Social marginality and ill health can form an unholy dyad: firstly, groups who suffer from chronic or infectious diseases often find themselves pushed to the margins. Secondly, people who are already on the edge of society tend to suffer more from illness than those at the centre. In development discourse, marginal people are defined as those who are ‘not yet’ on the same level as the developed mainstream and are in urgent need of aid from the centre. The papers in this special issue take a different approach by insisting that marginality is a radically relational concept: the centre and its margins constitute each other, and the boundaries between them are constantly shifting. The papers show that there are many types of marginality (based on geography, class, caste, sex/gender, ethnicity, etc.), and that each of them has different effects on the health of a particular group. Yet instead of speaking of a plurality of unrelated ‘group identities’, marginality preserves a sharp sense of unequal power relations between groups. The specific ethnographic contribution to the study of marginality comes from its attention to the point of view of marginal people. This is of critical importance since marginality puts health most under stress when it is clearly and steadily perceived in everyday life. This, in turn, makes it possible to show that living on the margins is not always and everywhere bad for health. While all of the papers present South Asian case studies, the insights and questions are relevant for the study of the ills of marginality in a global perspective.

Many Margins, Many Ills

In its original sense, ‘margin’ signifies ‘border,’ and to be ‘marginal’ means to be somewhere outside the centre, at the edge. The border of a printed page of writing is one common meaning of the term. But ‘margin’ has other meanings in different contexts: it may be a measure of difference, or it may be the bare minimum below
which living becomes impossible. Economists speak of ‘profit margins’ and statisticians of ‘marginal probability’. ‘Marginal people’ are those deemed to be of less importance to the mainstream. The social sciences have taken up this meaning but reversed what is at stake. The situation of marginalized, stigmatized, and excluded groups is now regarded as being of central importance. This volume explores how marginality affects physical and mental health in South Asia.

There is not just one form of marginality, but many. People are marginalized because of their class, caste, ethnicity, or sex/gender positions. The literal meaning of ‘border’ implies, first of all, a spatial location. As soon as we begin to think of marginality in this sense, we can see that it is a thoroughly relational term because people and places are defined as ‘marginal’ only in relation to a ‘centre’. Spatial marginality is often temporalized and put into a historical frame. This has been done, for example, by those influenced by Wallerstein’s (2004) idea of the ‘world system,’ in which marginal areas are those less integrated into global capital flows. Similarly, temporalization of spatial marginality can be found in the writings of scholars interested in globalization, for whom marginal people are those who are not—or not yet—affected by the expanding net of global flows. Indeed, marginality is normally viewed as a spatial-cum-temporal condition by scholars examining the historical and geographical spread of political and economic forms, discursive regimes, and powerful institutional structures.

A prime example of a global practice that is both marginalizing and de-marginalizing is biomedicine. In relation to biomedicine, marginal people are those who are relatively little affected by its spread or in some way excluded from it. Several examples of this form of marginality are discussed in this volume. For example, Vishvajit Pandya looks at the changing relations between the Jarwa tribal people of the Andaman Islands and the state, here both the British colonial state and the postcolonial state, while Stefan Ecks looks at how ideas about the mental health of people living in one of India’s mega-cities, Kolkata, are being redefined due to the global spread of psychiatric disease categories and the marketing efforts of pharmaceutical companies for antidepressants.

People are often stigmatized when their bodies look different, when they speak non-dominant languages or behave in ‘queer’ ways. What are the health effects of this kind of marginalization? This is the central issue in several papers. The problem of sexual marginality is taken up by Gayatri Reddy in her discussion of the Hijras (or ‘eunuchs’) of Hyderabad in central India. While remaining profoundly stigmatized as socially and sexually anomalous beings, Hijras have also become a target group for HIV/AIDS-related health programmes aiming at their demarginalization. Sexual marginality has become a resource in the competition for health funding, with often surprising results. Focusing on caste inequalities in relation to stigmatization and health, Karin Polit argues that marginality must always be seen in a specific context. She argues that low-caste people in a majority high-caste village suffer much more from stigmatization and prejudice than they do in a low-caste village. Stigma, like marginality, is shown to be a thoroughly relational concept. With regard to Punjabi refugees in Germany, Michael Nijhawan demonstrates how the state not only delineates the boundaries between the centre and the margins,
but also how these interventions have an immediate health effect on those whose citizenship status is in question. He describes the contradictions engendered by a health policy that seeks to shield the German population from potential health risks brought along by marginal refugees, while at the same time operating with a humanitarian rhetoric when deciding whether such refugees are medically fit to be deported or not. Instead of reducing marginality to one single criterion, the papers in this volume show that there are many forms of marginality, and that each of them has specific and often unpredictable consequences for health.

