holm & Daspit, 2011; Dimitriadis, 2009). These scholars think of popular culture as a pedagogical site of struggle where youth negotiate interpretations to produce new meanings, and are therefore interested in exploring how the inclusion of popular culture in the curriculum can create democratic possibilities in knowledge production (Dolby, 2011).

Most of these studies, however, have been conducted in the context of K-12 schooling in the United States. The distinctions of 'high' and 'low' culture where popular culture occupies the 'low' are not entirely valid in the Indian context as people's consumption practices are shaped by their linguistic identities more so than their class identities, although class may be influential in how people privilege popular culture texts in Hindi and/or English over regional languages (Dolby, 2011; Nandy, 1998). However, these texts are rife with classed, raced and gendered tropes, which while being regionally specific, may get consumed differently by people from different backgrounds. In this study therefore, I define popular culture as cinema and television programs in vernacular, that is, non-English languages. I did not, however, examine specific popular culture texts nor did I explore students' consumption practices of specific texts. I examined instead, how students deployed and negotiated popular culture knowledge in the co-construction of scripts about the community in the context of the health education skits and the monsoons simulation game.

Although the monsoons simulation game did not involve 'direct' interactions with the community, it required students to imagine and perform community members in what they perceived to be, and others would recognize as, 'authentic' (Ellsworth, 1997). In that sense, the community as it was imagined by students and teachers constituted a site of engagement. Students drew from their existing sociocultural resources in imagining the rural community. The narrative of this simulation game was different from other kinds of narratives such as in books or movies in that it was relatively open-ended. This means that facilitators- primarily post-graduate students or tutors, and participants- the students,

co-constructed narratives by drawing from their different sociocultural resources, and negotiated their different imagined realities of what villagers' lives in South India might look, feel, and be like. As a result, the narrative in the game's booklet, created by a development NGO in South India and circulated to other sites, was not only different from the one that PSM teachers constructed in the CBTP to meet their own purposes but also enacted differently in its multiple iterations by different groups of students and facilitators.

Although I explored a single iteration of the game, it provides insight into how students brought in their knowledge of rurality drawing from lived experiences or popular culture to both produce a grand narrative and destabilize it. Similarly, while I observed only one health education skit when it was performed on site and others when students were negotiating and rehearsing their scripts, it provided insight into how certain grand narratives were both produced and negotiated. These processes suggest that while performative pedagogies such as these while having the potential to undo recognitional injustices through the inclusion of students' diverse epistemic resources, community members did not necessarily get an opportunity to disrupt these scripts, thus amounting to a representational injustice, and perpetuating the universalization of these scripts. The familiarity and generality of the scripts produced about rural communities and urban slums in India is suggestive of their pervasiveness in popular culture and their uncritical bleeding into 'scientific' discourses and practices.

Co-construction of knowledge. In order to understand the game narrative as a co-constructed and negotiated cultural product, I need to bring back what I omitted in my

description of the game in the previous chapter: the chaos and the deafening noise produced by 50-60 participants. The dominant mode of communication between the facilitators and the students was the striking of a serving spoon with a plate, both made of stainless steel, used to silence the students into listening to announcements. Students, meanwhile, were excited to let their imagination go wild, many of whom took role-playing villagers to heart. Students created 'classroom disruptions' through melodramatic performances illustrating how they both created, and challenged popular culture representations of particular stock characters in the rural imaginary.

One student, who was from a rural area in North Karnataka, knelt on one foot and prayed to the goddess dressed in a makeshift sari. He spoke in Kannada but using a genre reserved for theatrical performances that is characterized by changes in intonations to produce dramatic, even melodramatic effect. He made a compelling case to the goddess about his family's extremely pathetic situation before the game had even started, and cajoled her for deliverance through good monsoons. This performance generated laughs among the other students, and further improvisations by other students until a facilitator amusedly commented that their situation was yet to worsen as the game had not even begun. What this performance did illustrate, however, was that he drew from popular culture representations of perilous rural lives that was familiar if not to most of the audience in the room, at least to myself as an observer. What the game succeeded in doing was to connect the crisis in farmers' lives to their dependence on the randomness of the physical environment with religious ceremonies being an important, if not the only strategy to achieve some sense of control.

Another instance of a disruption was when the money lender and his *goondas* (thugs) entered the room with an exaggeratedly aggressive interpretation of masculine body language, wielding a wooden club-like prop in one of their hands, and sporting curly moustaches with big, black *teekas* on their foreheads, not an uncommon way to depict villainy. Village money lenders represented a stock 'villainous' character in Hindi cinema of the 50s and 60s along with the *zamindars* or rich landowners who were notorious for how they exploited innocent and hard-working villagers to poverty. Indeed, these representations were not too different from Shakespeare's Shylock, the Jewish moneylender (Stallybrass & White, 1986). Further, students characterized moneylender and his goons as sexual predators threatening the safety of girls and women in the village. My intent of pointing out these characterizations is not so much to debate the accuracy of their representations but to argue that students improvised game characters using their own sociocultural resources to create representations that were 'familiar' and recognizable because of their ubiquitous presence in popular media.

These familiar tropes become problematic when read in relation to the larger development discourse of modernization in which the rural space represents the last frontier of traditionalism characterized by oppressive feudal and patriarchal structures such as moneylending and the dowry system, as well as a dependence on the vagaries of the environment, and the power of a religious entity. Further, what was striking to me was that while this village was located geographically somewhere in South India, it was characterized by game authors and students as timeless. Thus, the game narrative, whether the 'original' one, that is the one scripted in the 'how to' booklet of the game, or

the one that was co-constructed in practice, positioned the village in opposition to modernity that the teachers and students themselves represent.

Unlike the monsoons game, however, the health education skits were rehearsed performances. The scripts and characters were carefully thought out and negotiated around themes that were predetermined. For the year of 2012, the themes were to promote a healthy lifestyle, sensitivity towards HIV positive and AIDS patients, and counseling for alcohol abuse. Students who spoke Kannada and Telugu played a crucial role in creating dialogues and in bringing in popular culture elements that would, in their perception, appeal to their audience- the village community, although students from other cultural backgrounds also contributed in sharing their situated meanings of rurality around particular public health issues, and in acting out 'rural' characters in 'authentic' ways. Students also contributed in deciding the use of rhetorical devices such as hyperbolic body language, juxtapositions, aphorisms and different language and popular culture genres and styles to make political statements effectively. These phenomena could be understood from functionalist perspectives as neutral processes whereby scientific knowledge was translated or repackaged into narratives in ways that would be culturally palatable and comprehensible to the audiences- the local community (Huesca, 2008). Here, language and popular culture would be used in functionalist ways as vehicles for the transmission of messages. I argue, however, that language and popular culture are also sites where ethnic, class, and gender identities are negotiated, and therefore shape the content of the 'message' itself.

Mode of address and rhetorical devices. In order for the skits to work, their modes of address needed to be directed towards certain subject positions that students imagine would constitute their audience (Ellsworth, 1997; Fairclough, 2001). Students developed this mode of address by employing a colloquial linguistic style, a brusque manner of speaking, and popular music from Kannada cinema to create the illusion of an authentic representation of rural people. Students who were native speakers took center stage in developing this mode of address, although other students contributed their own knowledge in character development or in creating plausible situations. Thus, even if temporarily, students speaking local languages or those with substantial lived experiences in rural areas were valued in these pedagogical activities. A couple of postgraduate students/tutors mentioned to me how this inversion of the local language taking on the dominant position in pedagogical proceedings was empowering for such students.

Indeed, I remember feeling quite impressed not only by students' creativity in producing scripts in short periods of time but also in their ability to connect with the audience through humor, emotions, and a colloquial style of communication. Nevertheless, students' mode of address through the use of comparison as a rhetorical device created subject positions for the community and themselves, and suggest how those might be informed by normative desires and ideals of what rural characters and families should be like from middle-class, urban perspectives.

A common rhetorical device that students used was to compare two characters- one that embodied valued public health behaviors, and the other that embodied the opposite of this model public health citizen. Emotions were mobilized to make the

audience seek to identify with the model citizen (Fairclough, 2001). For instance, students had created two teeth on white thermocol and personified them with one being sparkling white with a smiling, happy face while the other was black, with personified germs and a sad face with tears.

Another example was the organization of an imaginary classroom in the skit with 'dirty' children sitting together in one place and 'clean' children in another place. The complaint of an offensive smell ensured the regulation of this spatial separation of children. Much like a full-fledged pathological syndrome, dirty children possessed all the symptoms of an unhealthy lifestyle- they smelled, did not cut their nails, wash their clothes, come to school on time, wear footwear or eat vegetables. The model child, on the other hand, displayed a well-regulated body as she wore washed and ironed clothes, brushed her teeth twice daily with a brush and toothpaste (and not the indigenous ash mixture), had combed and plaited hair, wore footwear, came to school on time, and so on. Ironically, during the enactment of the skit in the village, the audience too was segregated with the people from the city including the children of faculty members sitting on chairs while the rural school children sitting on the playground with little interaction between them.

The two characters employed in the rhetorical strategies described above represented, much like Inkeles' 'modern man syndrome' the cultural, and particularly class differences, between the modern and yet-to-be-modernized citizenry. This is not to suggest that the upper class or middle class "are" clean and healthy but that the body is a site of cultural struggle and identity production, the regulation of which allows these

classes to distinguish themselves socially from the lower and lower middle classes (Stallybrass & White, 1986). Further, as the lower class disrupts these significations by looking more like the upper and middle classes, the latter produce new symbols to distinguish themselves (Holston, 2008). One instance of this disruption was when a facilitator remarked with surprise and amusement that the rural school children all had 'modern' names like 'Divya' while the students had named their adult characters with what could be termed 'traditional' and 'authentically' rural names like 'Malaiah', 'Chenni', and 'Savitramma'. The sanskritization of their names was thus recognized to be a shift towards modernity, a phenomenon earlier described by the acclaimed Indian anthropologist, M.N. Srinivas (1966).

The storylines usually juxtaposed these characters in relation to each other in the context of a Hegelian-like conflict which could potentially lead to the death of the 'other' or alternatively triggered a transformation. This juxtaposition was often also time-dependent as the other's transformation to the model citizen was developed temporally through the storyline. For instance, one conflict that school children were presented with was the arrival of a popular actor- Rajnikanth- who talked to only those children who were clean. This presented a conflict for the dirty children who could speak to their favorite actor only if they became clean. Another example is of the sad teeth being attached by germs that created terrible pain for the child in concern at school which was resolved by brushing her teeth in the appropriate way. Apart from the model health citizen, the primary health care (PHC) center or practitioner also played a significant role in this transformation through whom a core public health message was often delivered.

For example, while the model child demonstrated the brushing of teeth to help transform the sad teeth into happy teeth, in the plays on alcoholism, stroke, or HIV/AIDs, the PHC practitioner, or neighbors who had previous experience with the PHC, would talk about the availability of counseling or certain new drugs at the local PHC. In the climactic scene, the character's utilization of the PHC led to the successful transformation of the victim or deviant subject. Thus, the PHC and medical students themselves were positioned in this narrative as the actors triggering this transformation with healthy lifestyles being defined in terms of their own, or claimed for as their own. But, they needed the fictional character of the 'other' in order to produce their own subjectivities (Prakash, 1999; Stallybrass & White, 1986).

Subject positions and character development. In this subsection, I describe a few characters that I encountered in the plays across seven different student groups. Of these, I observed two student groups closely while I looked for similarities and differences in patterns in my observations of the other groups' plays. The suffering wife, the wife-beating alcoholic rural man, the philandering husband, and the prostitute were some characters that drew my attention. These characters struck me as extremely familiar tropes in middle-class conversations that I have been a part of in relation to fictional characters in popular culture, media as well as in academic circles or in relation to 'real-life' female domestic workers with whom I've interacted with on an everyday basis.

The philandering, wife-beating, alcoholic husband for instance, represents the uncanny double of the modernized middle-class Indian male whose existence depends on the regulation and sublation, that is surmounting or repressing, of the apparent masculine

and lower class impulses to aggression, hypersexuality, drunkenness, and gambling. The uncanny, according to Freud (1919), is something that is very similar to an object that is familiar and intimate or "home-like" yet strange and alien that when confronted, depending upon the context, could be threatening, tempting or comical (Stallybrass & White, 1986). Student groups differed in how they redeemed the male alcoholic. In one play, he succumbed to alcohol leaving his wife and children in disarray while in another he responded to his family's pleas to seek the local PHC's counseling initiatives, survive, and restore his family's happiness. Yet, it was remarkable to me that this character was ubiquitous in all the student plays, and one that I have encountered with in conversations with domestic helper-women in my own life as well as in popular culture. When I questioned whether and how this may be a stereotype, Dr. Sumathi (April 1, 2013) justified the mobilization of this representation for its rhetorical and political value.

> It may be biased but what is ultimate aim of health education is to get away the message that alcoholism is bad. See that is the main purpose. May be it's not true that every husband alcoholic husband beats his wife but you've to show one of the things and this is the commonest thing what they students have observed. And I think it's okay because they are showing the negative impact of alcoholism in that context. I think it's fine. I don't see it should be any harm maybe even if it's biased. Also here we're looking at showing the negative more maybe there are certain times we can show the positive ones also. We have positive advertisement which encourages people to adapt healthy lifestyles.

Hence, the alcoholic male had to symbolize all that could go wrong in a domesticated lifestyle- the ultimate horror in the bourgeois imaginary. This hegemonic construction of lower class masculinity, thus, was necessary to avert the horror of a disrupted domestic lifestyle as much as it was necessary to assert middle-class masculinity (Stallybrass & White, 1986).

The lower class alcoholic man, however, could be redeemed. As mentioned above, he was redeemed through the fetishization of alcohol as the substance that transforms an otherwise productive and respectable family man into one who is irresponsible, undisciplined, violent and uncaring. Fetishization in the anthropological literature was earlier referred to the attribution of life and power to inanimate objects such as in shamanistic and voodoo cultures (Rose, 1977; Taussig, 1980). Commodity fetishism is a specific form of fetishization where commodities are fetishized as having qualities of power while the human actors and social relations that shaped the production and circulation of the commodities are erased (Rose, 1977). Alcohol, thus, in these plays was viewed as a substance that could produce instant gratification, and a desire for more while erasing its situatedness in the capitalist system whose sale produces revenue for certain social groups, and most especially the government through taxation on its consumption (Chatterjee, 2003; Cronin, 2002; Jayne, Valentine & Holloway, 2008; Singer, 1986). Instead, the government was positioned as the benevolent actor who would provide opportunities for counseling to get rid of this individual habit. My argument is not to suggest a banning of alcohol or to suggest that alcohol use and abuse did not exist in premodern times but to point out the irony in the framing of the issue as an individual behavioral one, rather than a societal one.

Unlike the alcoholic man, however, the licentious male husband and the debased female prostitute were constructed as irredeemable in the plays on AIDS. These abject characters represented threats not only as the carriers of the HIV virus but also threats to the settled, and sexually regulated domestic lifestyle (Stallybrass & White, 1986). The

theme of the play, it must be noted, was focused on reducing the stigma faced by HIV and AIDS patients and sought to develop within the community an attitude of sensitivity towards them. In attempting to remove this stigma, however, it became necessary for students to displace the abjection of the HIV-infected patient from the faultless and unaware victim to the willful prostitute, and/or the sexually prolific husband (Stallybrass & White, 1986). For instance, in one play the protagonist was a woman who was positioned as a victim of her husband's philandering, and who was further marginalized by the shunning of her in-laws and other community members. In another play too, the woman was positioned as the victim of her husband's visit to a prostitute. Interestingly, 'bad company' was a popular medium through which the innocent were introduced to alcohol and the prostitute while the PHC counselors and the neighbors who referred the protagonists to the PHC in contrast could be interpreted as the 'good company'. Students thus, directed their mode of address to the families in the community, and to the women in particular while positioning themselves as their well-wishers (Ellsworth, 1997). In building this rapport, students could not assign blame to the husband, particularly since the goal was to detach patients from the stigma of AIDS. However, they could not do so without bringing their own moral positions around sexual practices into the picture. The best that they could do was either to speak about how a patient could get AIDS through blood transfusion or without any voluntary action of their own. While the man could be redeemed because he was swayed by bad company, the social stigma associated with AIDS seemed justified in the case of the philandering husband and the prostitute. At the

very least, they were not the subject positions that the skits intended to address (Ellsworth, 1997; Fairclough, 2001).

In the above section, I have discussed how students co-constructed scripts or narratives about certain rural characters in the context of the monsoons simulation game and health education skits, and how such scripts might be shaped by their class and gender backgrounds as well as place-based knowledge. The pervasiveness of these scripts across student groups could be understood as the naturalizing effects of certain powerful representations in the urban middle-class consciousness. However, certain moments of crises illustrate how dominant narratives were transgressed to enter unfamiliar and uncomfortable zones.

Community as counterpublics: Transgression of narratives. I offer one significant crisis during the game that illustrates how a departure from the grand narrative of the traditional rural life was discursively regulated. Not surprisingly perhaps, this transgression arose from the margins occupied by the untouchable family. Like Don Quixote, Ahmed, the student who played the head of this untouchable family, seemed to be the lone crusader against the unequal social structures of the village. While the other more privileged families found more underhanded ways to get their daughters married so that they could avoid the dowry cost with instances of families 'selling' their daughters, the head of the untouchable family refused to do so, and announced instead,

> We too have respect and we have realized that Family E is not good since they married their daughter to the moneylender who's such a mean guy despite being able to afford it[4] [the dowry cost]. It shows their greed and selfishness. I won't

[4] Family E was the richest family and had negotiated a marriage deal with the moneylender to avoid paying a dowry cost based on their power.

> marry my daughter to the moneylender either as I don't want my daughter to be a slave.
>
> Reconstructed dialogue from field observations, January, 6, 2013

This statement generated a lot of laughs amongst students. The moneylender was inspired to negotiate with Ahmed but was dismissed by him. At this response, the facilitator, Sheela, tried to negotiate with the deviant untouchable-student arguing that a more authentic portrayal of his character would require him to be subservient and meek rather than to take up an aggressive posture with the powerful moneylender. Despite this attempt by Sheela to regulate his performance, Ahmed stuck to his moral ground and refused to get her married. This prompted Sheela to dismiss the family from the game on account of having faced 'social disapproval' by the entire village.

This conflict was interesting for at least two reasons. Firstly, the game had a point system that was based solely on economic productivity. Since the game's rules mandated that each family gets their daughters' married within a particular timeline at a significant cost, student groups decided to name only one family member as a daughter- the minimum number required by the game. Implicitly, the practice of female feticide, and the gendered organization of the family was attributed to an economic cost so that students could 'empathize' with the decisions and actions that produced gender inequalities now that they could 'understand' the stakes involved. Secondly, the discursive regulation by the facilitator of one's student's enactment of a lower caste father based on assumptions of authenticity closed any possibility for resistance, thus reinforcing static understandings of social positions of caste. Thus, by resisting the characterization of the untouchable victim on a moral ground, the student implicitly

argued against the economic criterion based on which the game was defining villagers' constructions of gender norms about marriage, and created the possibility of 'revolution'.

The student's transgression did indeed trigger an insurgence as an unmarried son from another family offered to elope with his daughter. This prompted one facilitator to dismiss the other family from the game as well on account of social disapproval while another facilitator conceded that such 'love marriages' between upper caste and lower caste marriages do happen in villages. Among the many protests and arguments that followed which was impossible to record, the facilitators brought the game, and the insurgence to a quick end by announcing a 'poor' monsoon that eliminated all but two families.

In articulating the co-construction of this game narrative, I want to point out that students and teachers both brought in their sociocultural imaginations of rurality and the people who live in rural places pointing out its fictional character. Further, they tended to characterize the rural space as traditional in opposition to medical students' and teachers' own modern selves. Such characterizations are extremely familiar within the discursive framework of modernization suggesting its pervasiveness in the sociocultural context of India. Although students did attempt to trouble this grand narrative of the traditional village to an extent, they were quickly regulated to fit in with the development discourse of modernization on the grounds of inauthenticity. Thus, the game's simulated reality, and the culture it represented appeared to acquire fixity on the grounds of authenticity, and truth value.

