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**PARADOX OF DEVELOPMENT AND
ANTI-POLITICS IN MALKANGIRI
DISTRICT IN ODISHA, INDIA¹**

JENS SEEBERG AND RIKKE AARHUS

Development and the Creation of the Cut-off Area

This chapter describes healthcare—one of the key services of the modern state and a measure of its level of development—in the shadow of a large dam, another material symbol of development, in Odisha, India. Odisha has one of the largest concentrations of tribal population accounting for approximately 22 per cent of the state's population. If Odisha is one of the poorest states, the southernmost district of Malkangiri is one of the poorest districts in India, and within Malkangiri district, Kudumulugumma block must be one of the poorest blocks in the entire country. This is so not only because of lack of economic development in a general sense; it is so because of one specific development project, which dates back to 1962, and following which point in time there has been no development possible in the so-called Cut-off Area. This was probably not the intention or even included in the discussions, when Nehru and Khrushchev agreed on a hydroelectric power plant as part of India's Third Five-Year Plan. What they did agree was, with Soviet engineering expertise, to construct the Balimela dam across the Machkund river in Malkangiri to meet the increasing power needs of the neighbouring state of Andhra Pradesh. The project involved the flooding of a large area along the river banks that was inhabited by Scheduled Tribes. Those living on the western bank

were moved to the resettlement villages that were subsequently constructed and given acronym names: RSC-1, RSC-2 etc., standing for Resettlement Colony. These are still village names 50 years later. The households that complied with this resettlement plan were paid INR 500 per individual. However, not all agreed to the plan. Those living along the eastern river had their land there, and their ancestors and identity were buried in those hilly fields. They refused to comply and withdrew to the strip of land adjacent to the mountains that separate the district from Andhra Pradesh, soon to realize that a lake took shape that was too time-consuming and expensive to cross for any daily needs. They came to inhabit the “Cut-off Area”, as it was appropriately named, and area where no compensation could be paid, nor could the electricity that soon would travel in the wires above them reach down to the ground level where they lived—a fate that they, unknowingly, shared with their former neighbours in the numbered Resettlement Colonies.

In 2004, when the authors first visited the Cut-Off area, an estimated 37,000 people were living there.² The launch—a small square barge that was dangerously overloaded with people and goods to get value for money, four Rupees per person—took four hours from departure at Chittrakonda to reach the clay bank that was identified as harbour on the Cut-off shore. After a short stop it returned back. It was not possible for people from the Cut-off area to reach the hospital in Chittrakonda and return the same day. In fact, due to the opening hours of the hospital and the early, albeit somewhat unpredictable departure time of the launch, they would have to spend 48 hours of travelling and two overnight stays, in addition to the hours of walking between their village and the clay bank harbour, to manage to be seen by a doctor, if, that is, they were not unlucky that he had gone out for some personal business. It was little wonder that there was only one registered tuberculosis (TB) patient in the Cut-off Area, named Anand. It was more like a small miracle. However, when we found him, Anand was left with an empty medicine box. He had finished the medicine in less than the prescribed two months and had done so without the existence of relevant support mechanisms for supervised treatment. Anand had no medication for the four months continuation phase, and he had fallen down from a Salop tree when he was tapping palm beer and hurt his leg too badly to be able to make the necessary journey to the hospital in Chittrakonda, across the water, had he wanted to.

In the Shadow of the Balimela Dam

This visit was the point of departure for development of four studies to assess the situation in seven villages on both sides of the water, and one of these studies was undertaken by RA under the supervision of JS, who was also in charge of an interdisciplinary research project in the district. RA's study, described in the following, focused primarily on the Paraja tribe, which was one of the largest original inhabitants, indigenous groups in the area. We use the term '*Adivasi*' as it is used in the area. In the context of a society dominated by high-caste Hindus, in Malkangiri District both people classified as "Scheduled Tribes" and as *Dalit* (Scheduled Castes) identify themselves as, and are called, *Adivasi*. Only few *Adivasi* people lived in Chitrakonda, as most of the town's inhabitants were non-local people. *Adivasi* villages were scattered around Chitrakonda in a radius of one to 30 km. Most of these were resettlement villages established after the construction of the Balimela dam.

