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# Tibetan Women's Experiences with Childbirth: A Comparative Study of Present-Day Shangri-La and Previous Studies in Tibetan Communities

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*SIT Study Abroad*

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**Tibetan Women's Experiences with Childbirth:  
A Comparative Study of Present-Day Shangri-La and Previous Studies in Tibetan  
Communities**

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Religious Studies; Women, Gender, and Sexuality Studies

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## **Abstract**

What are the experiences of Tibetan women living in and around Shangri-La with pregnancy, childbirth, and motherhood? In order to explore this topic, one must first understand the context in which this topic exists: Tibetan Buddhism and culture. This paper gives a short background on women and the female body in Tibetan Buddhism, the Tibetan Medical system, and the current accessibility and regulation of hospitals, before entering into the topic of Tibetan women's experiences with childbirth. The experiences and traditional practices of childbirth are important, as birth is universally significant as well as particularly religiously significant in Tibetan Buddhism, and the idea of cultural preservation is highly relevant to our globalized world, particularly China. Additionally, previous studies on Tibetan childbirth are not located within Yunnan, generally outdated, and do not include new hospital regulations.

My field work was located primarily in Shangri-La, with additional study in three other Tibetan areas within Diqing Prefecture. Observation and contextual study of the areas I worked in and the residents of those areas was crucial to better understanding my topic, which led me to include Tibetan women I observed for extended periods of time within my list of human resources (Appendix A). Officially, I had twelve interviews, but a total of seventeen human resources.

My findings turned out significantly different from how I had originally anticipated, and very different from previous studies on Tibetan birthing traditions. It is because of these differences that this paper is a comparative exploration of different aspects of the birthing process depicted in previous literature and from my own field work. In what ways are my findings different, and why might the discrepancy between my study and previous studies exist?

Keywords: Obstet&Gynecol, Gender Studies, Religion/Philosophy

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**Abbreviations:**

TTM – Traditional Tibetan Medicine

PH – People’s Hospital of Diqing Prefecture

TAR – Tibetan Autonomous Region

## Introduction

“Just as a mother would protect her only child even at the risk of her own life, even so let one cultivate a boundless heart toward all beings.” From the Metta Sutta, this famous excerpt depicts a mother’s love and nurture of her child as the height of compassion.

Compassion and rebirth, two cornerstones of Buddhist philosophy, are at the heart of motherhood:

the creation and bringing forth of new life is deeply valued and rooted in Tibetans’ religious and ethnic beliefs about the nature of existence, particularly the gift of being reborn as a human being and the possibility for spiritual achievement this might engender. (Craig, 2009)

Although motherhood and birth are seen as important and natural in Tibetan culture (Maiden & Farwell, 1997), their significance within Buddhism is complex due to the intricacies of purity, gender and gendered bodies, and the ultimate achievement: enlightenment. This dynamic is fundamental to understanding the context in which this study was conceived, conducted, and analyzed.

At the heart of Tibetan Buddhism, and therefore much of Tibetan culture (a relationship discussed in depth in my discussion) lies the story of the Buddha. The four most important events of the Buddha’s life, depicted both iconographically and textually, are his birth, enlightenment, first sermon, and death (Young, 2004). As this study is greatly impacted by the intertwining relationship between doctrinal Tibetan Buddhism and the experiences of lay Tibetans, the story of the Buddha’s birth is incredibly symbolic. The story begins with Maya’s immaculate conception of the Buddha in a dream. The image of Maya “asleep on her side while above her an elephant descends” can be seen in temple murals and in texts, “symbolizing the Buddha’s miraculous conception through a dream rather than intercourse” (Young, 2004). While in Maya’s womb, the Buddha “was enclosed in a jeweled casket (*ratnavyuha*) to protect him from its pollution” (Young, 2004). The Buddha never came into contact with “the foul matter of the womb” during gestation nor later during delivery. In the

