Medicine Between Science and Religion

Explorations on Tibetan Grounds

Edited by
Vincanne Adams, Mona Schrempf and Sienna R. Craig
Introduction

This chapter examines the extension of biomedical obstetrics within the Ladakh region of the Indian Himalaya. More particularly, it looks at the factors that both promote and constrain the shift of birth from home to hospital in Ladakh. My preliminary findings suggest that while there has been a marked increase in the number of hospital births in Ladakh in the last two decades – greater than the Indian average – home births continue to be popular in many parts of rural Ladakh. Certain factors promoting hospital birth are unique to Ladakh, namely the presence of motivated and charismatic doctor who originate from the Ladakhi community, although they received their training at some of the finest institutions of Indian medicine. Yet many factors seen in Ladakh hold true for other parts of rural India, such as the desire to appear modern, the unfailing belief in the benefit of hospitals and their attendant technologies, and the greater value placed on each birth in a context of lowered fertility (Chawla 2006, Van Hollen 2003a, Van Hollen 2003b, Pinto 2008, Wiley 2002). Nevertheless, interviews with women across Ladakh confirm that home births continue to hold a strong appeal, not only because they privilege the agency and experience of the mother, but also because they obviate the substantial economic and psychological costs that hospital births present. Furthermore, discourse does not always reflect actual practice so that it is not unusual to find women who may aspire to but not achieve a hospital delivery.

In Ladakh, as elsewhere in the Himalayan and Tibetan realms, Buddhist women and their families negotiate and navigate among the competing
rationalities of biomedicine, Tibetan medicine and Buddhist ritual. Overall, my research suggests that biomedical discourse has displaced rather than replaced both Tibetan medical and Buddhist discourses on birth in Ladakh. In other words, women and their families continue to employ both biomedical and Buddhist narratives around childbirth as each offers valid explanations for disastrous or dangerous deliveries. While obstetric discourses offer explanations such as obstructed labour or postpartum haemorrhage to account for maternal and neonatal demise, Tibetan medical and Buddhist discourses explain such misfortunes as the result of ritual pollution, negative wind or demonic spirits that can be purified or ameliorated through herbal and/or ritual treatments. Both biomedical and Buddhist experts provide their female clients the promise of limited protection and nearly unlimited meaning-making in a climate of shockingly high infant and maternal mortality.

My ethnographic research in listening to women describe their choices around childbirth grows out of the trend towards applying participatory types of ethnographic research and analysing the broader structural constraints that crucially limit women’s efforts to pursue health-seeking behaviour (Inhorn 2006). It also builds on a broader effort in maternal health discourse to understand how both the supply of and demand for biomedical interventions or facility-based obstetric care interact. In other words, this essay seeks to explore the subjective factors such as women’s experiences and motives as well as the broader social and demographic factors that structure the choices available around childbirth in India. Several maternal health experts summed up two decades of maternal health policy and research by arguing for a shift away from global policy and towards local implementation as follows (Freedman et al. 2007: 1384):

We are not advocating a single universal approach to implementation, but neither are we suggesting that every situation is so unique that it has to start from scratch. In short, we know what to do, but how to do it varies by context. Understanding context entails an appreciation of the relation between supply and demand within the district level health system – i.e., the continuum from home or community, up through health posts and health centres, to the first referral level facility.

The noticeable shift from ‘what to do’, to ‘how to do it’, as well as from supply to demand, implies a recognition that any intervention must crucially consider both women’s choices in accepting or rejecting the given intervention as well as the surrounding cultural, social and political context.
within which strategic choices are negotiated in both public and private. This policy statement also recognizes the continuum from home and community to local health centres and other biomedical institutions, each populated by individuals with disparate degrees of authoritative knowledge and power around childbirth (Davis-Floyd and Sargent 1997, Jordan 1993). In short, while still displaying the hubris of the policy expert (‘we know what to do’), the statement admits that universals have failed and that it is time to recognize local contingencies and cultural context. As an earlier essay in the *Lancet’s* Maternal Survival Series argued: ‘Ensuring the availability of a package of effective intrapartum interventions in health facilities does not guarantee an effect on maternal mortality, which is contingent on uptake by the target population, the quality of implementation, and the avoidance of harm introduction’ (Campbell and Graham 2006: 1292). After pouring billions of dollars into the construction of clinics and the provision of intrapartum services across the developing world, policy-makers recognize that the demand and the desire for such services is as critical as their provision.

More significantly, maternal health experts realize that they must provide services of sufficient quality and minimal harm to generate increased demand. Yet this assumption belies an underlying positivist belief in progress that somewhat elides the complex socio-cultural or psychological factors that may drive or derail what is hardly an uncomplicated process of ‘uptake’. Moreover, as our study in Ladakh shows, the degree of ‘uptake’ by a given ‘target population’ is contingent on local social or cultural contingencies that remain largely outside the purview of many policy frameworks. Yet our study does bear out the finding that the quality of care, avoidance of harm, and factors of both demand and supply in the home and community have influenced the steady growth of institutional birth across Ladakh.

This essay builds on previous research on birthing practices among Tibetan Buddhists in the modern TAR (Tibetan Autonomous Region), historic Tibet and among exile Tibetans in India. While the research in the exile community and historic Tibet has concentrated on the rites and beliefs around conception, pregnancy and childbirth, research in the TAR has examined the policies around safe motherhood, interventions for postpartum haemorrhage, and the difficulty of translating evidence-based medicine and randomized controlled trials (RCT) into Tibetan medical culture. This essay explores the changing nature of birthing practices and patterns in the Indian Himalayan region of Ladakh over the last two
decades. It aims to provide a diachronic perspective across both time and space, in examining the shift of birth from home to hospital across the rural countryside and in the urban area around Leh city.

