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The Amchi at the Margins

Notes on Childbirth practices in Ladakh

Laurent Pordié and Pascale Hancart Petitet

The social study of birth opens up a range of questions on maternity along an axis that runs from private life to the state. The event of birth appears as an experience of the body and the construction of the person and helps to understand maternity in its social, familial, medical and technological environment. Obstetrical practices are therefore embedded in a broad contextual sphere, for which the anthropology of reproduction offers some useful approaches. Reproduction touches on the relationship between nature and culture, production and reproduction, the individual body and body politics, and the examination of how power works, and is thus a vibrant category for anthropological understanding of the world (Ginsburg and Rapp 1995). Traditional birth practices have been studied extensively and are the subject of a vast literature which could be, perhaps schematically, organized into two clusters (McClain 1989). The first explores social organizations, theories of procreation, precautions and prohibitions around pregnancy, as well as representations of childbirth, the pregnant body and the supernatural world. This socio-cultural take on birth contrasts with the second cluster issuing from a "biomedical approach" (*ibid.*) that considers traditional childbirth practices as an ultimate form of recourse in a context of unsuitable biomedical healthcare and inaccessible obstetrical services. In this vacuum, traditional birth attendants are often integrated in the framework of development programmes and agencies for a variety of trainings inspired by biomedical practices and conceptions surrounding childbirth (Pigg 1997). While families and traditional birth specialists may still have important social and symbolic functions, they have

thus been displaced and downgraded by the biomedicalization of birth coupled with the rise of technology (Casper 1998, Cominsky 2016, Morgan 2009). Birth has become largely, if not exclusively, a biomedical affair where the biological body finds itself embedded within increased regimes of surveillance (Foucault, 1994). This has direct implications for alternative childbirth practices and non-biomedical conceptions of the body, as shown in Tibet by poststructuralist approaches to the production of knowledge claims and their effects in the world (Adams, 2000).

This chapter takes all that into account by considering the role of the practitioner of Tibetan medicine (*amchi*) in childbirth in two distinct settings of Ladakh, in north-western India. We will examine how birth occurred and how it was managed in the very isolated area of Shun Shade at the turn of the millennium and contrast this with material from the urban milieu in Leh, the capital city of the region. This comparison will allow us to explore the amchi's position on the margins in both territorial/political and medical terms. Shun Shade is a salient case of territorial periphery where the practice of Tibetan medicine has been central while biomedical coverage remains poor or non-existent. The case of Leh stands in stark opposition. This town is the political centre of the region, marked by rapid urban and biomedical developments. But it is also a place where, in the early 2000s, the practice of the amchi was increasingly being marginalized. Both cases show the amchi as a peripheral agent on the margins, either territorial (where he was the only medical recourse) or medical (when he was at the heart of the urban/biomedical world), and their comparison can provide important insights into social and therapeutic transformation, medical power, control over bodies, and authority in childbirth.

We will pay particular attention to a set of "emergency" practices among the amchi, including a treatment based on blessed butter (*sngas mar*) fashioned in the form of a fish and prescribed in the case of complicated childbirths. These undocumented practices were present in both of our research contexts, and their analysis will help to unpack the positionality, transformation and aspiration of Tibetan medical practice in a plural medical society. With the advent of Indian biomedical infrastructures and hegemony, the role of the amchi in childbirth was increasingly limited to exceptional events, especially in the urban milieu. While the biomedical provision of care for pregnancy and childbirth in the maternity hospital in Leh was a valued recourse (Wiley 2002), we shall see how the unexpected occurrence of a complication during labour at the hospital redirected the therapeutic trajectory of the patient towards the amchi. Our rural-urban comparison will thus illustrate and add complexity to the concept of

"authoritative knowledge" in obstetrics (Jordan 1993). Indeed, the authority of knowledge in our study field is not necessarily the authority of medical power. Finally, by introducing the question of "amchi obstetrics" into that of contemporary issues of Tibetan medicine in Ladakh, this chapter will also be situated in a more political approach to reproduction.[1]

Giving birth in Shun Shade

The region of Ladakh comprises two administrative districts: Leh and Kargil. The Shun Shade area, located to the east of Zangskar and under the administrative control of the Kargil district, is one of the most remote places of the region. The two closest biomedical health facilities to Shun Shade are located in Ladakh's capital Leh, reachable in three days (two days trekking to the nearest road and a one-day bus ride), and in Zangskar's main town Padum, reachable in four or five days of trekking over inhospitable high-altitude terrain. This makes Shun Shade a particularly important example of what may be called "territorial periphery". The zone under study included four Buddhist villages, Sattak, Yarshun, Mashun and Shade, home to a total of 250 persons in 2001.

A widespread perception that we encountered in Shun Shade was that a child about to be born was the reincarnation of a deceased person. During their pregnancy, several of the women in Sattak speculated whose reincarnation their unborn child would be.[2] It was not uncommon for the parents to be attentive to the words and behaviour of their child so as to understand some elements of its past life. Yangchen Lhamo remarked, "when my son was a baby he was saying that he had four cars and that he must go and get them.… He was certainly very rich before." Dawa Drolma later added that she was convinced her daughter was the reincarnation of the deceased grandmother from the house next door: "when she was two, she used to go to the neighboring house screaming "I am the grandmother". She used to take the grandmother's personal objects and bring them back home." People in Shun Shade thus had clear ideas on what happens before childbirth.

[1] Research was conducted in the framework of Nomad RSI, an organization that contracted anthropologists to gather relevant information with the aim to translate it into sensitive development programmes (see the chapter by Besch and Guérin, this volume). This chapter presents parts of the results obtained between 1998 and 2003, especially 2001. Both authors have done ethnographical work alone or in tandem, both in Leh and in rural Zangskar. The work in Shun Shade presented in this chapter has been conducted by Pascale, while Laurent mostly covered other isolated areas and the capital of Leh. The authors had regular and intensive exchange during fieldwork and after.

[2] This situation shows a significant difference with Hindu India, where the concepts of karma and reincarnation are known to a fraction of the society only (priests, some members of the upper castes, scholars) and generally ignored by the common laymen, especially those belonging to the lower castes (see Deliège 2001).