depiction of the actual moment of the Buddha's birth, he is "born from [Maya's] side in order to avoid the pollution of the birth channel" (Young, 2004). In many iconographies of this miraculous birth, Maya can be seen "as a beautiful, young, seminude woman, with the slim-waisted and full, curvaceous figure that to this day remains the female ideal in South Asian art and literature," with the infant Buddha held by attendants beside her (Young, 2004). Not depicted in most iconographies, particularly those of the Buddha's life, but textually recorded, is Maya's death. Like "the mothers of all buddhas, of the past and of the future," Maya dies "seven days after giving birth because it is inappropriate for them ever to have sex again" (Young, 2004). The powerful imagery of Queen Maya and the birth of the Buddha creates a two-fold effect of representing a very female experience of childbirth and motherhood, while simultaneously creating a distinction between human and divine women (Young, 2004).

As one of the most important aspects of the Buddha's life, his birth is significant as it sets a precedent in its representation of women's bodies and birthing through the creation of Queen Maya as an ideal mother figure. Maya is simultaneously portrayed as a powerful female figure of "fertility and wealth" (Young, 2004) and an archetype of the polluted, impure female body. This seemingly contradictory dynamic<sup>1</sup> is foundational within Buddhism and constantly being created and recreated in Buddhist texts and iconographies, trickling down to the experiences of lay Tibetan women. Maya's identity as the ultimate mother, yet ultimately an obstacle to be avoided in order for the infant Buddha to retain purity, exemplifies the double standard Tibetan women are held to: to uphold the responsibilities of procreation, childcare, and family structure, while having to remain in the

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<sup>1</sup> Young expands upon this dynamic, saying: "when it comes to biological reproduction, Buddhism faces a dilemma. The Buddha advocated celibacy as necessary for achieving enlightenment because sex is connected to attachment, which does not lead to enlightenment, at least not in early Buddhism. Nevertheless, beings need to reincarnate in order to achieve enlightenment, and monastic institutions require the laity for financial support." (Young, 2004)



confines of a body that has been defined and limited by one's own religion, culture, community, and often family.

Within Tibetan Buddhism, women and their bodies are defined and their capacity to function outlined by Buddhist texts and beliefs. Discussing Tibetan Buddhism doctrinally and theoretically is an important start to understanding the experiences of Tibetan women, or Tibetans in general, because the culture is inextricably embedded within the religion and ideology of both doctrinal and monastic Buddhism. In this way, the degree to which the doctrines are ingrained into social law might vary between communities, but the infrastructure of Tibetan culture is undoubtedly shaped by the religion. Therefore, to understand women's roles within society and the cultural understandings of gender, one must understand the ways in which Tibetan Buddhism has established the physical and spiritual boundaries of male and female, masculinity and femininity. The relationship between culture and religion is reciprocal and so intertwined that it is hard to say which is influencing which over time. Buddhism, however, has not always been the religion of the region, and religion is not adopted within a bubble. Buddhism not only came to an area with already established social structures, including a gendered hierarchy, but originated from an altogether different society and culture in India. Because of these social hierarchies, "Buddhist discourse on gender was based on observations of prevailing gender inequality that were interpreted in terms that not only left the status quo intact but also served both to support it and to blame women for it" (Young, 2007). Women, having been already subordinate to men, were now destined to be subordinate within the structures and laws of Buddhism, because "biology [is] destiny shaped by one's karma" (Young, 2007). If a being has more merit, they are more likely to have the karmic disposition to be born as a man, because a man's body is pure and able to achieve enlightenment in his lifetime. In Buddhism, many things can be considered polluted, but there is inherent "pollution associated with female bodies" that renders a female

body impure and unable to be overcome by any “purification efforts (in this lifetime)” (Makley, 2003). This impurity restricts beings within a female body from attaining enlightenment within their lifetime;

the message is that it is females who can and who need to change sex, who must acquire masculinity, in order to achieve spiritual and social status. This is confirmed by practices to assure the transformation of females into males in the next life... this is connected to the Buddhist notion that men are more capable of achieving enlightenment than women or, in some cases, the belief that women are totally incapable of achieving enlightenment. (Young, 2004)

If women create enough merit to be born a male in their next life they have the hope of possibly ending their cycle of suffering and rebirth.