Slightly smaller than Norway but home to roughly 270,000 people, Ladakh accounts for half the area of the Indian state of Jammu and Kashmir but only a fraction of its population. After 1979, Ladakh was split into the Buddhist majority Leh district and the Muslim majority Kargil district, each of which is served by a single district hospital. With an area of roughly 7,000 square kilometres – slightly larger than Delaware – the Zangskar sub-district comprises more than one half the area of Kargil district while its

Image not supplied

Figure 8.1: The districts in the Indian state of Jammu and Kashmir. (Officially, both Kargil and Leh district comprise the Ladakh region, while Zangskar is a sub-district within Kargil district. This map is adapted from the Indian Census website and includes the 37,555 sq km claimed by China known as Aksai Chin.)
The Extension of Obstetrics in Ladakh

population accounts for only one tenth of the district’s population. Zangskar is ninety-five per cent Buddhist, Leh district is over eighty per cent Buddhist, and Kargil district is more than eighty per cent Muslim. By 1995, more than half of all births in Leh district took place at the hospital, while only a fifth of all births in India were in hospitals in this era (Jejeebhoy and Rao 1995, cited in Van Hollen 2003a: 56). The Ladakh region has some of the lowest population densities and fertility rates in the nation. With a Total Fertility Rate (TFR) of 1.3, Leh district ranked lowest on the fertility rates of all of India’s districts in the 2001 census, while the nearby Kargil district had a TFR of 3.4 (Guilmoto and Rajan 2002: 668). Because the total population of Buddhists and Muslims in Ladakh are nearly identical, political and religious leaders have made family planning and abortion highly controversial and politicized topics (Gutschow 2006).

The Shift to Hospital Births in Leh

The shift of birth from home to hospital in Leh district in the last three decades has been dramatic, particularly for such a rural and remote part of India. When the government completed the Sonam Norbu Memorial Hospital (SNMH) in 1980, it was the only hospital to serve Leh district.

![Figure 8.2: Deliveries and stillbirths at Leh District Hospital: 1979–2007](image)

Figure 8.2: Deliveries and stillbirths at Leh District Hospital: 1979–2007
The first year, there were only 114 births but by the the next year, the number had doubled and it grew steadily over the next decade. By 1995, nearly half of all births in the district were at the government hospital. The number of hospital deliveries rose every year until they reached 1241 in 2003/04, when Dr Lahdol, the chief obstetrician who had been at the hospital since its founding, retired. When Dr Lahdol opened an obstetric clinic at the nearby private Mahabodhi Hospital in Leh, she drew some of her devoted clients with her, as the dip in births at Leh District Hospital between 2003 and 2005 indicates. However, after Dr Lahdol retired in late 2006 and her niece, Dr Padma, became the new chief obstetrician at (SNMH), the number of hospital births rose again as expected. When Dr. Lahdol retired from the Mahabodhi hospital in late 2006, the hospital promptly closed its obstetric ward.

Dr Lahdol’s reputation spread into the neighbouring district of Kargil, as in 2006 one fifth of all women in Zangskar travelled to SNMH to deliver their babies. These Zangskari deliveries accounted for ten per cent of the deliveries at the hospital in early 2006 according to my estimates. While 74 per cent of all deliveries in Leh district were institutional by 2007, only 45.5 per cent of all deliveries in Kargil district were institutional that year. The inexorable rise of institutional births here and elsewhere across India is expected to continue as the Government of India launched the Janani Suraksha Yojana (JSY, or ‘Save the Mother’) initiative in 2005 to promote institutional births in an effort to reduce maternal mortality (Government of India 2005). The scheme, which was widely promoted on the radio and other media outlets in Leh district, offers women who deliver in hospitals or clinics a modest sum of 1400 Rupees. It was plagued by bureaucratic complexity and initial controversy over provisos that mothers without marriage certificates or BPL (below poverty line) verification, as well as those having home births, did not qualify for the benefit. Although these provisos were overturned by 2007, a nationwide survey concluded that less than half the eligible women across India had benefitted from this ambitious programme (Nanda 2008). By 2007, half the women who gave birth institutionally in Leh district had benefitted from the JSY scheme (Government of India 2007b). In Kargil district by contrast, the programme was just being introduced in 2006 and there was no data on how many deliveries benefitted from the JSY scheme in 2007. During a training session I observed in Zangskar, the medical bureaucrats who presented the programme seemed nearly as confused over its particulars as the midwives they addressed.

Many women go to the Leh hospital to deliver because of its access to critical technology or techniques unavailable in the home birth setting.
These include the capacity to perform emergency caesareans and ultrasounds that can help diagnose all manner of obstetric complications including ectopic pregnancies, placenta praevia, or intra-uterine growth restrictions and demise, and the ability to proscribe life-saving drugs like methergen and oxytocin that treat or limit postpartum haemorrhage – one of the leading causes of maternal mortality in Ladakh, India, Nepal and Tibet. However, the Leh hospital still lacks some of the drugs or equipment recommended by the WHO for obstetric emergencies including a laboratory to diagnose some infections as blood gases are sent to Bombay and the delays can affect treatment options. In addition, the obstetric team lacks an adequate set of emergency obstetric protocols to guide the labor and delivery nurses before obstetricians reach the hospital when they are on call or away from their posts.

The perceived safety to the mother of a hospital delivery in Leh district is largely borne out by maternal health statistics. If one considers only maternal mortality – for there are no reliable official statistics on maternal morbidity or infant and perinatal mortality/morbidity – SNMH has made great strides in a very short time. The maternal mortality ratio (MMR) at SNMH fell
precipitously from 746/100,000 in 1988 to 91/100,000 in 2006. The rate of maternal deaths at SNMH was far less than that estimated for the rural countryside in Ladakh and Zangskar, which I calculated to be roughly 416/100,000 in 2006. In 2005, the MMR at Leh Hospital was less than half of that found at a teaching hospital in Trivandarum (215/100,000) and a fraction of that recorded in at a teaching hospital in Allahabad (3778/100,000).

By contrast, infant mortality ratios (IMR) for home and hospital births are not that disparate, and both are far higher in Ladakh than the averages reported for Jammu and Kashmir and all India. Looking only at SNMH, Wiley (2004) reported an IMR of 184/1000 in 1990 and an IMR of 151/1000 in 1995, which were slightly higher than rates reported for the countryside, although the latter may be unreliable. While Zangskar-wide estimates for infant mortality are unavailable, Elford (1994) reported an IMR of 170/1000 in one Zangskari village between 1972 and 1981, and an unpublished survey of central Zangskar by a French NGO reported an IMR of 225/1000 in 1999. More significantly, the infant mortality ratios for Ladakh were more than double the nationwide average of 79/1000 in the early 1990s. The official statistics in 2007, claiming an IMR of 34/1000 for Leh district and an IMR of 57/1000 for Kargil district, strain credulity. It is entirely possible that infant mortality rates have declined but these reports suggest the under-reporting I observed over a recent research trip in 2006 where one well-known maternal death, three stillbirths, and one neonatal deaths all were unrecorded in the statistics reported at the subdistrict and Kargil district level, even as they were openly discussed by midwives and health officials.