Public transportation was only available to a few of the villages. Most of the villagers would walk, travel by boat or go by bicycle to Chitrakonda, which was the centre for trade, medical treatment and education in the area. A hospital was established in Chitrakonda at the time of the construction of the hydropower project. However, the hospital was not the only place where *Adivasi* people would seek treatment. In fact, most consulted other providers, if provider is broadly understood as anybody who would provide care for the sick against some form of payment. In many *Adivasi* villages, there were traditional healers (locally known as *disari*, *gurumai* and *alekh*), who were often consulted in case of health problems. At the time of fieldwork, in 2005, there were three privately-owned medical stores in Chitrakonda. They were frequented by *Adivasi* people as they could get both medical advice and medicines there, although the chemists had little or no formal training. *Anganwadi* workers covered all villages, either living in the village or in a neighbouring village. Most *Anganwadi* workers were illiterate, which, according to their supervisor, was an obstacle for fulfilling their duties. Some providers practised biomedicine with only a little or no biomedical knowledge. They were known as doctors among villagers and as 'quacks' among government providers. In Chitrakonda, three registered medical practitioners (RMPs) had clinics at the time. Government-employed multipurpose healthworkers (MPHWs), most of them female, also covered the area. Ideally, they should live in the villages they worked in but in

practice most lived in Chitrakonda and travelled by bicycle and/or boat to the villages.

Tuberculosis in and Around Chitrakonda

Thus, villagers had a broad spectrum of providers to seek treatment from, and many made use of more than one provider. In what follows, we shall focus in particular on tuberculosis (TB), since this disease is the target of the Government Programme known as the Revised National Tuberculosis Control Programme (RNTCP). While we noted that Anand was only partially treated for TB in the Cut-off Area, the only formally recognized centre for TB treatment in the area was the hospital in Chitrakonda. Contrary to WHO and Government standards, TB medicines were also sold at medical stores, prescribed by RMPs, and some traditional healers also claimed to be able to cure TB. In the following, 'provider' will be used to refer to government-employed health personnel only, as they are officially recognized providers of TB treatment. RNTCP, based on the DOTS strategy, was introduced in the district of Malkangiri in 2001. Before this, TB patients were mainly referred to a private Christian missionary hospital in Lamtaput in neighbouring Koraput district. Many villagers still linked TB with Lamtaput. At the hospital in Chitrakonda, the lab technician was trained under the RNTCP. Multipurpose Health Workers (MPHWs) were trained and worked as DOT providers, responsible for overseeing to oversee that patients took their medicines every second day during the initial two-months treatment phase. In some cases, the MPHW had informally trained an *Anganwadi* worker or a local villager as a DOT provider, when a positive case was identified in the village ("spot training"). Among providers, it was generally believed that there were many undiagnosed TB patients in villages. Often, providers blamed the patients for this: villagers were thought to consult traditional healers instead of Government doctors and "not to care about health". Providers would also mention problems with those patients actually coming to the hospital: they often failed to deliver the three required sputum tests; they did not adhere to the treatment regimen; and they did not have any confidence in the hospital doctors until their condition deteriorated. So, according to providers, if TB treatment was not successful, villagers/patients were responsible for this. A few providers, however, were sensitive to the difficulties faced by patients in getting treatment in Government hospital, such as lack of transportation,

unsuitable opening hours and the frequent absence of health care staff. Common negative stereotypes among providers, who in their private lives condemned tobacco and alcohol for religious reasons, were that all *Adivasi* people smoked and drank excessively. Many providers linked drinking and smoking to TB, either as a cause, an aggravating factor, or a reason for the patient not being able to follow the treatment. Providers also talked about villagers' unhygienic houses and living conditions and bad food habits and pointed to a relationship between these conditions and the diseases they suffered from, thereby effectively blaming *Adivasi* people for their impoverished and vulnerable life conditions. But the front-line health workers also worked under frustrating circumstances.