On a day to day basis, female impurity affects women’s access to religious spaces and their contact with men, particularly ascetics. “A menstruating woman [can] pollute temples and other sacred places through even the most casual physical contact, and that belief [leads] to women’s exclusion from spiritually charged sites” (Young, 2007). Often, because of the private nature of menstruation, women are, in general, excluded from certain religious spaces to avoid any chance of their pollution affecting the purity of the space. This fear of polluting what is pure is not limited to religious spaces, but extends to men and male bodies. In the same way a menstruating woman can pollute a temple with “the most casual physical contact,” so follows that a man will be affected and need to undergo purifying rituals such as needing to “bathe while reciting mantras, [putting] on fresh clothes, and [ingesting] certain pure foods” to regain their original state of purity (Young, 2007). The idea that women can endanger a man’s spiritual integrity simply with their bodies can go as far as the belief that “having contact with a woman [pollutes] a man and [renders] him incapable of communicating with the sacred or [can] lead him to illness” (Young, 2007). Within this discourse is a fear of women: their bodies, sexuality, and the potential threat they pose to men’s power and therefore their spiritual potential; this fear, though, creates a religious justification for women’s subordination (Young, 2007). Women’s bodies and sexuality, however, are at the

center of life itself: birth. Birth is simultaneously seen as one of the main sources of suffering and a necessary, natural process of life and reincarnation. Birth, in many ways, represents the complicated nature of being a woman; “birth is considered a natural and spiritual process, it is also in some ways considered unclean” (Maiden & Farwell, 1997).

In the context of Tibetan Buddhism, how does the female state of impurity and women’s place within the religion and culture affect birthing practices and traditions in Tibetan communities? This question sparked my interest in the topic of this paper, however this study has adapted based on literature read, interviews, observations, and experience. Reflecting back to the story of the Buddha’s birth and Queen Maya’s role as an iconic mother, showing both “the auspicious fecundity of human and divine females” as well as the inherent, spiritual flaws of the female body, there seemed to be much to uncover within this question (Young, 2004). Maya, in many ways, represents the divine, which effects, but does not necessarily reflect, the experiences of lay Tibetan women. My interest in Tibetan women’s health experiences, although related to and effected by aspects of Tibetan Buddhism, was not centered around impurity or pollution, but rather the traditional birthing knowledge and practices that exist within communities and families.

Within the literature that exists about Tibetan birthing practices, everything from the moment of conception to the naming of the child is significant both spiritually and for the family. An important aspect of this topic is the way in which the Tibetan medical system is, at its core and inception, connected to Tibetan Buddhism. The Buddha himself, also known as the “Master of Remedies” or the “Divine Healer,” “established the basis of Tibetan Medicine thousands of years ago in the form of the Gyushi, or Four Medical Tantra” (Baker, 1997). The major principles within Tibetan Medical system rely on the concept that suffering and the “root of all disease and discontent” is peoples’ “erroneous conception of reality” (Baker, 1997). Healing becomes more than just physical, but mental and spiritual; Tibetan

medicine “[heals] the body to liberate the spirit and overcome the conceptual structurings of reality” (Baker, 1997). This even further connects Tibetan culture, and therefore the lives and experiences of Tibetan Women, to Buddhist doctrine, institutional structures, and philosophies. The more specific literature read and used within this paper gives detailed information on Tibetan women’s pregnancies, births, and mothering traditions from many different locations within and outside of TAR, portraying the diversity of Tibetan communities and cultures as well as a diversity to who is meant by ‘Tibetan women.’ The literature explores spiritual and religious aspects of the birth process, common superstitions, individual women’s personal accounts, and Tibetan Medical knowledge. While these texts supply a well-rounded basis of knowledge on Tibetan women and their traditions around health, conception, pregnancy, superstitions, birth, and infant care, the information is not current. The bulk of these bodies of work were written in the early 2000’s; the earliest piece of writing used within my paper was published in 1983 and the latest 2010. This pool of knowledge, however, is not made irrelevant by time; rather, it creates a stable foundation of traditions, context, and history in which my paper contributes to as a present day study of birthing experiences amongst Tibetan women living in Shangri-La, Yunnan, China.