One fact emerges clearly from these statistics. In Ladakh, as elsewhere in India, birth and the first month of life are the most critical periods for infant survival. Neonatal mortality accounts for sixty-nine per cent of infant mortality at Leh Hospital as it does across India (Wiley 2004, Chatterjee 2006). Obstetric practices are related to neonatal mortality, as most early neonatal mortality is related to labour and delivery factors. Thus far, however, there is little data on how hospital or midwifery protocols or practices relate to maternal or infant health outcomes in Ladakh.

**Shifting Birth From Home to Hospital in Zangskar**

When I first started interviewing women about birth and postpartum experiences in 1995, not one of several dozen women I interviewed had delivered a child in a hospital or clinic. Until recently, most Zangskari women gave birth at home attended by an elderly relative, or perhaps a
government-trained auxiliary nurse midwife (ANM). In Zangskar, as in most Tibetan societies, there were no traditional midwives or other traditional birth attendants such as the dai that are ubiquitous across much of North India (Adams et al. 2005a, Chawla 1994, Jeffery et al. 1989, Jeffery and Jeffery 1993, Pinto 2008, Pigg 1997, Rozario and Samuel 2002, Van Hollen 2003a, Van Hollen 2003b). The discourses surrounding birth pollution discussed below stigmatize both the mother and the work of the midwives, who hold a position near the bottom of the health care hierarchy. However, unlike the traditional dai in much of North India, the midwives in Ladakh do not come from the untouchable strata, although their work is spoken of as ‘polluting’ (dribchen) and unclean (matsangpa).

Most of the rural auxiliary nurse-midwives (ANM) have the skills to refer and diagnose but not always to triage some of the most common obstetric complications such as postpartum haemorrhage, eclampsia, obstructed labour, placenta praevia, or uterine rupture. Most critically, most of the Zangskari ANMs do not have the means to transport women to the hospital in a timely fashion for the most common obstetric complications. Indeed, I would estimate that less than half of the ANMs in Zangskar fit the WHO definition of a skilled attendant as ‘an accredited health professional – such as midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns’ (Freedman et al. 2007: 1385, my emphasis). Yet local ANMs capably manage routine deliveries and antenatal care, including fundal measurements and the administration of folic acid and tetanus shots. They are dispersed throughout Zangskar but do not always reside near the health post to which they are assigned, which further limits their access to births and complications that can develop without warning. Although most of the women I spoke to in the 1990s had never given birth with a skilled attendant, by 2007 roughly seventy-three per cent of all deliveries in Zangskar were undertaken in the company of a skilled birth attendant or ANM.

So what has changed in the Zangskari landscape since the early 1990s? In an effort to improve the region’s dismal maternal and infant mortality, the Indian government increased the number of local clinics and ANM posts substantially over the last decade. The number of local health outposts was more than doubled from ten to twenty-three between 1996 and 2006. The construction of health clinics across Zangskar included newly upgrading the Padum clinic to a Community Health Centre (CHC) and
Karsha’s Allopathic Dispensary to a Primary Health Clinic by 2007. Unfortunately, shoddy construction techniques, such as the use of concrete and tin roofs rather than passive solar designs or traditional rammed-earth construction, has hampered the efficacy of these health centres that remain frigid in the winter and hot in the summer. Moreover, none of the health centres have twenty-four-hour coverage nor adequately trained personnel to effect timely referral or obstetric triage. The expansion of medical centres has also had little impact on the availability of drugs, which are all too often diverted to the black market. My interviews in 1999 at select dispensaries in Zangskar revealed a critical lack of staff and medicines. Well before the winter, at least one primary health centre had exhausted their supplies of ampicillin for the common but deadly respiratory ailments, sepsis and meningitis, and metronidazole for the giardia that contributes to chronic malnutrition in children as well as neonatal and infant mortality.

However, Padum’s Community Health Centre has made noticeable progress in attracting out-patients and deliveries in recent years. The Padum Health Centre was open to deliveries and abortions briefly in the mid-1990s, when staffed by a Buddhist doctor from Mulbekh who spent winters at the clinic and gained the trust of his female patients. By 1999, however, staff at the Padum centre had ceased performing emergency deliveries, abortions or sterilizations. Some said that the new doctor, a descendant of the royal house in Padum, may have been concerned with birth pollution. More critically, Padum’s family planning services had come under heavy criticism by the local Zangskar Buddhist Association (ZBA) due to the rising conflicts between Muslims and Buddhists who were agitating for political and religious power (Gutschow 2006). Both the ZBA and the Ladakh Buddhist Association continue to strongly oppose any efforts to limit the population of Buddhists, already a fragile minority and electorate in a state dominated by Muslims and a nation dominated by Hindus (Van Beek 1997, Aggarwal 2005).

By 2005, however, the opportunity for institutional deliveries in Zangskar had changed dramatically. When Dr Ravia, a Muslim from Padum with an MBBS (Bachelor of Medicine and Bachelor of Surgery) degree, arrived at the Padum clinic in 2004, she was the first female doctor to work there. Although Dr Ravia has no training in obstetrics, she worked with two senior nurse-midwives in Zangskar, who had been recently promoted after a two-year training period in Srinagar. As their return coincided with the beginning of the JSY scheme, which is pushing rural health centres like the Padum clinic to perform institutional deliveries,
these nurses were able to obtain critical drugs such as oxytocin, misoprostol, and epidosin as well as a foot-operated suction pump for neonatal resuscitation.

By late 2006, the Padum clinic was staffed entirely by local Zangskaris, including three doctors with an MBBS degree, two nurses, and a handful

Figure 8.4: The labour and delivery room at the Padum clinic in 2006
of female and male multi-purpose workers. The Padum clinic is undergoing major construction and now houses a labour room, a vaccination clinic, a primary care clinic and a functioning twenty-bed ward for infectious, operative and obstetric patients. There are still no facilities for anaesthesiology, caesareans or other major operations, and emergency transport in the winter months remains a serious problem.