Another instance of a crisis was during the preparation of a skit on HIV/AIDS in which students, primarily two male students- one from rural North Karnataka and the other from rural Andhra Pradesh, enacted the roles of a man and a prostitute. Their enactment was characterized by overtly sexualized body language and profane dialogues that prompted several embarrassed and uneasy laughs as well as improvisations from their group mates. For example, one male student acted as if he were approaching a pimp, played by another male student, and asked if he knew of an 'item' and could help him get one. This was followed by another male student walking in using the body language of a woman attempting to proposition the male customer. In the background, students improvised by thinking of 'item songs' from Kannada popular culture to play in the background that usually include a woman dancing sensuously typically in rural settings surrounded by men dancing around her. Part of the humor arose from the carnivalesque environment that the skit licensed where students could perform and react to hypersexualized body practices without censure (Stallybrass & White, 1986). Part of it also arose, however, from the queering of a normative heterosexual body practice that produced the uncanny, that is, a feeling produced on encountering something that eerily or comically resembles the familiar but not quite (Royle, 2003). I invoke the concept of 'queer' here not so much to suggest that these body performances were transgressive in a progressive sense but to highlight how queerness disrupted the mixing up of the naturalized separation of sexual categories and identities only to perversely reinforce their separation through humor.

The students, however, deviated away from the objective of the skit, which was to create compassion for people suffering from HIV/AIDS, as they improvised on making the skit more humorous through the abject character of the prostitute and the queering of body practices. This prompted the facilitator, an assistant professor, to advise students to amend the skit significantly or to cancel it. Although she acknowledged students' efforts in creating this skit, she justified its cancellation on the grounds that "it is inappropriate to talk about sex and prostitutes", and that "we can't risk them misinterpreting our message, it is like teaching them how to get a prostitute." Students, particularly the actors, reacted to this strongly by arguing, "But, this is the reality," while another co-facilitator suggested that community members are mature, and need not be mollycoddled. Thus, teachers and students negotiated the meaning of the message based on how they imagined the community, and their possible interpretations. The sexualized and 'queered' prostitute also might have contributed to an uneasiness that led to its cancellation, although it was ultimately cancelled on the grounds that the message was directed at prevention of HIV/AIDS rather than on the objective stated above. What wasn't critiqued, however, and therefore seemed justified, was the moral grounds on which the prevention of HIV/AIDS was made through the abject character of the prostitute.

In the above discussion, I have explored how students drew from their tacit knowledge that may include popular culture or lived experiences to co-construct certain stock rural characters, and how such characterizations were shaped by their class and gender positioning. I have also suggested that departures from certain narratives were regulated because of their perceived inauthenticity or inappropriateness. Through this

discussion, I argue that the inclusion of popular culture as an alternate "lived" curriculum or actual lived experiences does not necessarily lead to a disruption of grand narratives or dominant stereotypes about marginalized others, particularly when students perform the 'other'. Rather, this alternate knowledge was marshaled in the legitimate circulation of these stereotypes thereby producing recognitional injustices where certain communities or specific kinds of people and their practices were characterized as pathological (Fraser, 1996). In the case of the health education skits, although community members could react to the skits' narratives, remarkably students were not expected to collaborate with them in the production of scripts that concerned their lives. Having said that, community members did undo the power of these narratives, knowingly or unknowingly, by treating it as entertainment that some of the students I spoke to expressed as frustrating. Ironically, in one village, students reported that the audience had a poor attendance and comprised largely of young children which meant that they could not perform the HIV/AIDS skit anyway.

Indigenous knowledge. Although I did not witness any explicit resistance on the part of community members, one male student (interview, June 3, 2013) from a previous year did mention a crisis that their group experienced which brings to light the confrontation of two different knowledge systems. He recounted this experience as follows,

> One of the things we have to do in the COP is host educational programmes for the children and ad adults or old ages as well to mostly dispel traditional or superstitious beliefs and introduce healthier practices. One of those things in particular was with regards to childbirth. Now childbirth ideally should be handled in a very sterile, aseptic manner so that you prevent death. But, during one of our plays one of the older ladies probably a very experienced midwife

> passing by, she passed by the entire play and she just commented quite loudly- your methods are all unnecessary, we've been doing this for so many years. And it's like that, and we took it at that. Like yes, at some point, people will stick to their traditions or their superstitions regardless. Sometimes you just can't argue with them, in spite of that, because like it or not their methods work sometimes, they sometimes don't work. They have their own reasons as to why they don't work. So justifying so suddenly is very difficult. In that sense gives you a very broad outlook on how people are.

This quote brings together points about community agency and the issue of 'local' knowledge. Firstly, it illustrates how the skit's narrative might have positioned indigenous child birth practices as 'traditional' and 'superstitious' implicitly in opposition to 'modern' practices that are 'scientific' thus committing a recognitional injustice to midwives' indigenous knowledge practices. It also illustrates that despite the midwife's strong reaction to the skit's epistemic misrecognition of their time-tested knowledge practices, the student continued to use this binary system of knowledge classification, although he conceded that they may work and midwives might have their own reasons for why they work. His primary argument for invalidating midwives' knowledge was that "they would stick to their traditions or superstitions regardless." This suggests a reluctant acknowledgement of medical pluralism, one that was echoed by Dr. Mangala (March 27, 2013) in one of my conversations regarding the inclusion of indigenous knowledge in the CBTP. Interestingly, she characterized 'traditional' knowledge as non-scientific, that is, everyday practices by the poor or visits to 'quacks' not licensed as practitioners of alternate medicine who were nevertheless popular amongst poor communities. She distinguished institutionalized and state-recognized indigenous and alternate knowledge systems including Ayurveda, Unani, Siddhi, and Homeopathy, referred to as AYUSH, as scientific acknowledging that depending on the specific purpose these approaches could

be more efficient than 'Western' medicine as well. AYUSH was thus, modern in that it employed an evidence-based and systematic or scientific approach which 'traditional' medicine as employed by 'quacks' or unlicensed practitioners did not. According to Dr. Vijay, although rural people were just as likely to visit a traditional medicine 'quack' as a medical doctor, PSM teachers acknowledged that an explicit attack on such practices by medical doctors would only ensure an alienation of community members from them. Thus, medical pluralism was a phenomenon they had to acknowledge, some that they perceived as valid while others that they had to reluctantly and pragmatically accept.

Finally, the student's account, while illustrative of the possibilities that unpredictable encounters with the community as counterpublics can disrupt dominant representational knowledge systems, it also suggests that these encounters were not taken up collectively as generative points of inquiry by students and teachers so that at best students made sense of them in uneven but unknown ways, and at worst they continued to adopt binary categorizations of knowledge systems to exclude or devalue alternate perspectives. This failure to collectively engage with knowledge produced during encounters, thus, amounted to the perpetuation of representational injustices towards the community.

Conclusion

In this chapter, I have discussed how the community constituted an alternative pedagogical site of engagement in that it required students to make use of different cultural tools for different purposes as compared to the hospital or the classroom. I

discussed in particular how going to the community altered doctor-patient relationships and produced local, place-based knowledge. I suggested that the knowledge produced through 'direct' interactions or through imaginary ones with certain place-based communities were mediated by the convergence of different discourses and social histories into particular moments in time and points in space. Although global science/fictions largely mediated students' understandings of locality, I have noted how encounters of students with communities as counterpublics also created moments of crises that troubled or destabilized students' naturalized understandings of places and people. However, local, place-based knowledge negotiated during such moments was not collectively engaged with, or they were fitted into existing discourses so that they did not necessarily reframe dominant science/fictions. In the next chapter, I attempt to renarrativize these science/fictions through my conversations with PSM teachers and discuss the pedagogical implications of understanding the community as counterpublics, and of knowledges and knowledge production processes as political.

Chapter VI. Renarrativizing Science/fictions

In this chapter, I discuss my conversations with PSM teachers regarding how alternate meanings of localities could be explored and included in the CBTP with the aim of renarrativizing universalizing science/fictions.

I shared some of my early interpretations with PSM teachers, and here, I consider their reactions to these interpretations. In doing so, I illustrate the dialogical processes between myself as the researcher and PSM teachers and students, the participants. These dialogues disrupt my position as a distanced observer, and as a knower. The uncertain phrasing of my questions, and the assumptions I make in such articulations suggests an ongoing process of theory-building, which is shaped by my encounters with participants (Fabian, 2001). By focusing on my own uncertainties and assumed certainties, I also wish to point out that teachers' articulations need to be understood as instantiated understandings that are being constantly evaluated and re-evaluated rather than as fixed in time (Fabian, 2001). This also means that while I have had the privilege of articulating a revised and reflexive presentation of my understandings, my participants have had fewer opportunities to offer revisions to their utterances.

Another goal in this chapter is to similarly highlight the tentativeness of scientific narratives about communities. While improvisations of these scientific narratives can be debated upon regarding the universal truth value they represent, I suggest that stressing the uncertainties and the tentativeness of these truth claims can destabilize the authority of science/fictions that can create an interpretive space where alternative perspectives can be heard. In this sense, the iterations of the CBTP can be understood as improvised

performances whose representations are always questionable with regards to their claims of authenticity.

This chapter is organized into two sections. In the first, I discuss the place of materiality, and the materiality of place in understanding culture (DeJaeghere & Lee, 2012; Stevenson, 2008; Greenwood, 2013; Vavrus, 2003). This has implications for how the public health curriculum and pedagogy is politicized or not in practice. In the second section, I discuss how teachers' pedagogical approaches are shaped by implicit assumptions about the relationships between knowledge and reality. My attempts to question certain naturalized assumptions produced counterquestions and assertions that in turn pushed me to reconsider my own ontological assumptions, and to take seriously the place of objectivity in theorizing relationships between science and fiction, or representation and reality.

Thus, in this chapter, I suggest that the term 'science/fictions' demands us, researchers, teachers, and practitioners, to engage with the relationship between material objects and culture on the one hand, and the subjectivity of materiality on the other (Stevenson, 2008). Further, it requires us to consider how we theorize and problematize the knowledge produced through pedagogical activities as 'real', and the implications this may have on closing off other perspectives. Throughout the chapter, I consider the implications of a depoliticized community-based pedagogy in public health for democracy and social justice.

The Place of Materiality and the Materiality of Place in Understanding Culture

PSM teachers' environmental activism inspired me to consider the place of materiality, and the materiality of place in understanding culture. My own training in critical and post-development perspectives to education and development practice predisposed me to look for 'answers' in the political ecology literature that complicated and politicized the 'natural' relationship between environments and people (Anand, 2011; Bailey & Bryant, 2005; Escobar, 1999; Latour, 2009; Peet & Watts, 2002; Robbins, 2012; Tsing, 2005). This literature drew my attention to how PSM teachers were implicitly deploying neoliberal discourses in their individualistic arguments for environmental change. These arguments have implications in the production of new valued behaviors and subjectivities for doctors who are positioned as stewards of the environment, and in turn, they construct deterministic relationships between individuals and the environments they inhabit (Robbins, 2012). I was therefore keen to explore how PSM teachers understood the role of politics, power relations, and political actors in shaping environments, and therefore the health conditions of people differently.

Interestingly, PSM teachers differed significantly in their understanding of politics and political actors as shaping environmental conditions, and made different arguments for the depoliticization of public health teaching. I argue that such a depoliticized public health conceptualizes the relationship between places and people as co-producing each other, and preclude structural and relational understandings of this relationship thus enabling a social and spatial distancing of certain place-based

communities. Further, this distancing creates an illusion of objectivity that allows spectators to understand material and cultural difference as 'real'.

Theorizing relationships between human and non-human actors. As discussed earlier, I was intrigued by the focus in public health on non-human environmental actors such as landscape, physical environments, water, sewage, and milk as shaping the lives of people as well as the privileging of technology in making environmental change, and therefore improving the health conditions of people. In this section, I discuss my conversations with PSM teachers on how they conceptualized the relationship between people and places followed by a discussion on how they taught students to think about the role of people in bringing about environmental change.

Places and people- understanding material difference. As discussed in chapter 4, students assessed the quality of the physical environments of community members' homes. Although my observations suggest that survey questionnaires may have restricted students' attention and how they structured certain material differences more than others (Jones, 2005), I was curious to explore how PSM teachers conceptualized these differences in relation to the people that inhabit these spaces. Specifically, I was interested in pushing the conversation to explore how they theorized sociospatial relations in understanding these material differences between (upper) middle class urban spaces that we inhabit and the spaces that we visited.

Dr. Vijay's (March 13, 2013) comment below suggests, however, that the materiality of the geographical difference itself was designed to be a spectacle for consumption.

> The whole idea of taking them to the rural setup is to show them that geographical difference, to say that this is how things are here, this is how things are there. This is what 75 kms is the difference is the distance but the difference is huge.

Consuming the magnanimity of the difference itself was a goal that suggests a correlative association between certain places and the health conditions of the people, that is, the places, and the people inhabiting them were imbued with meanings symbolizing not just difference but a deficit in ways that they could not be separated from each other. Dr. Mangala (March 27, 2013) understood this difference as one of social class, and assumed that students would draw from the sociology lessons in making this inference. In this case, meanings associated with these spaces symbolized social class.

> This is the difference where the social class comes in. This is the environmental difference, or physical environmental differences, which happens when the class differs from one to another to where they are living to where they were taken to the rural aspect. As I said, these are some of the things which we think they would infer upon. We've not uh that is one grey area about sociology which we [pause] we understand but still telling that across is little bit difficult according to me.

The use of expressive modalities such as “is”, and “are” by Dr. Vijay and Dr. Mangala such as “this <u>is</u> how things <u>are</u> here”, “this <u>is</u> how things <u>are</u> there” or “this <u>is</u> the difference where social class comes in” suggests that the difference itself conveys an absolute meaning which requires no further interpretation (Fairclough, 2001). Hence, merely “staging” the difference in living conditions is sufficient to attribute absolute meanings to spaces and the people that inhabit them (Prakash, 1999).

These theorizations of difference as real and ‘out there’, waiting to be ‘seen’ and consumed, were shaped, at least in part, by the discipline’s engagement with largely positivist sociological perspectives, although Dr. Mangala frankly admitted that

sociology was a ‘grey area’ in the teaching of public health. For instance, taking students to ‘see’ the differences in living conditions in rural areas and urban slums was a way for students to see how living conditions correlate with socioeconomic status or not.

> Now when we actually take them to the village we give them that exposure. See, these are both the same socioeconomic status the urban slum and the villages but there is a vast difference between their living conditions there and here. So the whole idea of family study in COP is to let open students’ eyes to that. - Dr. Vijay (March 13, 2013).

In the above statement, Dr. Vijay suggests that the difference in living conditions in rural areas and urban slums cannot be attributed to socioeconomic status alone making a reference to a consistent finding that students have reported over the years from their comparative environmental assessments of these two places. While the above comment could be interpreted as pointing out a limitation of the classification schemes used to identify socioeconomic status or how social class is theorized in the discipline (Fairclough, 2001), further clarification suggested that he was implying that the difference lay in the ‘family dynamics’ in these two areas, that is, the poor living conditions in the urban slums could be attributed to the families themselves. Thus, taking students to these two areas was also about confronting students with cultural difference and not only material difference. Further, this cultural difference was implicitly used to explain material difference so that implicitly the bourgeois self had a role to play only in the solution but was not implicated in the problem.

> We ask them, see, when we are doing the environmental assessment, it's just not assessment. They must also look at the practical feasibility. When they telling suggestions is it practical [?], so they must find out what are the factors which will influence for them to change. In that context during the process of history-taking only, they will try to elicit the information and see whether it is feasible or not. For example, if it is a rented house definitely there is not much even if they ask

> them even that family they might say it's a rented family. We cannot alter them windows or anything like that. Or, if it's their own house they have to change window, then they can make out the family dynamics what's happening. They might say my husband has to take the decision or my in-laws have to take the decision, or something like that. They can understand social dynamics in the process also. It is not just environmental assessment per se, so we have taught them teaching history-taking itself and observation also. One is what is the social dynamics which is happening which will influence their decision-making or whatever that process is. - Dr. Sumathi (April 1, 2013).

Thus, students' assessments of physical environments could also provide insight into an examination of the 'social' environment, both of which they would have to take into consideration while suggesting feasible solutions. Understanding the social context, therefore, was crucial from a diagnostic point of view- the source of the existing or potential illness or disease lay in the physical environment that could in turn be shaped by the social or family dynamics. Family dynamics, therefore, was as much under investigation, as was the physical environment since it shaped material differences, even if constrained by social class and natural environmental conditions. Dr. Chandra (Mar 28, 2013) narrated this anecdote to illustrate the point of how the social environment, or family dynamics, indirectly influenced the health conditions of the people living in these spaces.

> I'll just give an example, uh there's a lady. Just recently when we went for one of those family studies we saw. She's hardly 19 years or 20 year old lady, already has got three children and the fourth one is coming through, and she's only 20, and husband is alcoholic, and she has to make an effort to earn the living plus support the children sometimes probably support the her husband also. So these kind of setup our students will not appreciate if it is in a hospital setup. This they can appreciate in a home condition, so they can understand those cross-cutting issues of so many social factors which play a role there in the disease. So that's what family study gives them the opportunity.

The above anecdote reiterates again the domestic space as an alternate pedagogical site of engagement that allows students to 'see' the complex social factors in play in this family that can contribute to their health presumably in adverse ways. As discussed in the previous chapter, he too draws attention to the abject and irresponsible male alcoholic whose only contribution seemed to be to produce more children while this young woman had to bear the burden of caring for them thus repeating the gendered script that students employed in their skits. Historically, the gender relations of the 'other' has always been under the scrutiny of privileged groups on the basis of which they have constructed themselves as morally superior, and have mobilized political momentum to enter their private spaces and save helpless women from their men (Abu-Lughod, 2002; Hassan, 2011; Forbes, 2005; Lazreg, 1994). In that sense, this story was no different in its ability to provoke emotions such as pity directed towards the woman, anger or disgust towards the man, or perhaps a sense of futility regarding the persistence of traditional patriarchal cultural practices in these spaces in contrast to the ones the upper and middle class Indians inhabit. In this way, health and environmental conditions in particular places were attributed to the cultural practices and gender relations of the people inhabiting those places. Such an understanding of culture and gender has implications on how people's agency in changing their material conditions of their environments was conceptualized.

People and places- understanding agency. My usage of the term 'environment' triggered responses from PSM teachers that brought to light a particular global form of

environmental activism that PSM teachers were deeply engaged in both within and beyond the context of the CBTP.

Dr. Murali - a senior professor in the department- stressed that the environment is central to many of the public health concerns taught in the CBTP (March 30, 2013):

> We teach them [students] about drinking water, we teach them about sanitation, we teach them about waste disposal, we teach them about sewage disposal, we teach them about pressure, temperature, humidity, housing, overcrowding- all these areas. In the all aspects of our community medicine. Similarly, subject environment is the basic thing with which we teach.

Dr. Mangala (March 27, 2012), clarified, however, that in her perspective, teaching about the role of people in producing environmental change was not the objective in the CBTP. Rather,

> For that objective, generally we usually for the past few years we have been observing the environmental day on June fifth. That is where we stress on how people can change the environment.

Her description of this event shows how PSM teachers sought to promote consciousness-building around the environment on this day. But, it also shows how their practice of observing this day is connected with a global practice, one aligned with such global actors as the World Health Organization, the UN, and Al Gore (Tsing, 2005), and disconnected from the concerns of local communities.

> Generally WHO, we celebrate June 5th as an environmental day. Every year there is a theme for it and each year we tend to do certain specific activities. Uhh. Initially when we started off we started off with saplings, if you can see the new hosp, the memorial hospital next to that there is a big parking lot, there are a few trees on this and the opposite side. They were all planted in the year 2004, if I'm right or 2005 from the department initiative. Uhh. So like that each year we've been having few more saplings we added. Then one year we had just a cycle rally. Then maybe next year we had paper bags collection or we have some sort of competition for the students to come out this thing. So each year we have one one

> activity that is done……and once we had screened that ‘uncomfortable truth’ what is that Al Gore's, we had a small UN picture of that documentary film which was done.

This conversation, amongst others, pushed me to think about how the department’s strong environment activist orientation goes beyond curricular goals. The following excerpt illustrates how the institutionalization of new rules and policies in the context of health waste management produced not only new environmental actions but also a new subjectivity whereby the very definition and role of a doctor is broadened (Robbins, 2012):

> If you look at some of the people in the hospital what they do is their job is to just take care of the patient. This is how we were taught. Of course now the things are slightly changing. At least we ensure that these people they look at it in total, in the sense your job is just not to look at the patient. Also to see that whatever waste you generate is also taken care of properly. Till 1998 we did not have any rules for health care waste management, so you can imagine it has just been a decade since those rules have come in. So, to bring in those kind of attitudinal change in the present day doctor it is going to take quite some time. So if you start off early now in within the curriculum then even when they are practicing outside as a practitioner outside they are not totally ignorant at least they know certain basics where they can practice. And they also have that attitude that this is not something which I can ignore. I need to take care of that also and even the patient care also. That is what we are aiming big at. I will not say that every person or every doctor who walks out with the MBBS degree in our college will be aware and will do all this things. Out of the 150 who go out even if I can bring a change in the attitude in at least in ten of them, I would consider it [pause] achieved. My objective achieved. - Dr. Mangala (March 27, 2013).