The most important difference between the situations of Tibetan women in previous literature and present-day, is that women now have to give birth within hospitals. Based on a UN initiative to decrease infant mortality rates and increase birth registration, particularly among underdeveloped areas or countries, China began implementing increased standards for women and infant health care within hospitals, particularly in obstetrics and gynecology. In 2001, the regulations of hospital’s obstetrics departments and deliveries in general; only government hospitals at a county level and higher can handle deliveries. This law extensively regulates all aspects of the care for women, infants, and childbirth. The technicalities of the legal regulations are not the focus of my paper, however knowing that this law went into

effect in 2001 and has made great strides towards the goals of decreasing infant mortality and increasing birth registration is important background to understanding the experiences of the women, and also men, who I spoke with. Detailed in the discussion of this paper are details regarding these hospitals and their birthing services as they relate to my participants. (Li & Feldman, 2010; 中华人民共和国母婴保健法实施办法)

My study in Shangri-La arose from the current divergence between the history of traditional Tibetan birthing practices detailed in the existing literature and the new circumstances requiring women to give birth in hospitals. I hoped to explore what birthing traditions existed in specific Tibetan communities and families, and the degree to which those birthing traditions were changing or being lost, the impacts this was having within communities, and what women's personal experiences were, both individually and across generations. This intended path of exploration guided my project in the creation of interview questions, the demographic of people I interviewed, and my location. As I put my plans of study into action, though, I slowly came to realize that my original expectations for the study were not present in the experiences of my interviewees. My results did not align with either the existing literature nor the issues I expected to find in the current difference in where, how, and with whom women are now giving birth. This discrepancy in the previous research and my own data is what I intend to explore in this paper; discussing the differences within aspects of the previous literature and my own findings of Tibetan birthing experiences and why these differences might exist.

## Methods

I conducted my field work primarily in Shangri-La, with short trips to three other Tibetan areas of Diqing Prefecture: Feilaisi, Benzilan, and Yangla. As my topic revolves around Tibetan women, it was important for me to be located within at least one Tibetan

community. I chose Shangri-La for a few important reasons, the first being my previous experience in and knowledge of the area. I had previously done field work with a professor and two fellow students from Guilford College in Shangri-La for one month, making me slightly more familiar with both the location and the people. My second reason was the access a city such as Shangri-La would provide me with; it is a developed enough city to have access to more established hospitals, but not a very big city. Finally, Shangri-La is a small city within a mostly rural area and would provide easy access to Tibetan areas outside of a city, giving me a diversity of location, access to health care, and lifestyle. Traveling to Feilaisi, Benzilan, and Yangla were in the hopes of diversifying my participants and therefore my data. Feilaisi was chosen based on its religious significance; *Khawa Karpo* is a sacred mountain and a pilgrimage site for Tibetans. Benzilan was another location I had previously visited with my small field work group from Guilford and it was both a beautiful area and I stayed again in a small Tibetan village close to town with very welcoming and kind residents. My trip to Yangla was particularly important, as it was I was accompanying Dr. Briggs, an American doctor who has worked in the Shangri-La area for thirteen years and Yunnan for around twenty. Yangla is a far more remote area than I ever would have been able to access alone; Dr. Briggs treated many Tibetans within three different villages in Yangla and I was able to observe and ask questions, as well as live in one Tibetan family's home for two nights. In the short amount of time I conducted this field work, I believe my two weeks spent in Shangri-La and one week to Feilaisi, Benzilan, and Yangla was sufficient in giving me access to different kinds of people, environments, and lifestyles to round out my data.