By 2007, roughly eighty per cent of all deliveries in Zangskar still took place at home. However, a small and growing minority of women are choosing to deliver at the Padum clinic or at district hospitals in Leh and Kargil. Between April and August of 2006, twenty-three babies were delivered at the Padum clinic, while the previous two years had seen roughly twenty-five births per annum. There are no reliable statistics on how many Zangskari women deliver in Leh or Kargil hospital, yet Leh Hospital records from early 2006 suggest that roughly twenty per cent of the pregnant women from Zangskar had left to deliver in Leh. SNMH, the Leh district hospital, lies twice as far from Padum as Kargil’s hospital, and jeep transport to either may be blocked by landslides in summer and by snow for most of the winter. All of the area hospitals require a journey over the Pensi-La pass, which is closed every year from November through May. Many Zangskari women prefer to deliver at the hospitals in Leh or Srinagar rather than the Kargil hospital whose staff is reputed to be less competent and more corrupt than the staff at SNMH.

If a pregnant woman develops complications in the middle of winter, she has limited choices. She can attempt to traverse a set of passes over 3500 metres or travel along the Zangskar river gorge during the few weeks that the river is partly frozen each winter. Alternatively, she can request an emergency medical evacuation by helicopter, a free but highly unreliable service. During the two decades I have worked in Zangskar, which included three winters, I knew several women who died in childbirth due to helicopter delays. The helicopter’s arrival is contingent on a confluence of many factors including weather and visibility, communication between Padum and the army base in Udhampur, availability of helicopters, and sufficiently skilled pilots. Finally, a Zangskari woman may choose to leave for Leh or Kargil well before her delivery date. Yet even families who can afford travel costs may balk at renting an apartment and covering food costs all winter in urban centres like Leh or Kargil. Let us turn then, to a story that illustrates the strategic choices women make around childbirth.
After getting married at the ‘late’ age of thirty-five, Nyima was pregnant soon after in the autumn of 2005. Although she had always wanted to spend time in Leh, Nyima was reluctant to spend the winter in Leh with her husband Jamyang, a tour guide. She begged off at the last minute, deciding she preferred the comfort of her friends and her home for her pregnancy. She was due to give birth in spring and hoped that the pass to Leh would be open by then if needed. She did not have the chance to tell her husband to return home all winter as the phone offices and internet café in Padum were shut. But she was relieved that she had not yet moved into her in-law’s house, where her elderly in-laws, Jamyang’s uncles and unmarried aunts, and her sister and brother-in-law and their children lived in cramped quarters.

Nyima enjoyed the simplicity of her natal home where she had only to cook for her father, her stepmother and two stepsisters who still lived at home and were at school. Eight of Nyima’s ten siblings had married and moved out, long after the stormy family quarrels that followed her mother’s death during the delivery of her tenth child and her father’s subsequent remarriage. Nyima was closest to her sister, Karma, who lived next door in
a new house she had built after scandalizing the family by eloping with an ex-monk. Her other sister, Lhamo, a midwife, had recently been promoted as a nurse at Padum’s Community Health Centre.

Lhamo made the trip from Padum in mid-winter to commiserate on Karma’s daughter’s death from meningitis a few weeks earlier after the Losar or New Year celebrations. During her stay, she said that Nyima’s belly was riding too high and was too pointy for a singleton pregnancy. Nyima refused to consider the idea of twins, which were believed to attract the evil eye (mikha) as they were a sign of excess auspiciousness or good fortune. She did not go to Padum for an ultrasound as the newly arrived machine had already broken and was still awaiting parts two years later, I discovered.

In late May, after spending a day racing back and forth along the lengthy irrigation channels that carried water to the fields, Nyima felt a deep ache in her lower back. She assumed the hard work was to blame and thought nothing more of it as she finished the delicious stew (phagtug) of garden greens, dried cheese, and homemade wheat noodles that Lhamo has cooked and went straight to sleep. Lhamo awoke in the middle of the night to her sister’s groans: ‘Ahroowahhh. Ahroowahhh.’

When Lhamo heard this cry, she guessed immediately that Nyima was in labour. This was no random lament but one scripted for female pain in the stoic Zangskari culture. After finding a match and lighting the kerosene lantern, Lhamo searched for and found the assorted syringes and ampoules of glucose and epidosin that she had sent Nyima a few weeks earlier in case she did not arrive in time for the delivery. Lhamo put the large pot on to boil as her sister Nyima stirred under the warm blankets. Lhamo went into the living room next to the kitchen to sweep the floor and the woollen Tibetan carpets before laying down a fresh blanket and rubberized mat on the spot where she piled extra blankets. Lhamo knew that Nyima should not deliver in the kitchen, which would risk polluting the hearth goddess (tablhamo) who, together with subterranean spirits known as the lu, ensured household prosperity. While Zangskari women are banned from delivering in the warmest room of the house, the kitchen, they are not banished to the stables as are the women from the neighbouring Shia Muslim villages of Kargil district and among the Tibetan nomads, for instance.23

As Nyima’s groans became more insistent, Lhamo washed her hands and began her first internal examination of the evening. She discovered two things in almost immediate succession. Nyima was already ‘two fingers’ (three centimetres) dilated, but even more importantly, the baby was not lying headfirst. She removed her hand and smiled calmly at her sister to
reassure her. Lhamo’s thoughts tossed as she pressed the blankets around Nyima’s lower back.

As she went into the kitchen to brew the butter tea, she briefly considered trying to transport Nyima to Leh Hospital. Most of Lhamo’s deliveries had been headfirst or vertex, and all of her breech deliveries had been carried out with another midwife. She knew that the Padum health centre had no facilities for emergency caesareans, but that breech deliveries offered far more risks than a normal delivery, including cord prolapse, head entrapment and obstructed labour that could lead to foetal asphyxia. Even if she sent someone on foot to Padum’s police headquarters to radio Leh for a helicopter, it could be days before the helicopter arrived. If she found a jeep and driver willing to risk the pass, it was unclear that they could pass through the snowbanks on top of the pass.

As she steadily pushed and pulled the wooden handle of her mother’s tea churn, Lhamo thought about her own mother, who had died during a breech delivery thirty-three years earlier. Nyima had been just a baby, two years old, sleeping through the chaos. But Lhamo, who had been six, had known something was wrong when Zangskar’s two most prominent amchi had come to the door that night. Lhamo recalled the palpable fear in the kitchen where her father prayed and watched the amchi prepare their medicinal butter and herbs, while her mother delivered a stillborn child and then bled to death in the room next to the kitchen. She was relieved that her father had built a new house, where Nyima would soon deliver her baby.