The amchi we spoke to understood the phenomena preceding birth in a very similar – although generally much less elaborate – manner as that found in the classical texts. “When a person dies, there are forty-nine days before she is reincarnated. The consciousness can then choose any womb to take life. If the person made wrong choices in a past life, she will take a dark womb. If the person performed good actions, she will take a nice and pleasant place”, said amchi Thundup.[3] The fact that the consciousness enters the womb because it is directed by the effects of earlier acts and their “stains” underscores the role of *karma* in reincarnation. *Karma* conditions the reincarnation as a human being, as well as dictating who the parents will be, for conception also depends on the compatibility between the *karma* of the reincarnating being and that of its future parents. The amchi referred to the explanatory treatise of their most influential (and often sole) classical book, the Gyüshi, which is devoted to embryology (*chags tshul*), and gave lesser or greater detail on the original causes of conception, foetal development and the signs of childbirth.[4] Their knowledge of embryology largely depended on their knowledge of this canonical text. They identified the three zoomorphic phases, which correspond to the development of the embryo in three phases, linked to the three terms of pregnancy. These phases are known to the amchi as “fish”, “tortoise” and “pig”, which provides an image of the body of the foetus at different moments of its evolution. The amchi also explained the various aspects of physiological development, and how the body and organs are formed. They used two diagnostic methods to determine the sex of the foetus: the pulse was taken at the beginning of pregnancy and the position of the foetus in the womb was examined. If the foetus was positioned on the right, the Zangskari amchi would affirm that it was a boy, and if it was on the left, a girl.[5]

In the villages of Sattak and Yarshun, pregnant women received no special care during their pregnancy. Their way of life, behaviour and diet remained more or less the same. The

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[3] These ideas are found in the *Bardo Thödol* (*bar do thos grol*), a mortuary text read over a dead or dying person to help him/her escape from rebirth or have a good rebirth in the next life. The book describes the states which separate the moment of death from that of birth. *Bardo* designates the intermediary state in which the individual finds him/herself after death and before rebirth. At the time of death, the five fundamental elements constituting the physical body dissolve and the consciousness is set free in space. The spirit of the deceased is then directed according to his/her *karma* to agreeable or disagreeable experiences. He must follow the teachings of the lama (*bla ma*), the spiritual master, so as to attain liberation from the cycle of rebirth (*saṃsāra*). The chapter entitled ‘The closing of the door of the womb’ explains how the deceased must proceed in order not to be attracted by the womb, and in the case of failure, how to choose a good womb (see Govinda 1980).

[4] The primary causes of conception, for example, are said to be the union in the mother’s womb of a psychic individuality in search of a new incarnation with the non-vitiated sperm and menstrual blood of the parents. The secondary causes are the gathering of the five fundamental elements. This is also found in medical theory. See the works by Meyer (1981, 1987) and Parfionovitch *et al.* (1992). For a specific study on embryology in Tibetan medicine, see Garrett (2008).

[5] This diagnostic aspect is mentioned in the Exegetical Tantra, chp. 1 and 2, p. 181, lines 70 and 71 (Parfionovich et al. 1992).

women had a poor diet in general and continued to work in the fields as long as their physical state permitted (see also, Craig 2009). Their hard and impoverished lives left women with little time to be weak, including during labour and delivery. The amchi affirmed they had no particular role *vis-à-vis* these women, apart from recommending appropriate behaviour and diet.

All the amchi we worked with in Zangkar were male, a gender that represented 93 per cent of the total amchi population of Ladakh at the time of research. The entire region then comprised between 110 and 140 practicing amchi (including Tibetan amchi residing in Ladakh) which amounted for 7 to 10 female amchi overall (Pordié 2003, 16). In Shun Shade, the parturient women had no problem to be consulted and treated by male healers but they rarely managed to follow their instructions. It was not easy for them to improve their diet and reduce their workload during pregnancy insofar as this advice ran counter to the other demands of life.[6] Aside from problems of the availability and economic accessibility of certain products (meat, eggs, fruit and vegetables), it was not common for a young wife who had newly moved in with her in-laws to demand particular treatment. Such a request would be seen by other members of the household as putting one's pregnant state to the fore and would thus be inopportune and shameful (Wiley 2002). In addition, the women avoided discussing their pregnancy publicly so as not to attract the wrath of the spirits or to cause jealousy among their fellow villagers, because such occurrences were thought to be potentially harmful to the baby.[7]

The women in the Shun Shade area give birth at home in the presence of family and neighbours. According to the amchi, the foetus, who is responsible for the onset of labour, also decides when to enter the world.[8] Childbirth takes place in one of the rooms of the house, where the woman would stay throughout her entire period of labour. The key recommendation during the hours between the first labour pains and birth is to keep the body warm. Thus, the woman in parturition should be wrapped in blankets, the warmth of which is said to "improve the vitality" and "relax the muscles" (Amchi Sonam Thundup). Women take turns to care for the future mother, which mainly involves preparing hot soup and massaging her skin with butter.[9] Local techniques to alleviate labour pains include the application of a heated powder made of sheep excrement as a poultice to the kidneys, and massaging the kidneys with salt. Delivery

[6] In the Tibetan Autonomous Region some villagers, men and women, may recommend that women be active during pregnancy. The women often "work right up until the onset of labor" (Adams et al. 2005, 832-833).
[7] See also Adams et al. (2005, 829-830) in the case of the Tibetan Autonomous Region.
[8] The explanatory treatise of the Gyüshi gives reasons for this, however, without the amchi having mentioned them: "In the course of the thirty-seventh week the consciousness of the foetus, afflicted by the state of dirtiness, foul odours, obscurity and imprisonment, conceives of the idea of escaping." (Meyer 1981, 112)
[9] Massaging with warm butter several parts of the body (e.g. temples, palms, feet) of women in labour was also practised in most rural societies of Tibetan cultural origins across the Himalayan region.

usually happens in a vertical position on the knees,[10] wrapped up in the warmth of the covers. Women told us that they would not look at, or check, the vulva when assisting in a birth; similarly, they would not provide manual assistance to control the rotation of the head of the foetus or the elasticity of the perineum.