**Medicating Marginality**

There is a growing body of literature which argues that social marginality has clear, and clearly negative, effects on health (Brown & Harris 1978; Kawachi & Kennedy 1997; Kleinman *et al.* 1997; Marmot 2004; Marmot *et al.* 1991; Roberts 1997; Sen 1993, 1995; Sennett & Cobb 1972; Wilkinson 1996; Wilson & Daly 1997). Because of stigmatization, poverty, lack of education, and diminished access to health services, people at the margins are usually much more susceptible to sickness than those at the centre. Moreover, it is well established that there is a two-way relation between bad health and marginality: social marginalization can exacerbate sickness (isolated people whose health suffers from contact with the outside world), and sickness can trigger or aggravate social marginalization (lepers, the mentally ill, HIV/AIDS sufferers). Ideals of equality and justice are invoked by those who pursue an interventionist agenda for change—above all the development sector, but also professionals in public health and in the clinical disciplines, and many medical anthropologists. Health planners and workers, scholars and activists, bureaucrats and politicians develop forms of knowledge and intervention to ameliorate marginality by bringing marginal people to the centre, or by bringing new techniques and forms of knowledge (medicine, food, education, hospitals, drugs, doctors) from the centre to the margins.

In the documents that support such interventions—academic reports, government and NGO policy documents—marginal people are often represented as being in need of more drugs, more doctors, and more technology; as the ‘patients’ of central ‘agents’. Yet certainly such people have their own agency, their own moral discourses, their own notions of marginality. Who counts, after all, as ‘marginal’, and according to what criteria? Where are their voices, what are their experiences? Do they in fact perceive themselves as marginal? Do they have their own discourses of marginality, their own ways of coping? And if so, do such projects correspond to the projects initiated by the ‘centre’? What are the effects of interventions to redress or ameliorate marginality? The papers presented here pose these questions in relation to one particular region of the world: South Asia.

As anthropologists thinking about the ills of marginality and how they might best be understood, we feel that an empirical, fieldwork-based approach to such questions is by and large lacking in the relevant literature. The highly influential Subaltern group of historians (Guha 1997; Ludden 2001) sought to recover a ‘subaltern perspective’ on many issues related to marginality in South Asia, but they rarely
conducted fieldwork, and although some of the forms of resistance they documented were related to colonial medicine, health issues never loomed particularly large for them. For us, however, in-depth fieldwork has always been the *sine qua non* of research, and its importance was increasingly recognized in the 1990s, not only by scholars in neighbouring disciplines, but also by international development agencies, which began attempting to understand people’s immediate experience of poverty and discrimination, turning their attention to ‘participatory assessment’ of poverty. The World Bank’s *Voices of the Poor* project (Narayan *et al.* 1999) is a key example of this shift in priorities, yet it did not amount to a thorough, fieldwork-based study. We therefore decided to assemble a number of social scientists from various disciplines, scholars who have lived among ‘marginal’ people of South Asia and could speak to these issues.

It might well be asked what fieldwork can contribute to a discussion of social marginality and its consequences for health. Are public health and epidemiology not the authoritative disciplines here? One answer is that, to the extent that marginal people are at some geographical or social distance from ‘the centre’, they are more likely to be misrepresented and misunderstood by health policy makers and health professionals, and that it is therefore necessary to investigate their situation and listen to their views ‘on the ground’, in their actual social, political, and environmental context. Beyond that, it is increasingly recognized that fieldwork is a dialogical process. By engaging directly with our research subjects in their local contexts, we are enabled and indeed encouraged to revise our concepts in light of their views, experiences, and critical input. This is the great strength of ethnographic fieldwork. One consequence of this approach is that anthropological discussions of health tend to keep a critical distance from development interventions, whether they come from the state or from non-governmental organizations. This stance informs all the individual contributions to this volume.