MPHWs who, in most cases, acted as DOT providers, faced heavy workloads combined with the absence of any recognition for their efforts. Going to the villages was physically strenuous, and some MPHWs feared going there due to personal experiences of, or rumours about, drunken people, people demanding money or medicines, or fights. When reaching a village MPHWs might not find the patients there, and villagers did not wish to present their health problems. Almost all villagers in the study villages had heard of TB and could cite an example of someone who (apparently) had died from TB, although they could not always describe the symptoms of the disease. Those who knew of TB feared it as it was considered fatal. Few villagers were aware that TB medicines were supposedly available at the hospital in Chitrakonda free of cost as they were accompanied by prescriptions of other drugs, including unnecessary cough syrups and vitamins. In combination with transportation costs, this practice undermined the claim that the treatment was free.

A commonly mentioned symptom associated with TB was cough. Cough was often treated with different medicines bought from medical stores and/or from traditional healers. Some villagers often believed that alcohol and tobacco could cause TB, but most did not know the bacterial cause of the disease. For most villagers, the Government hospital was often the last resort. They were of the opinion that medicines at the hospital were of inferior quality compared to medicines from medical stores and RMPs. In addition, their preference for injections was rarely fulfilled at the hospital. Villagers experienced ending up paying for 'free' services at the hospital. Compared to the examination and behaviour of RMPs, villagers found examination procedures less thorough and the behaviour of providers more offensive at the hospital. Many villagers expressed insecurity about going to the hospital and interacting with providers. They

also often experienced that the hospital was either closed or providers were not available when they went there. Traditional healers were often consulted, either in combination with another provider or as the sole treatment provider.

Local healers enjoyed great respect in the villages and took part in many spheres of village life and were highly trusted in health matters. MPHWs came to the *Adivasi* villages about twice a month. Villagers felt less insecure interacting with MPHWs than with hospital providers. However, villagers complained that the MPHW came irregularly, that he/she came in the middle of the day when many were working in the fields, that the MPHWs were not able to treat any other condition apart from malaria, and that some of them demanded money in exchange for the government-supplied medicines they brought. The authors did not come across any MPHW who sold government-supplied medicines. But some MPHWs told how they sometimes sold medicines they had bought in medical stores, e.g. injections, a practice that was observed by RA.

Interaction between Patients and Providers

Choosing a suitable provider in case of illness was a difficult task for villagers. Quality and availability of medicines, payment, opening hours, trust as well as previous experiences affected their choice. Personality and behaviour of the provider also played a major role. Experiences from contexts other than health also influenced the decision. Conflicts from everyday life in the village and experiences with a provider outside the medical sphere affected whether a certain provider, whether government or private was consulted in case of health problems. In Chittrakonda, provider-patient interaction was largely influenced by the fact that patient and provider did not belong to the same ethnic group (Barth, 1969). Unequal social status and power equations influenced interactions and their outcome. Ethnic identities worked to identify as a specific *Adivasi* community *vis-à-vis* other groups (*ibid.*:13). Both in Chittrakonda and in the villages surrounding it, people made a clear distinction between *Adivasi* people and “Odia people”. *Adivasi* people were people who belonged to “Scheduled Tribes” as well as low-caste people who lived in villages. Odia people (literally meaning people from Odisha) were here understood as those who lived in Chittrakonda, including both non-tribal people from Odisha and other states, notably the bordering state of Andhra Pradesh. According to this classificatory scheme, the majority of providers

working in the area were Odia while the patients in the study were *Adivasi* people.