Newborn babies are wrapped in clean linen, and the placenta placed in a piece of cloth or linen. If present, the father of the child or, in the case of a polyandrous marriage, the eldest brother, would cut the umbilical cord. This practice does not follow the instructions of the Gyüshi, which states that the cutting of the cord should be carried out by a woman who has already experienced childbirth. Nor does our research support Pinto's assertion (1999) regarding the absence of male involvement in childbirth in Tibetan culture, for motives of impurity or "dirtiness" associated with birth.[11] The practice of cutting the cord by a man – or the involvement of a male amchi in case of complications – was common in Shun Shade, although the placenta – along with blood, urine, faeces and amniotic liquid – was indeed considered a product of the excretion of childbirth and thus impure. It was associated with *drib* (*grib*), a concept of pollution.[12] So as not to offend the tutelary deities, the *lha*, and specific categories of "masters of the ground",[13] whose wrath could lead to the appearance of illnesses among new-born children,[14] the placenta should be seen by neither men nor dogs, nor should it

[10] Amchi Yeshi Dhonden states that the advantage of the kneeling position is that 'the baby's weight works for the childbirth, whereas "on back" the weight works against it' (1980, 36). According to Gelis, the squatting position, as in having a bowel movement, is certainly the most instinctive posture (1984).

[11] The author explores the concept of impurity, dirtiness and messiness with regard to childbirth in Tibetan culture. She states: 'Keeping birth within the realm of women only is felt to be entirely logical behaviour, as birth is believed to be something that concerns women alone, something "naturally" female. To include men in this process is felt to be entirely illogical and unnecessary' (Pinto 1999, 164). Kim Gutschow, on the other hand, has also noticed the involvement of men in the cutting of the cord in Zansgkar (2004, 209), as did Rozario and Samuel (2002) elsewhere in the Indian Himalayas.

[12] See Gutschow (2004, esp. 199-215) for an account of impurity and *drib* (*grib*) in childbirth in Zangskar and more generally in Tibetan culture. Also read Rozario and Samuel (2002) for a comparative study among Tibetans and Indians in Dalhousie, India.

[13] Isabelle Riaboff (1997) notes that the Zangskar-pa have relationships with three main categories of originally non-Buddhist deities: the *lha* (gods), the *klu* (spirits of the underworld and aquatic milieu) and the *'dre* (demons). The Wheel of Existence is conceived of as a vertical cosmic space in which living beings are ordered. One finds, from bottom to top: the beings of the underworld, the starving spirits, animals, men, the titans and then the *lha*. The latter are, according to the same arrangement, the *lha* of the domain of form and, above them, the *lha* of the domain of the absence of form. The *klu* are associated with the subterranean world ('lower world', *og' la*), the *lha* with the zenith ('upper world', *steng la*) and men are between the two ('median world', *bar la*). The *'dre* are without a specific topographic location (ibid.). In her research elsewhere in Ladakh however, Pascale Dollfus (1996) observed that a specific class of demon, the *bstan*, are associated with the 'median world'. In addition, despite the liturgical context in which the "Master of the Ground", *sa bdag*, are distinguished from the *klu* (aquatic and subterranean deities), the villagers seem to also classify the *klu* as specific categories of 'Master of the Ground' (Dollfus 1996).

[14] In her study in the Ladakhi village of Photoksar, Fernanda Pirie (2006, 183) suggests that *drib* (*grib*) is a cosmological concept with pragmatic significance for the villagers, a concept which is not morally imbued. Babies and mothers are particularly vulnerable to spirit attack and must 'avoid proximity to, and even sight of, shrines of powerful protector deities lest they be struck by illness'. Such pragmatic behaviours are also found in Tibet by

be exposed to the outdoors. Instead, it is buried at a prescribed place by the amchi, who, in the case of Yarshun, was also an *onpo* (*dpon po*), a ritualistic astrologer. As Samuel (2006, 124) remarks, the interventions around childbirth and the personal and cultural environment of birth affect the way the parturient deals with the process of childbirth. The rituals undertaken for the placenta cast light on the social management of childbirth (Jeffery and Jeffery 1993), on forms of social belonging and societal bond (Santoro 2011), and on the logics underlying the representation of the body, the person and the role of cultural "symbols" (Samuel 2006).[15]

In the births we could observe, the women in parturition were separated from the rest of the community, their bodies wrapped in blankets and concealed. For a period after giving birth, they remained in a phase of marginality – secluded in their house and expected to follow defined prescriptions (see also Gutschow 2004, 209-210) – which, according to the classic schema of *rites de passage*, is associated with pollution by the products excreted at childbirth. Even after gradually being reintroduced to the rest of the group, they remained in a state of impurity for some time, although the duration of this would vary from case to case. They had to avoid transgressing taboos such as collecting water or stepping over an irrigation rivulet, for this could bring misfortune to the baby, household, or even to the entire hamlet or village. The husband was also considered to be polluted and had to follow certain rules, although generally for a shorter period than his wife. Indeed, the state of impurity also applied to the house itself, which, as shown by Gutschow (2004, 210), could be rid of pollution through variable and complex purification and propitiation rites (*bsangs*) performed by monks. Hence, beside the treatment of the placenta and the prescriptions followed by both parents, a series of important rituals also addressed the purification of the house and the propitiation of local and monastic deities.

Abnormality and the role of the amchi

In Shun Shade, the amchi remained the only medical recourse in cases of complicated deliveries. The complications we noted were obstruction, placental retention and haemorrhage at the expulsion of the afterbirth which, in the absence of effective medical care, inevitably led to the death of the woman in childbirth.[16] The most frequent sign of abnormality in childbirth

Adams et al. (2005, 828-829). In this case, however, the occurrence of pollution is also presented as the conflation of moral and spiritual significations.

[15] The precautions vary in degree and can reach the point of lending the placenta an anthropomorphic character, as among the Malaysians where it is described as the youngest brother of the new-born child (Laderman 1987). See also Bonnemère (2000), for comparative materials in Oceania.