**The Gaze in the Gift: Jarwas and Medicine in the Andaman Islands (Pandya)**

On 6 January 2005, two correspondents of Associated Press reported on the situation in the Andaman Islands in the immediate aftermath of the Indian Ocean tsunami of 2004. It was feared that thousands of the Islands’ inhabitants had been wiped out by the floods, yet nothing was known for certain. The correspondents were relieved when they saw several members of the Jarwa tribe emerge from the forest armed with bows and arrows, and heard that all of their 250 fellow Jarwas had survived both the flood and its aftermath. The news report included several stereotypical notions of ‘primitive’ tribes, anecdotes about how the Jarwas survived by the most primitive means, how they were living in isolation for more than 70,000 years, and about how they kept a skeptical distance from strangers: ‘My world is the forest’, one of them is quoted saying, ‘your world is outside. We don’t like people from outside’. Their reticence towards the outside makes sense. As the correspondents warned, the emergence of the Jarwas from the forest did not mean that they were ‘safe’: contacts with people outside the forest are still threatening to annihilate this small
group, because outsiders bring infectious diseases for which the Jarwas have no bodily resistance.

The Jarwas and their relation to the outside world is the theme of Vishvajit Pandya’s contribution to this volume. With respect to their geographical location and ethno-historical trajectory, the Jarwas are undoubtedly the most ‘marginal’ group presented here. Through a combination of ethnography and historiography, Pandya retraces how the Jarwas of the Andaman Islands related to outside influences, especially to allopathic medicine, from the mid-19th century to 2004. The story he tells is full of surprises. He shows that although colonial medicine constituted tribal bodies as ‘marginal’, their marginality was also mediated by the presence of another group of marginal people on the Islands, namely the Indian prisoners held captive in the Andaman Penal Settlement. Pandya also shows how marginality is not simply engendered between a centre and a margin, but rather how the (medical and governmental) treatment of one marginal group can condition the treatment of another marginal group in a fundamental way. Foucault (1977, pp. 303–305) argued that power is exercised through a ‘carceral network’, that is, a range of institutions (prisons, hospitals, schools, etc) which are all structured along the same principles, and which aim at ‘normalizing’ subjects. Pandya’s analysis opens up an alternative perspective: the medical regime in the Penal Settlement normalized the prisoners, but not the tribals. Instead of trying to normalize the tribals, the authorities of the Penal Settlement moved them in and out of the margins according to changing demands. Since 1996, there have been an increasing number of non-hostile encounters between the Jarwas and medical staff at the local hospital. It is yet another surprise to hear Pandya argue that it was not the lure of effective medical treatment, but rather that of food, clothing, and consumer items that brought the Jarwas out of the forest. What the hospital staff gained from giving gifts was the incorporation of tribals into the ‘gaze’ of medical science, and their compliance with tests and treatments.

Instead of being a source of healing, the ‘centre’ remains, for the Jarwas, a potential (and actual) source of devastating epidemics. Further, the paper argues that medicine neither simply draws people from the margins, nor pushes them there, but can in fact be used for both purposes. Medicine, an epitome of the ‘centre’, can be subverted by marginal groups in unexpected ways. When, as has happened in recent years, the Jarwas become familiar with different forms of healing (biomedical, homeopathic, Ayurvedic) and are asked which one they prefer, they can even assume (for a moment) a central position.

‘A Great Disproportion’: Relative Marginality of Dalits in Uttarakhand (Polit)

Karin Polit contributes an ethnographic perspective on how different degrees of marginalization can produce different effects on health and well-being. Her example is the Dalits of Uttarakhand, one of India’s Himalayan states. Dalits, formerly known as ‘Untouchables’, have long suffered from being marginalized by higher castes throughout India. In Uttarakhand, Dalits are also disadvantaged, but not to the same degree everywhere. On the surface, it seems that the Uttarakhand Dalits are
marginalized twice over: they are geographically marginalized from India’s urban centres of power, and they are socially marginalized through caste inequalities. Moreover, Polit focuses on Dalit women, who are relatively disempowered in comparison to male Dalits. By focusing on the chal puja, a ritual performed for demon-afflicted Dalit women, Polit develops a much more fine-grained picture of marginality in Uttaranchal. Her key insight is that marginality is never absolute, but always relational. Neither the geographic, nor the caste-based, nor the gender-based marginality of the people she studies is sufficient to predict the degree of their marginalization in an absolute way. Instead, she argues that relative marginality in a particular local context is far more important. Based on a comparison of three different villages, she shows that where Dalits are locally in the minority vis-à-vis dominant higher castes, they suffer much more deprivation than Dalits who make up the majority of a village’s population.