Dr. Mangala, thus, points out passionately her understanding of one of the goals of medical education, and of public health in particular, as producing new doctor subjectivities. Doctors in this new regulatory regime do not merely take care of their patients but are also cognizant of their responsibilities to the environment, and avert the harm they might inadvertently cause. To aid in the production of the doctor-cum-

environmental activist, Dr. Chandra (March 28, 2013) also mentioned about how they invited eminent personalities who were themselves engaged in environmental conservation activities to speak on the World Environment Day.

The production of this new subjectivity can also be understood through the concept of governmentality. The use of certain ideological words such as ‘ignorant’, and ‘attitudinal change’, quite reminiscent of how community members are spoken in relation to their understandings of health and the environment, signal the deployment of neoliberal individualistic discourses where environmental and health issues are framed as behavioral practices. Indeed, structural changes are perceived as having already taken place with the necessary rules, schemes, and programs in place. Whether we speak about community members or of medical students, change is about producing new subjectivities engaging in self-regulatory practices in alliance with the rules and regulations that have been set up by governing agencies, such as in the case of sexual health, personal hygiene, environmental protection, and so on.

These conversations occurred in the context of enquiring about the role of people in the production of healthy spaces and bodies. In attempting to understand how PSM teachers, and public health more broadly conceptualized agency, in my initial reactions and analysis, I had constructed a binary where technology and the government were actors, and people or civil society were not. Through these conversations, I began to reframe PSM educators’ narrative of change as employed in the CBTP as not one that erased people altogether but one that created space for certain kinds of environmental activists such as responsible doctors or community members while positioning less

environmentally conscious people as ignorant or irresponsible. By reducing change to the production of subjectivities who would interact with environments in appropriate ways, this 'peopled' narrative theorized human-environment interactions as equal across social groups and spaces, ignoring the social and political relations between doctors and community members that shape their different interactions with the environment, as well as unfairly positioned certain groups as in need of regulation.

The example of water conservation- a huge issue in Bangalore city- that Dr. Chandra (March 28, 2013) brought up in one of our conversations illustrates how individualistic notions of agency, such as in classical and neoliberal discourses, are considered to be crucial in changing structural issues:

> Usually we tell them the importance of attitude. We usually try to stress them that, see, you might be having excellent knowledge about certain things how to do, what not to do, all those. But only thing is, for that knowledge to be converted to be practice as a practice you need to have that right attitude. So, usually stress upon when we are talking about environment about this attitude component in most of our classes, when we are talking about environment-related issues. So, even there like, if for example, when we take them to the sewage treatment plant, forget about the technology part- we have not technocrats to know about in detail about the technology all those things. But what usually [we] try to put across to them is like say, for example, city like Bangalore where already it is water scarce, so how to conserve water, like and uh what happens. This may be probably the situation ten years down the line. Right now, the recycled water is going waste. Probably we'll have to start reusing it. So those sort of things.

Here too, the issue of environmental change in the context of public health reform is a matter of having the 'right' attitude that will inform the 'right' practice. In other words, change is about producing the 'right' subjectivities. While water conservation was not a focus in the CBTP or of the public health curriculum for that matter, this specific example of water conservation triggered memories of my mother chiding me to not waste water having grown up in an arid small town herself, and of seeing her reusing cooking

utensils to minimize the use of water, for instance, as an everyday conservation practice learned through the experience of water scarcity. I wondered about the presumptuousness of global discourses that assume that water conservation practices needed to be 'taught' to people living and experiencing water scarcity who may already be using everyday strategies to conserve and reuse water in creative ways (Vavrus, 2003).

The example of water conservation also reminded me of the times when in drought periods, the Cauvery water debate flared up between Tamil Nadu and Karnataka states. A particularly vivid memory is of my school being burned down in one of these conflicts! My point is that the distribution of the Cauvery river water to different places is not determined only by the proximity of places to the river body but is, and has been subject to political deliberation, overt conflict, and mass riots between the two states of Tamil Nadu and Karnataka in post-independence India and even during the colonial period. Policies that focus on producing subjectivities that engage in desirable practices such as water conservation tend to shift the focus away from the larger issue of the distribution of water, whose flow is shaped as much by social and political 'pressures' as physical, to reframe it as an issue of individual behaviors who are all assumed to have access to equal amounts of water across social groups (Anand, 2011; Vavrus, 2003). Different neighborhoods in Bangalore city for instance, do not have equal access to 'natural' river water. Indeed, it is a common practice for real estate buyers to ask whether the water source is the Cauvery river or the borewell in a particular neighborhood with the property prices typically being higher in the case of assured Cauvery water. This theorization of my experience with convenient access to water, and brief periods of water

scarcity having lived in middle-class neighborhoods prompted my questions regarding the role of social and political actors in shaping environmental conditions, beyond that of the role of agentic doctors, individuals and communities.

Politicizing relationships between human and non-human actors. PSM teachers responded to the phrase 'social and political actors' in very different and interesting ways. Dr. Sumathi (April 1, 2013) mentioned how powerful celebrities including both movie stars and politicians take up certain causes to influence other people:

> We have so many film stars or political people who are taking up a issue so that has an impact. We discuss about political involvement and its role in the uh improvement of health of the people.

Dr. Vineetha (March 29, 2013) talked about the department's ongoing relationships with the local political leaders who acted as gatekeepers in the rural field practice area, giving them the necessary permissions to work with community members, and supporting or even facilitating their endeavors.

Dr. Vijay (March 13, 2013), similarly, spoke about the various interactions with local village leaders, anganwadi workers, with community members in their homes, and with *streeshakti* groups[5] as ways in which students could understand about their different roles in bringing about health and development reforms.

> Now when they talk to the village, I mean the *panchayat*[6] member, he will tell them a few of the schemes which are available from his side. When they go to the *anganwadi* they figure out who are the people who are getting health there and how the health is. When they go to school they realize what the school health system, school health check up [is like] when the medical officer comes and how

[5] Stree shakti (translation: women power) groups are village level groups of rural women designed to economically 'empower' them through encouraging saving habits, and are formed through anganwadi workers.

[6] Panchayat is the local governance structure made up of five members of the community.

> the immunization is done. Similarly when they go and visit some of the like, say the women's groups which we have, the *stree shakti sanghas*, when they talk to them they find out few more schemes which are available, right? Of course we give them a background and a preview of all this before they go there, but we want them to learn from the horse's mouth. So, they go and actually talk, interact, and figure out plus they have a visit to the primary health center…

Whereas Dr. Vijay perceived these interactions with different members within the village as a way for students to learn from the "horse's mouth" about their roles in implementing various public health government schemes, the horse in my interpretation was the government with the groups whom they visited merely being its mouthpieces. To be sure, the anganwadi workers, for example, expressed their frustration with the supervisory practices of the bureaucratic structure. Yet, the goal of most of these visits was for students to learn how well the public health system was functioning.

Taken together, all of the above were instances of how people with a certain standing can influence the future of health and development agendas in positive ways. These responses pointed to me the functionalist orientation underlying the teaching of public health practices where power (by virtue of social status or position in bureaucratic, governance, and political structures) is garnered to achieve the efficient communication and implementation of predetermined plans.

In contrast to the above examples, Dr. Mangala (March 27, 2013) interpreted the word 'politics' very differently. Her immediate reaction was to laugh and say that politics was something that she did not think about and moreover, was something that *nobody* talked about, despite making the claim with great certainty that "politics and health go hand in hand":

> Aaah, nobody talks about political aspect at all. Nobody talks about it at all. And uhh, okay… politics and health go hand in hand. That understanding I got only after when I was a postgraduate. I never looked at it that it does have any political, health has got any political bearing. It was beyond my scope of understanding as an undergraduate. I always used to think- okay, we are doctors. I mean, you are being trained to become doctors, and then you do whatever that is required [laughs]. Politics is one thing which frankly speaking I have not thought about it at all. I've not thought about it.

I was intrigued to know more about what had prompted this shift in understanding about the relationship between politics and public health. While this shift came in large part through her experiences on the field where they have to negotiate with local political leaders, she also mentioned a professor during her postgraduate period of study who introduced her to a book published by the WHO titled vaguely as "Politics is health" or "Health is politics". She recounted a story that she remembered from the book about how the insistence on the use of a WHO-certified Oral Rehydration Solution (ORS) cost the life of a woman in a place in Africa when she could have survived through some home-made remedies. Another example she gave was of how a pentavalent influenza vaccine was being mandated in national immunization schemes for Hepatitis B and *Hemophilus influenzae* b (Hib) when there wasn't sufficient justification for it in terms of a public health burden. With these two examples she problematized how certain products were "bulldozed" and "forced" upon countries with few people thinking about "these things" as they go about their everyday practice of doctoring. Yet, she did acknowledge that these aspects of public health were not within the scope of the undergraduate curriculum, or even in the postgraduate curriculum suggesting a silencing of the role of politics in public health, although her candid laughter suggests that she was very much aware of its role through her experiences.

My conversation with Dr. Vijay (March 13, 2013) too was quite revealing in the way that he, and possibly others in the department understood the relationship between politics and public health, yet did not explicitly consider discussing this topic with their undergraduate medical students. Curiously enough, he responded to my question about social and political actors in a functionalist way, as mentioned above, in the early part of our conversation. It was only later when I asked him how they taught about the impact of interventions on different sections of the community including the defluoridation plant that I learned about how they negotiated local politics.

> AAA: For example, this defluoridation plant or the special school[7], how do you teach or how do you help students understand how it impacts different sections of the community, like classes, castes?
> Dr. Vijay: Yeah yeah. See this both special school [name hidden] and our de-fluoridation plant is is a public health intervention from the department's side, right? …. And then they go there and see how it actually works, and how this water which is being uhh it's it's available to everyone. There's no it goes to the *adi dravida* [indigenous people of South India] colony, it goes to the temple [priests from the Brahmin or upper caste Hindu community], and goes to, so they see that there's no bias in the distribution. At the same time, they say they also see acceptance is not so easy. Even with some with an intervention like that. Not everyone accepts it.

In my observation of the visit to the defluoridation plant, the impact of the defluoridation plant was not spoken about explicitly, let alone its impact on different sections of the community. In that regard, I would argue that Dr. Vijay was articulating his desire, hope, or an assumption rather than stating an empirical observation of students 'seeing' how acceptance was not easy because that was not a discussion that we had, at least in the group that I participated in. My own understanding from the visit to the defluoridation plant was that it was beneficial

[7] The department in collaboration with an NGO with which it has had a long standing relationship started this special education school in the rural field practice area.

to all equally. In posing the question that I did, therefore, I wanted to both check this conclusion that I had drawn and problematize it. Although in the above excerpt, it appears as though Dr. Vijay perceived that the distribution of the plant was equally beneficial to all, his mention of how 'acceptance' is not easy, even with an intervention presumably as unquestionably good as this one, suggested a more complicated situation.

> AAA: okay so you said that it's not it's not been accepted or sometimes something like that.
> Dr. Vijay: See the thing here again is there are many barriers which come into any public health intervention. You your intentions could be good but it could be read quite differently and thing. So even though we said that this water should be supplied to everyone, there's a panchayat with ten panchayat members with ten different ideas about how that should be done. And everytime it goes and, and they are divided into three political parties also. So you supply one area the other guy gets pissed off. You supply him and the third guy gets pissed off. Then each one wants to control the supply, you know, so those are few of the challenges we face and deal with along the way.

This visibly frustrated anecdote of how the best-laid plans go awry because of its appropriation by certain political leaders is illustrative of a functionalist understanding of reform (Feinberg & Soltis, 2004).

A functionalist conceptualization of health initiatives or solutions is problematic for a wide variety reasons. Firstly, it positions PSM educators, the planners as well-intentioned, socially just, and rational so that failures can never be attributed to them. Rather, failures lie with the community leaders or the community itself who are positioned as irrational, corrupt, selfish, and/or unfathomable. Secondly, idealistic plans are assumed to be culturally universal and politically neutral rather than sites of struggle. All humans are assumed to be equally positioned in relation to governance structures and

technologies, and will therefore benefit equally from these 'universal' schemes. Therefore, conflict is never expected, and when it occurs it is something that needs to be managed. Tsing's concept of friction suggests, however, that not only is conflict inevitable but that the friction produced when universals engage with particular contexts provides the necessary 'grip' to stabilize and get them going. Taking this perspective, I explored how they interpreted another instance of friction between the department and the urban slum and rural communities: 'community fatigue'.

Politicizing relationships between human actors. The phenomenon of community fatigue is an example of friction between the department and communities that was illustrative of the power relations between the two. The medical institution's relationships with communities are primarily through the government primary health care centers (PHCs) in these specific areas. Their associations with these PHCs are officially registered with the government. Interns are placed every year in both these field practice areas to fulfill the nationally mandated practical component of their medical degree. In addition, students have 'block postings' in the urban field practice area that is mandated by the regional university. The medical institution's relationship with the rural field practice area, however, while more recent (about 9-10 years since the CBTP was initiated as compared to about thirty years in the case of the urban field practice area) was motivated also by the founder's long-standing personal, familial, communal, and religious affiliation to the rural area where the PHC is located. When I inquired of PSM teachers' about their relationships with these two communities, Dr. Chandra (March 28, 2013), in his inimitably frank style, compared them as follows:

> Urban field practice area I should say, it is not. It was not great, it is not great, it will not be great also. Why because uhh urban field practice area- of course it's a migratory population who are there today, two years down the line that same family's not there. So to really build that kind of a rapport it's really not possible in urban field uh slums especially. But [rural field practice area] yes definitely. Over a period of time, few sections at least. I'm not telling that that whole community is really satisfied with us. But at least there are certain beneficiaries because of our efforts in terms of various programs that we have conducted. So, of course it's been strengthening day by day because of the activities various activities that we have undertaken in the area.

While Dr. Chandra mentioned such specific programs such as the defluoridation plant and the special education school that they had organized as a department, Dr. Murali (March 30, 2013) spoke of health camps and health education skits during the CBTP as contributing to the strengthening of these relationships with the rural community.

> Health camps, this is one major [service]. Second is they [community members] are proud that they are teachers for the students. You know they want us to go to them. Their education awareness levels on different diseases and healthful living [has increased?]. Two important things have been health camps health education".

In the above quote, Dr. Murali speaks of a mutually beneficial relationship between students and communities. Students provided services through activities such as health camps where they conducted free health check-ups of community members, distributed medicines free-of-cost when available and appropriate, and gave prescriptions for future purchases. They also gave referral slips to patients for further examination and treatment as necessary. Similarly dental students conducted diagnostic and treatment procedures in the mobile dental van. These health camps included interns and post-graduate tutors from other disciplines such as internal medicine and surgery as well who guided undergraduate students about procedures of taking history, assisted them in

interpreting physical signs and symptoms to make appropriate diagnoses and treatment prescriptions. While learning these important practical skills through hands-on experiences, students also learned about the prevalence of particular health troubles, occupational stresses and practices, and the socioeconomic capabilities of those who attended the health camps to access health services. The turn-outs at two of the health camps that I attended were impressive and included people who were interested in gaining health advice as well as those, especially children, who were interested in interacting with the visitors thus fulfilling both health and entertainment needs as the case may be.

Children were similarly attracted to the health education skits although a lot more effort went into cajoling adults to attend them. Health education skits from medical teachers' perspectives constituted an important service for the community in that they offered information about specific diseases, appropriate health measures to address these diseases or for healthy living in general, and about the government health services available at the local PHC. In the process, students actively learned this content as well as gained important health and interpersonal communication skills.

The notion of service in the CBTP in general was driven by the philosophical idea that each of us accrues in our lives debts towards our parents, teachers, and society that we need to pay back. The very first page of the CBTP manual as well cited the following Sanskrit *shloka* to articulate this philosophy.

जायमानः मानवः, सयाचनऋणीभवते ।
सेवयाः समाजस्य अऋणिभवति॥

स्मृति वाक्यः

- Retrieved from CBTP manual

The *shloka* states that humans can become debt-free through service to society. In reference to this shloka, speakers on the inaugural day of the CBTP spoke of service-related activities as 'payback time'. One of the speakers reminded students,

> The community specially in the rural areas consider the doctors as next to god. It is with such reverence and respect the people look at the doctors .When such honourable position is accorded to the doctor in the society, do they not have to repay the gratitude to the society?
>
> - Field notes, December 24th, 2012.

Thus, the symbolic capital of doctors was redefined by PSM educators and college administrators as an accumulation of karmic debts from society that needed to be paid back through service. The *shramadaan* activity at the end of the CBTP, literally meaning a 'labor donation', is particularly motivated by this philosophy where students offered their labor through the painting of school and anganwadi buildings or in contributing certain material necessities as suggested by the schoolteacher and AWW.

Although the philosophy informing the CBTP places much important on service to the community and desires a mutually rewarding relationship, the framing of service activities did not necessarily take into consideration community perspectives. For instance, the topics for health education skits were selected by medical teachers, and the information gathering processes such as surveys and social mapping activities were not linked to service activities. Dr. Chandra in response to a different question regarding how the rural community benefited from the CBTP, suggested that the program has largely been student-oriented despite some of the tangible benefits the community might have gained over the years.

> uhh I would say village is benefited not much, to be very frank, because all the surveys that we conduct there, it's more student-oriented than community-

> oriented. It's more student-oriented. Because we are kind of giving uhh we are providing an opportunity to learn how to conduct surveys. Those things in mind we are doing that survey. If at all we want those surveys to be community-oriented then we really have to do a different job, because since that is not really the objective I would say not much, because that's not our objective also. Because more student-oriented than community-oriented.

Unlike Dr. Murali's somewhat utopian understanding of the CBTP, Dr. Chandra's pragmatic understanding suggests that the CBTP is not designed to be mutually beneficial but primarily designed for the benefit of the students, although the department may engage in other projects designed specifically for the benefit of the community. Underlying this pragmatism, however, is the power that the institution holds that enables it to facilitate the entry of students into the homes of the community with the promise of some material benefit in the immediate or near future. The CBTP can thus, be construed as exploitative where students are the ones who benefit from the encounter, although in rhetoric the CBTP is spoken of as an event where the community is benefited through the numerous services offered.

The community cannot be characterized as an exploited victim lacking in agency however, particularly when the relationship between the urban slum communities and the department is considered. Although the urban slum community constitutes a migratory population that may contribute to a disruption in their relationships with the department, a couple of PSM teachers also spoke of overt resistance to students' entry into their homes. Dr. Chandra and Dr. Sumathi described this resistance as 'community fatigue' while Dr. Mangala referred to it as 'community saturation'- an issue that the department faculty have historically faced with urban slum communities and seek to preempt in case of the rural community.

> Urban, yes, we have because we have only one rural [possibly misstated and meant 'urban'] field practice area. So, every year we visit with students for the exams, for our [community-based teaching program], for our block posting, then apart from that we have nursing faculty in same area. So we have some lot of resistance there in the urban area. - Dr. Sumathi (April 1, 2013).

> Sustenance of this program will be a challenge because see just like how the community has got saturated with us- they wouldn't want us anymore in the urban slum. So we do not know when we are going to face that kind of a situation in the villages. So what should we call it as community saturation or community; there was one specific word I used to use. So, that could be a challenge. I might not face it right now but I'm sure I'm going to face it few years down the line could be 5 years down the line or could be three four years down the line. If we have to avoid, that service component should increase. – Dr. Mangala (March 27, 2013).

Thus, the phenomenon of 'community saturation' or 'community fatigue' could be understood as agentic reactions on the part of the community to the continuous presence of medical personnel in their spaces that would be tolerated and justified only if they were provided with adequate services. This push back from the urban slum community, thus, limited the design of the CBTP and other community-based educational activities as exclusively student-oriented requiring the department to contribute services to them in tangible ways. Indeed, Dr. Chandra (March 28, 2013) spoke of the community as being so vocal and unrelenting in demanding services that they were pushed to occupy a position that was somewhere between a rock and a hard place.