Adivasi people were considered among the lowest in the social hierarchy and were expected to behave in a highly respectful manner towards Odia people. Clothes, habits, adornments, language and appearance served as social markers that allowed *Adivasi* and Odia people to categorize each other. Differences between Odia and *Adivasi* people were especially stressed by Odia people and served to distinguish ‘us’ from ‘them’, often involving disrespect and symbolic violence. *Adivasi* people tried to diminish the differences to get accepted by Odia people, to appear to be similar to them and therefore increase their opportunities and status. This was seen when men from villages came to Chitrakonda dressed in trousers and shirts in contrast to the waist cloth and shirt they wore in their village setting. The characteristics (drinking alcohol, smoking etc.) attributed to *Adivasi* people affected the way a provider treated a patient. Providers often looked down upon patients and justified their behaviour by referring to these stereotypes. Communication between providers and patients is one example of how a person’s ethnic identity shapes the way one is perceived by others (*ibid.*:15). Often diagnosis and recommended action were not explained to patients, since it was considered to be a waste of time due to their perceived ignorance and carelessness. *Adivasi* people, on the other hand, would never ask for a diagnosis themselves due to their inferior status.

Instead, AR often observed villagers discussing what the patient was suffering from after a consultation, and she was sometimes asked about the diagnosis. A set of taken-for-granted rules governed the interactions restricting what could be said and done (*ibid.*: 16). Examples of such rules were: the provider was always right; the patient should only speak when asked to; the patient should not make any demands; and the provider did not have to behave politely and make the patient feel at ease. One of the consequences of these implicit but effective rules was that patients did not always report all symptoms or any previous treatments to the provider. Family history of TB and other important information was thus not available during clinical decision-making. Whether the rules of interaction could be changed or challenged depended upon the different ‘capitals’ the patient could bring to bear on the situation.

Capitals are resources which can be economic, social and cultural and have asymbolic value (Bourdieu, 1986). Odia providers were generally more powerful in the interactions as they controlled more capital

than *Adivasi* patients, in addition to the hierarchy between patient and healer. They had more social capital due to their higher social status; they were literate and economically better off. Even literate *Adivasi* people were not able to benefit from this capital as they were presumed to be ignorant and primitive due to their ethnic origin. However, being literate often gave them confidence to ask questions, and they felt less insecure dealing with providers than their illiterate kinsmen. The inequality between patient and provider was further enhanced by the fact that not all *Adivasi* people spoke Odia (the official language of Odisha), and many did not speak it fluently. The providers, who spoke Odia, had the power to decide in which language the interaction should take place. This meant that patients sometimes had insurmountable communication difficulties in expressing themselves and in understanding what was said. Only literate *Adivasi* people asked questions if they did not understand the providers.

Several MPHWs explained how difficult it had been for them to understand the villagers when they first came to the area, but that with time they had learned key words in local languages. However, as the area was not considered attractive to be posted in, there was a relatively high turnover of MPHWs, and patients therefore frequently encountered new MPHWs who had yet to acquire even the most basic local language skills. Language problems were also observed at the hospital, although these were largely denied by hospital staff. Such problems were seen, for instance, when a patient was told to have a sputum test. When the patient did not understand what to do and remained seated, the doctor would tell the patient to leave the room without further explanation. As a consequence, it happened regularly that patients did not get the prescribed test done, because they had not understood what to do and where to go.

Social Distance

From the above, it is clear that many non-medical factors influence treatment of diseases in Chittrakonda. As the providers complained, there were problems with patients not coming to the hospital, not reporting symptoms to MPHWs when they went to their villages, or not showing interest in treatment. However, this was not on account of the patients' perceived ignorance and carelessness about health as the providers claimed, but due to a pragmatic way of handling their misfortunes (Whyte, 1997). *Adivasis* did not have much confidence in government providers or medicines. They had bad experiences of absentee providers and of

rude and disrespectful behaviour towards them. These experiences influenced villagers' preference for non-governmental providers. To be seen as an equal (and equally) human being and not being branded negatively on the basis of ethnic background was important for them. Hence, the practice of providers to treat them as ignorant, abusers and incapable of understanding messages constituted a significant access barrier, exacerbating the social distance in everyday life between Odia and *Adivasi* communities. Even if physical distance constituted another important access barrier, the villagers seemed to find it easier to overcome this than the social distance.