[16] For a study of maternal mortality in Ladakh, see Hancart Petitet (2005). For a critical analysis of the establishment of facts on, and quantification of, maternal mortality in Tibet see Adams (2005).

was an extension of the period of labour beyond twelve hours. This would lead to a referral to the amchi, a decision that could be taken by anyone attending the woman in parturition.

This practice was primarily due to structural elements which effectively limited the available options for the people of Shun Shade. As said above, health service facilities were located at a considerable distance from the area. No biomedical services were available in this zone at the time of research in 2001.[17] Moreover, there were no formalized birth attendants in Ladakh at all.[18] This can be explained by the taboos imposed by the *pha-spun*: these are village groups formed by a few families or houses, based on the worship of the same tutelary deity (*lha*) (Dollfus 1989, 181), who maintain reciprocal privileges and duties among themselves. Traditionally, a woman could only manage the childbirth of another person from her own *pha-spun*. Social equality united the people of the same *pha-spun,* and this could explain the absence of candidates to assume the role of birth attendant and deal with impurities. This explanation echoes what some authors have shown in India and Nepal, countries in which the local birth attendants, or *dais*, were poor women who, for a little money, were willing to handle the impurities of childbirth (Jeffery et al. 1989; Jeffery and Jeffery 1993; Pigg 1997). In Ladakh, although they generally held a high social status in their community, the amchi sometimes considered themselves to be immune to the impurities and negative effects connected with childbirth on account of the protection which is bestowed by Sangye Smanla (*sangs rgyas sman bla*), the Buddha Master of Remedies (Pordié 2007, 105).

The major reason cited by the amchi to explain complications in childbirth lay in the responsibility of the woman herself: "She was not able to keep her body warm." For them, the consequence of this was an augmentation of the *rlung*, some causes of which were "desire", "jealousy", "excessive exercise on an empty stomach" and "speaking much to say nothing".[19] From conception onward, the pregnant woman was held completely responsible for the well-being of the foetus and for all incidents arising during pregnancy and childbirth. The woman's responsibility extended to the level of physical, social and moral propriety.[20] The amchi also

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[17] The situation seems to have since changed, as a nurse midwife was reported to be practising in Shade in 2006 (Kim Gutschow, personal communication). See Gutschow (2004, ch.2), for a description of the health services in Zangskar.

[18] As with other Himalayan places of Tibetan culture (Craig 2009), Ladakh has no specialized attendants for birth events. We do not use the term 'traditional birth attendant' because it is a politically connoted category invented to satisfy a bureaucratic function in international development and public health administrations (Pigg 2001).

[19] According to the Gyüshi, the disorders of wind (*rlung gi nad*) may be classified into 63 types, 48 of which are general and 15 specific. See Meyer (1981) and Adams (1998) for more details.

[20] This is also found in classical texts. The relationship between the mother and the intra-uterine child appears in the work entitled '*The Jewel Ornament of Liberation*' by Gampopa (*sgam po pa*), a Tibetan doctor, philosopher and saint from the eleventh century, who described the misery experienced by a being in the womb (Genther 1959).

stated that the act of labour in childbirth results in the action of the "wind which blows downward" (*thur sel rlung*, abridged form of *thur du sel-ba'i rlung*) which is responsible for pushing the foetus out.[21] The amchi observed that the *thur sel rlung* is seated in the genital centre and circulates as far as the intestines, the bladder, the sexual organs and the thighs. It controls the functions of respiration, expectoration, muscular activity, speech, menstruation, micturition, defecation, the ejaculation of sperm, menstrual blood, the opening and closing of the uterus, and childbirth.

The concept of *rlung* is central to the Tibetan medical system and links the body to the mental faculties.[22] The mind and *rlung* are inseparable as the consciousness needs the physical support provided by *rlung*. The amchi understood the aggravation of *rlung* to be a factor responsible for the obstruction of the birth canal,[23] which directed their interventions to the various dietary and behavioural causes of such disturbances. These practices cast light on the different explanatory registers of the disorder signified by complications in delivery. But under what conditions did the intervention of the amchi take place during childbirth, if it took place at all?

Although the Gyüshi makes no mention of childbirth practices among the amchi (Parfionovitch et al. 1992), our ethnographies in Zangskar show that the amchi did indeed play a role; this may be very limited but it nevertheless existed. When a labour was prolonged for many hours without any indication of an imminent birth, the amchi prepared a mixture of butter, pepper (*pha ri lu*: *Piper* sp.), *Myristica fragans* (*dza ti*) and seeds from another unidentified

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The way pregnancy and childbirth is conceived in theories of procreation also sheds light on the hierarchy of genders (Héritier 1996). The Gyüshi indicates, for example, that the spirits 'of little merit are thereby born as womankind endowed with breasts and womb and red menstrual blood' (Instructional Tantra, ch. 74-82 *in* Parfionovitch *et al*. 1992, 107). Generally, on the subject of women in Zangskar, their status, and the local conceptions and meanings pertaining to the impure nature of the woman's body, see the monograph by Kim Gutschow (2004). For other accounts from South Asia, see Samuel (2006).

[21] There are five types of *rlung*, each responsible for a variety of bodily, physiological or mental actions described in detail in the Tibetan medical theory: 1. *srog 'dzin rlung*: "life-grasping" *rlung*, seated in the heart, 2. *gyen rgyu*: 'upward-moving' *rlung*, seated in the chest but circulating in the nose and throat, 3. *khyab byed*: "all-pervading" *rlung*, seated in the head but circulating in all parts of the body, 4. *me mnyam*: "fire-accompanying" *rlung*, seated in the abdomen but circulating in all parts of the intestine and stomach, and 5. *thur sel rlung*.

[22] These considerations were only expressed by the amchi. None of the villagers whom we met in Ladakh had any detailed understanding about even the most basic concepts of Tibetan medicine (e.g. *nyes pa*). This shows a very different picture from the situation that Adams et al. (2005, 830) describe in their study of childbirth among villagers in Tibet.