> Community's expectations will be always high, community's expectation will be always high. Usually in our subject we talk in terms of health needs and health demands. So demands from the community will be always high. See the moment JDMC hospital is coming there means they expect that everything has to be free. That means if I'm suffering from some disease. Then this JDMC hospital has to take me from here, get me admitted there, perform whatever is necessary, and then send me back royally. Me without paying one single *naya paisa*[8]; so that

[8] *Paisa* (plural: *paise)* is the lowest denomination of the Indian currency. *Naya paisa* or new *paisa* is referred to the newly minted coins in the period from 1957-1964 when India shifted from a 'predecimal' coinage system to a 'decimal' one. At this time, coins from both systems were in circulation and the term '*naya paisa*' was used to distinguish the new coins from the older ones. Although the term '*naya paisa*' was dropped in 1964, it is used colloquially, interchangeably with '*pie*' and '*anna*' (older terms for low

> expectations will always be there. And number 2 since every year we've been going there, one challenge that will always be there in the back of our minds is community fatigue because the more and more we're going to interact with them at the end sometimes they've not told but probably they might told after few years. 'What you people every time you come here and utilize our resources' in terms of like bringing our students and all those things 'but in return we're not getting anything'. So those are the certain challenges in the community. The other one is institution last one I think. Challenge is again because uh when it comes to the face of JDMC is community medicine department in [rural field practice area]. It's not the principal, it's not the medical superintendant nor it's not anybody else. The face of JDMC is community medicine staff and postgraduates because we are the ones who interact with them regularly, almost everyday. So they uhh institution yes some kind of service provision has to be made. Of course concessions all those things are there. There is lot of scope for further strengthening the service component for the institution to the [rural field practice area] community. So that itself is a challenge for the institution because when we go there we will get those brickbats from the community.

On the one hand, Dr. Chandra alternated between a legitimate need to provide adequate services to the community and the unreasonably high expectations, from his perspective, some community members made of them. On the other hand, he expressed their limited power in providing such services because while they were the 'face' of the institution in the community, they were not the decision-makers in the institution. Thus, while PSM teachers acknowledged that they had to increase the 'service component' of the CBTP, they were caught between the community and the institutional management so that the CBTP leaned towards benefiting students at the expense of the urban slum community.

The term 'community fatigue' is interesting also because it resembled in its framing as an analogy of the biological phenomenon of 'muscle fatigue' which is the reduced performance or resistance of the muscle to contract on continuous stimulation

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denomination coins), to describe an extreme condition of penury or miserliness when a coin even of such a low denomination cannot be spent.

due to an accumulation of metabolites when muscles reach their point of 'saturation'. After an appropriate amount of time when the muscle is allowed to relax, it would again be receptive to stimulation. Such a biological conceptualization shaped how resistance from the community was understood as being an inevitable phenomenon that would occur due to their continuous interactions of medical staff and students. Further, this resistance could be avoided if an appropriate amount of time would be maintained between visits so that the community would always be receptive to their presence. Thus, villages in a given year were selected on a rotational basis. Dr. Sumathi (April 1, 2013) described this rationale well.

> We have our rural field practice area PHC which has about 36 villages initially now its scaled down to further 23 or 24. So we see to it we rotate we usually select 6 to 7 in a year and we keep rotating so that there is no community fatigue and they will not accept us easily. We go very frequently we likely to see they might not be welcoming us so much. So we rotate, so every village might probably get once in three years, so people also welcome us more.

In the case of the urban slum communities, she said that such a policy was far more difficult.

> Very difficult because we cannot move into a to new area because it requires one is from BBMP [city municipality] we need to clearance for that. We are adopting new area we need new form and this thing. But anyway this year we've got adopted a new center there this thing. So we are exploring that area also. Probably maybe that could be an area which we can take a break here and then start working there.

Although there is more bureaucratic paperwork to deal with in the case of the urban field practice area, the department has dealt with this persistent issue by adopting a new PHC that will allow them to give a 'break' to the older community so that it can become receptive eventually. In sum, the department negotiated the tension between the

community's demands on the one hand, and the institution's control over resources on the other by rotating communities to the extent possible. In this way, the institution and students accrued maximal symbolic benefits with minimal material losses that sustained relationships with a particular community would never allow. Although such a conclusion may suggest a conspiracy on the part of PSM teachers and institutional leaders to exploit the community, I suggest that the strategy was informed by the application of a biological concept on a physiological phenomenon to address a social one as well as by the normalization of this historically exploitative institutional practice. By exploitation, I refer not only to redistributional but also to representational and recognitional injustices (Fraser, 1996). While the institution could claim to have achieved redistributional justice to a degree as it provided some material resources to the communities, although its adequacy was contested, the phenomenon of community fatigue raises questions regarding the recognitional and representational injustices that may have been committed in that community members' 'resistances' were not engaged with as legitimate concerns but as a phenomenon that should be avoided so that they were perceived to be incidental to processes of knowledge production, that is, not understood as epistemic knowers, thereby fostering their participation at the level of method where they acted merely as sources of 'information'.

Pedagogical implications of a depoliticized public health. Above, I discussed how frictional encounters above between institutions and communities could be interpreted in ways that necessitate more inclusion of local community voices in constructing knowledge about public health. Such inclusions, however, will require

significant structural changes, some of which are institutional. Some changes would require changing assessment structures that go beyond individual institutions. These structural changes are concerned with the organization of the curriculum itself.

The politics of organizing the curriculum. Dr. Vijay was of the opinion that students would learn about politics eventually but that was not what they wanted to talk about with students. Perhaps, this is what prompted Dr. Mangala to amusedly state that "public health and politics go hand in hand" even though that's not something they talk about, at least not in the undergraduate curriculum.

> AAA: So uh do you share these the politics of this with students?
> Dr. Vijay: Not really not really. We uh they'll get to it when they need to but right now what we're trying to tell them is this is how this is a public health intervention. There we talk so much about changing this and changing that rarely do we do it. Here's a live example where we are actually put our money where our you know put your money where your mouth is here. We've stopped talking about it and we've started doing something about it. That's what we want to portray.

Dr. Vijay (March 13, 2013) argued that the goal was to talk about something they were doing, about action rather than merely talking about what can be done and how. The defluoridation plant was an example of such proactive drive. Indeed, he mentioned elsewhere in our conversation that, "We actually teach by example, and we like to showcase the things our department is doing. The students are with us for 21 days. We also want to show them what we are up to in the field. That makes our [PSM department] credibility better with them." Certainly, I too was impressed by the passion and commitment of the department as a whole in undertaking diverse projects in the development of this particular community, and to "showcase" (a term that I had used in an earlier interview question) or to speak about these projects is a valuable way for students to learn about how public health interventions are designed and implemented.

My critique, however, is not directed at the intention of the department but at the way that public health interventions have been conceptualized and taught so that its technologies of governance are positioned as unblemished (Prakash, 1999). A standardized and depoliticized curriculum that silences the local politics shaping public health practices not only denies students the valuable experience of PSM teachers but also valorizes the discipline, the government, and in this case, the department and the college as a whole.

Dr. Vineetha's (March 29, 2013) perspective on not talking with students about the friction that occurs in public health practice was different. Her argument was that they did not want young students to learn about such things as it may disillusion them from working in rural areas in the future, and because it was too 'deep' for them to consider at this stage.

> No no. We don't I feel it is uh we have uh the depth of these schemes and all- these things are too much for them at this point, at this point of time. And and one more thing it is, we are trying to, if we tell them all this no, it will give uh, it will have a negative impact on the students. They'll feel government is not doing anything so that negative thing should not be instilled into the these young minds. So that tomorrow if they are want to work as medical officers in the rural areas all these negatives things will come into their mind and maybe they may not decide to work in the rural areas even if they are inclined to it just because of these negative things they might think twice before going to the rural areas.

For Dr. Vineetha then, talking about friction or politics would be to talk about the government not doing anything. This was consistent with some of my interpretations that the CBTP and the public health curriculum in general sought to stage the government as the good guy. What was interesting however, that this deliberate illusion about a functioning and equitable government, or for that matter the discipline of public health was being constructed to protect young students from purportedly the 'problems' of

public health practice. Dr. Vineetha hoped that such a fiction would at least not deter students from working in rural areas in the future.

The developmental model of organizing knowledge. Dr. Vineetha implicitly invoked a developmental stage model of organizing curricular criteria. These students, age18-22 years, are presumably too young for political and prickly 'real-world' discussions. I argue, however, that youthful innocence is a class privilege and an effect of systematic hegemonic practices in medical colleges that protect medical students from not seeing and confronting their privileges, and also to perceive their privileged lives as part of a natural order. The ordering of the curriculum, therefore, that privileges certain learning objectives at an early stage while deferring other 'higher-order' objectives at a later stage are neither 'natural' nor arbitrary. Rather, the hierarchical organization of learning objectives is motivated. For instance, most PSM teachers suggested that the pedagogical activities were designed in alignment with the nationally recognized syllabus. The content was thus related to what students would be most likely tested upon in examinations at regional and national levels. A mastery of much of this content would enable students to understand how the system works, and to become a functional part of it. In the context of teaching about healthcare waste management, for instance, Dr. Mangala (March 27, 2013) asserted that the content was firstly part of the syllabus, and secondly, that they needed to learn how to be part of the system.

> Health care waste- there are two or three issues here. One, as I said, it is a part of the syllabus- they need to know. Two, tomorrow they are going to be interns and working in the same hospital so you start introducing these systems right from the beginning. So, when they will come and work under us as an intern they will not mess up with the system. In the sense [unclear] if the, one person is enough to spoil the system completely. You don't need ten people for it to do it.

In this case, Dr. Mangala was talking specifically about students learning the hospital system. But, this point about learning the working of the system was brought up by Dr. Sumathi (April 1, 2013) as well, in justifying the objective of a particular pedagogical activity.

> The utilization per se by the community or the people probably will be; just teach them based on our experience what is the involvement and we may not be able to tell in much very further detail because contact point is very short, and they are not uh there are not in the sense our objective is different. We are not focusing on that much. We are telling how it functions as a system and what is the use of that system in that place. That is the more focus.

Thus, in response to my question of how the CBTP explores community perspectives on particular schemes or interventions of the government, Dr. Sumathi suggested that the focus was to understand the functioning of the system, although they may share their experiences about the impact of schemes and their utilization by communities. Dr. Chandra (March 28, 2013), however, suggested that such an attempt is not made also because students may not understand it or be interested in it because it is not required by the standard curriculum.

> AAA: Uhhm there may be so there may be instances when health and development schemes they are produced for one purpose but they are utilized for some other purpose or they're they may be resisted by people. So can you give examples of how you teach about these unintended consequences of schemes?
> Dr. Chandra: mmm. I don't think any attempt has been made. I mean at least as far as I can remember because see one thing we need to remember here with these students is they are just in third term that means they are just entered the second [year of] MBBS [undergraduate medical degree]. We cannot really go very deep into the social issues and the really talk about the core community and community health and development all those things because that will be above their head. And they really cannot understand and appreciate also. And looking at their background that they come from we need to sustain their interest also in the program. So if you start teaching them about all these things they lose interest. So we need to have that equal mix of the way they need to learn and things that we

need to also put across. So somewhere some balance needs to be made. So we really don't dwell very deep into those health and developmental issues.
AAA: What about in the syllabus itself, is there something?
Dr. Chandra: Syllabus, see since we teach them about these national health programs during their final year MBBS. So, that time during that theory sessions we bring in these issues and tell them we bring in these issues and tell them but per se we don't really get very deep into them into those
AAA: Okay, it's not required?
Dr. Chandra: It's not required if you go by the curriculum because none of the questions will be asked where how the developmental things may affect health so those kind of things might not be asked directly. So even if you teach them either they'll listen and forget or it's not very important to them ultimately for a student I have to pass my exam that's my objective.

Thus, although students may inquire community members about the impact of certain schemes or interventions on their lives, or teachers may share their experiences about their perceived impact of these schemes, these concerns were not the focus of the undergraduate curriculum because it was not required by the syllabus or qualifying examinations. Implicitly, Dr. Chandra too believed that the syllabus was designed based on a developmental model (as used in behavioral psychology) that ascertains the appropriate level of knowledge at a particular stage of the curriculum when he commented that talking about social issues may "go above their heads", although he also suggested that their inability to appreciate sociopolitical complexities could be because of their backgrounds referring to their relatively elite and urban positionings. However, consistently, all PSM teachers, at some point in the interview, suggested that they did not explore sociocultural issues in such depth because the syllabus did not require it, and because it was implicitly 'too much' at the undergraduate level. As Dr. Mangala (March 27, 2013) put it,

Dr. Mangala: I expect more from a postgraduate student. uhh I would be looking for impact I would be looking more in terms for a postgraduate student, and not

> an undergraduate. For an undergraduate, if they know that these exist itself I would say 50% of my objective is enough uh achieved. Now if uh if my undergraduate is very well aware very much read and answers up to this point I would be all the more happy.
> AAA: That is the expectation.
> Dr. Mangala: That is the expectation, that is. It is like good to know.
> AAA: good to know
> Dr. Mangala: Very good to know something like that. It does It might not come under a must know area. but if if they want to score more marks or be ahead of the race. Or you have those differentiations right. May be they score extra brownie points if they mention these points there.

While this organization of knowledge into undergraduate and postgraduate levels, and into "must-know areas", and "good to know" areas might be informed by criteria of previous knowledge and ability, it also suggests an organization that privileges universalistic knowledge about systems as they exist over local, place-based knowledge. This organization of knowledge was informed by teachers' knowledge of assessment structures that they directed towards enabling students' to master that knowledge they needed to pass examinations and continue studying. These structural and material constraints thus condition teachers' privileging of certain areas more than others as they need to ensure high pass percentages for students in university examinations, and attract future students being a private medical college.

The issue, however, is not limited to the institution or the individual teachers. The organization of knowledge sustained by assessment structures is political in that knowledge about the functioning system is crucial for the politically socialization of students where they learn to value the system they would be a part of rather than to explore how it might be disrupted or (mis)appropriated. This belief in the system shapes how students are implicitly taught to interpret the friction that occurs when local

community members interact with universally designed schemes in unpredictable ways as ignorant or irrational utilization or implementation practices on the part of certain individuals rather than as a fault with the schemes or the system.

In conclusion, therefore I suggest that the depoliticization of public health content is highly deliberate and motivated (Apple, 2004). While this may be justified by the legitimacy of the curriculum and assessment structures, I argue that the exclusion of PSM teachers' and community members' experiences in the implementation of certain health and development schemes is motivated by the privileging of knowledge about 'universal' and 'rational' systems that positions the government in good light. These fictions are problematic because they are anti-democratic as alternate perspectives are not sought from counterpublics (Fraser, 1990). The underlying issue, however, is that knowledge produced from pedagogical activities are assumed to be scientific truths rather than fictions. In the next section, I explore the ontological assumptions underlying PSM teachers' pedagogies, and their implications for how alternate perspectives are sought and interpreted.

Ontologizing Fictions, Fictionalizing Science

In this section, I explore PSM teachers' ontological assumptions underlying various pedagogical activities. The values associated with certain pedagogical activities such as empathy and effectiveness implicitly held ontological assumptions. This had implications in how knowledge produced was understood as fact or fiction. Students' narratives of skits and the monsoons simulation game were particularly interesting to look at as they occupied that ambiguous zone between fact and fiction. In the previous

chapter, I argued that students drew from familiar stock characters in constructing these narratives. In my interviews with PSM teachers, I explored how they understood and addressed the production of these stereotypes. These conversations pushed me to explore my own ontological assumptions, and to consider the pedagogical implications of ontologizing fictions on the one hand, and fictionalizing scientific knowledge on the other.

Empathy and authenticity. One of the important goals of the CBTP was to develop certain attitudes among students, such as being 'patient', 'good listeners', 'empathetic', 'trustworthy', and 'compassionate' without differentiating on the basis of religion or between the rich and the poor. During the pre-orientation session of the CBTP, empathy was cited repeatedly as a valued goal. Dr. Sumathi (April 1, 2013) articulated the importance of this goal in the context of personality development:

> We are looking at personality development indirectly indirectly we are focusing on values to be cherished during the program so that they learn about not just sympathy empathy.

Indeed, the pre-CBTP evaluation specifically sought to check students' understanding of empathy as a concept.

> Tick the appropriate answers:
> a. Empathy means:
> 1. Sympathy 2. Caring
> 3. Non –discrimination 4. Getting into one's shoes
>
> - Retrieved from pre-CBTP evaluation questionnaire.

Empathy was often spoken of in opposition to sympathy as in the cliché, "It's empathy, not sympathy", as illustrated in the two different sources of evidence above. The question sought to test students' awareness that the two words signify different

concepts. Unlike sympathy which generates a sense of pity or the emotion of feeling sorry for the 'other', empathy, it is argued, is about understanding that is made possible by 'getting into the shoes" of the 'other'. The CBTP manual offered the following definition of empathy,

> EMPATHY: We will not be in a position to understand someone`s pain and suffering, unless we ourselves undergo the similar suffering. Put yourself in the patient`s position and try to imagine how the suffering would be.
>
> - Retrieved from CBTP Manual, p. 31.

According to this definition, although understanding is assumed to be possible by having undergone similar experiences of suffering, paradoxically imagining oneself in the other's position can also take the place of experiencing to achieve understanding. Thus, even though students may not have similar experiences, imagining the lives of the other can takes the place of experiencing through which they can acquire understanding. Through such an understanding, empathy somehow negotiates the hierarchical relationship between the self and the other, and moves towards sameness. In this sense, empathy could be confused through association with 'non-discrimination' or 'caring', the two other choices in the pre-CBTP question above.

The monsoons simulation game was touted as an activity that facilitates empathy as it allowed students to 'get into the shoes' of villagers. In clarifying the objective of the monsoons game to me in an interview, Dr. Vijay (March 13, 2013) pointed out,

> See, we wanted them to actually the whole thing of monsoons is to put the students in villagers' shoes, right? And that's the main attempt there…. so you could be in a harijan's family or you could be and that gives them a real insight into what actually happens in the village. So it is a game where they are allowed to feel what the villager feels choose the crop the villager has to choose, and then try and live that life…

The monsoons game created a simulation of the reality in which villagers apparently live, and facilitated students to experience that simulated reality. By 'getting into villagers' shoes', students were assumed to gain a "real insight" into what "actually" happens, how villagers "feel", and so on. Although Dr. Vijay did not use the word 'empathy', the consistent association of the phrase 'getting into the other's shoes' implies that the monsoons game was enacted with the goal of producing an empathetic identification and understanding of villagers' lives. This understanding or insight without any doubt was assumed to be 'real' or 'authentic'. The knowledge produced through empathetic identification as a process was both homogenized and ontologized. What I mean is that as a pedagogical process, role-playing or simulation was assumed to facilitate an essentialist understanding of villagers' lives and their social context while also asserting its truth value through a direct relationship with reality.

This understanding of empathetic identification as a way of knowing is not unique to this particular teacher, program, college, or context. While there may be locally constituted discourses that make similar assumptions, empathy as a concept has enjoyed an influential discursive presence in behavioral and social psychology, counseling, and related fields (Dolby, 2012). As a way of knowing, neopositivists have historically misappropriated Weber's and Dilthey's concept of *Verstehen* as a subjective process, and assumed that inquirers are capable of grasping the psychological state of individual actors (Schwandt, 2000). Although a few educational philosophers such as Martha Nussbaum and Maxine Greene have suggested that literature and the humanities in general would be important in the development of an aesthetic empathy and imagination, in general

multicultural education scholars have been wary of the assumption that the concept makes of an easy cognitive and emotional access to the 'other' merely through imaginative experiences (Boler, 1999; Dolby, 2012; Lather, 2009). Lather has argued that the concept of empathy entertains "fantasies of mutualities, shared experience, and touristic invitations of intimacy" (p. 19). In generating such fantasies, inquirers can escape the discomforting negotiation of unequal relationships through a process that is comfortable, and even enjoyable thus ignoring the violent nature of the process in its appropriation of the 'other'. Further, as I argue below, it ontologizes what are circulating fictional narratives that have crystallized over time as truths.

Effectiveness, critical thinking, and empirical evidence. PSM teachers frequently characterized classroom teaching as an undesirable, although prevalent pedagogical method. The CBTP, in this sense, represented a departure from the norm as it attempted to address some of the limitations of classroom teaching. This included considerations of efficacy in terms of performance outcomes such as enhancing the memorization of facts required by the official syllabus, or the development of communication skills, research skills, critical thinking skills, and so on. Problem-based learning (PBL), and community-based education (CBE) have both been advocated in medical education discourses as *effective* teaching learning processes, and was popular amongst Dr. Murali, and Dr. Mangala with the latter having acquired professional training from the US-based Foundation for Advancement of International Medical Education and Research (FAIMER) Institute (http://www.faimer.org/education/institute/index.html). This is important to note as

FAIMER is an influential player in shaping the discursive frameworks on medical education internationally offering professional training opportunities, and publishing academic articles on training PSM teachers in innovative and effective pedagogies (Supe & Burdick, 2006; Bansal & Supe, 2007).