Lhamo then sent for her neighbour, the amchi’s son-in-law, Gara, a pharmacist who had been called to attend many births due to his poise during difficult deliveries. After Gara arrived and confirmed that Nyima’s child was presenting as breech, he went into the kitchen while Lhamo stayed at her sister’s side, applying hot stones wrapped in cloth and massaging her back with butter. When Nyima seemed to tire after a few hours, Lhamo gave her sister a shot of glucose for energy and a shot of epidosin to hasten her cervical dilation.

Nyima responded well and began to groan in the throes of transition. Lhamo confirmed that she was fully dilated to minimize the risk of head entrapment, before asking Nyima to push. She helped to support Nyima’s back while Gara waited to catch the baby. He was careful to keep his hands off the breech as the buttocks pushed into view. When the baby had slipped out up to its navel, he slipped in a finger in to pull out the first shoulder, rotating it expertly as required. With the risk of cord compression greatest, the head came quickly. Since Jamyang was not present Gara cut the
umbilical cord with a pair of scissors that Lhamo had sterilized on the stove. Lhamo wrapped her new nephew in a clean flannel cloth and laid him on his mother’s chest, while Nyima rested after her exertions.

Lhamo then checked for the placenta, but realized there was indeed another baby to push out. After Nyima recovered from this news, she gathered her strength to push the next baby out. Her daughter, who was headfirst, slipped out with one strong push, as her brother had widened the opening quite conveniently. Lhamo asked Gara to cut the cord while she dried off the second baby and placed her on Nyima’s other side, where the baby began to suckle vigorously. Nyima closed her eyes and began to cry as the two little infants sucked and wailed as they fell off her breasts. Lhamo then helped her sister deliver the placenta, which would be buried later in the winter kitchen (yogkhang), the symbolic womb of the house near the shrine to the lu, a fertility spirit. She brought her sister a celebratory cup of tea to welcome her children into the world. Nyima would spend the next two weeks in seclusion in the room where she delivered, while her sister and family members brought her food. She would only be allowed out of the house after a series of Buddhist rites of purification and blessing were

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**Figure 8.6:** Nyima and her sixteen month-old twins in September 2006. (Although she had only travelled fifty yards to her sister’s house, Nyima had smudged her twins’ foreheads with ash to ward off the evil eye (mikha) or demonic spirits (dud) that are tricked into thinking the children belong to the blacksmith caste.)
performed to cleanse herself and household members of the ritual pollution (drib) incurred by birth.\textsuperscript{26}

Three days after Nyima’s delivery, two monks were called to perform the first of three juniper purification rites (sangs) at the household altar to the clan deity (phalha). The monks came again at one and two weeks after the birth to complete the cycle of purifications that would cleanse the household and its inhabitants of the dangerous birth pollution that the delivery had produced. During this period, Nyima followed a set of interdictions (dzem ches) that included staying inside and avoiding windows or doorways where she might be in view of the monastery’s shrine room (gonkhang) or village shrine (lhato) whose guardian spirits might be offended by her polluted state. She was forbidden from cooking or touching the hearth for fear of angering the hearth goddess (tablhamo) and underground spirits (lu) who are responsible for fertility.

**Strategic Constraints for Ladakhi Women**

As Nyima’s story articulates, there are numerous constraints that limit the degree of choice a Ladakhi woman has about where and how to deliver her child. A woman’s childbearing decisions are influenced as much by the perceived safety or benefits of a hospital delivery as by season and geography, household wealth, and access to prenatal care, transport, referral or skilled intrapartum services. While many of my Zangskari informants readily admitted that a hospital birth might be safer than a home birth, not all agreed it was preferable or feasible. For some costs were prohibitive; for others it was fear of arrogant nurses in Leh, while yet others were embarrassed to give birth in front of strangers and far from the comfort of their family and homes. A few of my Zangskari informants also suggested that concerns about ritual pollution played a part.

Palmo, a long-time friend in Zangskar, described her own home births as follows: ‘I would prefer to have all my children at home, alone, even now when going to the hospital is an option. I am most comfortable pushing the baby out alone, with nobody present, not even my husband.’ When I asked Palmo why she preferred complete solitude, she shrugged and said that her labours were easier and quicker that way. For Palmo and several other Zangskari informants, birth was a private process best accomplished in solitude, rather than in a public hospital or clinic setting. The French obstetrician Michel Odent understands this mammalian predilection for privacy during labour as allowing the primitive brain and the autonomous
nervous system to take over from the more rational neocortex that can inhibit the physiological progress of uterine contractions. Women in Zangskar also described their reservations about the harsh treatment that was dealt out by nurses in Leh, who frequently scolded their patients for arriving in the throes of labour with complications that were misdiagnosed or insufficiently referred by their colleagues in the field.

In Zangskar, as in Ladakh, the main factors that contributed to a rise in clinic births were: rising household income, better education, better antenatal care and a Ladakh-wide shift away from *amchi* medicine towards biomedicine (Pordié 2003, 2008). As incomes and education levels have risen, women – and their daughters – have begun to place a premium on the safety of hospital or clinic births. Rising income permits women to travel outside of Zangskar, where they may discover improved birthing facilities and services. Furthermore, the rise in household incomes and the proliferation of private taxis and bus lines in Zangskar has facilitated the transport of pregnant women to Padum’s Community Health Centre as well as to district hospitals in the towns of Leh and Kargil.

Very little has been published on who attended births in Zangskar prior to the advent of government midwives in the 1960s. My elderly informants insisted that it was mostly experienced mothers or aunts, and in times of distress, an *amchi*, practioners of Tibetan medicine. *Amchi* are still consulted during pregnancy and the postpartum period, yet they are called only rarely during childbirth, if there is an emergency and if no midwife is to be found. My interviews in 2007 and in the 1990s with obstetric staff at Leh Hospital revealed that *amchi* are unwelcome but not barred from the obstetric ward. Yet the labour and delivery staff showed clear scorn for *amchi* diagnoses or treatments. Less than five per cent of my informants at Leh Hospital in 1995 had consulted an *amchi* during their pregnancy, while Wiley’s (2002) research in the same period reported that only six per cent of her informants consulted an *amchi* during pregnancy. Hancart-Petitet and Pordié (in press) describe a single case in which an *amchi* intervenes to avert a caesarean but do not discuss the hostility of hospital-based obstetric staff towards *amchi*.