However, unable or unwilling to directly and openly question this social hierarchy, both Odia providers and *Adivasi* villagers said physical distance was the biggest obstacle to accessing treatment at the hospital. Social distance was less obvious for those who were part of the social hierarchy and had grown up embedded in its framework, and rather than articulate the issue openly *Adivasi* villagers would demonstrate their resentment against this treatment through their preference for traditional healers. Furthermore, despite the alleged barrier of distance, villagers—at least those residing on the Chitrakonda side of the Balimela Dam—regularly made use of medical stores and RMPs and went to the weekly market in Chitrakonda. To most people in the Cut-off Area, this was not an option, and they generally did not appear on the mental horizon of formal or informal healthcare providers in the town.

Dam-Health Dynamics

Development as a discursive trope and a material articulation works at many levels in the above scenario. Development is demonstrated by the hydroelectric prestige project of the sixties which was essential for the production of electricity for urban and industry consumption but not for village development in the area where it seriously disturbed the infrastructure of the original inhabitants. And development is demonstrated in the government-funded healthcare system that is set-up to replace traditional forms of treatment with biomedicine. Lack of original connectedness and the negative impact of one development project (the dam) on another key development area (the health system) complement Ferguson's argument in "the Anti-Politics Machine". He uses this term to capture the usually unintended effects of the workings of the development industry in Lesotho in the context of development projects

that often fail to meet their stated objectives (Ferguson, 1994). Ferguson, while pointing to the uniqueness of the circumstances of Lesotho as a nation state surrounded by South Africa, and discussing the rationale of development projects that systematically “fail” according to their own stated objectives of poverty reduction and increase in agricultural production, defines two sets of “side effects” of development projects: growth of state administration and bureaucratization in geographical (and administrative) areas that were not well accessed/accessible for the State machinery earlier, and at the same token, delinking this process from the political consciousness.

Poverty, and its reduction, is defined as a ‘technical’ problem, not a political one. Along with this depoliticising—or because of it—development projects can carry out highly sensitive activities under the disguise of ‘development’, such as expanding state power to control populations—or control populations more effectively—than was the case before ‘development’ took place, says Ferguson (*ibid.*). Ferguson wonders to what extent these mechanisms are indeed unique to Lesotho or whether they represent general and generalizable dynamics that—to varying degrees—are part of the workings of the development industry globally. He notes that “development” projects all-over the world tend to be formed by a shared, context-independent “development” expertise as one reason why the Lesotho experience would be part of a very general phenomenon; another standardizing effect comes from the tendency to standardize programmes into “packages” of standard available “inputs” (*ibid.*: 258).

In the case of Malkangiri, perhaps as a within-state parallel to Lesotho, the district may be seen as being surrounded by more powerful centres of government that decides on the use of the district’s natural resources for external benefit and to the detriment of the people living in the district, while placing this decision exclusively in the realm of the national and state politics, disregarding and actively ignoring the politics of *Adivasi* rights—a concept that was even weaker at the time of the construction of the dam than today.

Both hydro-power infrastructure and health system are developmental milestones from the perspective of the state, but their systemic de-linking is an act of “anti-politics”. The two—the dam and health—are, of course, dynamically entangled, but ignoring this makes it possible to also ignore their paradoxical and conflicting developmental effects. Damming the river and creating the lake changed the ecology in favour of certain species and not others, hence improving breeding conditions for the *Anopheles*

mosquito, the vector of the parasite causing malaria, and its construction was followed by an increase in the incidence of the dangerous *P. falciparum* malaria. This epidemic change, it should be noted, co-occurred with the effective cutting off of a large area and a substantial population from meaningful access to services normally associated with the development of the “modern state”, such as education and health care (Prince, 2013).