The distinction between absolute and relative marginality is linked to another crucial distinction, namely between ‘real’/structural marginality and subjectively perceived marginality. Closely examined, these two distinctions tend to overlap: structural marginality tends to be measured with an ‘absolute’ scale (e.g., household income), whereas perceived marginality is always already relative and dependent upon a particular point of view. A similar mechanism was already described by the Scottish philosopher David Hume for feelings of envy:

It is not the great disproportion betwixt ourself and another, which produces [envy]; but on the contrary, our proximity... the greater the disproportion is, the greater must be the uneasiness from the comparison... But we may consider on the other hand, that the great disproportion cuts off the relation, and either keeps us from comparing ourselves with what is remote from us, or diminishes the effects of the comparison (Hume 2000, chapter 56).

In other words, the grass is not only greener on the other side, but extremely green when it is immediately next to one’s own, instead of far away. Polit illustrates how this mechanism becomes a distressing force in Dalits’ lives where they live in the minority, and a liberating force where they make up the majority of a local population. What she also shows is that, perhaps paradoxically, different strands of marginality do not necessarily ‘add up’ to produce maximum marginality, but that they can also reduce each other, or even cancel each other out. For example, Dalits who live in geographically marginal places might suffer more because access to quality health care is limited, yet at the same time, caste-based deprivation might make their suffering worse. Polit’s paper argues plausibly that the relative geographical marginality of some villages actually reduces the effects of caste-based inequalities. This makes her emphasis on relative marginality, instead of absolute marginality, particularly important.

Demarginalization Through Pharmaceuticals: Antidepressants in Kolkata (Ecks)

Stefan Ecks’ contribution begins with an analysis of how marketing strategies for antidepressants entail a promise of demarginalization. The notion that
Antidepressant drugs are ‘reintegrating lives’ is a leading theme not only in Euro-American marketing campaigns, but also in Indian ones. Both international aid organizations (e.g. World Health Organization, World Bank), as well as pharmaceutical companies, tend to regard those who are deprived of medical substances as in some sense ‘marginalized,’ so that providing drugs comes to be seen as an effective strategy of demarginalization.

In his article, Ecks analyzes recent bioethics discussions concerning antidepressants in the United States. One influential bioethics statement, the *Beyond Therapy* Report by the President’s Council on Bioethics, stresses that depression is a form of social marginalization that can only be ‘truly’ overcome by rebuilding social ties. Ecks argues that this Report relies on a one-sided critique of antidepressant use as a form of commodity fetishism, and that this position is inadequate. Drawing on ethnographic fieldwork in Kolkata (Calcutta), Ecks describes *mon kharap* (‘bad mind’), a Bengali idiom of distress akin to the psychiatric definition of depression. Reflecting on the notion that strengthening social ties is a universal remedy against depression, Ecks argues that some Bengali ideologies of the self put more emphasis on *unravelling* worldly ties as a way out of distress.

To conceptualize the dynamics of marginalization and demarginalization in relation to antidepressants, Ecks coins the term ‘pharmaceutical citizenship’. The current anthropological debate on ‘biological’ citizenship (e.g. Rose & Novas 2004) is centred on the notion that the sources of citizenship are located not only in the politico-legal sphere of nation states, but also in a number of overlapping transnational citizenship projects, many of them driven and defined by biomedicine. The promise of demarginalization through drugs, Ecks argues, is one of these projects. Pharmaceutical citizenship revolves around two questions. One is the question of how citizenship status affects an individual’s access to pharmaceuticals in times of sickness. The other is the question of how the use of pharmaceuticals has implications for an individual’s citizenship status. He shows that these drugs promise not only to alleviate symptoms of depression, but also to transform those who take them into proper (middle-class) citizens. Although this promise of pharmaceutical citizenship has not yet been taken up by the general population, it might only be a question of time until this happens.

The Politics of Intersectionality: Hijra Health in the Era of AIDS (Reddy)

Gayatri Reddy’s paper deals with sexual marginality in India. She starts off with the frightening assertion that India now has the second highest rate of HIV-infections in the world after South Africa, and that current public health interventions against the spread of the disease have turned out to be entirely insufficient. One group that is particularly hard hit by the HIV/AIDS epidemic is India’s *Hijras*, the ‘third sex’. *Hijras* are ‘men’ who dress as women, live in separate communities, and often have their genitalia surgically removed. Many *Hijras* work as prostitutes, and this is the reason why they are strongly affected by the disease, with more than 70% of *Hijras* testing HIV-positive in some areas of the country. Reddy suggests that current health policies are ineffective, partly because they lump the *Hijra* community together with
other marginalized groups in the MSM (men having sex with men) category. One of the most striking insights she brings to the relation between public health policies and the Hijras is that these policies not only change sexual practices, but also change the identity politics related to sexuality. While previously situated beyond the male/female dichotomy, health policies tend to push the Hijras into the ‘male homosexual’ category, thereby changing their marginality. One strategy of resistance adopted by the Hijras against such policy incursions is to essentialize ‘Hijra identity’ to a previously unknown degree. But Reddy argues that these politics of sexual difference, when played out in legal cases or in the political sphere, re-marginalize the Hijras rather than liberating them.