None of my Zangskari informants in 2006 had consulted an *amchi* during their delivery, even when they suffered major complications. I interviewed both daughters of the most prominent *amchi* in Karsha (who had attended Lhamo’s mother’s death). Neither daughter had asked her father to attend their six home deliveries, which included a life-threatening haemorrhage, obstructed labour, and stillbirth for one daughter and severe dystocia and cord entanglement for the other. Elsewhere (Gutschow 2004,
1998), I described a case in which a young woman died from a precipitous postpartum haemorrhage, while being attended by her grandfather, an amchi. While the grandfather did little to help his granddaughter to expel the placenta that exacerbated her haemorrhage, he was careful to take his medicines out of the room shortly before his granddaughter expired. I have heard several amchi explain that death pollution (drib) can negate the auspiciousness of Tibetan medicines. This may help to explain why amchi did not routinely attend births in the Tibetan plateau.

The Buddhist Discourse on Birth Pollution or Drib

Birth pollution affects the choice over where to deliver, because Zangskari culture defines new mothers as ritually polluted. As long as a woman remains in seclusion until purification rites are performed, this pollution is tolerated by the clan deity where the woman resides. Generally this would mean a woman's marital house unless she has not yet had a formal wedding, like Nyima. When Nyima eloped with Jamyang, she did not have a formal or 'large wedding' (bagston chenmo) in which the bride formally takes leave from her natal guardian deity and then supplicates and passes under the protection of her new husband's clan deity. Once a woman shifts her allegiance away from her natal clan deity (phalha) to her husband's clan deity, she can no longer appear before or worship her natal clan deity. Although individuals can worship any number of village or regional deities, each person worships and comes under the protection of only one clan deity.28

Gutschow (1998, 2004) describes the seclusion period for new mothers that can vary considerably according to region, village and household. The new mother (and her husband, to a lesser degree) are required to remain indoors for between one and four weeks of seclusion until the requisite juniper purifications have been performed. Even after the husband is free to leave the house, he may be forbidden from crossing irrigation channels or visiting monasteries for a month, to avoid angering the monastic protectors and the lu who protect household fertility as well as snowfall, springs, streams and water supply.

Several Zangskari informants told stories of births that took place accidentally in their natal homes and resulted in a stillbirth, obstructed labour or other complications. Even well educated women succumb to the belief that they have ‘offended’ a deity by delivering outside of their husband’s house, the ‘proper’ place to deliver a child according to traditional Zangskari beliefs. A schoolteacher with an MA swore that going
to her natal home and/or crossing the village stream while in labour resulted in a terribly difficult delivery. Although she knew the interdictions against delivering in her natal home, she went into labour in an uncomfortable new apartment and knew that her mother’s house, across the riverbed, would be much warmer. When she delivered a healthy son after twelve hours of excruciating back pain, she blamed her natal deity, the four-armed Mahakala (Gönpo chag zhipa), who was considered especially strict regarding pollution practices. She recollected that her pain was alleviated by a local amchi who brought some long-life medicine produced by Dharamsala’s Astro and Medicine Institute (Men-Tsee-Khang). She never gave birth at home again and delivered her second and third children at SNMH. Another informant recalled losing her first child when she delivered at her natal home, although her second child was safely delivered in her husband’s home.

These beliefs have a direct impact on the choice to deliver in a hospital because they define mothers as highly contagious or polluted (dribkhen) immediately after their deliveries. When a new mother returns home from the hospital, she puts herself and her child in danger, as her unpurified presence angers household, village, regional, and monastic protectors whose shrines she passes on the way home. Since most of the shrines or chapels are located high up in a largely treeless landscape, the potential for offense is considerable. The only way to defuse this problem is to perform a purification rite at an altar dedicated to her clan deity.

Those who choose hospital deliveries may find ways to perform these purificatory rites, albeit by stretching the traditional notion of ‘seclusion’. Many of my Buddhist informants at Leh Hospital admitted they would perform purification rites immediately upon returning home from the hospital, so as not to offend their household clan deity. Many women chose to stay in rented quarters for the first week after their delivery where they would hold the purification rite before returning home. One new mother from Sabu village – who feared that her journey home would take her across Sabu’s streams and springs where the lu are especially powerful – decided not to return home for a week. Even her sister, a senior nurse-midwife in the hospital, agreed that it could be dangerous to offend the lu in Sabu. Yet most women are not fortunate enough to have a relative living near the hospital who shares their clan deity, and some relatives balk at a visit from a woman who had recently delivered out of fear of pollution. Overall, women in Ladakh have developed a range of responses to the ritual interdiction about giving birth outside their residential home. At one
end of the spectrum are the women who deliver at Leh Hospital without any regard for the deities they offend. This group includes Muslims, migrants from elsewhere in Jammu and Kashmir and India, and Nepali migrants. It also includes increasing numbers of modern Ladakhi women who may have been educated beyond Ladakh and who no longer follow traditional ritual conventions. At the other end of the spectrum are Zangskari and rural Ladakhi women who avoid hospital deliveries for fear of offending guardian deities when they return home. In the middle of the spectrum is the largest group—women who deliver in the hospital, but observe purification rites at nearby apartments shortly after discharge. Many women from remote parts of Ladakh and Zangskar who deliver in Leh Hospital perform the necessary purification rites in their rental apartments, where they have set up a temporary shrine to their household deity. Because these rentals are recent constructions in urban slums, with no surrounding fields or shrines to the lu, there is less concern about angering the deities that control water and fertility. One might posit a selection bias that also explains that couples who choose a hospital delivery are more educated or modern and thus less likely to be interested in purification rites.