A syndemic is an epidemic of co-morbidities and social conditions that mutually reinforce each other (Singer, 2009). The increase in malaria came to interact syndemically with a host of other conditions that were common in the area on both sides of the dam, involving anaemia, splenomegaly and fever (all potentially linked to malaria) as well as upper respiratory tract infection, musculo-skeletal diseases, goitre, eye diseases such as cataract, dental problems, skin diseases and ear diseases, as well as widespread undernourishment of children (Sahu, Satapathy, Sahani, Bhattacharya & Seeberg, 2005), all of which had to be managed without treatment, or with a precarious combination of traditional, herbal and/or randomly accessible biomedicines distributed through informal channels. A systematic comparison of health status of villagers on both side of the Balimela Dam showed a statistically significant difference with higher prevalence of splenomegaly in the Cut-off Area compared to villagers closer to Chitrakonda, but otherwise villagers on both side of the dam suffered from the predominantly treatable conditions mentioned above to similarly high degrees, pointing to the astounding efficacy of normalized social distance as a barrier to health care. We propose that the workings of what Ferguson called the anti-politics machine have played an important role in keeping ‘development’ represented by the dam and ‘development’ represented by state funded health care in separate domains. Both are seen by the state as ‘technical’ rather than ‘political’ matters, something that itself, of course, represents a politics of ignoring *Adivasi* society.

As far as the disruption of *Adivasi* society by the dam is concerned, it may be defined as collateral damage by the state, and the ‘choice’ of tens of thousands of *Adivasi* inhabitants to stay at ancestral land in the Cut-off Area seems to have been interpreted by state representatives as a justification for the state to withdraw from all responsibilities in the area. The above analysis shows, however, that even if this withdrawal of state responsibility were somehow to be remedied, the performance of social distance would continue to outweigh the importance of physical distance as a barrier to access to health care. Importantly, social distance is intrinsically political and irreducible to a “technical issue”. Hence, we

argue that the systematic domination of *Adivasi* communities by the dominant society as exemplified in the present study can be directly measured in the extremely high incidence of unaddressed yet medically treatable diseases—a syndemic relationship that Farmer has defined as an expression of structural violence (Farmer, 2001, 2005).

Notes

1. Parts of this chapter constitute an edited version of a text previously published by Aarhus (2005).
2. The authors wish to express their gratitude to Dr. Nilakanth Panigrahi, who organised and participated in this visit.

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Vulnerability, Marginalization and Culture

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FOREWORD

Professor Deepak Kumar Behera is one of the few internationally renowned anthropologists in India. He is also a fine administrator and last not least a human being of immaculate integrity. I have closely cooperated with him over the last 20 years and could count on his word in every minute during this long period of time.

I first met Dr. Behera in 1981, when he was an assistant of Professor S.N. Ratha and a dynamic young man full of energy and drive. He had been an excellent Cricket player before he made up his mind to hit a century in the game of anthropology. His doctoral research had taken him into the very heterogeneous Christian community of a good number of denominations, tribes and castes. Very early it was an indicator of his independent and analytical mind. Thereafter, he engaged himself in the study of *Ashram* schools in the tribal areas with the result, that he did not hesitate to denounce the callousness of officials, the corruption of staff members and the very obvious fact that the tribal pupils were badly exploited. Perhaps in the course of this research he found the topic of his career and of his life, the protection of the most vulnerable among us, the cause of the children against the brutalities of the world of adults. Professor Behera did not advocate certain educational improvements. He was a revolutionary. He wanted and wants children to decide, what is good and right for them. Perhaps the confident young humans among the Kisan tribe had impressed him, when he spent another long spree of ethnographic research among them.

Many of us preach water and drink wine, but not Deepak Kumar Behera. No discrepancy can be discovered between his words and his actions. His child, young Titli, grew up as a fully self-determined young human. Mrs.

Rita Behera, a wonderful educationalist, along with Titli's father included the girl, whenever a decision had to be taken. It also goes without saying that the eminent anthropologist makes no difference between females and males in matters of politeness and respect, opportunities and positions of power. His behaviour is equally decent to rich and poor, man and woman, old and young, or Hindu and Christian. I could feel this in a very personal experience which is unusual for Europeans.