The visual and performative aspects of the CBTP from this perspective enhanced the efficacy with which learning took place so that the pedagogical goals themselves weren't different.

> Visual impression will have a longer impact than that what we teach in the classrooms. So especially if you take sewage treatment plant, the process and all they can learn very well, recall and write uhh in the uh exams or something like that. And it makes makes them more interesting rather than us talking about it theoretically, or with the diagram and those things. Here they get the actual process how its works. - Dr. Sumathi (April 1, 2013)

In the above quote, the visit to the sewage treatment plant functioned as a spectacle that is more 'interesting', and palatable for student consumption than classroom teaching. Memorization continues to be a learning objective. The visual impact of this pedagogy merely enhances memory retention, and recall. However, witnessing the process in person also appears to serve as empirical evidence of how the phenomenon *actually* works in practice, and is superior than reading about processes in theory. While theoretical learning occurs in the abstract engaging only the rational and logical mind, personally going there and seeing for oneself involves an engagement of the entire body and its senses, particularly the eye, in the learning process. As Dr. Mangala (March 27, 2013) argued, "How much ever you say in the uhh classroom setting they'll not get the idea until you personally go there and see it for yourself." Thus, actually 'seeing' in person was perceived as a more effective learning process than in the classroom.

Interpreting such an engagement of the body and its senses in the learning process as a disruption of the mind/body duality would be a facile conclusion. I suggest, instead, that these sensory experiences are valued primarily from an empiricist point of view in the sense that they serve as evidence to validate authoritative texts rather than to question or decenter them. In this context, critical thinking has a specific meaning. Dr. Murali, one of the senior most professors urged students to not take what he was saying at its face value but to critically evaluate his arguments. Critical thinking was thus, understood as the ability to critically evaluate theoretical claims made by curricular texts on the basis of empirical evidence. However, the activities such as visits to technological plants, for instance, were structured to exhibit the curricular texts, or to put them into relief by using the visual or observational modality (Cohn, 1996). Since the goal was to use a visual pedagogy to effectively represent curricular texts, the activities were overwhelmingly structured to offer students empirical evidence that verified, and legitimized curricular texts. Thus, although the CBTP employed extremely innovative pedagogies, their success was primarily in the effective recycling and universalizing of particular storylines. This was in part due to logistical difficulties that teachers faced to engage with students, and reframe what they had learned during and after a pedagogical event that I discuss later. It was also, however, because the pedagogical and discursive frameworks that they had had access to through previous training informed their assumptions about the nature of science and critical thinking, points I have raised throughout this chapter.

Ontologization of fictions. In this subsection, I explore how PSM teachers recognized and addressed the issue of the production of stereotypes in student narratives,

taking the monsoons simulation game and health education skits as examples. Note that at the time of the interview I was struck primarily by the stereotypical characterizations, and had not theorized the relationship between simulation, representation, and reality. Consequently, I did not have well-developed counter-questions to teachers' responses about the relationship of these representations with reality. Rather, I have been able to conceptualize what I found problematic about these stereotypes through a sustained engagement with teachers' theorizations of these relationships, and a search of alternate ones in the literature. This is to point out that while my inquiries were shaped by theory and began from particular interpretations of the game, they also changed through dialogue with my interlocuters who triggered a search for alternate interpretations in areas I had not looked before. In this sense, the interviews were intersubjective processes where I encountered some of my own assumptions while engaging with some of the assumptions that teachers made.

In my first two interviews with Dr. Vijay and Dr. Mangala, I realized that their interpretions of the term 'stereotype' differed from mine or at least required a little bit more clarification. Whereas I understood the term as a common or popular characterization of certain groups of people in fixed and essentialized ways, the term 'stereotype' seemed to invoke another meaning akin to a classificatory method or scheme such as 'ideal types'. Hence, they responded to my question of how they thought the game or skits produced stereotypes in an unproblematic affirmative. Although I changed my interview questions subsequently, this was an extremely productive 'misunderstanding' (Fabian, 2001). It led me to think of stereotyping as an acceptable

mode of thinking in the biomedical sciences where things and phenomena are categorized according to typologies. Stereotypes could therefore be interpreted as ideal-typical categories similar to other procedures such as 'karyotyping' or 'genotyping'. Consequently, my question did not create a conflict as I anticipated. It was only on clarifying the term through colloquial phrases such as "this happens in villages only" or "villagers are like this only" that I was able to get at their understandings of the relationship between stereotypes and reality.

While classifications according to ideal types may serve well for particular purposes in biomedical sciences, it becomes problematic when applied to providing explanations for how people live their lives. Historically, this ideal-typical way of classifying modern and traditional societies by modernization theorists such as Parsons, Levy, Inkeles, and others solidified these discursive structures that continue to persist as the game's narrative illustrates. What is problematic about ideal types is that despite being conceptual categories, they lend themselves to be easily conflated into 'real' and 'fixed' categories.

> AAA: Like students might take it in as a stereotype and think that villagers' religious beliefs control their behaviors or something like that.
> Dr. Vijay: That's pretty true right? So there's nothing wrong with that. (laughs) I'm saying that that that's the way it is.
> AAA: No there (laughs) but you know not be but not be but but what if it does not make them open to other ways in which villagers' behave. That's what I mean.
> Dr. Vijay: It opens them to both the th [unclear] if you actually look at monsoons seriously. It it gives you exposure to everything. And finally the villager actually gets up to this religious thing when he has no other go. He goes to the uh the town temple or whatever he does because his crops are not, and that's quite it's quite true and it's it's nothing to hide or be ashamed of cuz thats the way it is.
>
> – Interview with Dr. Vijay (March 13, 2013)

In my first attempt to understand how teachers negotiated the stereotypical characterizations that the game produced, I was taken aback conceptually by Dr. Vijay's assertion that it was true, and there's nothing wrong with that, or it is nothing to hide or be ashamed of. Part of the problem about stereotyping, as I understood at the time of the interview, was that it constructed 'culture' or 'religion' in this case, in very deterministic ways allowing no possibilities for villagers to be interdiscursive or agentic in any way. This, and the following interaction illustrate my understanding of stereotyping and an assumption that I held regarding the truth value of such a characterization at the time.

> AAA: One follow-up question to the point about stereotyping that I I guess what I was trying to mean by stereotyping is that given that India there are so many diverse communities and then uh there might be uh a tendency to understand that a villager's religious beliefs in North India is the same as villager's beliefs in South India but there might be so much variation in that.
> Dr. Vijay: Definitely ma definitely I agree with you that point. But uh don't you think this is better than sitting in the classroom and reading from the book.

Note that while earlier I had critiqued the deterministic construction of religious belief systems, in this attempt at articulating my understanding of stereotyping, I argued that the game portrayed only one instance of villagers' belief system. Dr. Vijay acknowledged this latter issue so that it seemed that we reached consensus around the truth value about the existing relationship between religious beliefs and the control over the actions of the rural farmers. At the same time, he raised an important point that the monsoons game activity was better than sitting in the classroom and reading from the book. I would argue, however, that if effectiveness is the criterion for judging quality, then yes, the game can be considered better than reading a book. However, as argued in the previous two chapters, pedagogical activities that are interactive and performative do

not necessarily offer superior knowledge to books in the sense that they are just as mediated as textual modes of learning when their democratic potential is taken to be a criterion of judgment. According to the latter criterion, whether and how the knowledge produced through pedagogies foster a contestation of and confrontation with preconceived assumptions about people and places would be of value. Such a possibility, however, is closed off if knowledge produced through these activities is understood as 'real' or 'true'.

While Dr. Vijay took on a defensive posture, Dr. Chandra (March 28, 2013) acknowledged that the game did stereotype the rural poor, and articulated stereotyping using a different analogy.

> Yeah that's one wrong thing because it's something like our bollywood movies. In all of bollywood movies all Madrasis are idli eating people and they eat lungi, I mean, they wear lungis, dark skin so something like that. It stereotypes a village environment but yes of course the game is like that, probably we need to make some changes so we don't stereotype. At least these present conditions what they see in monsoons are not the same situations what I come across in rural areas right now currently, that is majority of the rural areas. Probably we need to make some amendments and changes in those games.

Dr. Chandra described his understanding of stereotyping as a reductionist representation of particular groups of people by using the analogy of how South Indians feel when they are stereotyped in Bollywood movies. Yet, as he went on to address this stereotyping, he suggested that the game needed to be renarrativized in a way that would reflect reality more closely and accurately. Thus, the problem in the game's narrative, according to Dr. Chandra was that it did homogenize and caricaturize villagers but also that it was not in sync with reality.

Dr. Sumathi (April 1, 2013), however, attributed the stereotyping produced in the game to the problematic ways in which students enacted the roles of different rural characters.

> Yeah yeah I think so that's a limitation of that game and often it happens so that the students get carried away with the money money components they go with points and scoring points and become like that. In fact forget the what is the reality what happens many I see to get the money or to get more points they in fact they marry their daughter to the goondas which may not be true in all the times at all the times may be one odd times.

The tendency for families in the game to 'sell off' their daughters, or to get them married with thugs was certainly consistent across different iterations of the game. This tendency, she suggested, was because students were more concerned with gaining points or money as a result of which they exaggerated or departed away from 'reality'. In a subsequent statement, however, she argued, "see anyway it's a simulation game not necessary it has to be the same thing it's okay to closer to the truth but there very wide gap we try to bridge the gap". Thus, her understanding was that the game's narrative constructed reality in a way that was possibly not the 'same thing' but possibly a close approximation to the truth. Their goal was to bridge the large gap between students' understanding of rurality, given their urban life experiences, and reality. Besides, she argued that students were 'mature' enough to understand that this was not representative of all rural people. Indeed, in my interviews with students, while all of them stated that they thoroughly enjoyed the game, and wished that everyone had taken it a little more seriously, a couple of students did comment on how the game was 'dated' in its representations of rurality, giving the example of banks and other credit options in rural areas.

Consistent across these different interpretations of the game's construction of stereotypical representations was the assumption that they were either close approximations of reality, and if found wanting in any way, their goal as teachers was to move towards bridging the gap between representation and reality. Teachers thus, positioned themselves as those who knew what rural reality was like. Being largely dependent on popular cultural representations of Indian rurality rather than 'direct' experiences myself, I yielded to teachers' knowledge of rural lives because of their extensive experiences working in this particular rural field practice area as well as others.

However, as I continued to explore and ruminate over the data beyond the monsoon simulation game, I found that what was problematic about these representations were that they fit far too comfortably in the development discourse of modernization. Although the terms 'traditional' and 'modern' were not used, the game's narrative characterized rural lives that positioned it on the traditional end of the evolutionary timescale of modernization and development. What is problematic is not whether and to what extent the specific characteristics are true in different contexts but that those are the only parameters by which rural lives can be understood. Hence, when I make the argument that these rural spaces have been characterized as if they have not been touched by modernity, I'm not suggesting for a re-narrativisation that is updated to current times. Rather, my argument is that the stereotypical representations of a traditional way of life foster cognitive and emotional associations with a crisis narrative, and by implication construct symbols of modernity, including PSM teachers and students, as inherently progressive. Thus, the game maintains, and solidifies the relationship between the

participants, and the rural poor whose lives they imagine, and supposedly 'experience'. Further, since the game's representations are assumed to be close approximations of reality, upheld not only by their pervasiveness but by PSM teachers' own expertise, these fictional narratives get ontologized to acquire the legitimacy of scientific truths.

My argument, however, is not to discourage a re-narrativization of rural lives but to caution against its ontologization and homogenization. I suggest instead the game and its representations need to become objects of critical analysis, and be taught *against*, rather than merely serving as the medium of learning, so as to avoid static understandings of culture, comfortable negotiations with the 'other', and epistemically violent acts of representations (Abu-Lughod, 1991). My argument, therefore, is to fictionalize science. Below, I discuss what I mean by fictionalizing science, and explore possible sources for alternative storylines.

Fictionalization of science. By fictionalizing science, I do not mean that scientific knowledge must be understood as false because fiction too is often based in reality (Haraway, 1989). Hence, I am not suggesting a deontologization of science. Rather, what I mean is that scientific knowledge needs to be understood as imaginative storylines about particular groups of people that while aiming to mimic reality are nevertheless partial, biased, incomplete, and situated representations of reality. Further, fictionalizing science means that it would no longer occupy the heady heights of universal and objective truth but be brought down to the realm of subjective interpretation (Fraser, 1989; Haraway, 1989). Pedagogically, this would mean interrogating the subjective and partial nature of scientific narratives as well as teachers'

and students' narratives. It would mean constantly destabilizing the scientificity of existing storylines, and looking for and creating alternative ones. Knowledge then would not occupy the position of facts already known but would remain within the realm of fiction that, while being based in reality, is always being refashioned and recreated (Haraway, 1989).

I entered the 'field' with the goal of problematizing storylines that felt 'natural' and 'familiar' to me (Yanagisako & Delaney, 1995). Although I could have interacted with community members to find 'evidence' to disprove existing storylines, assuming that such evidence exists, the danger also lay in privileging my interpretations as more 'real' or 'true' as compared to those of PSM teachers. My goal in this project, however, has been to show how interactions with the community are mediated by pre-existing understandings of the community. My argument has been to highlight the dialectical nature between discourses and practices, that is, exploring how discursive texts mediate practices, and how practices disrupt such mediating texts (Norris & Jones, 2005). Pedagogically, this means that the community needs to be understood as multiple counterpublics whose perspectives can challenge existing storylines and produce new ones. However, alternate storylines can also be sought by exploring interpretive resources such as in other disciplines and paradigmatic perspectives, and it is the latter that I depended upon in this particular project. I do not suggest that these interpretive resources are adequate replacements to interactions with community members. My point, instead, is to suggest that actions are often celebrated over texts, and 'direct' interactions with communities are often overvalued at the cost of reflexive thinking when the relationship

is a dialectical one. Thus, while pedagogical practices were extremely innovative as they promoted active and interactive learning, they were, nevertheless, conceptually conservative. The issue, however, is also an ethical one. Entering marginalized communities is much easier politically as a boundary-crossing practice with much symbolic capital to be gained for the educational institution, students, teachers, and researchers. Although engaging with such communities is always exploitative and self-serving in this respect, engaging with different disciplinary and paradigmatic perspectives would be important if only to foster a suspension of deeply held beliefs to the extent possible, and to minimize recognitional and representational injustices.

My fieldwork was characterized by doubt of whether the familiar and natural could be problematized, whether alternative scripts existed, and whether stereotypes had a basis in reality, after all, given PSM teachers' confidence in some of them. At the same time, it was characterized by belief that the familiar and natural could be problematized, and that while stereotypes might have some basis in reality, there are alternative ways to make sense of them. It was this Kuhnian belief in postpositivist[9] perspectives that pushed me to explore alternative texts (Kuhn, 1962). These included disciplinary discourses in cultural geography, political ecology, gender studies, and performance studies. Below, I discuss how these engagements shaped my confrontations with familiar scripts. These engagements are exploratory and serve to suspend familiar storylines into the realm of fiction. Each of these scripts could, however, be explored in future research projects or future community-based pedagogies at this site.

[9] I use postpositivist here in the sense that Patti Lather has referred to (1986), that is, paradigmatic perspectives other than or 'after' positivism. These include interpretivist, critical, postcolonial and poststructural perspectives.

Cultural geography and political ecology. I explored the literature in cultural geography and political ecology to understand the relationship between places, environments, and people. As discussed earlier in this chapter, my own understanding of people and places was largely deterministic, and I had always considered my relationships with material objects such as water and land as 'natural' rather than political. The program's focus on the environment made me confront the familiarity of these scripts. While teachers had spoken of 'updating' the monsoons game narrative, I offered them research articles at the conclusion of my data collection that I found useful not so much because they might be more up-to-date but because they departed from the hegemonic narratives of modernization (see http://prezi.com/0rmadppympwr/?utm_campaign=share&utm_medium=copy&rc=ex0share). These research articles suggest that global multinational seed companies such as Monsanto exploit farmers to buy certain seeds, and cultivate certain crops that decrease the quality of the soil, and that microcredit initiatives have been just as exploitative as traditional moneylenders driving certain farmers to suicide (Reddy & Galab, 2006; Shiva, 2004; Taylor, 2011). Further, Vandana Shiva (2004), an ecofeminist, has pointed out, farmers' suicides are often attributed back to cultural practices such as alcoholism. By negating the game's narrative, I do not intend to deny the existence of hegemonic traditional power structures, nor do I suggest by providing the above counter-narrative, that one can unfailingly attribute rural poverty to modern practices. Rather, my goal is to suggest that the power of the hegemonic discourse of modernization in the context of public health education tends to construct one particular narrative as scientific truth, and

forecloses alternate, and equally valid ways of seeing the world. Whether or not the game's narrative is modified, it can be a point of inquiry where students and teachers place their own understandings of rurality under scrutiny, and engage with alternate disciplinary perspectives to question the situatedness of their different understandings, and to raise potential research questions around community members' relationships with their environments and modern institutions in the rural field practice area.

Gender studies. While I eventually employed the lens of intersectionality in this study, the initial design of the study sought to explore the gendered nature of public health narratives in terms of how they ignored or medicalized women's health concerns or targeted women and women's bodies for instrumental purposes as discussed in chapter two. The gendered script that I repeatedly encountered during fieldwork, however, was of the 'family dynamics' as a 'social determinant' of poor health conditions in marginalized communities. In other words, the pathological gender relations and the consequently disempowered woman in these communities was assumed to influence their poor health and environmental conditions. As mentioned earlier, the wife-beating alcoholic man was a commonly cited deviant character in health education skits. I therefore enquired PSM teachers about their reaction to the ubiquity of this script. Dr. Chandra stated, "That's what the situation is, that's what the situation is" as did Dr. Murali who commented, "It happens in our villages, it happens in our slums", and Dr. Sumathi who laughed and said, "It's a common picture in India". Given the prevalence of such a phenomenon, I was curious to know how they theorized men's use and abuse of alcoholism and domestic violence as gender and class issues in the sense that they were shaped by gender and class

structures and norms. Dr. Chandra (March 28, 2013) clarified that they did not look at alcoholism as a gender issue but as a public health issue.

> AAA: how do, in public health is alcoholism understood like a as a gender issue like?
> Dr. Chandra: Not as a gender issue but definitely as a public health issue
> AAA: As a public health issue but is that meaning is it shaped by the social expectations for men is it influenced by
> Dr. Chandra: When we talk about public health issue anything we usually talk in terms of its magnitude, its impact, socioeconomic impact, its health impact. So thats what we mean by public health issue because it should have socioeconomic impact also it should also have that health impact also. So that's how we look it look at it as a public health issue. And the moment we talk it as a socioeconomic impact probably those gender gender issues might also come into the picture there but not in a very prominent way how a sociologist will look at but yes it's part of a socioeconomic impact when you look at it from a public health point of view.

Thus, according to Dr. Chandra, alcoholism was understood as a public health issue because of its socioeconomic impact as well as the health impact and not as a gender issue in the way that a sociologist might look at it, acknowledging that different disciplines look at issues differently. Similarly, Dr. Sumathi (April 1, 2013) suggested that while they did not understand alcoholism as a gender issue, they did consider it as being more prevalent in males.

> No, not as a gender issue. We talk as it's more in males. Statistics we discuss with that context not with the related directly to gender as such.

In the case of domestic violence, Dr. Murali (March 30, 2013), suggested that it may not be related to 'gender'.

> AAA: After drinking alcohol again this was something that I saw in few skits. So, what might have influenced students' association of alcoholism with gender-based violence.
> Dr. Murali: So it is may not be related to gender it may be what is observed in the neighborhood in the villages. It happens- one is gender, second is apart from gender.

The concept of ‘gender’ therefore seemed to be underexplored in public health, both in understanding alcoholism and domestic violence. In general, gender seemed to stand in for biological sex as a variable or as code for ‘women’ rather than as social constructions or performances. Thus, although women were targets of health interventions often using the rhetoric of women’s rights and women’s empowerment, gender as an analytical concept seemed to be underutilized. As discussed in the context of the monsoons game, the concept of culture and tradition in opposition to modernity was often used to construct women’s conditions in static and problematic ways. At other times as in the case of the framing of anganwadi work, certain gender norms such as motherhood and women’s caring work were naturalized. Historically, the naturalization of women’s relationships to domestic spaces and of their contributions to the development of functional families was mobilized in women’s movements internationally in the late 1800s to early 1900s, and were taken up in various nationalist, religious, and cultural reform movements in India as well (Ahluwalia, 2008; Hodges, 1999). These naturalized relationships solidified the state’s interventions into domestic spaces through the regulation of women’s behaviors and practices. At the same time, these policies also constructed heteronormative families and domesticity as natural (Hodges, 1999).