Following Paul Farmer’s (2003) suggestion that we should always think of health in relation to human rights, Reddy argues that Hijras can best overcome their marginalization not by claiming special rights as a separate group, but by linking up with other marginalized groups in India. Their struggle against injustice and discrimination will be more successful, Reddy claims, if it can be successfully linked to those of other interest groups. One example she cites is the Delhi-based ‘Voices’ collective, a coalition of queers, feminists, children’s rights groups, HIV/AIDS activist groups, and human rights organizations. This movement functions without fixed sex/gender identities. It links up different interests with the common goal of overcoming the injustices inflicted by Section 377 (an anti-sodomy law) of the Indian Penal Code, which are seen as injustices against human rights generally. Reddy calls these the ‘politics of intersectionality’ instead of the politics of sexual identities. It seems that struggling against a common reference point such as Section 377 is more effective in overcoming sexual marginalization than struggling for a fixed sex/gender identity.

Reddy shows that for health programmes to be effective, one needs to know the local dynamics of marginality, rather than simply applying crude categories such as MSM. She also brings home the fact that ‘the margins’ are constantly changing, both through external re-inscriptions and internal redefinitions. Her ethnography reveals not only how Hijras are marginalized by society at large, but also how certain categories of persons are relatively more marginalized within the Hijra community. Her main example here is the relative marginalization of Hijras who engage in sex work as against those who do not. In her discussion of the nirvan operation (the excision of male genitalia), she illustrates how becoming marginal to the world can also mean becoming a central member of a marginalized group. Reddy uncovers how HIV/AIDS policies can have detrimental effects on the people they are supposed to help, and at the same time, she shows how certain forms of resistance among marginal groups against such policies may backfire.

‘File Selves’: Sikh Migrants in the Margins of the German State (Nijhawan)

While we were preparing this volume, several events brought international media attention to the Sikh community. The year 2004 marked the 20th anniversary of the Indian Army’s attack on the holiest shrine of Sikh religion, the Golden Temple of Amritsar, in 1984. Ordered by Indira Gandhi, the assault led to the death of more
than 450 Sikh people. In revenge, Mrs. Gandhi was assassinated by two of her Sikh bodyguards five months later, which led in turn to a massive retaliation against Sikhs throughout North India. In March 2005, a long-drawn court case against two Sikhs suspected of planting a bomb in an Indian Airlines machine that killed 329 passengers in 1985 was concluded with a ‘not guilty’ verdict. May 2005 saw the bombing of two cinemas in Delhi that screened Jo Bole So Nihaal, a Bollywood film that was deemed offensive by Sikh spokesmen. No one claimed responsibility, but the press immediately suspected Sikh terrorists behind the attacks. Subsequently, the film was withdrawn from cinemas across India. More positive news arrived in 2004: Manmohan Singh became the first Sikh prime minister of India.

While widely discussed across South Asia, these events made virtually no headlines in Germany, which is itself a symptom of the marginal position of the Sikh community there. Yet Michael Nijhawan’s paper shows how recent Sikh political history is a core aspect of Sikh asylum cases in Germany. He explores how many Sikh migrants in Germany have to face the everyday stresses of ‘deportability’, and he presents an incisive commentary, both on the situation of Sikhs in Germany, and on current German immigration policies. He shows how medicine can support as well as subvert the rationales of the state. Drawing on ethnographic fieldwork in Frankfurt/Main and the surrounding Rhein-Main region, Nijhawan shows how laws relating to traumatized refugees and political asylum seekers often produce unforeseen effects. Conflicts over the psychiatric category of ‘Post-Traumatic Stress Disorder’ take on a special importance in this context. Nijhawan demonstrates how migrant communities of Sikh Punjabis are at the margin of German society while being simultaneously under constant surveillance and regulation by German authorities.