Hoping to discover the community and family traditions around pregnancy and birth as well as women's experiences giving birth in hospitals, I sought interviews with different generations of Tibetan women from inside and outside Shangri-La. My ultimate goal for interviewees was to interview multiple generations of women within one family, but this

posed significantly harder than expected. The limitations and difficulties faced during the interviewing process and field work in general will be discussed shortly. I had two main groups of people as my target interviewees: pregnant women and mothers, and two periphery groups that I hoped to interview: Tibetan Medicine doctors, and monks or lamas. With pregnant women and new mothers, my questions and goals for the interview revolved around experiences within the hospital system as well as any knowledge they might have about Tibetan birthing practices pre-hospital births or perhaps any specific traditions within their family that would have been passed down. This is an important demographic, because it is relatively new for women to be giving birth in hospitals; hearing about the conditions and women's personal feelings about the process, environment, and care are important for a current understanding of Tibetan women's births as well as for a comparison with older generations' home births. Additionally, I was interested in whether or not the younger generation of mothers, or soon-to-be mothers, would know anything about their mother's, grandmother's or great-grandmother's birthing experiences and if there was knowledge about the birth process and familial or generally Tibetan traditions that had passed down to them. Are there generational differences in knowledge and traditions around giving birth or pregnancy? Is knowledge and experience passed down in general, and if so does this generation of hospital births still receive the information and tradition? To know more about the birthing traditions and practices in Tibetan communities and families – if there were any and what specifically they were – as well as the experience of giving birth at home, I needed to speak to mothers of older generations, most likely grandmothers or great-grandmothers. From this generation, I expected to hear more similar things to what I had read: the natural, religious, and traditional aspects of pregnancy, labor, and infant care. This information was equally interesting to me and necessary for my study, as it gave historical and traditional context as well as contrast to the experiences of new mothers in hospitals. Finally, as

additional information to my focus on women's experiences, I wanted supplementary interviews with doctors and lamas, who would give insight into the Tibetan Medical and Buddhist side of birth. For doctors and lamas, I hoped to ask questions more rooted in Tibetan Medical or Buddhist doctrine and opinion on women's bodies and the effect these religious or medical beliefs had on birth and birthing practices.

The questions I posed varied based on who I was interviewing, the environment in which the interview took place, and the degree to which language was a barrier. For my two main focus groups, pregnant women and mothers, the questions I hoped to ask often overlapped, but I ended up only interviewing mothers, and no pregnant women. For new mothers, the feelings and experiences leading up to delivery were important to my line of questioning, including, but not limited to: how often and for what reasons they had to go in to the hospital, how they felt about their pregnancy and the care they were receiving or had received, whether they would rather, if they could choose, a home birth or a hospital birth, and if they were aware of any traditional, Tibetan birthing practices. Additionally, I asked new mothers if they knew anything about their own mother's delivery. For older generations of mothers, the questions centered around their own home births, and whether or not they knew of or personally used any traditional Tibetan birthing practices. To gain a more official, medical view of birth in Tibetan culture, I asked Tibetan Medicine doctors about what procedures they had for pregnant women, births, complications within the birthing process, and if Tibetan Buddhism effected these procedures in any way. I hoped to ask lamas about how doctrinal views of women and women's bodies might affect birthing traditions or practices in Tibetan communities, but I, unfortunately, did not have the opportunity to speak with a monk or lama.

The significance of who, exactly, I interviewed is in the demographics and patterns and not necessarily who each of them were individually, however a list of human resources



can be found in Appendix A. The majority of my interviewees were women between the ages of twenty-five and thirty-five. My youngest interviewee, Ingrid, was twenty with no children and my oldest interviewee, Phoebe, was forty-seven with two husbands, two children, and two grandchildren. I interviewed six men: two male, Tibetan Medicine doctors between the ages of thirty and forty-five; one American male doctor, fifty-six; two fathers between the ages of thirty and forty; and one unmarried man around thirty years old who grew up in a nomadic community. The majority of my interviews were done in Shangri-La, with residents of the area. These people had easy access to the Prefecture Hospital and lived a city, albeit small city, life. I interviewed two people within rural families; one of the families had three generations within the home and the other family had four generations. Crucial to the information I learned through interviews, is the participant observations made while in Shangri-La and in surrounding Tibetan communities, particularly Yangla. In Shangri-La, I spent two-and-a-half weeks volunteering at The Shangri-La Handicraft Center helping local children and one adult with the English language, sitting in on an American Dr. Brigg's clinic, getting a tour of the PH, and getting to know the area and its residents. To diversify the information I was receiving, I traveled north/north-west of Shangri-La to three different Tibetan areas: Feilaisi, Benzilan, and Yangla. As women in all of these areas go to Shangri-La to deliver at the PH, it was important for me to both understand the distance and condition in which one would have to travel, and also observe different Tibetan communities, whether they be significantly more rural, a higher concentration of Tibetans, a pilgrimage site, or just a different natural environment. In Yangla, specifically, I spent three days living in a fairly remote Tibetan home village in a Tibetan's family home. The lifestyle, environment, and family structure within the Yangla villages I was in contrasted the Shangri-la way of life I had been immersed in and gave more depth and understanding to my study. While more diversity in location, family structure, and generations would have benefited my