Cultural flows between North India and Ladakh, as well as changing socio-economic conditions, may exacerbate rather than erode anxieties about birth pollution. To understand how the very spirits who preserve fertility (lu, tablhamo) are offended by birth pollution, it helps to look at broader South Asian representations of birth, female power and pollution. As Chawla (2006) cogently argues, childbirth as well as the work of midwives or dais are constructed as shameful (sharam) or polluting in patriarchal religious discourse, precisely because it is an arena of female power and experience that men cannot access. The infusion of Ladakhi culture with North Indian Brahmanic and Bollywood culture may strengthen the stigma around birth pollution, if recent years are any guide. Anxieties over birth pollution have become stronger rather than weaker in Leh according to some Zangskari couples, who have had difficulty finding rooms for rent in Leh. Although the number of guesthouses, most of which are unoccupied all winter, has increased precipitously, their owners rarely rent them to pregnant couples. It was implied that the landlords feared the birth pollution incurred if a woman delivered precipitously at home or once she returned from a hospital delivery. Most Zangskari couples have an easier time renting in urban slums on the outskirts of Leh that are downstream from Leh’s cultivated areas and elite neighbourhoods. The successive wave of droughts, locust plagues and other effects of climate
change in recent years may also contribute to heightened concerns and ritual activity around the *lu*, even as watershed development projects regularly transgress the *lu*.\(^{30}\)

**Conclusions: Obstetric and Buddhist Discourses as Explanatory Mechanisms**

Birth pollution beliefs and biomedical discourses are both legitimated by their ability to provide explanatory mechanisms preventing a disastrous delivery. In other words, both discourses imply that they can protect mothers and their children against the rather pervasive reality of death or disability. In Buddhist ritual discourses, the woman in childbirth is conceptualized as ‘dangerous’ to the guardian spirits because of her birth pollution and thus she is ‘in danger’ of offending the guardian spirits of household, village, clan.\(^{31}\) By contrast, obstetric discourses define a woman in childbirth as ‘in danger’ of complications while the delivery is defined as dangerous if she insists on an unassisted birth, home birth or otherwise flaunts obstetric protocols.

Buddhist discourse defines a woman as in danger if she does not deliver in her husband’s home, where she is under her (by marriage) clan deity’s protective influence. She is also in danger of offending the hearth goddess or the *lu* if she delivers in the kitchen, or if she transgresses the dictates of postpartum seclusion. By delivering in a hospital, a woman waives the protective influences of her household *phalha* and *lu*, while risking the offense of other protective deities. In such cases, a stillbirth, early neonatal death or other misfortune is cast as the retribution of offended deities. Yet what do people say when a mother or child dies at home, even under the purported protection of the clan deity? These cases do not negate Buddhist discourses because there are other unappeased spirits or sources of negativity – witches, evil eye or angry spirits – to be blamed.\(^{32}\) By refusing a verifiable rationality, Buddhist discourses are self-legitimating and circular, as long as initial belief in spirits and *karma* is maintained as I have shown (Gutschow 2004, in press).

The state-sponsored biomedical discourse argues that institutional deliveries are safer than home births for mother and newborns. In promising women ‘safe deliveries’ at the hospital, such discourse may elide the real risks that remain for women and newborns even in the hospital. Although Leh Hospital has noticeably reduced the maternal mortality ratio, compared to the Indian average and the surrounding countryside, perinatal
and neonatal mortality rates at hospital may be similar to those for home deliveries, although far more research is needed on this point. Hospital discourses may promise a degree of protection by having front-line access to emergency obstetric care; yet the degree of care available may be contingent on timely referral and transport. At Leh, as at other district hospitals in rural India, there may be cases in which a woman arrives with dire complications that could have been averted with adequate transport or attention as well as cases of women admitted for normal deliveries who later develop misrecognized intrapartum complications.

In promising the pregnant mother more safety in childbirth, obstetric discourse overlooks the significant difference between routine deliveries that may be handled safely at home and deliveries that require emergency obstetric care. Across the developing world as in Ladakh, it is unavoidable that some maternal and foetal deaths will continue to occur in the hospital. Some medical bureaucrats try to blame such deaths on the innate pathology of birth rather than on the delays in timely diagnosis, transport and treatment of life-threatening obstetric complications. It is a well-known truism that while most obstetric complications are neither predictable nor preventable, they are readily treatable if handled in a competent and timely fashion (Maine and Rosenfield 1999). This is as true for home births as for hospital births, although biomedical discourse continues to downplay this fact. For the time being, women and their midwives in Ladakh will strategically adapt both obstetric and Buddhist discourses to their other ever-shifting needs around childbirth.

Notes

1. I would like to thank Padma Dolma and Dr. Lahdol for their generous time and on ongoing Socratic dialogue on obstetric emergencies and treatments in Ladakh that dates back to 2006 and 1995, respectively. I thank Cecilia Van Hollen, Claudia Gras, Mona Schrempf, Sienna Craig and Vincanne Adams for highly productive conversations including an editors lunch at Dartmouth that helped shape the essay in important ways.

2. Adams (2001) describes the way in which Tibetan medicine upsets the enlightenment division between the rationalities of science and religion. Adams et al. (2005a) describe the differences between biomedical and popular or folk conceptions of what a ‘safe delivery’ might entail in the TAR. Gutschow (in press) and Pordié (2003, 2008) describe the overlap and intersection of Tibetan medical and Buddhist healing practices in Ladakh.