Despite feminist historiography and gender studies being well-established fields of study within India (Pappu, 2008; Sangari & Vaid, 1990), the undertheorization of gender as a concept in public health is indicative of the chasm between the natural and biological sciences, and the humanities and social sciences. An engagement with feminist concepts could generate lines of inquiry into how alcoholism, substance abuse, domestic

abuse, and mental health could be conceptualized as issues shaped by class, race, and gender relations. While one study (Doron, 2010) provided insight into the local meanings of masculinity surrounding the use and abuse of alcohol amongst a diver community in Benares, India, another examined the political economy of alcohol in India from historical perspectives (Chatterjee, 2003). These studies suggest that framing alcoholism as behavioral problems shifts complicity from occupational stresses and oppressive class relations to specific individuals- an argument I have made earlier. Rural women's anti-arrack movement in Andhra Pradesh, India is an example of how the state was engaged in addressing the sale of arrack (Sharma, 2006).

A failure to engage with alternative scripts can contribute to a conceptualization of an absolute difference between 'us' and 'them' as Dr. Vijay's (March 13, 2013) comment did.

> It does happen because especially in the rural areas where women are not as uhh what do you call it empowered as they are here. It does happen and it's a problem which I think should be brought out to the light because that's how you deal with it. The more you behave and believe that it's not happening, the more it's going to. So [unclear] that that's why that whole thing of bringing it out into the open. So this happens and it's wrong, it's not acceptable to have a man drink and beat his wife.

While I concur with Dr. Vijay regarding the seriousness of domestic violence as an issue, at stake is the linkage of particular kinds of places and people with pathological gender relations and behaviors. Such deterministic interpretations are not only too simplistic, they are often used to 'other' certain groups of people and places while distinguishing themselves as unblemished. Consequently, students and teachers did not feel it was necessary to explore the incidence of alcoholism or domestic violence in the

communities that the skits were enacted in or their perspectives on these issues. Certainly, there are logistical and ethical issues around making such inquiries. However, they were bypassed because the underlying assumption was seemingly true enough statistically to justify the enactment of these skits. The claimed prevalence of such phenomena or practices in particular places, thus, stood in for authoritative explanations.

Communication studies. One of the most important intended outcomes of the CBTP was to enhance the communication skills of students as doctors. This included the development of certain dispositions or traits such as being patient, empathetic, and good listeners as well as developing language skills to build rapport with patients and community members during their interactions. Public health communication, however, also included the spreading of awareness regarding particular health issues and services to the community- an important part of the syllabus. Health education skits were concrete, active and creative ways in which students could learn about the principles of public health communication by actually doing it. Students learned how to employ rhetorical strategies to communicate public health messages in persuasive and effective ways. These were in accordance with the principles of health communication outlined in the standard textbook- a linear, sender-centric model of communication that came into prominence in the 1950s and 1960s inspired by Shannon and Weaver's linear source-transmitter-channel-receiver-destination model, and Everett Roger's diffusion of innovations model both of which were conceptually aligned with larger discourses on modernization (Servaes & Malikhao, 2008). These functionalist and behaviorist approaches to communication have been critiqued as ideologically motivated forms of

domination and manipulation where elite groups impose their values on relatively marginalized groups (Huesca, 2008). Further, the diffusion model of communication has been critiqued for its focus on persuasion to change individual attitudes and behaviors while ignoring social, political, and economic structures that contradict their local realities (Huesca, 2008; Servaes & Malikhao, 2008).

Participatory forms of development communication that are more receiver-centric and focused on the processes of meaning-making and exchange rather than on persuasion of sender-centric messages have gradually gained precedence (Servaes & Malikhao, 2008). These forms of communication have been inspired by Paolo Freire's critiques of 'banking' models of transmitting knowledge and his call for more democratic and dialogical forms of participation where communities are treated as full human beings. Robert Chambers' participatory rural appraisal methods too have gained popularity for their inclusion of community members' perspectives in making decisions regarding development interventions (Chambers, 1994). However, the enactment of health education skits and social mapping activities in the CBTP suggested an appropriation of methodological tools from radical street theater and participatory rural appraisal without their associated epistemological arguments. Hence, students used persuasive strategies to transmit their message through health education skits without seeking to explore community members' meanings regarding particular practices or phenomena. In the case of social mapping activities, although students interacted with community members, they were merely sources of information regarding the spatial organization of the village rather than contributing to the identification and framing of particular health issues.

Similarly, students assessed domestic spaces based on external criteria rather than exploring the meanings that residents themselves made of their homes, the labor they did to make their homes livable, and the challenges they faced in doing so. I, therefore, inquired of PSM teachers on how survey questionnaires could include such explorations.

> AAA: Umm so in the family study for example, they had they took they went and looked at the environmental conditions in the homes and how it can affect their health, and they also gave suggestions to them, and from what I learned looked at in the proforma I could not gauge, but I was wondering how can students learn from women and the family members about the efforts that they are already putting in making their homes livable and the challenges that they face in making their homes livable?
> Dr. Mangala: Aah okay [pause]. That when we generally give them input, hmm. Maybe we don't look at it in terms of challenges what they face to make it more livable. We kind of probably assume that when they go there that during their interview or during the rapport what they build with the people there they would get to know these things. They look basically at the physical environment, but when it comes to the social environment I don't think we equip them with that kind of uhh skill in terms of interviewing the people, trying to look at it from that mode, but we think that at least they would know certain things to ask and find out or create that interest in them and then learn things from people is what we think that they would gain by repeatedly visiting with the family study. Now this is just an introduction in this term, when they come again for us in the sixth term. Another year after they finish this one, that time they have an extended period for six weeks in the urban setting itself, where on a regular basis they visit the families.
> AAA: the same family?
> Dr. Mangala: Not uh not necessarily the same family, but different families they will visit. They have a set of activities that need to be done during those postings, that is when we expect them to learn more about the social environment and the physical environment is what we stress in the first visit when they go. So, based on the physical environment we ask them to, when they suggest those changes that is when they will come out and say okay it's not possible. There the dialogue comes in, maybe they would learn that okay they are making some efforts. But it is not so easy for them to do it. So uh at least through that they'll be able to understand is what we expect. There'll be some amount of learning as they grow right as adults it's not that they're small kids where it has to be spoon fed. So these areas are generally we generally don't consider as uh to the extent what I know. I have not generally considered so far yet, but probably since you mentioned may be I'll make those changes next when I take a session the next year or in the next coming whichever batch that comes.

In this conversation, Dr. Mangala (March 27, 2013) admitted that they do not consider exploring community members' perspectives regarding how they make changes to their environmental conditions, as an example. She also admitted that such inquiries would depend upon students' interviewing skills, which requires a particularly epistemological perspective, that they did not necessarily equip them with. However, she suggested that they assumed and hoped that students would develop that interest and initiative, if not in the first encounter then in subsequent ones, and ask such questions. Her argument for depending on this hope was that there were logistical constraints to which students could be told what to do, or spoon-fed, as she referred to it as well as pedagogically undesirable. Dr. Chandra (March 28, 2013) too raised this issue of spoon-feeding.

> See what happens is since when it comes to this family study we divide them into small groups. Ideally in each of the family one of us should go there and sit with the students and then we can explain all these things to them then and there itself. Like it's not that like say for example. Currently in this particular house ventilation is poor, but with all those limitations the but still the family is trying to make something possible to make it a livable condition. But if one of the faculty is present there then and there along with them through and through for that two hours that they spend in that family we can explain to them then and there itself that structurally it may not be possible for them to make any changes to improve the say ventilation lighting or whatever it is, so what we do is. They'll note down the things, we go around and have a look at all these households. So when we come back for discussion we'll raise up these issues and try to explain to them. That's what we usually do. But of course we agree that ideally one faculty member should go with some four or five students sit in the family spoon feed them.

Both Dr. Mangala and Dr. Chandra responded to my question of how students could explore questions beyond the survey questionnaire as issues that were beyond their control, and that required monitoring that was not logistically possible and pedagogically advisable. This may have been because my question was framed around students'

questioning practices rather than the framing of the survey questionnaire itself. Nevertheless, their responses suggested that part of the problem was also the development of students' own interviewing skills that would enable them to ask relevant questions beyond the questionnaire. Secondly, as Dr. Vineetha (March 29, 2013) clarified, time was primarily a logistical issue that shaped the mode of inquiry.

> The problem is you know we take them for a family study, it's only for half a day isn't it? So, during that half a day we need interaction at least three or four times you know to break that barrier. If there is any barrier between us you know that barrier to be broken you needs to have more regular contact with them. So just that one day of contact or half a day of contact will will not be sufficient for them. If they go back to the families and talk to them for example, in [competitor] college they go and stay in the villages. The students go and stay in the villages but that is because numbers are very less. The students here the numbers are more so it is not possible. They stay with the villages in their respective houses and they interact with them so maybe they are able to do it faster than us. That is one more thing, and secondly we we have a problem we say that that is a this security also no security reasons. For example, females female students when they go to the villages there may be a problem, and even between the doctors itself, the students itself, if there is some problem we'll have to face those things.

Dr. Vineetha, thus, raised important logistical issues around employing participatory modes of inquiry and communication in their pedagogical activities that would require longer residence in a particular place and raise security concerns for female students as well as a need for additional resources.

Certain epistemological issues, however, continue to persist in the discursive frameworks used whether or not those are materialized pedagogically. Consequently, the linear and sender-centric modes of communication employed in the CBTP tended to foster both representational injustices by excluding community voices in inquiries, and recognitional issues by describing them in assertive and unflattering ways (Fraser, 1996).

Social mapping, health education skits, and the family study activity were all communicative events with different purposes and with different histories. Yet, the focus was largely on the method, and not on the epistemological issues and debates that shaped these methods. While these debates are certainly beyond the scope of the undergraduate syllabus, their exclusion can also be understood as being shaped by historical separation of public health as an academic field from the humanities and social sciences. Since PSM teachers were connected with development practitioners and non-governmental organizations, these methods had permeated the public health academic space but their histories had not. Returning to Dr. Vijay's counter-argument that it is better to do something rather than read books, I would argue that in order to understand the ethical implications of historical communication practices within public health, it may indeed be better to engage with texts from interpretive, critical and poststructural paradigmatic perspectives in communication studies and with radical anti-oppressive theater groups when one compares what's at stake.

Conclusion

In this chapter, I have attempted to renarrativize science/fictions by suggesting a politicization of relationships between materiality and culture in the framing of public health issues. Such a reframing could be done by engaging with frictional encounters with communities as productive moments to learn more about their perspectives rather than as roadblocks in their activities. I argue that such an engagement is necessary not only for conceptual reasons but also for ethical reasons. However, I also acknowledged that since institutional and larger assessment structures sustain depoliticized narratives of

public health, repoliticizing public health would require significant structural changes including the reconceptualization and reorganization of knowledge.

Nevertheless, I suggest that fictionalizing the knowledge produced through pedagogical activities rather than ontologizing it, might be one way to politicize public health texts. Crossing disciplinary and paradigmatic boundaries may be important and necessary steps in reconceptualizing certain assumptions within public health before boundary-crossing into local communities in order to not only alter pedagogical practices but also to ensure that the knowledge produced through such encounters will be subjected to collective political interpretation.

Chapter VII. Conclusions

Review of the Research Problem

I began this dissertation with an interest in exploring the class and gender 'orientations' that community-based teaching programs in medical colleges in India offer towards marginalized communities. My interest in exploring these orientations was in part motivated by my desires to confront my own naturalized assumptions towards rural and urban poor. In many ways, this dissertation could therefore be understood as autoethnographic, as projects that study "up" and "sideways" often can be (Nader, 1969; Ortner, 2010). The study, however, was also designed as such because I was curious to understand the assumption underlying initiatives such as the 'Re-orientation of Medical Education' that sought to shift the focus of medical education from a narrow biomedical paradigm to a community-based one, and from one geared towards upward mobility to one that was concerned with community development (WHO, 1991). The increasing trend of specializing in hospital-based disciplines such as internal medicine, radiology, surgery, obstetrics and gynecology, and migrations to urban and international centers of development was attributed to an orientation of medical education towards the global medical and health industry and upward mobility rather than towards local communities (Dongre et al., 2010; Nair & Webster, 2010; Qadeer & Nayar, 2005; Sood, 2008; Supe & Burdick, 2006). Hence, calls for a 'reorientation' of medical education were made assuming that PSM teachers would be able to make this structural shift through changes in the socialization patterns within medical colleges.

Review of the Purpose of the Study

In my initial rounds of interviews with PSM teachers at JDMC, it became increasingly clear that their primary goals were not to alter students' specialization choices. Rather, their goal was to offer particular 'orientations' towards local communities that they hoped students would employ no matter which discipline they specialized in. These orientations were distinct from 'clinical' disciplines in that they sought to broaden students' understanding of health from the narrow understanding of an 'absence of disease' to one that situated biological bodies within their sociocultural, psychological, and physical environments. In this sense, PSM or public health is a rebellious or counterhegemonic field within medical colleges (Qadeer & Nayar, 2005). PSM educators' struggles in JDMC to make the CBTP a multidisciplinary program rather than one coordinated by the PSM department alone tells the story of the CBTP as a counterhegemonic practice, one that I could not dwell sufficiently on in this dissertation. However, since the history of public health in general, and particularly in postcolonial contexts has been one of violence, involving forced physical segregations and evacuations as well as social and epistemic exclusions (Harrison, 1994; Kumar, 1998; Porter, 1999), I chose to explore public health's relationships with its communities at this medical college, and with disciplines in the social sciences rather than with the biomedical sciences.

The postcolonial state in India has played an ambiguous role in the history of public health, opening up opportunities for women's empowerment through such initiatives as anganwadi centers where women from the local community are engaged in

early education and nutrition efforts as well as in the administration of numerous health and development schemes (Parpart et al., 2003; Gupta, 2001). On the other hand, its paternalistic governance structures have foreclosed opportunities for different counterpublics to politicize top-down interpretations of their needs (Fraser, 1989). In that regard, the insistence on community-based teaching programs (CBTP) in medical education creates the possibility where such dialogue between PSM teachers and students with local communities could happen which in turn has the potential to challenge dominant interpretations of the latter's needs. Hence, this dissertation explored how a CBTP at a medical college could alter the dominant orientations towards communities shaped by the influence of the markets and the state. At the same time, as noted earlier, I was skeptical of this possibility as historically the medical profession was a means for upward class mobility for both men and women (Forbes, 2005; Zaidi, 1986). I wondered how the class and gender orientations backgrounds of PSM teachers and students on the one hand, and their place-based knowledge on the other would shape the kinds of orientations produced towards marginalized communities.

Summary of the Findings: Science/fictions about the Rural and Urban Poor

Through observations of the CBTP, interviews with teachers and students, and an analysis of curricular documents, I found that the CBTP offered students several opportunities to gain valued research and communication skills as well as humanistic dispositions towards their patients irrespective of their cultural backgrounds. In designing problem-based activities, the pedagogies employed engaged students' sociocultural resources and encouraged them to be creative and active agents of their own learning

while providing necessary information and support to enable them to successfully achieve learning objectives. Hence, there was no doubt in my mind regarding why this particular CBTP could be considered as exemplary given that only a handful of medical colleges offer such programs. My study, however, did not pursue this storyline although bits and pieces of such a story are visible in the description of the activities.

I instead constructed a story that illustrates how these active, interactive, innovative, and learner-centered pedagogies engaged with communities and disciplinary frameworks in the social sciences as counterpublics. I suggest that while community-based pedagogies opened up possibilities for frictional encounters between medical students and rural and urban poor communities with diverse sociocultural histories, institutional structures of assessment largely privileged the knowledge of the national public health system, its functions and schemes, and technological understandings of the transformation of 'natural' entities such as water, sewage, and milk to improve the health and environmental conditions of entire communities. Hence, the orientations produced towards marginalized communities were nationalist and modernist as repeatedly the government and technology were positioned as central actors in a narrative of progress in public health and national development.

The communities that they served, however, were at times characterized as modern and empowered, and at other times as not-yet-modern, and in need of reform depending on the context. Such characterizations of communities, and particular abject characters such as the prostitute and the male alcoholic, enabled PSM teachers and medical students to construct their own identities as modern citizens of India, and as

agents of public health and environmental change. Communities were understood as agentic in largely neoliberal terms when they 'participated' in the sustainability of health interventions or as individuals who were aware of their responsibilities towards their bodies, communities, and environments. Thus, structural issues were conceptualized as issues that could be resolved by developing the 'right' attitudes and by employing 'right' body practices. These findings suggested that students' interactions with communities were implicitly mediated by modernization and neoliberal discourses of development and governance embedded within the standard curriculum, yet unnamed as such. Hence, students were largely unaware of these discourses that mediated their practices.

I noted that while the standardized PSM textbook engaged with disciplines such as sociology, environmental science, psychology, communication, and others, the theories employed were largely positivist, and in that sense, subscribing to scientific claims of truth. My observations and interviews with teachers as well pushed me to consider the relationships between nature and culture such as between people and their physical environments, with material "needs" such as water, sewage, and alcohol. I also discussed with teachers the relationship between certain cultural stereotypes and reality, or in other words, the naturalization of cultural ideas. I theorized these different emerging patterns therefore as science/fictions whereby I could suspend my inquiries into an exploration of the relationships between science, nature, and reality with fiction, culture, and representation.

The notion of science/fictions enables me to argue for a dialogue across these domains that have historically been kept separate. The autoethnographic elements within

this study reflect in many ways my own journeys across these boundaries, having begun the study with one tentative foot in both these domains.

Recommendations for Changing Orientations towards Communities

I have raised several issues within this study regarding the limits and possibilities of changing orientations towards communities through community-based teaching practices. Some of these issues were raised by medical teachers as around security, travel, and accommodation for large groups of students and the financial resources available to them that influenced how long students could stay at particular places, and the services that could be offered to communities. Issues that I have raised, however, around how brief visits to communities reinforce existing orientations towards them, and the production of fictions about them suggest a lot more preparatory work prior to students' visits to communities, a possible restructuring of the program itself, and addressing several structural issues beyond the institution itself. Taking preparatory work in language as an example, I offer certain alternatives for the CBTP that could be employed, and their different implications for social justice education.

Significantly, language courses were not a part of the preparatory work for students although the CBTP was designed around two communities defined in terms of their linguistic relationships to the places that they occupied. Student groups therefore were designed so that every group had at least one Kannada or Telugu speaker placing the burden of framing non-speakers' learning experiences while simultaneously learning themselves. A feasible alternative that requires little restructuring of the CBTP in its current form could be to offer language and popular culture courses in Kannada and

Telugu. However such an alternative would mean a denial of the multiculturalism of Bangalore as a city as well as of students' existing linguistic resources while also privileging functionalist goals of language learning and communication.

Instead, I suggest that comparative courses in language, literacy, and literature from critical perspectives would be necessary and more relevant for undergraduate science students while pursuing the functionalist goals of gaining fluency in languages learned earlier or in new languages if they so choose to. Critical perspectives in literacy including media literacy would offer students ways to understand and analyze multiple meaning of texts including popular culture and health communication literature in particular languages, and how they are shaped by power. The CBTP would then need to be restructured so that students could choose the communities they would like to work with based on their fluency in particular languages. The program's focus would be to provide students with conceptual resources to develop equitable and long-term relationships with particular communities around specific health issues over five years, the duration of their entire undergraduate degree as well as to serve as a collective forum where students share and discuss their field experiences. Such a program, however, would require collaboration across not just the subdisciplines within medical education but also with social sciences and humanities disciplines. This study thus makes an argument for the establishment of medical humanities and social sciences within medical education not merely for holistic reasons of producing well-rounded individuals but for altering knowledge production practices in public health from social justice perspectives. At the same time, developing students' critical literacies would have to begin early and

continue in high school. The current organization of high school curricula into science, arts, and commerce streams is highly undesirable as language learning is perceived to be unrelated and peripheral to the realm of science learning, a perception that continues in undergraduate professional science and technical education.

While achieving these structural changes through policy is a long-term goal, continuing education programs for existing medical teachers around diverse epistemological perspectives in science studies, medical geography and anthropology, history and philosophy of science, and other interdisciplinary fields of relevance could be a feasible third option. Currently, medical teachers seek out continuing education programs that extend their knowledge within clinical fields with fewer engagements with fields in the social sciences and humanities. The latter, however, could significantly alter how medical educators think about their assumptions around the nature of science underlying their clinical and teaching practices. Hence, continuing education programs could be focused on making policy in medical education by fostering changes in practice.