[23] This is also found in the Gyüshi, which states that the birth canal can be blocked by a malfunctioning or by a stagnation of *rlung* to explain the prolongation of the term (Parfionovitch et al. 1992). According to Lobsang Khangkar (1986), prolongation of the pregnancy could also result from a malfunctioning of the *thogs me rkyen* with the consequence of a bad position and presentation of the foetus in the birth canal – this she presented as the *rlung* of the thirty-eighth week, which is responsible for the foetal position with cephalic presentation at childbirth. However, none of the amchi referred to this specific *rlung* nor did they say, as found in the Gyüshi, that the term may be prolonged when the mother has lost blood during gestation or when she has eaten to excess.

plant ("*chega*"). This mixture was used to massage, successively, the kidneys, the thighs and the legs. The preparation was thought to increase the efficacy of the hand massage. Performed at length, this had the effect, according to the amchi from Yarchun, of "causing poisons and tensions to leave the body". The application, when carried out in a circular fashion, was said to make it possible to focus the action on the massaged area. Should this first practice not succeed, the amchi prescribed the *agar so-nga* (*a ga ru so nga*) medicine, a composition of thirty-five (*so nga*) medicinal substances, of which *a ga ru* (*Aquilaria agallocha*) is the main ingredient. This treatment was indicated for illnesses related to an aggravation of the *rlung*. According to the amchi, it made it possible "to make the *rlung* go out". When delivery was still late in coming, despite these two interventions, the amchi would fashion a fish with yak butter, and give it to the woman in parturition, as described below. If this practice in turn failed, the last recourse consisted of the manual extraction of the foetus. Failure here would result in the death of the foetus and, in the next few hours, that of the woman.

The butter fish

The butter fish remained a major element in the amchi's treatment of complications experienced in childbirth. An effigy in the form of a fish was prepared in yak butter. Amchi Sonam Thundup from Yarshun stated that it was a matter of "what the women prefer, otherwise they would spit it out". The preparation entered a ritualized framework during which the amchi recited specific mantras (*sngags*) and imbued them into the butter. The fish (*nya*) was thus made of blessed butter (*sngags mar*) and was generally called as such, nag mar / nags mar. While most amchi had no idea as to how the mantra consecrated the butter – an *acte de parole* efficacious in itself –, Amchi Dorje from Sumdo claimed that "the mantra carries an invisible and imperceptible "wind" (*rlung*), which comes from Sangye Smanla (*sangs rgyas sman bla*)". Once fashioned and consecrated, the fish was then given to the woman who had to ingest it at once and head first. The practice of the butter fish also appears to have existed among the Tibetans. Thubten Sangay (1984, 8) wrote that "a small piece of butter is moulded into the shape of a fish with two eyes. The mantra "*Om ka-ka-mahi-lam-phye ki-ki-mahi-lam-phye shon-shon-mahi-lam-phye ma-mo-hbyung bzhihi-lam-phye*" (Ladakhi phonetics) is recited a thousand times and blown onto the butter which is given to the mother to swallow head first, without biting into it."[24] It is possible that the practice of the butter fish in Ladakh is related to the dried fish from

[24] The text also gives information about another ritual in which the mantra is identical, but the practice differs. This practice does not exist in Zangskar today, and seems to have fallen from favour among Tibetans. It involves

Lake Mapam-yumtso in Tibet, which is one of the commonly-mentioned medicines given to women with difficult childbirths, but we lack evidence to confirm this hypothesis.

Among the different products derived from cows and yaks, the fatty substances include clarified butter, *shun mar*, the cream and cheese from an animal which has just given birth, and the cream deposited on the walls of the milk container, *jo mar*. Butter is used in a variety of medicinal compounds, including for new-born babies (van Vleet, 2010-2011, 363-365). In contrast to butter from goat's milk which has cold qualities, yak butter, similar to sheep butter, has warm qualities (Meyer 1983). In Zangskar, the fish was made from clarified butter which, according to chapter 16 of the Gyüshi in its description of the different fatty substances and their therapeutic action, was "the best fatty substance. It sharpens the intellect, clarifies the memory, increases body warmth, strength and longevity" (*ibid.*, 300). Tibetan medical theory associates pregnancy with a "hot" state. It is recommended that the woman should not consume "cold" food during the period of gestation (see also Wiley 2002) and that she should keep her body warm. According to the amchi, the absorption of the fish follows this logic, as its basic matter is characterized by a warm potential.[25] It enables a reduction in excess *rlung*, in this case cold in nature, which represents one of the causal explanations for complications in childbirth.

The effigy in the form of a fish does not appear to have any particular symbolic relation to the amchi's descriptions of the three phases of pregnancy. Although it belongs – as do the otter, the crane and the stork – to the aquatic animal group in the classification of meat given in the Gyüshi (Meyer 1983, 229), fish was not generally eaten by the Buddhist population of Ladakh.[26] Ladakhi Buddhists often claimed that one needs to kill a lot of fish, and thus take many lives, to feed a family. They therefore preferred to eat yak meat, for "a single yak feeds the entire family". Some also said that fish should not be killed because they are shy animals. However, not eating fish also relates to the explanation of the Zangskari supernatural world in which animals living in water or those in close contact with the earth are related to the deities/spirits of the subterranean and aquatic worlds, the *klu*. The worship of the *klu* has developed under the influence of the Indian mythology of the *nāga* (snake-divinities). The *klu*

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a preparation made with a peacock feather and eight hairs from a bear which are burned and the ashes mixed in a glass of water. The mother then drinks this preparation which is supposed to induce delivery immediately (Thubten 1984).

[25] Tibetan medical theory pertaining to pharmacology is highly complex (cf. Meyer 2006, 20-23). Five levels of action are mentioned in the classical texts (cosmo-physical elements, tastes, post-digestive tastes, potentialities, and the synergy issuing from various combinations). However, in practice, the potentialities of the drugs (*nus pa*), together with their various combinations, play a significant role over and above the other levels of action.