3. See Adams et al. (2005a, 2005b) and Miller et al. (2007) on safe deliveries, postpartum haemorrhage, and the challenge of clinic trials in Tibet, while Sangay
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4. In 2001, Leh district had 117,637 residents, while Kargil was home to 115,227 people.
5. I culled the data on deliveries and stillbirths from Leh Hospital records in 1995, 1996, 1997, 1999, 2006 and 2007. Hospital data is reported according to the fiscal year, which runs from April through March. Thus a year ending in ‘1980’ actually refers to 1 April 1979 to 31 March 1980. This may explain why Wiley (2002: 1092) reports only thirty births in 1980.
6. During the month of April 2006, 16 per cent (12 out of 73) of the deliveries at Leh Hospital were by women from Kargil district and 9.5 per cent were by women from Zangskar. The high percentage of Zangskari women is all the more remarkable as the mountain passes to Zangskar are not yet open in April.
7. The rates of institutional deliveries and home births are quoted from the Leh District Health Plan (Government of India 2007b: 49) and Kargil District Health Plan (Government of India 2007a: 48). Elsewhere in each report, the institutional delivery rate is mistakenly calculated from pregnancies rather than live births; I have ignored those rates.
8. Miller et al. (2007: 217) reports that 13.4 per cent of 1100 vaginal deliveries at Lhasa hospital resulted in postpartum haemorrhage. Rising Nepal (19 December 2006) reports that half of all maternal deaths in Nepal are due to haemorrhage while Rawal (2003: 45) attributes nearly one third of all maternal deaths in India to the same cause.
10. Maternal mortality ratios were estimated using Leh Hospital records in 1995, 1996 and 2007, and Lahdol’s unpublished paper on birthing trends at Leh Hospital.
11. My calculations from the Zangskari medical census in 2006 yielded an estimated maternal mortality ratio (MMR) of 416/100,000. WHO (2007a) estimated India’s maternal mortality as 450/100,000 in 2005, while Adams et al. (2005a) estimated the MMR in the TAR to range between 400–500/100,000.
12. The Leh Nutrition Project (LNP) estimated the infant mortality ratio (IMR) in rural Ladakh to range between 102–110/1000 in 1988. Bhasin (2005) found an IMR of 98/1000 for Ladakhi Buddhists and an IMR of 152/1000 for Ladakhi Muslims in the last decade, but does not cite her source. Wiley’s (2004: 98) data helps corroborate Bhasin’s data on the difference between Buddhist and Muslim outcomes as Buddhist newborns were on average 193 grams heavier than Muslim newborns.
13. The Leh Nutrition Project (LNP) estimated the infant mortality ratio (IMR) in rural Ladakh to range between 102–110/1000 in 1988. Bhasin (2005) found an IMR of 98/1000 for Ladakhi Buddhists and an IMR of 152/1000 for Ladakhi Muslims in the last decade, but does not cite her source. Wiley’s (2004: 98) data helps corroborate Bhasin’s data on the difference between Buddhist and Muslim outcomes as Buddhist newborns were on average 193 grams heavier than Muslim newborns.
recorded the IMR in Sankoo Block of Kargil district to be 125/1000 in 1996. Hancart-Petitet’s (2005:123) report of a maternal mortality ratio (MMR) of 21,000/100,000 may reflect her tiny sample pool and it is unclear whether she estimated her term “le taux de mortalite maternelle”) estimates the maternal deaths per live births or per reproductive aged women, which would technically be the maternal mortality rate. She notes that her data was drawn from a single village of four households, using three generations of data—including deceased individuals, and so it may have been difficult to verify all deaths as due to maternal causes.

15. The National Family Health Survey (NFHS), which was completed in 1993, 1999 and 2006, are considered the gold standard of demographic surveys in India. See http://www.nfhsindia.org/ and http://www.measuredhs.com/. By 2006, the IMR in Jammu and Kashmir had dropped to 45/1000 while the all-India rate dipped to 57/1000 according to NFHS-3.

16. The WHO (2007b: 5) reports that ‘early neonatal deaths occur during the perinatal period, and have obstetric origins, similar to those leading to stillbirths’. The WHO also reports that three million out of the four million neonatal deaths in the world each year are early neonatal deaths.

17. The District Health Plan, Kargil (Government of India 2007a) and District Health Plan, Leh (Government of India 2007b) report infant mortality ratios, but do not give any indication of how the statistics were gathered. In light of the considerable under-reporting of infant and neonatal deaths, as well as maternal deaths, this data should be treated with caution.

18. Compare Van Hollen’s (2003a) description of government health workers and traditional midwives or maruttuvaccis in Tamil Nadu, as well as Jeffrey and Jeffrey’s (2003) description of dais in North India.

19. I collected statistics on institutional and home births in Zangskar as well as a basic medical census from clinic records in Padum in September and October 2006.

20. Gutschow (2006) discusses an incident of ritual pollution that the Padum royal household faced during Partition and its subsequent effects on the family’s social status.

21. The official statistics on home versus institutional births, as well as for infant and maternal mortality for Zangskar, are highly unreliable. Padum records had registered twenty-three institutional births between April and August 2006, yet the data sent to Kargil noted only eighteen institutional deliveries. During the same period, midwives told me of a single maternal death and several stillbirths, but the Kargil data omitted these deaths in Zangskar.

22. The rigours of Chadar travel and the remote geography of Zangskar are detailed in Crook and Osmaston (1994) and Gutschow (2004) who also describes a maternal death in midwinter due to postpartum haemorrhage. According to my interviews at Padum clinic, there was only one helicopter transport of an obstetric patient between 1993 and 1995, although there were several maternal deaths during that period.

23. In nomadic communities in Tibet, Adams et al. (2005a) report that women deliver their children in the stables or outside the main tent.
24. Gara, whose real name is Stanba Gyaltsen, is nicknamed ‘blacksmith’ (gar ba). This nickname is often given after several children or infants die and the parents wish to fool negative spirits into thinking their child is a blacksmith or outcast (rigs ngan).

25. Epidosin is the trade name for valethamate bromide, which the Journal of the American Medical Association (anonymous 1959: 1316) described as an antispasmodic drug used in the U.S. for treating spasms of the gastrointestinal, genitor-urinary and biliary tracts. Kuruvila et al. (1992) RCT reported no significant benefits in hastening cervical dilation for epidosin over a placebo, while later studies such as Kaur et al. (1995) and Batukan et al. (2006), comparing intramuscular (IM) and intravenous (IV) administration of the drug, found significant improvements in the IM method in hastening cervical dilation.


27. Odent (2004) theorizes that the mammalian uterus is a highly efficient muscle that needs little input from the brain's neocortex or the sympathetic nervous system.

28. Gutschow (1995, 1998) contrasts the loose relationship between clan affiliation and household deities as described by Dollfus (1989) for Leh district and the close connection between clan affiliation and household/clan deity in Zangskar. The kinship categories that hold in Zangskar are no longer in use in Ladakh, perhaps due to Ladakh's greater social mobility and immigration during the twentieth century.

29. Craig (2006) discusses the rhetoric and consumer demand for the long-life pills in Tibet, which are produced by several medicinal institutes in Lhasa.


31. Douglas (1966) and Ortner (1973, 1996) have both noted the connection between ritual pollution and moments of danger for ambiguous figures like women in childbirth.

32. Gutschow (in press) explains how amchi diagnose and treat the disorders caused by these spirits.

33. Ronsmans and Graham (2006: 1196) describe the considerable evidence that many maternal deaths take place in hospital settings, where confidential inquiries ‘suggest the proportion for which substandard care played a substantial role is often more than a third’. In other words, the quality of care in health facilities may be directly contributing to the very maternal deaths such facilities were designed to prevent.

34. Johnson and Daviss (2005) offer a prospective cohort study and analyse several other studies, all of which show no differences in neonatal mortality or morbidity between low-risk home and hospital births, while Sakala and Corry (2008: 4) describe the ‘over-used maternity practices’ in the U.S. that show little proven benefit.
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