understanding of the topic, I was able to observe enough of rural versus city dynamics, differences in family life and organization, and enough of a diversity in age, that language barriers could allow, to create more holistic findings and analyses. Along with many other barriers faced during my study, language made who I was able to interview and the amount or quality of information I received more challenging.

The major limitations faced during this study were access to a diversity of locations and the languages barriers of both Chinese and Tibetan. As depicted in my discussion of location, without someone to both transport and introduce one into a rural community, there is little hope of entering rural Tibetan areas, let alone having the ability to speak with the residents there. Most of my information came from Shangri-La residents who lived within a short distance of both the prefecture hospitals: the People's Hospital (PH) and the Tibetan Medicine Hospital and who lived in a city with developed infrastructure such as roads and communication. This was clearly not representative of all Tibetans living in the Diqing prefecture, particularly Tibetans living in more remote villages with significantly less access to hospitals. Accessing remote villages would not have been possible without Dr. Briggs and his Tibetan nurse. Not only might I never have observed remote village life, but I never would have been able to communicate well enough with those who lived there. This was an issue in general, but heightened within rural Tibetan villages; many Tibetans, particularly in the older generations, know little to no Mandarin and only speak Tibetan. Knowing no Tibetan, other than how to greet someone and say 'thank you', and having limited Chinese, myself, it would have been impossible to communicate with older Tibetan generations and perhaps younger generations as well. This particular language barrier was overcome by the presence of Dr. Briggs' nurse who translated between Chinese and Tibetan, and if the Chinese was still unclear Dr. Briggs was able to translate from Chinese to English. This made the impossible possible; however, in many other instances in Shangri-La, Feilaisi, and

Benzilan I was unable to communicate with women and men who only spoke Tibetan. This significantly limited the pool of interviewees and therefore the diversity of information I gathered. Additionally, communicating with Tibetans in their native tongue might have changed the dynamic of the interview and possibly their answers and comfortability. Since I am unable to speak Tibetan, Chinese was the primary language spoken. My Chinese language skills are intermediate, at best, which gave me the ability to have conversations and interviews in Chinese with varying degrees of success. While I was able to get plenty of information out of my interviews, it is important to recognize the limitations of conducting such conversations in a language I am not fluent in. This limited the degree to which I understood my interviewees and the ease at which conversations could occur. Additionally, even if I had fluency, the fact that my notes from interviews in Chinese and my analysis of the information gathered within this paper are all in English pose an altogether different issue of how accurate translations are between languages. As I am neither fluent nor capable of official translations, it must be said that certain information in this paper has been gained through the Chinese language and unprofessionally translated into English. Lastly, gaining access into government hospitals, which I had intended to take full advantage of, posed cumbersome and sensitive; I was unable to access the hospitals in Shangri-La for observation or interviews of employees or patients.