[26] There were however exceptions, as some Buddhist Ladakhis in rural and urban areas ate fish to complement or vary their diet. An urban minority had also taken up freshwater fishing and ate, often *in situ*, the fish they caught.

are mainly described as zoomorphic and may thus appear in the form of fish (*nya*) (see elsewhere in Ladakh, Dollfus 2003 and Kaplanian 1987). In general, people also did not eat fish because they considered them to be pure, a quality that mirrored the inherent purity of the *klu* (Dollfus 2003, 11). In contrast to men, who were associated with the *lha* and with social institutions, women, were thought to be closer to the *klu* due to their daily tasks of hoeing, irrigation, water collection, and milking, and thus the most vulnerable (Dollfus 1996; Kaplanian 1987). It is in order to please the *klu* that the women wore the perak (*be rag*), a headdress sewn with turquoise thread in the shape of a cobra, and conch-shell bracelets (*dung lag*) (Karmay and Sagant 1987). The *klu* were thought to be sensitive to their habitat, and could react violently to any kind of human pollution, such as excrement and blood, as well as to any contact with iron.[27] The appearance of a complication during a birth could express the discontent of the *klu*, assaulted by the pollution of the blood and excrement of childbirth. However, in "responding to an aggression even if the culprit meant no harm […], the *klu* bestow kindness on whomever worships them devoutly" (Dollfus 1996, 33). It is in keeping with this necessity that, as in other rituals for spatial purification and for the elimination of stains due to impure acts, fashioning a fish out of butter is similar to making an offering.[28]

The actions of the amchi during childbirth link the gestures and the prescription of substances with the recitation of mantras. Ideally, treatments in Sowa Rigpa are administered on the basis of a principle of progressiveness according to the severity of the disease (Meyer 2006). They include an initial behavioural and dietetic stage, then the provision of powders and pills, followed by external therapies, and finally rituals.[29] Faced with an extreme situation that endangers the life of both of the woman and the unborn child, and if no other remedy was able to bring about birth, the practice of the butter fish appears to combine different phases in medical treatment (medication and ritual). The amchi thus gave meaning to an illness, assigning to it organic, emotional and supernatural origins. The corresponding therapeutic schema conceives the failure of a therapy not necessarily as the failure of its efficacy, but as a reason to conduct a more thorough investigation into the moral nature of the two beings present: that is,

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[27] See Gutschow (2004, 111, 203) in Zangskar, and Kaplanian (1987) and Dollfus (1996) elsewhere in Ladakh.

[28] By the same token, some women in Stok, in the Indus valley, also spoke of various practices involving fish, such as eating a dried fish from the Lake Manosarovar in Tibet when labour is difficult. The Tibetan astrologer Jhampa Kalsang Tsipa Kachupa, advised Tibetans to save the life of an animal, usually including a fish, about to be slaughtered when the birth chart made by the astrologer shows any threat to the child's life (Kalsang 1992).

[29] Modifications should however be noted in which the amchi depart from the rules of progressiveness given in the medical texts. This results from the socio-economic changes in Ladakh and the patients' desire for a 'rapid recovery'. The amchi directly prescribed treatments based on plants which thereby acquired a new temporal positioning in the therapy (Pordié 2002).

the mother and the child. That is why, according to amchi Tsering Phuntsog, the failure of treatments used for complicated deliveries indicates the karmic character of the problem which cannot be healed through ordinary remedies.

Parallel views in the urban milieu

Whereas the amchi in the remote area Shun Shade should not be overlooked as a key actor in the case of complications during childbirth, in the city of Leh, where birth was already increasingly seen as a medical event, the vast majority of women gave birth in hospital in the presence of biomedical personnel.[30] The amchi stood at the margins of the medical world, his role secondary or even non-existent. Especially – but not only – in the case of complicated births, the presence of an obstetrics department in the Sonam Norbu Memorial (SNM) Hospital in Leh, which was free of charge and judged to be of good quality, appears to be the major factor in the transfer of responsibility for childbirth from the woman's family or the amchi to the medical personnel of the maternity ward. This transformation had much to do with the social image of biomedicine and its clinical performance, but also with the distribution of wealth and power in the family and community in rural Ladakh, since they influenced the move to hospital (Gutschow 2010; Hancart Petitet 2005). In addition, local state policies favoured the development of biomedicine, in particular with regard to questions of maternity and childbirth. The role of the state in the provision of care at birth is a fundamental structural factor in contemporary changes in the health field (Ginsburg and Rapp 1995).[31]

The amchi in Leh noted that their patients did not expect them to attend their pregnancy and delivery. However, when biomedical care proved to be unsuccessful, they were often asked to intervene at the last stage of long therapeutic itineraries in the cases of infertility or complications experienced in childbirth. All the amchi we talked to in Leh knew of the existence of the butter fish and some of them used it in particular circumstances, regularly but not frequently. The modalities of such a practice are illustrated in the following case. When a

[30] According to Wiley (2002), the penetration of biomedical maternity care in Ladakh has been facilitated by the lack of involvement of traditional institutions and the high rate of miscarriage and neonatal mortality, among wider ecological and cultural factors. See Wiley (2002, 2004) for an analysis of the reasons for the increase in the use of prenatal services and hospitals in Ladakh. Similarly, see Rozario and Samuel (2002) elsewhere in the Indian Himalayas.

[31] In Tibet, government health policies also encourage women to visit hospitals or biomedical clinics, which has led to the compilation of a census register of rural populations and helps to monitor people's attitudes towards central policies, especially those aiming to control births (Chertow 2003). This author sees in these processes an expression of the new modes of governance in rural Tibet and of women thus becoming part of China's nation-building project.

complication occurred during labour in hospital and a caesarean was advised, the family of the woman about to give birth requested time to consider the matter. During this period, one of the family members went to Amchi K., to whom the situation in the hospital was described in detail. The relative explicitly asked him to provide the "fish which induces delivery" in the shortest possible time. The amchi swiftly made the preparation and the relative returned to the hospital with the carefully packed fish. This he gave secretly to the woman, who gulped it down as soon as the situation allowed, concealing her act from the hospital staff. No perceptible mantra recitation was involved. This could be argued to be a case of re-ritualizing the butter fish through forms of secret practice in the biomedical milieu.