'Doing' as Mediated: Evaluating pedagogical practices using MDA

The major argument I have made in this dissertation has been to stress on the mediated and political nature of action and experience. Different kinds of pedagogical approaches stress upon action and activity. Proponents of activity-based learning and learner-centered pedagogies often argue that learning by doing is more effective than rote learning, an issue that has been raised particularly in the Indian educational system (Clarke, 2003). Similarly in higher education, experiential learning has been influential in service-oriented professional education such as medicine, social work, and teacher

education where students can gain early clinical exposure and learn practical skills by observing and doing. As discussed earlier in chapter two, instrumental approaches to learning including service learning pedagogies tend to privilege actions, activities, and doing as they foster efficient acquisition of predetermined skills and outcomes. These efficiency-oriented pedagogical models are also attractive to policymakers as they lend themselves well to evaluations through the measurement of acquired skills and outcomes. Yet, this focus on efficiency tends to foreclose discussions and debates around what knowledge, skills, and outcomes matter in educational processes, and limit such discussions amongst educators, educational researchers, evaluators and policymakers with little input from students, parents, and communities in the case of community service learning pedagogies. Certainly, research evaluations assessing the efficiency of pedagogies are important. However, evaluations need to also examine how pedagogies employ democratic processes in determining objectives and outcomes of learning, and to consider what is gained and lost when certain outcomes are privileged over others.

In this study, I employed mediated discourse analysis (MDA) and critical discourse analysis (CDA) as both theory and method and showed that curricular goals and outcomes mediated activities and interactions in ways that privileged dominant ways of knowing the rural and urban poor, and marginalized community perspectives in setting the learning agenda. MDA as a methodology lent itself well to evaluate both the efficiency with which actions and interactions mediated curricular goals and outcomes as well as how they created democratic possibilities or not to broaden and problematize these goals and outcomes. By foregrounding action, MDA allowed for a microanalysis of

moment-to-moment interactions while simultaneously insisting that agency is distributed among actors across time and space beyond the timescale of the interaction itself. Thus, MDA historicizes and politicizes apparently benign and innocuous actions and interactions and pushes one to look at the cultural histories of the discourses and practices informing these actions and interactions.

MDA also stresses upon the relationship between theory and practice as a dialectical one rather than oppositional. In teacher preparation and other service-oriented programs, theory is often sacrificed and even denounced in favor of action as if doing is not already mediated by theory. In stressing upon action, such programs privilege one particular theory of doing that values certain skills and attitudes. In contrast, MDA fosters an examination of the theories mediating particular actions. Engaging with alternate theories of doing therefore fosters a deliberation over the politics of our actions.

Critical Interdisciplinarity towards Reframing Local Public Health

For scholars, educators, and practitioners in public health, I argue for critical interdisciplinarity that draws on critical, feminist, and postcolonial perspectives in the teaching and framing of public health issues both for intellectual and ethical reasons. In chapter six, I have raised some possible research questions at the interstices of public health and gender studies, communication studies, and cultural geography. These include a shift from epidemiological approaches to understanding the prevalence of diseases in particular regions to questioning the naturalized relationships between people's health conditions and practices and their environments. Employing feminist perspectives, studies could explore gender-based violence as a public health issue and alcoholism as a

gender issue. Also, anti-representational theories of communication could significantly alter how health communication is conceived, taught, and practiced.

My interest in making arguments for critical interdisciplinarity is not limited to the academy, however. While doing fieldwork in Bangalore, I was amazed not only by the numerous NGOs that abound the city but also by their diverse political positionings. Of interest to this study were an NGO that conducted workshops to train NGO personnel and faculty in radical theater approaches to community dialogue in the tradition of Augusto Boal, and an educational center which collaborates with other higher educational institutions to mainstream women's studies and cultural studies perspectives in different disciplines including scientific fields. At least three newly constituted HEIs designed to address particular issues in urban policy, environmental policy, and educational policy have also been established in the last three to five years from interdisciplinary perspectives. These institutions sparked my interest as they highlight how privatization of higher education has triggered a reconstitution of civil society that could be both hegemonic and counterhegemonic. The existence of these institutions offers concrete possibilities to create networks of scholars in these diverse fields of study as opposed to mere rhetoric when I argue for transdisciplinary dialogue using post-foundational paradigmatic approaches. Local networking with scholars in these different institutions could foster epistemic democracy, that is, an inclusion of diverse counterpublics and the collective deliberation of their politicized interpretations of dominant discourses in academic knowledge production. Further, this study opens up for exploration within comparative higher education and international development the historical formations of

disciplines, and contemporary formations of interdisciplinary fields in developing countries and their contributions. It prompts questions of how disciplines and interdisciplines have shaped and continue to shape development landscapes in hegemonic and transformative ways.

Institution-Community Relationships

Community engagement initiatives vary significantly by institution and location. Service learning programs constitute a relatively popular institutionalized form of community engagement in several HEIs in the U.S. (Butin, 2010). In the Indian context, there has been relatively little research on the community engagement initiatives employed by HEIs. Indeed, service learning is not a popular term used in developing countries such as India with terms such as internships, field visits, or community-based education used to refer to programs that involve both student learning and community service. On the other hand, although the international development literature is deeply concerned with institution-community relationships and employs terms such as participatory development or participatory research to describe more inclusive forms of such engagements, non-governmental organizations (NGOs) have been the dominant focus with relatively little research on HEIs. In this study, I have shown how transnational development discourses crucially shape HEI-community relationships in the context of a medical college. For instance, neoliberal understandings of community participation and sustainability informed how the institution related with communities in the context of the defluoridation plant. Yet, an important distinction between NGOs and HEIs is the latter's commitment to student learning which may likely take precedence

over community service. In contrast, while NGOs may be interested in practitioner training and institution learning, community development remains their primary prerogative. Hence, HEIs in developing countries face unique challenges in organizing community engagement initiatives that cannot be understood using the parameters of U.S. service learning programs or NGO-based community development alone. Yet, both scholars and practitioners in service learning and community development may find this study useful in informing their practices.

Both HEIs and NGOs or community-based organizations (CBOs) are familiar with the challenges of developing long-term sustainable relationships with the communities they work with. In this study too, the institution had an established relationship with the rural community. On further examination however, it became clearer that medical educators had developed trustworthy relationships with the gatekeepers of the community that facilitated their pedagogical and development efforts. Hence, it would be important to consider the community not as a broad, homogenous entity but as constituted of multiple and intersecting publics with unequal relationships to material and cultural resources. Secondly, friction is inevitable in institution-community engagements and while political differences may apparently obstruct the smooth operation of institutional projects, these differences must be recognized and interpreted as the voices of different groups. In the case of JDMC, rather than rotating communities to avoid ‘fatigue’, interpreting fatigue as friction would facilitate an understanding of what matters to different publics within the community, and how the oppositional discourses that they produce might be taken up to renarrativize institutional discourses, and alter

practices. Building sustainable relationships with communities thus would mean embracing friction to learn about the power relations between different publics and counterpublics and their politics rather than managing it.

Larger structural constraints and discursive frameworks, however, limit the extent to which institutions can build sustainable relationships with local communities. National standards and systems of assessment significantly influence how educators balance the distinct agendas of community service and student learning tending to privilege the latter. Educators might find it useful to teach *against* the curriculum, that is, to examine the sociospatial orientations shaping the standardized scripts they are expected to learn, and encourage students to explore the politics of alternative scripts as compared to standardized ones. Similarly, while NGO projects are constrained by donors' funds, timelines and their development agendas, practitioners could consider how data collected from monitoring and evaluation efforts is shaped by their sociospatial orientations, how the reports they write constitute situated interpretations that achieve the rhetorical and practical goals of donors, institutional management, and/or government agencies, and how alternative interpretations of this data could point to different ways of framing and addressing issues within particular communities.

Multicultural Education and Science Education

This study contributes significantly to the conceptualization of science education from sociocultural perspectives, and argues for an engagement of science education with the history and philosophy of science similar to scholars who argue for teaching about the contested 'nature of science' in science teacher education in the U.S (Abd-El-Khalick &

Lederman, 2000). It also contributes to research on critical and multiculturalism pedagogies as I argue that engaging with and problematizing the curriculum, especially in the "hard" sciences, would be necessary in reflecting on how power relations shape material and cultural inequalities, such as health disparities among different groups, rather than speaking of diversity in abstract terms.

Addressing educational policymakers, this study argues for an integration of the humanities within medical education, and in other scientific educational institutions for both intellectual and ethical reasons. In India, and in other countries with similar educational systems, students are expected to choose as early as in high school between science, commerce, and the humanities and social sciences. As argued in this dissertation, such a separation is ideologically motivated and contributes to the hierarchical organization of knowledge in hegemonic ways. However, policymaking at the state level is not sufficient. Activist networking and teaching are also necessary when policy is conceptualized as practice (Sutton & Levinson, 2001). Particularly relevant in the case of engineering education, the state has already established humanities and social science disciplines in reputed engineering colleges, eg., the Indian Institute of Technology (IIT) network of institutions. From anecdotal evidence, however, while the humanities and social sciences in these institutes offer courses, they are generally perceived by students as separate and unrelated in nature, content, and goals to the engineering curriculum. The role of the humanities and social sciences in altering knowledge production in engineering could be productive lines of inquiry as well as sites for curricular and pedagogical interventions.

Future Research Agenda

Amongst several fruitful lines of inquiry generated through this research study, I have found postcolonial and feminist perspectives in science studies, medical geography, and political ecology amongst others most productive in making culture, politics, and ethics matter not only for the practice of science for the sake of ethics but also for the sake of science itself. Hence, my future research and practice agenda is concerned with exploring both how scientific knowledge, and processes of scientific knowledge production are and/or can be interrupted in pedagogical contexts with the goals of having critical conversations around identity, intercultural relations, and social conflict on the one hand, and around the very nature of science on the other.

One of the limitations of this study was that I did not engage with community perspectives, and only to a limited extent with student perspectives. I hope to extend my dissertation research to explore community perspectives regarding the department's various interventions. I also plan to explore the consumption and learning processes of students from different sociocultural backgrounds, particularly through their written narratives in reflexive portfolios. Through this research, I hope to contribute to the further development of the CBTP in collaboration with teachers.

Within science education broadly, I plan to explore questions such as how science educators' engage with various epistemological understandings of the nature of science in different disciplinary and geographical contexts. My goal is to argue for epistemological diversity in science teacher preparation programs while also seeking to understand its implications. Thus, I plan to continue exploring how popular culture and language are

implicated in the production and negotiation of stereotypes in the science classroom, particularly when critical, feminist, and culturally-relevant pedagogies are employed. Through these explorations I hope to continue my research trajectory in undergraduate public health education as well as to broaden it to other disciplinary areas in general science teacher education and environmental education.

Another strong area of interest is in exploring the role language plays in sociocultural learning and identity development shaped in part by my identity as a native speaker of a minority language without a script. In the analysis of my dissertation data, I paid much attention to how language and popular culture were deployed and negotiated as semiotic resources in medical students' communicative encounters with and representations of rural and urban poor communities. I am eager therefore, to explore in the future how critical pedagogical practices such as critical media literacy, theater pedagogy, and critical game studies use popular culture and language to democratize content and learning processes. For example, I am interested in comparing how street theater is conceptualized and practiced pedagogically in non-governmental organizations and different disciplinary contexts including public health and the performing arts.

Whether I look at science education or multicultural education, the central questions that drive my research interests are also questions around pedagogical praxis. I remain committed to understanding how critical and culturally-relevant pedagogies can be enacted in their different forms, and to participate in enacting diverse forms of critical pedagogies to inform teacher preparation programs even as I critique their utopian claims and assumptions.

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Appendices

Appendix 1a: Correspondence for getting access into JDMC- November 21, 2012

Respected Madam,

As per our conversation on November 21, 2012, I wish to provide further details on my dissertation project for your consideration. I have attached a project description, an informed consent form for the educators with whom I shall be communicating should you agree to participate, and my curriculum vitae with contact details. Thank you for taking your time to consider my request. My contact details are below:

Aditi Arur
PhD candidate in comparative and international development,
University of Minnesota Twin Cities, USA.
404, 12th Cross, 8th Main, Sadashivnagar, Bangalore- 560080
91-9740399995
arurx001@umn.edu.

Looking forward to a positive response from you,
Thanking you,
Sincerely,
Aditi Arur
November 21, 2012

Appendix 1b: Correspondence for getting access into JDMC- December 12, 2012

Dear Madam,

This is regarding my request to conduct a research project with the Department of Community Medicine. I appreciate the time you have taken to consider my request and for granting me permission. I wish, however, to make a few clarifications regarding the terms of my participation. I hope you will consider them in the interest of a long-term productive relationship for both of us.

Firstly, I wish to clarify that I am not a student seeking a degree/internship/training certificate at your institute. Rather, I am a fellow educator and a researcher of potential benefit to you. Please note that I have taught for four years in a medical college- in India and in China. Further, I have gained specialized training during my Ph.D on social justice teaching methods which I have employed as a professional consultant and evaluator for two educational projects in India. Hence, I believe I can contribute to the development of your community orientation programme as a professional educator while simultaneously learning about your teaching practices.

However, the institution and the department will benefit from the research process and findings only through quality time spent with research participants. With a fee of Rs 8000/- per month, I shall be able to afford a study of only one month. Although a one-month study might be sufficient for me to get my degree, the research findings will not be beneficial to you in a significant way. Hence, I request you to waive the fee as it limits my ability to conduct a study that is meaningful not only to me but also of potential benefit to you. Moreover, the fee is not applicable to me as I am not approaching you as a student, nor am I a foreign national (I can furnish documents attesting to the same). Instead, please accept my appreciation and contribution in the form of professional services such as workshops and seminars on educational methods and qualitative research methods, collaborative publications, and professional support in curriculum development for your community orientation programme.

Finally, I request you to reconsider the condition of mentioning your institution's name in my dissertation/publications in the interest of the institution and the research participants. I make this request to maintain the anonymity and confidentiality of the individual participants. By mentioning the name of the institution, I shall be making it easy for readers to identify individuals from a small pool that places their identity and privacy at risk. Keeping the institution's name confidential is a conventional ethical practice in my academic field and is recommended by the University of Minnesota's Institutional Review Board. Hence, while I am willing to support the dissemination of the department's experiences and practices through collaborative publications so that the issue of confidentiality is addressed, for publications where I am the sole author I would like to retain the right of maintaining anonymity of the institution and the participants for ethical reasons.

Thank you for taking your precious time to consider my request. Looking forward to hearing positively from you.

Thanking you,
Sincerely yours,
Aditi Ashok Arur
December 12, 2012

Appendix 2a: Informed consent forms or sheets for educators

Project Title: Exploring 'orientations' towards the community: A critical ethnography of service learning programs in medical colleges in India.

You are invited to participate in a research study in order to understand service learning as a teaching practice. You have been selected as a possible participant in this study because of your experience as an educator in the department of Community Medicine (CM) in conducting community orientation programs (COP) in your college.

I shall give you information about the purpose of the research, the procFedures and the benefits and risks that you will have. Based on this information, you can make your decision regarding whether you would like to participate in this study or not. I request you to read this form and ask any questions you may have before agreeing to be in the study.

Purpose of research

The purpose of this project is to explore how CM educators teach about the 'culture' of a particular community during service learning programs that are focused primarily on gaining technical skills. The intent is to know how the disciplinary training of CM teachers and their personal backgrounds influence their knowledge about the community, and similarly, how their interactions with the community influence their teaching practices.

Benefits of research

This study will benefit the PSM discipline as a whole to think about how it implicitly or explicitly teaches about cultural differences with local communities to students. It will provide an understanding of how PSM teachers learn and teach about the cultures of communities with whom they interact. This will enable them to critically reflect upon the relations they develop with communities and what they teach about them. Although the study does not benefit participants materially, participation in this study can enable knowledge sharing between the researcher and participants through collaborative interactions.

Risks

There are minimal risks in participating in this study. Findings from this research may involve a critique of existing teaching practices that you may feel is not justified. I encourage you to discuss these differences of opinion with me.

I will protect your privacy and ensure that all information you provide me is confidential. I shall be asking personal information about your experiences of interacting with communities and about your teaching practices. I will not use your name or any other identifiers that could reveal your identity; nor will I share any information related to you individually with the College, the community, or others. You can decline to give

information you are not comfortable in giving me and it will not affect your relationship with the college. If you say something and later change your mind, you can request me to not include it as part of the data and subsequent reports. First let me brief you on the procedures you will be asked to undertake.

Procedures

As part of this project, I shall be interacting with you periodically from April 2013 to August 2013. I am asking permission to observe you when you conduct COP activities, during instruction in the classroom when relevant, and to engage you in informal conversations. I will conduct two formal interviews with you- one before for approximately 1.5 to 2 hours, and one follow-up interview after field visit observations. The questions I ask you will pertain to your personal and professional backgrounds, your previous interactions with marginalized communities and the methods you use to teach about them during COP activities.

Interviews will be audio-recorded and transcribed. Informal conversations will be recorded by hand, if audio-recording is not possible. All transcripts and notes will be double-checked with you to make sure there are no misinterpretations. Both the audio and written transcripts will be confidential and will not be shared with anybody. All records will be stored securely and will be password-protected. Your name will not be mentioned on any of the transcripts or reports and your identity will be protected at all cost by the use of impersonal identifiers. Before publishing, I shall share my findings with all the participants where your identity will remain hidden so that you can give me your critical feedback.

You are free to make a decision to participate in the research project or not and to leave it at any stage. If you choose to not participate in this project, it will not affect your future relationship with the college or the communities. You are also free to ask any questions about how your information will be used in this research project.

Contacts and Questions:

The researcher conducting this study is: Aditi Arur, PhD candidate in comparative and international development, University of Minnesota Twin Cities, USA. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her. Her contact details are given below, and in the business card provided. The contact details for the researcher's adviser on this study are:

Dr. Joan DeJaeghere,
430B WullH
86 Pleasant St SE
Minneapolis, MN 55455
Tel: 612-626-8258**; Email:** deja0003@umn.edu

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher(s), **you are encouraged** to contact the Research

Subjects' Advocate Line, D528 Mayo, 420 Delaware St. Southeast, Minneapolis, Minnesota 55455; (612) 625-1650.

I appreciate the time you have taken to consider participation in this project and am grateful for the time you will spend with me, if you decide to participate in this study.

You will be given a copy of this information to keep for your records.

Appendix 2b: Advertisements or scripts for recruiting teachers

Note: This is the script I will follow to schedule an appointment by phone.

Hello, Sir/Madam. My name is Aditi Arur. I am a Phd student in education and international development from the University of Minnesota. Before that, I had done my Masters' in Pharmacology from Kasturba Medical College, Manipal and was teaching here in Bangalore at Vydehi Institute of Medical Sciences. For my dissertation research, I am interested to learn about how field visits are conducted in medical colleges in India and am looking especially at the more established colleges here in Bangalore. I'm hoping that your department will be a part of this research project. I wanted to schedule an appointment to discuss this possibility with you.

Note: This is the script I will follow in person to discuss the project.

Thank you for meeting with me. Like I mentioned to you earlier, I'm interested in working with your department as part of my research study on field visits in medical colleges in Bangalore. The study explores service learning as a teaching practice in higher education. There is much to be learnt from the long history of field visits in medical colleges in India, especially in a culturally diverse society like ours. This hasn't been studied systematically in the past and I am hoping for your participation in this study.

The purpose of this project is to explore the various sources of knowledge that PSM professors draw from in teaching about the community. These include their experiences of participating in field visits as students, professional experiences of working with diverse communities as well as their personal class and gender backgrounds.

Benefits of research

The study will benefit the discipline of PSM as it looks at how knowledge is gained about communities and how it is taught. This will be important for PSM teachers and the discipline as a whole to think more deeply into how they implicitly or explicitly teach about cultural differences to students. I shall also be looking at the history of how field visits have been conducted since the colonial period and its effects in today's practices. I'm hoping that this research project will encourage knowledge sharing between me and the teachers in the department and will build on the interdisciplinary connections of PSM with the social sciences and humanities.

Procedures

If your department were to participate, I plan to conduct interviews and observation over the period of nine months, during the academic year. I will contact teachers intermittently to conduct a brief interview with teachers who conduct field visits Then, I will attend field visits with teachers and observe them. After field visits, I'll

conduct a follow-up interview with the teachers again. If possible, I will request to see curricular materials that you use for field visits as well.