## Discussion

What are important documented traditions for women who are pregnant, giving birth, or new mothers in Tibetan culture and how do they compare to the current experiences of Tibetan women living in and around Shangri-La? In the following discussion I will explore the following aspects of the birthing process: the relationship between religion and health; the daily routines and activities of pregnant women or new mothers; conception; preparation for delivery and who is present; delivery, safety, and medical care; infants, family structuring,

and men's roles; and a discussion of rural versus city experiences. This exploration will be, more specifically, a comparative study between my findings and Anne Hubbell Maiden's work, *The Tibetan Art of Parenting*, as well as supplementary works by Sienna Craig and Norbu Chopel, which detail Tibetan women's traditional childbirth practices. Finally, I will hypothesize on how and why the differences between the literature and my findings might exist.

## Religion & Health

Noble one, think of yourself as someone who is sick  
Of the Dharma as the remedy,  
Of your spiritual friend as a skillful doctor  
And of diligent practice as the way to recover. (Baker, 1997)

As depicted in this Buddhist Sutra, the health of the body and the health of the mind are not mutually exclusive, nor is Buddhism and medicine. The ultimate healer, the Buddha, established the Tibetan medical system through the Four Medical Tantras and from there, Dalai Lamas and other important religious figures have built upon the medical system, with the main source of schooling coming from the monastic institution (Baker, 1997). Monks, historically, have been taught traditional Tibetan medicine and forms of healing. Within monasteries, monks would learn a variety of subjects including medicine, and those with the skill and passion would continue to study medicine from a practiced doctor within the monastery or at a Tibetan Medical college (Baker, 1997). This is particularly important when thinking about women's health, because "the texts were written by men for male doctors and were studied in male monastic colleges;" most of the medical texts and experience is for and about men, "with women being a sidebar, or an afterthought, if they are mentioned at all" (Young, 2004). Institutionally, the Fifth Dalai Lama helped establish the first Tibetan Medical college and hospital, and while much of the established systems created since then were destroyed during the "Liberation" of Tibet and the Culture Revolution, traditional Tibetan hospitals and colleges still exist in China today. The Tibetan Medicine Hospital of

Diqing Tibetan Autonomous Prefecture exists in Shangri-La alongside the People's Hospital of Diqing Prefecture (PH), offering traditional Tibetan health care and pharmaceuticals to the Diqing community.

Dr. Yao, the head of the Tibetan Medicine Hospital, explained how Traditional Tibetan Medicine (TTM), is a way to show compassion; physicians of TTM must have certain moral capabilities and status to even be trained, let alone become a practicing doctor. Dr. Xie, for instance, chanted every morning before seeing patients, preparing his mind and body to give truly compassion care; traditionally, TTM physicians would visualize themselves as the Medicine Buddha before their day of medical care began (Baker, 1997). This foundation of morality and compassion are vital to the holistic, spiritual approach to healing in TTM. Because of the overlap between doctors and religious figures, many Tibetans will seek medical care and advice from lamas. Many of the Tibetans I spoke with seek the help of their local lamas, or lamas that they have either a friendship or familial relationship with, about problems, medical or otherwise. Some interviewees, however, pointed out that many Tibetans won't go to a lama unless they believe an issue is big enough. Similarly, both Dr. Yao, and the American doctor, Dr. Briggs, spoke of the high number of cases they see of minor health issues that have gone untreated for so long that when the patient finally seeks professional help the medical problem is significantly more serious. Dr. Yao described this phenomena specifically with Tibetan women; it is common for Tibetan women to experience "female" health issues and be too shy or private to go to a doctor for help, only coming into the hospital when those small issues become bad. As far as women's health goes in TTM, though, embryology, pregnancy, and childbirth are the most detailed and discussed. Written about and studied within TTM are "the mechanics of conception and the process of fetal development...in which religious scholars and tantric masters were concerned with articulating and enumerating a Buddhist ethics and a guide to spiritual

practice and liberation through the language of embryology” (Craig, 2009). While fascinating and important within the Tibetan medical system, this highly medical knowledge is not as pertinent to my topic, which is centered on the experiences of Tibetan women and not on the extensive medical texts and practices. What is important, though, is the connection between TTM and Tibetan Buddhism, which influences Tibetan women, and Tibetans generally, throughout their lives.