Nijhawan argues that the migrants’ marginality in everyday life does not mean that they are at the margins of public discourse. Indeed, immigration laws and asylum procedures are of great public concern and have played a major role in German party politics since at least the 1960s. Yet these debates tend to operate only with stereotypes of ‘the immigrant’ or ‘the asylum seeker’, and the profound lack of knowledge about who these migrants are does not even appear as a problem. Drawing on Das and Poole’s (2004) recent work, Nijhawan’s ethnography shows how the margins of the state are not just to be found at its outer boundaries, but instead run through the body politic, for example in the form of ID checks of ‘suspicious’-looking foreigners. Marginality is constituted by legal interventions that draw a strict line between ‘documented’ and ‘undocumented’ subjects. One of the migrants’ responses against such dividing practices is to try to ‘pass’ as much as possible. Even if marginalization cannot be overcome in principle, at least one can try to cover its outwardly visible signs. Nijhawan analyzes how marginalization is not simply done to others once and for all, but rather how it is a continuous performance by state agencies. He reveals how Sikh migrants negotiate their status as political asylum seekers and as traumatized victims of violence. By doing so, he shows not only that marginality runs through the body politic, but also through the body of the migrant. One of Nijhawan’s most intriguing findings relate to Sikh ‘file selves’. In order to prove to asylum tribunals that they are activists for the Sikh cause,
migrants collect and file newspaper reports and other documents about themselves. Here, marginality ironically leads to a need for publicity. Finally, Nijhawan’s claim that the Frankfurt Sikhs marginalize themselves by staying within a close-knit community network gives another reason to reflect critically on current immigration policies.

Conclusion

What do the papers in this volume teach us about the ills of marginality? First of all, they show that marginality is a social process, a transitive action. Marginality is not an attribute or an essence, but rather a social practice: something that people do to each other. People are not marginal ‘by nature’; rather, they are marginalized by others. People may however choose to live at the margins, in which case they are not necessarily victims of others. Moreover, processes of marginalization usually involve complex social agents, not individual ones. This is true of Sikh immigrants in Frankfurt as well as Dalits in Garhwal. It is true of Andaman Islands convicts as well as the Hijras of Hyderabad. And processes of marginalization often have negative health effects.

All the contributions show that marginality is relational: a ‘margin’ implies a ‘centre’, as well as a perspective that orders both of them in spatial and/or temporal terms—and this relationality has important effects with respect to health. Centrality and marginality are relative for the Dalits of Garhwal: they depend more on village demographic conditions than on any absolute ranking of castes. From the emerging perspective of people in Calcutta, the social ‘centre’ with which they identify may have as much to do with consumerism and access to ‘new drugs’ as with local history and geography.

The papers also show us that marginality is never just about social differences and separations, but also about reversals and possible fusions. To speak of marginality always means to speak about points of crossing, paths of entry, and potential inversions. Even if a group’s actual health situation remains unchanged, it can always be challenged by bringing a new perspective on marginality and centrality. To speak of margins always means to speak of a particular standpoint. Marginality is never just a given fact, but always a perceived relation.

We believe that marginality is a concept that works well in today’s socio-historical scenario, where health policies are veering back and forth between ‘citizens’ (who are all, at least in theory, equal to each other in relation to the state) and changing ‘populations’ that are produced by flexible policies of governmentality, development, and welfare (Chatterjee 2004, p. 136). These policies operate with ‘development-speak’ such as ‘social capital’ or ‘civil society’ that makes entrenched conceptions of social inequality look like leftovers from a bygone era. Our focus on the margins is one attempt to engage in a new way with this sort of understanding of health policy.

Other concepts for the analysis of social inequality (such as class, caste, or gender) suggest clear-cut hierarchies: upper-class people are unmistakeably ‘high’ and lower-class people are clearly ‘low’ in relation to each other. It is always possible to pluralize these concepts by pointing out, for example, that people might not define
themselves as ‘lower-class’, or by adding that ‘class’ is multidimensional. When we speak of marginality, however, the hierarchical ordering is diffuse, multiple and unpredictable from the start. This, we believe, makes in-depth fieldwork and a dialogical engagement with people on the margins—however constituted—an absolute necessity.

While being more flexible than other concepts, marginality nonetheless retains their critical power. Marginality refuses to let our analysis slip to a level where all that is left is a murky plurality of unconnected ‘identities’. Marginality preserves a clear sense of the importance of power relations between social groups. The ill effects on health do not come from an indifferent pluralism, but rather from the stresses and strains of social hierarchy.

Whether it is conceived in terms of spatial distance, social rank, citizenship, cultural/sexual ‘otherness’, or access to medicine(s), marginality has immediate consequences for health and illness, and the array of essays in this volume shows how complex and challenging these ‘ills of marginality’ can be. We hope that this volume will bring about further debates on marginality in—and beyond—South Asia.

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