If you grant me permission to include your department in my study, could you tell me how I should proceed with getting permissions from the institution management to do this research? After gaining these permissions, I shall start speaking to teachers to gain their consent on the research as well.

Thank you so much for your time! Do you have any questions? My contact details are in this card. I will follow-up with you about your decision and about how to proceed with permissions and contacting professors.

Appendix 3a: Interview questionnaires for teachers, January 23, 2013

PHASE I

Personal and professional background of professors

1. Tell me more about your professional background (3 minutes)
   - Where and how many years worked before joining this department?
   - When joined this department?
2. What made you choose PSM for your postgraduation? Was PSM your first choice for PG? If not, what were your preferences and why? (3 minutes)
3. In what ways did your personal background influence your choice? (3 minutes)
4. What does wearing the white coat mean to you? As a woman, if a woman. What do you think 'the white coat' signifies for people living in villages and urban slums? (4 minutes)

History of the COP and its politics

Goals (13)

1) What activities in the community did you organize for students before the COP? (2 minutes)
2) What prompted the need for a program like the COP? (2 minutes)
3) What are the objectives of the COP in your opinion? (3 minutes)
4) What does the word 'orientation' mean to you in the context of the COP? (2 minutes)
5) In what ways do you think the COP affects students? (2 minutes)
6) Do you think it can affect their choice for specialization in their post-graduation? Why or why not? (2 minutes)

Organization (17)

7) This COP requires support from the other departments in the institution as well. How did you go about gaining that support? (2 minutes)
8) What were the challenges you faced in starting a program like this? (3 minutes)
9) What challenges do you continue to face? (3 minutes)
10) What alternative ways of organizing the COP have been adopted by other colleges as far as you know? (4 minutes)
11) What criteria did you take into consideration when you decided the structure of the COP? (4 minutes)
    a) Duration?
    b) Place?
    c) Safety of students?
    d) Finances?
12) What criteria do you have for selecting particular villages and not others in a particular year? (1 minute)

Evaluation and change (21)

13) What evaluation strategies have been used to know whether the objectives of the program are being met or not? (2 minutes)
14) In what ways is the COP today similar and different from when it began in 2004? (3 minutes)
    a) What prompted the changes? Such as selection of topics, sites to visit
15) What areas of improvement do you think are needed for the development of the COP, if any? (3 minutes)
16) How do you propose to address these issues? (3 minutes)
17) What strategies do you have to sustain and deepen students' learnings of the COP beyond this 10-12 days period? (3 minutes)
18) I'm particularly interested in the portfolios as a method of evaluating learning. I believe it was introduced this year. (5 minutes)
    a) What prompted this change?
    b) What do you hope to learn from these portfolios?
    c) What do you want students to reflect upon in writing the portfolio?
19) In what ways have the villages and slums benefited from the surveys and studies done during the COPs in the past as well as from the current one? (2 minutes)

PHASE II

Clarifications on COP activities

1. In the family study, there were many questions regarding the environment in and outside the house such as ventilation, lighting, presence or absence of stagnant water sources, and so on. Students found out that the environmental conditions in urban slums were often worse than in rural areas, and Principal Madam mentioned in her talk that this is a recurrent finding over the years.
    a. What do you expect students to learn from this finding?
    b. How do you explain the relationship between environmental conditions in one particular geographical area as compared to another?
2. Like I mentioned in my presentation, the water problem in Kaalwaru got me thinking a lot. I learnt that Kaalwaru is a dry area which depends largely on the monsoons and predominantly on borewell water. And so high fluoride levels are related to the fact that these communities depend a lot on borewells. Can you tell me about your experiences in identifying the need for a de-fluoridation plant in Kaalwaru?
    a. What sources of water does the plant utilize?
    b. How is the de-fluoridated water distributed?
    c. How did you ascertain the price for the de-fluoridated water?
    d. What do you expect students to learn from this intervention?
    e. Have you evaluated the impact of this intervention on the community? If yes, tell me more. If not, how do you plan to evaluate the same?

3. The Chikkanahalli game stressed on the importance of community participation and of community members taking responsibility. Can you give me examples of what this looks like from your experience?
4. Most of the health schemes target women, particularly mothers, and also the primary health care centers, and anganwadis have women as workers.
    a. How do you explain this woman-centric focus of health and development initiatives?
    b. In your experience, how have men responded to these schemes and initiatives targeting women and girls? Please give examples.
5. When students are asked to create skits, they have to draw not only their language speaking abilities but also from their cultural knowledge about that particular community. For example: The skits on alcoholism intended to tell villagers to avoid alcohol as it can lead to several problems including death. In doing so they had to create characters and situations that would seem familiar to the villagers and that they could identify with. There were some assumptions that they needed to make about men and women, as well as their gender relations within their homes in these villages. My questions are:
    a. Given that students have not visited this particular village before, how do you think students learnt to depict the ways in which men and women in this village behave with each other within their homes, especially in the context of alcoholism?
    b. I was wondering also about the connection between alcoholic men and gender-based violence.
        i. How do you explain alcoholism as primarily a male problem?
        ii. Would you say alcoholism is common primarily amongst poor and/or rural men? If so, how do you explain this?
        iii. Would you say that alcohol-induced gender-based violence is common among poor or rural men? If so, how do you explain this?
        iv. How is gender-based violence outside of alcoholism understood in public health? What is your perception regarding it's prevalence amongst poor and rural communities as compared to the middle, and upper classes?
6. The monsoons game was very interesting. It showed how monsoons and other environmental factors affect the livelihoods and health of villagers. It also pointed to villagers' adherence to religious beliefs and gender norms. What did you want students to reflect upon regarding villagers' beliefs regarding religion, gender, and caste as compared to their own through this game?
7. You had organized a lecture on Ayurvedic medicine in the pre-orientation program. What prompted this inclusion in the pre-orientation program?
    a. What experiences have you had in using or preparing home-based or traditional medicines?
    b. How do you incorporate these experiences in your teaching?
8. Tell me more about how the need for a 'special' school in Kaalwaru was determined and how you went about starting it.

Appendix 3b: Interview questionnaires for teachers (revised Phase II), March 20, 2013

ICEBREAKERS

1. What memories/experiences do you have of interacting with men and women in rural areas or urban slums before you took up this profession?
2. Can you tell me some memorable learning moments from your interactions with men and women in rural areas and urban slums during your professional life? Prompt- First 'exposure'?
3. In what ways did you feel the men in this community were different from men in your community? In what ways did you feel they are similar? What about women?
4. Would you say the perceptions you had or have about men and women in rural areas or urban slums are commonly held by the larger public- i.e. friend and family circles, media, news? Are there instances when you feel these perceptions are false or incomplete? If so, tell me more.
5. How have your interactions with these communities strengthened or altered your beliefs about them?
6. How do you incorporate these perceptions and your reactions to these in your teaching?

Informally- where are you from? Where grew up? Linguistic, caste community?

PHASE II INTERVIEW QUESTIONNAIRE

1. The visit to the sewage treatment plant, hospital waste management sites, and the de-fluoridation plant showcased the role of technology in improving environmental conditions. How do you (can you) teach students about the role of people in shaping environmental conditions?
2. For example, in the family study students look at the environmental conditions of the homes and how it can affect their health. Students also give suggestions to change those conditions. How can students learn from women and other family members about the efforts that they already put in making their homes livable and the challenges they face?
3. The family study activity allows students to see the differences in environmental conditions in rural areas and urban slums as compared to upper or middle class areas. How do you explain to students why these differences exist in different areas? How can these differences be understood in terms of the role of political actors involved in unequal distribution of environmental resources?
4. How do you teach students about the different impact that interventions can have on different sections of the community (classes, castes, abled/disabled, and particularly women/girls)? For example in the case of the defluoridation plant

how can students learn about your experiences of local politics influencing distribution of water? How can students learn about how this defluoridation plant affects women's work in collecting and utilizing water?

5. There are so many schemes targeting women. What opportunities do students have to learn from the women themselves about the effects of a health scheme on their lives and relationships? Can you give examples?
6. There may be instances when the health and development schemes are produced for one purpose but it is resisted or utilized for other purposes locally. Can you give examples of how you teach about these unintended consequences?
7. Health education skits, students taught people to not use a traditionally used mixture with ash or something like that and to use brush and toothpaste, instead. On the other hand, students were asked to learn during the session on AYUSH to learn about traditional health practices. What is your opinion on this? How are students taught to differentiate between health-promoting cultural practices and harmful ones? Similarly, how are students taught to evaluate not only the benefits of technology on the environment and health but also its harmful effects?

8. The Chikkanahalli game asked students to write adjectives describing villagers as well as themselves as development workers. At the end of the game, students possibly learnt that certain words such as 'backward' or 'ignorant' were inappropriate words to describe villagers. If these words are used, what does it imply about the relationship between doctors and communities? How important is it for them to learn about why these words were used in the past to describe marginalized communities, and why they may still be used? Through this activity, how can you facilitate students to reflect upon ethical doctor-patient or doctor-community relationships?
9. The monsoons game showed that daughters are less valued because of the expenses involved in marriage to the point that they were sold off in many cases. On the one hand, the game tries to show how villagers have to make difficult choices in the extreme conditions that they face to make students more sensitive and empathetic. On the other hand, do you think the game may stereotype villagers [pause] in the sense that they think 'this happens in villages only' or that 'all villagers are like this only'? If so, what do you do to address these interpretations?
10. I observed three skits and made the following interpretations. Please give your reactions to these interpretations.
    a. Alcoholism is a personality problem and counseling can change alcoholic behaviors. How do you facilitate students' understanding of alcoholism as an individual problem or as a social problem? [If monosyllable answer, can you explain?]
    b. Alcoholism is primarily a male problem. What might have influenced their portrayal of alcoholics as men? How do students learn about alcoholism as a gender issue, that is, as being influenced by social expectations of what men and women should/can do?

c. After drinking alcohol, men beat their wives. What might have influenced students' association of alcohol drinking with gender-based violence? How is gender-based violence outside of alcoholism understood in public health?
d. After drinking alcohol, lower class men beat their wives. If yes, what might explain this connection? On the other hand, what do you do if students think of alcoholism as a problem of the lower classes alone?
e. Knowing that students might be drawing from media and personal experiences in making these skits, how do you engage students to reflect upon how what they already know about men and women in this community might be based on biases or prejudices in society? Can you give examples?

Appendix 4a: Informed consent form for students

Project Title: Exploring orientations towards the community: A critical ethnography of community field visits in medical colleges in India

You are invited to participate in this research study to understand how community field visits in medical colleges in India orient medical students towards local communities. You have been selected in this study because you participated as students in the Community Orientation Program (COP) offered in this college. I shall give you information about the purpose of the research, the procedures and the benefits and risks of participating in this study. Based on this information, you can make your decision regarding whether you would like to participate in this study or not. I request you to read this form and ask any questions you may have before agreeing to be in the study.

Purpose of research

The purpose of this research is to explore how community orientation programs orient medical students towards the lives of men and women in a particular community. The purpose of interviewing medical students from different sociocultural backgrounds is to understand the different ways in which they learn about men and women in local communities.

Benefits of research

This study will benefit you by encouraging you to reflect upon your learning experience. It will also benefit your college, and the community medicine department in particular to improve upon their program by taking into your perspectives as students. Further, this study will inform other medical colleges as well interested in conducting similar programs.

Risks

There are minimal risks in participating in this study. I will protect your privacy and ensure that all information you provide to me is confidential. I shall be asking personal information about your learning experiences in the COP. I will not use your name or any other identifiers that could reveal your identity; nor will I share any information related to you individually with the teachers, the college, the community, or others. You can decline to give information you are not comfortable in giving me and it will not affect your relationship with the college. If you say something and later change your mind, you can request me to not include it as part of the data and subsequent reports. First let me brief you on the procedures you will be asked to undertake.

Procedures

As part of this project, I shall be interacting with you during the period of the COP and later when I conduct individual interviews with you. The questions I ask you will pertain to your learning experiences in the COP, and your personal backgrounds.

Interviews will be audio-recorded and transcribed. Informal conversations will be recorded by hand, if audio-recording is not possible. All transcripts and notes will be double-checked with you to make sure there are no misinterpretations. Both the audio and written transcripts will be confidential and will not be shared with anybody. All records will be stored securely and will be password-protected. Your name will not be mentioned on any of the transcripts or reports and your identity will be protected at all cost by the use of impersonal identifiers. You are free to make a decision to participate in the research project or not and to leave it at any stage. If you choose to not participate in this project, it will not affect your future relationship with the college, or the teachers. You are also free to ask any questions about how your information will be used in this research project.

Contacts and Questions:

The researcher conducting this study is: Aditi Arur, PhD candidate in comparative and international development, University of Minnesota Twin Cities, USA. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her. Her contact details are given below, and in the business card provided. The contact details for the researcher's adviser on this study are:

Dr. Joan DeJaeghere,
430B WullH
86 Pleasant St SE
Minneapolis, MN 55455
Tel: 612-626-8258**; Email:** deja0003@umn.edu

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher(s), **you are encouraged** to contact the Research Subjects' Advocate Line, D528 Mayo, 420 Delaware St. Southeast, Minneapolis, Minnesota 55455; (612) 625-1650.

I appreciate the time you have taken to consider participation in this project and am grateful for the time you will spend with me, if you decide to participate in this study.

You will be given a copy of this information to keep for your records.

Appendix 4b: Recruitment script for students

I am conducting a research study on the community orientation program (COP) conducted in your college. I had attended the COP with some of you and am here to invite you to participate in this study. The purpose of this research is to understand how the COP orients medical students towards local communities. The purpose of interviewing some of you is to understand how medical students from different sociocultural backgrounds learn differently about men and women in local communities through the COP.

This study will benefit you by encouraging you to reflect upon your learning experience. It will also benefit your college, and the community medicine department in particular to improve upon their program by taking into your perspectives as students. Further, this study will inform other medical colleges as well interested in conducting similar programs.

There are minimal risks in participating in this study. I will protect your privacy and ensure that all information you provide to me is confidential. Your participation or refusal to participate will not affect your relations with teachers and college authorities.

The selection criteria are:

1. I attended the COP with your group
2. You belong to one of the following sociocultural background
    a. Kannada-speaking
    b. Non-Kannada speaking
    c. Non-Hindu
    d. Non-residential Indian (NRIs) or citizen of a country other than India.

If you agree to participate in this study, I will interview you for about an hour about your learning experiences during the COP and briefly about your sociocultural background. I will also conduct a follow-up to confirm what you said in the first interview before publishing research findings.

Thank you so much for your time! If interested in participating in this study, my contact details are below.

Aditi Arur

PhD candidate in comparative and international development,

University of Minnesota Twin Cities, USA.

404, 12th Cross, 8th Main, Sadashivnagar, Bangalore- 560080

91-8861733493; 91-9740399995

arurx001@umn.edu

Appendix 4c: Interview questionnaires for students, May 14, 2013

Total of 16 students will be interviewed. I interacted the most with 2 groups (approximately 50 students) out of 6 in the whole batch during the COP. I shall recruit students from these two groups randomly provided they meet inclusion criteria, and are willing to participate in research:
2 girls and 2 boys each from the following groups amounting to a total of 16.

- Kannada/Telugu speaking (4)
- Non-Kannada/Telugu speaking or Kannada/Telugu as second language:
    - North India (4)
    - Non-Hindu (4)
    - International students (4)

Questionnaire for Kannada-speaking students

1. Tell me a little about your schooling, where you've lived, what languages you speak?
2. How would you describe your learning experience in the COP?
3. In what ways would you say were the communities you visited culturally similar or different from your own? How did it affect your intercultural interactions with them and in turn your learning experience?
4. **How did knowing Kannada/Telugu affect your learning experience in the COP as compared to regular classes? Give examples.**
5. **How did intercultural interactions with non-Kannada-speaking students facilitate or not your learning in the COP? Give examples.**
6. What did you learn from your interactions with men and women in the rural community you visited and urban slums at Bangalore? Probe- Informal questions not part of survey proformae and questionnaires- such as women's knowledge of traditional medicine (AYUSH), women's efforts in making their homes and environments more livable, impact of government schemes on their lives, and so on.
7. How do you think your interactions with men and women would have been different if you were a girl/boy? What do you think you might have learned differently through these interactions if you were a girl/boy? (Note- unmarried adults are referred to as girls/boys in Indian cultural context)
8. How did chikkanahalli and monsoons games help you learn about the lives of men and women in the rural community you visited?
9. What did you find problematic about these games, if at all? Probe- in terms of how they depicted men and women in these communities?
10. **In skits you created scripts for the roles of rural men and women and enacted them as well. The styles in which your characters spoke and behaved, knowing what jokes will make them laugh, and depicting how alcoholic men behave with their wives- where did you learn how to depict the characters in the ways that you did? What inputs did you take from non-Kannada speaking students in making these skits?**
11. Were there instances when teachers objected during the skits as to how you were depicting incidents or characters and/or asked you to change scripts or storylines? Why do you think they objected? What did you learn from this encounter?
12. In what ways has the COP changed your perceptions about men and women from rural areas and urban slums or not? Give examples.
13. How do you think the COP has helped you/will help you become a better doctor or not? Please give examples.

14. What does the white coat mean to you? What does it mean to you as a girl (if a girl)? What do you think it signifies to men and women in the communities that you visited during the COP?
15. Are you thinking about specializing after your MBBS? If so, what disciplines are you considering? What about community medicine? How has the COP experience made you think about choosing community medicine for specialization, if at all?

Questionnaire for non Kannada-speaking students

1. Tell me a little about your schooling, where you've lived, what languages you speak?
2. How would you describe your learning experience in the COP?
3. In what ways would you say were the communities you visited culturally similar or different from your own? How did it affect your intercultural interactions with them and in turn your learning experience?
4. **How did not knowing Kannada/Telugu affect your learning experience in the COP as compared to regular classes? Give examples.**
5. **What strategies did you use to learn in the COP despite not knowing the language?**
6. **How did intercultural interactions with Kannada-speaking students facilitate your learning in the COP or not? Give examples.**
7. What did you learn from your interactions with men and women in the rural community you visited and urban slums at Bangalore? Probe- Informal questions not part of survey proformae and questionnaires- such as women's knowledge of traditional medicine (AYUSH), women's efforts in making their homes and environments more livable, impact of government schemes on their lives, and so on.
8. How do you think your interactions with men and women would have been different if you were a girl/boy? What do you think you might have learned differently through these interactions if you were a girl/boy? (Note- unmarried adults are referred to as children viz. girls/boys in Indian cultural context)
9. How did chikkanahalli and monsoons games help you learn about the lives of men and women in the rural community you visited?
10. What did you find problematic about these games, if at all? Probe- in terms of how they depicted men and women in these communities?
11. **In skits as a group you created scripts for the roles of rural men and women and enacted them as well which required local cultural knowledge such as the styles in which your characters spoke and behaved, knowing what jokes will make them laugh, and depicting how alcoholic men behave with their wives. How did you contribute in making these skits? Where did you learn how to depict these characters?**
12. Were there instances when teachers objected during the skits as to how you were depicting incidents or characters and/or asked you to change scripts or storylines? Why do you think they objected? What did you learn from this encounter?

13. In what ways has the COP changed your perceptions about men and women from rural areas and urban slums or not? Give examples.
14. How do you think the COP has helped you/will help you become a better doctor or not? Please give examples.
15. What does the white coat mean to you? What does it mean to you as a girl (if a girl)? What do you think it signifies to men and women in the communities that you visited during the COP?
16. Are you thinking about specializing after your MBBS? If so, what disciplines are you considering? What about community medicine? How has the COP experience made you think about choosing community medicine for specialization, if at all?

Appendix 5: Research questions

November 2012

1. What discourses inform PSM educators' methods of learning/teaching about the community during field visits?
    a. What racialized and gendered colonial discourses persist or not in PSM educators' practice of community field visits?
    b. How do these methods produce particular characterizations of the community?
2. How are the discourses informing PSM educators' practice of field visits shaping and being shaped by their gender and class identities?

May, 2014

1. How did a community-based teaching program (CBTP) in public health at a medical college in India produce 'science/fictions' about communities living in rural areas and urban slums?
2. How were these science/fictions shaped by transnational discourses of development, and the situated knowledges of PSM teachers and students about these communities?
    a. How did these 'science/fictions' mediate medical students' performative actions and interactions with the residents living in an urban slum and a village?
    b. How did these communities constitute counterpublics or alternative pedagogical sites of engagement to disrupt these science/fictions?

c. How was knowledge produced through encounters with the community used to renarrativize universalizing science/fictions?