The fact that the amchi's practice was not recognized as such in India also was a matter of concern for many of them in urban Ladakh. They hoped to have their medicine recognized by the central government of India, in order to receive stronger economic and structural support, but also to prevent any legal complications. "We could get imprisoned if we have a problem with a patient, because today we need to be legal. Although we have practised for over a thousand years here, we are not legal", said Amchi Tsering Phuntsog in 2001. He was the Chief Amchi for the government, and took charge of the "Amchi Clinic" at the same hospital in Leh in 2004. He was aware of the butter fish practice but was not involved in the cases we witnessed. His remarks however shed light on a great paradox: the amchi considered his practice illegal and feared jail, despite working as a government officer in a biomedical environment. His medicine was, at the time, not recognized as an Indian System of Medicine, but he received his salary and project grants from central Indian institutions. Some said that the medicine of the amchi was simply tolerated. In fact, it was considered as belonging to the category of "tribal medicine" and received minor support for this reason.[32] In the domain of childbirth, however, there was no room for the amchi, and their medications, such as the butter fish, were considered inappropriate. The chief gynaecologist at the hospital in Leh strictly proscribed any recourse to the amchi in matters of childbirth, which included the "butter fish". According to her, their involvement during a complicated birth was characterized by the inefficacy of their practices and by a late referral of the woman in parturition to the hospital, with often fatal consequences.

In this context, the practice of the butter fish remained secret and the ritual surrounding it had to be altered by concealing mantra recitation. This reconfiguration facilitated the integration of this practice in the biomedical milieu. This transformation involved, on the one

[32] The recognition of Sowa Rigpa by the government of India occurred in 2010, after many years of efforts partly conducted by Ladakhis (Blaikie 2016; Kloos 2016), thus significantly changing the landscape of the practice.

hand, the patient's requirement for a rapid therapeutic solution in a case of emergency in an unfavourable medical environment and, on the other hand, the expertise of the biomedical staff which did not answer to the need experienced by the patient.

In hospitals, this recourse to the amchi only took place in an extreme circumstance (caesarean). This "reversal" of the therapeutic recourse was the decision of the patient and her family. Its purpose was pragmatic and aimed to avoid surgery and its consequences. As described in many studies of health seeking behaviour, the patient explored the array of available therapeutic possibilities when her distress was greatest. It also expressed a swing in the perception of the reason for the disorder from the biomedical explanation towards that of amchi medicine, which is more familiar to, although distinct from, the representations of the woman in parturition. For example, in biomedicine, dynamic dystocia (absence of dilation of the cervix, insufficient uterine activity) or mechanical dystocia (foeto-pelvic disproportion, malposition of the foetal presentation and so on) are the factors responsible for the progression of the presentation in the genital channel. The amchi perceive this problem as the disturbance of the *nyes-pa*, machinations of angry deities and/or a consequence of karmic law. In the case presented above, the amchi saw the complication in his own physiological terms (*rlung*), and the woman and her family believed in what the amchi said and in the efficacy of his medicine. They did not ask the amchi for detailed explanations, but did mention their fear of the wrath of village deities. Although rejected by the biomedical institution, the practice of the amchi in childbirth was still legitimated by the patients because it held meaning for them.[33] This offered a signifier to the patient, in contrast the biomedical explanation that uses a system of interpretation and care for illness which places the-body-as-object as its centre, as the almost exclusive place of action. The amchi intervened when the need arose for a treatment of the-body-as-subject.

The secrecy of the practice of the butter fish in hospitals illustrates the significance of biomedicine as the reference point in obstetrics. Biomedicine is a form of authoritative knowledge which is reproduced within a "community of practices" in a specific social situation such as childbirth. Brigit Jordan (1993) thus showed how biomedical authority ultimately came to dominate childbirth, and how the distribution of power among medical practitioners is linked to their ability to make use of technology. This dominance results in the exclusivity of the

[33] This point has been illustrated in Ladakh by the manner in which the amchi mobilized certain cultural and religious elements in the practice of their medicine, notably in the case of behavioural recommendations (Pordié 2007).

proposed treatments, the impossibility for people accompanying the woman to enter the labour ward and the obligation to assume a certain physical position at childbirth. Thus, whereas in Zangskar the women in labour were traditionally surrounded by members of their family or people from the immediate neighbourhood and adopted a semi-vertical position, in the hospital in Leh, anyone not part of the hospital staff was left outside and the woman had to adopt a dorsal decubitus with the knees pulled back for childbirth. However, the intrusion of the butter fish into the hospital milieu and the patients' therapeutic itineraries in such a context challenged biomedical authoritative knowledge. For these patients, amchi knowledge also had authority in the case of complications experienced in childbirth in a place where medical authority is typically assigned to biomedicine. The amchi was sought for beyond his usual context, when the biomedical staff offered the family a practice (the caesarean) which involved a higher degree of technology. Beyond the medical institutional framework, the construction of authoritative knowledge rests on what the parturient woman believed was good for her, in both a pragmatic sense and in her search for meaning.

Concluding remarks

Although there is no mention of the amchi taking a therapeutic role in childbirth in the classic medical treatises, the practitioners in rural Zangskar did in fact intervene in this domain. This function has not received much attention in the research conducted on childbirth in the areas of Tibetan culture. In Ladakh, Wiley notably observed an "absence of involvement [in pre-natal care and birth] of traditional institutions such as Tibetan medicine" (2002, 1089). This author however cited earlier works in which the intervention of the amchi in cases of complications in pregnancies or deliveries was observed, such as Nazki (1986) and Norberg-Hodge and Russell (1994). But in no case were the social or symbolic dimensions of the practice the subject of detailed investigations. Indeed, the functions of the amchi were primarily of this order and were only to a much lesser extent directly medical or technical. This chapter does not aim to exaggerate the limited role of the amchi, or to extol the effectiveness of their practices in relation to childbirth. Our aim was to bring these practices to light. To conclude this chapter, we would like to raise some issues that may be helpful to understand the emergence of an amchi practice in childbirth in Ladakh.