Whenever I came to India, Professor Behera made me stay at his house, so I met his mother who had long conversations with me, or his father, who treated patients as a homoeopathic doctor free of any charges. Like many other Indian and non-Indian colleagues I was immediately included into his entire family, perhaps because he did not know, what was in store for him. In fact, I exploited this situation beyond treasonable measure. From the late 1990s onward, one German scholar after the other came and stayed at the Beheras' house. Since that time seven or eight major contributions to the anthropological research of Odisha were completed and all of these authors had lived in the Professor's house and were guided or even personally placed in the field by their host himself. Clearly this important stage of tribal research could not have been achieved without our splendid and absolutely responsible Indian counterpart.

The innumerable international contacts were one obvious result of this combination of academic competence and personal integrity. Dr. Behera toured the globe several times, having friends on all continents. In Germany, he cooperated with the Free University of Berlin and the University of Tübingen and I personally had the honour to edit ten different volumes of *Tribal Studies* together with him. All members of the *International Union of Anthropological and Ethnological Sciences* elected him for ten years as one of the five leaders and only recently he could host a conference of this renowned body in Bhubaneswar.

Personally, I was a bit sad to lose this scholar to the field of administration, when he became Vice-Chancellor of Berhampur University, but now I am happy that he has returned to academic research and will once again engage himself in writing and thinking anthropology. Today, I am proud to say: Deepak Kumar Behera is my esteemed colleague and my close friend.

Free University, Berlin
(7.8.2017)

Professor (Dr.) Georg Pfeffer
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ACKNOWLEDGEMENTS

This volume brings together a range of renowned international scholars from India, Latin America, North America and Europe, who — as experienced fieldworkers — have approached Vulnerability, Marginalization and Culture from various angles including anthropology, sociology or cultural studies. The chapters result from long-term international collaborations with Professor Deepak Kumar Behera and the Department of Anthropology of Sambalpur University which he successfully headed for many years. During this time, he was instrumental in promoting a wide range of scholarly activities such as workshops, international conferences, field-work and excursions, various joint research as well as publications projects in which all of the contributors participated in multiple ways.

Professor Behera's intellectual, academic and institutional support was invaluable for the advancement of *Adivasi/Tribal Studies*, for the study of children and childhoods and for the understanding of marginalized and vulnerable communities from an anthropological and cultural perspective. The editors and authors assembled in this volume gratefully acknowledge Professor Behera's outstanding contributions to these fields.

As editors we would also like to thank the *Irish Journal of Anthropology* (IJA) for the generous permission to reprint the article *Cockfights and Champa Bird Fights: Adivasis, Farmers and Popular Pastimes in North-western Odisha* by Uwe Skoda published in IJA 2015, vol. 18 (2), pp. 48-64. Moreover, we would like to express our gratitude to Concept Publishing Co. (P.) Ltd. for taking up this volume and for the constant encouragement and support throughout the publication process.

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Other Books of Interest

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- Volume 9 : **Health in the Context of Tribal Culture**
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RASHMI PRAMANIK, UWE SKODA and LIDIA GUZY (Eds.)

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Vulnerability, Marginalization and Culture

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Vulnerability Marginalization and Culture

Felicitateion Volume for Prof. Deepak Kumar Behera

EDITED BY

Rashmi Pramanik | Uwe Skoda | Lidia Guzy

This *Felicitateion Volume* is dedicated to Professor Deepak Kumar Behera and his contribution to the Anthropology of Odisha, India and beyond. It highlights the intersections of the concepts of vulnerability, marginalization and culture – pivotal for his research, which constantly sensitized the academic community as well as the wider society to these themes throughout his career. The volume brings together researchers from India and beyond who collaborated with Professor Behera throughout the last years. All chapters focus on a fieldwork-orientated approach leading to rich ethnographic analyses informed by a long-term engagement between researcher and interlocutors.