Matters pertaining to childcare were seriously considered in the Tibetan medical milieu in 1916 Lhasa, when the Thirteenth Dalai Lama implemented a programme for the newborn.

This was based on a medical manual on childcare (*byis pa nyer spyod 'gro phan snying nor*: *On Childcare: Treasure of the Heart Benefiting Beings*) written in the same year by his most senior personal physician Jampa Tupwang (van Vleet 2010-2011). This kind of manual was unknown to the amchi we worked with at the time of research. In Ladakh, the harshness of the rural environment in the region and the isolation of the populations during several months of the year could have played a role in the appearance of an emergency practice in cases of complications experienced in childbirth. The social and political events that determined the changes in amchi medicine in contemporary Ladakh also contributed to transforming the amchi's knowledge and practice relating to birth. The case of development projects is here exemplary, since institutions, both governmental and NGOs, have played an important role in the transformation of Tibetan medicine in the region. In Tibet, for example, Chertow (2003) found a certain impact of non-governmental projects on childbirth practices, concomitant to those of the state. Similarly, the amchi's assumption of obstetrical responsibility could be a possible consequence of training sessions organized in Ladakh. Since 1989, the Department of Health of the Ladakh Autonomous Hill Development Council conducted regular training workshops for the rural amchi, in which matters of childbirth were repeatedly addressed. Concomitantly, since the mid-1980s the organization Leh Nutrition Project (funded by Save the Children Fund, UK) ran a multi-year project on issues surrounding mother and child health in which amchi – some of them from Zangskar – were included. Similarly, for a period of about ten years from the late 1990s, the French organisation Nomad RSI organised regular training seminars for the amchi. The role of biomedicine in local and international health organizations' interventions with the amchi varied according to approach, but remained largely dominant, apart from a few exceptions. Generally, the presence of Ladakhi biomedical doctors at seminars intended for amchi was particularly pronounced in the domain of pregnancy and childbirth. This domain represented, on the one hand, a major issue for public health in Ladakh where biomedicine showed real technical mastery and superiority, while, on the other hand, neither Tibetan medical texts nor the amchi were able to describe an obstetrics practice which would possibly be satisfactory in the eyes of development agents. The amchi were well aware that their knowledge on birth was scant and their practice limited to behavioural and dietary recommendations, and to a small set of practices. This explains why there was an explicit demand among the rural and urban amchi for training in this domain from biomedical doctors. The technical aspects pertaining to childbirth thus appear to be more heavily influenced by biomedicine than other areas of the amchi's practice. It remains to be seen, however, how the

representations of conception, pregnancy, birth and the associated taboos are also modified in the process.

The biomedical doctors never intervene solely as technicians. They also convey a whole set of medical ideologies which aim to eliminate "superstitions" in particular. The chief gynaecologist at the hospital in Leh spoke in this manner to the amchi at training seminars or other official encounters. She benefited from a status recognized by the medical communities in Ladakh and her position was influential. Her paper at the "Forum on Amchi Medicine: Training and Healing Material Exchange" held in Leh on 19-29 October 1998, covered the broad subject of "Pregnancy and Delivery Cases", and presented her arguments in an exemplary fashion. She told the amchi that some of their practices and "superstitions" should be banned, while introducing new ideas and denigrating some of the conceptions in Tibetan medicine. She touched on both the legitimacy of their medical practices and on their beliefs as regards childbirth. She sparked a debate among the amchi, who discussed her comments later in the evening. Amchi Norbu exemplified the position of the majority: "Dr. Ladhol knows many things… We also have ideas and knowledge, but we should learn, we must learn from her."

As shown by the variations in the practice of the butter fish in the urban area, biomedical science refuses both the amchi's thought-world and their practices because the consequences thereof are deemed problematic. While this is justified from the point of view of public health, the social dimension of the role of the amchi in childbirth is dismissed. Biomedicine largely dominates the medical arena of childbirth and tends to gain ideological credit in the social world. The amchi are subordinate health actors in a global medical system. They remain peripheral agents on the margins, whether they are the only available medical resources in the deep rural setting of Shun Shade or a last resort alternative to biomedicine in urban Leh. Biomedicine occupies an increasingly central role in the amchi's practice concerning birth. The negation or the recognition of their practice by different forms of power (biomedical, local or international organizations) places the problem of reproduction at the very centre of contemporary issues in Tibetan medicine in Ladakh. This issues also concern gender politics, understood as the place of gender in broader configurations of meaning, interaction, and power.

As said earlier, late 1990s and early 2000s the Tibetan medical milieu was demographically dominated by male practitioners (Pordié 2003, 16). The period of research, however, was at a crucial turning point regarding Ladakh's general modernization and Tibetan medicine's gender reconfiguration. The medical department of the Central Institute for Buddhist Studies in Choglamsar, located in the outskirts of Leh, had 11 students in 1999, among

whom female students were in the majority. Similarly, the Dusrapa school (named after the diploma it conferred, *sdus ra ba*) set up by Nomad RSI in 1999 included 50 per cent of women for a total of 22 students who graduated in the mid-2000s. Since 2010, these graduates constitute more than half of the Tibetan medical practitioners officially posted in National Rural Health Mission clinics throughout Ladakh (Blaikie 2019). The feminization of Tibetan medicine is increasing, as is the case in other areas of Tibetan culture (Fjeld and Hofer 2010-11; Craig 2012). A question remains as to how this feminization could change the amchi position towards birth and childcare, along with their practices. An alternative route could be thus taken, in which more woman could involve themselves in rethinking the role of Tibetan medicine on birth and childcare. One of the leading female amchi figures of Ladakh took such route in the 2000s and led a local NGO project on the matter for several years. Her actions had a lot to do with gender politics. In a male-dominated environment, her efforts came up against many hurdles that both her competencies and determination helped to cross (Pordié 2016). Feminist studies would see here a dynamic of resistance (Collier and Yanagisako 1989), informed by the way this female amchi behaved and subsequently gained credit in the real world (Conkey and Gero 1997). Would the transformation of Tibetan medicine's gender open up new avenues for such dynamic and undertakings? Further investigation is needed to answer this question.

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