This relationship between religion and health is central to Tibetan culture and to understanding Tibetan women’s experiences with pregnancy, birth, and motherhood. The spiritual understandings of women’s bodies, discussed in the introduction, blends in with medical understandings and into different aspects of women’s lives. It can take form in access to religious spaces, not being able to handle certain Tibetan medicines (pills) as a female doctor or nurse, or needing to purify and cleanse a newborn child of its mother’s polluted womb. Because of the pervasive nature of this relationship, spiritual elements of health are a theme present throughout this topic and my paper; in almost every aspect of the birthing process lies this spiritual, medical component. Daily practices are a very tangible example of this relationship.

### **Daily Practices**

Aside from seeking spiritual and medical help, Tibetans keep healthy with daily spiritual and preventative practices. The most common practice amongst those I spoke with was to chant and pray for spiritual and physical health. Many would chant daily, others less often, but the general sentiment was routine mindfulness and merit for personal health and karma. Particularly when they were sick, many of my interviewees would chant for recovery and better health. Chanting, or reciting mantras, circumambulating stupas, spinning prayer wheels, or going to temples are all forms of healthy spiritual routines (Maiden & Farwell, 1997; Tim; Ingrid; Lila; Theo). On how exactly chanting helps daily life, Lila mentioned

how chanting makes your heart feel calm and helps you to be a kind person. Tim spoke similarly: going to temples and chanting gives peace, assumedly internal peace and possibly general peace within communities as people develop compassion for others, creating peaceful environments. These routines are important throughout life, but at times such as pregnancy or birth the prayers and spiritual practices become more focused on the health and success of the woman and child. Parents, grandparents, and other relatives or close friends will chant and pray for a child's health and well-being and might also ask for the blessings of a lama. Specific rituals pertaining to birth will be depicted in more detail in "Preparation and Support."

Routine activities and behaviors for pregnant women were fairly similar between the experiences of my interviewees and the previous literature on the topic. Most common and important, besides the spiritual activities already discussed above, women incorporated activeness, a healthy diet, and rest into their lives before and/or after birth. Activeness, particularly in the form of walking, was very important to women in previous studies and to my interviewees. Whether it be circumambulating stupas or simply walking around the city or village in which they lived, Tibetan women purposefully walked more once pregnant (Maiden & Farwell, 1997). Jackie and Loraine walked more and tried to sit less during their pregnancies, a piece of advice passed down to them to prepare for the actual birth. Especially as the delivery was getting nearer, walking more meant an easier and faster delivery (Maiden & Farwell, 1997). Circumambulation has the double effect of easy exercise and spiritual significance. One woman observed and interviewed by Anne Hubbell Maiden, Palmo, "spent the early part of the morning circumambulating the temple and praying for the health of her baby. Her mother had told her... walking exercises the child – makes the child's body supple and provides it with a firm, upright body – and paves the way for a quick and easy birth" (Maiden & Farwell, 1997). Husbands I interviewed, Tim and Theo, both said they had helped

their wives during pregnancy by going on walks with them, sometimes the extent of husbands' help during the entire birth process.

Taking good care of one's own health through a good diet is important during pregnancy. Many of my interviewees discussed the need to eat healthy foods during pregnancy, and not any junk food. Lila stressed this, saying "its not just about being a healthy person, when you're pregnant you have to take extra care of your body, like eating healthy." While the definition of healthy foods might have differed for each of the women, Jackie spoke of eating more fruits and vegetables and not eating junk food. Sienna Craig, more specifically, pulls from Tibetan medical knowledge about what foods a pregnant woman should and should not eat: "foods that are cool in nature are generally preferred over foods that are hot in nature, as well as those that are 'spicy'" (Craig, 2009). After birth, women are generally encouraged to "eat and drink strong, nourishing food such as milk, meat stew, or bone broth" (Craig, 2009). Along with food, there are traditional, alcoholic beverages that breastfeeding new mothers are told to drink. There are different variations, but each has very low alcohol content. The two main kinds of alcohol are *mi jiu* and an herbal wine with a specific medicinal flower in it and often called *zang hong hua*. *Mi jiu* is a rice alcohol, but some Tibetans make variations of it with *tsampa* or yak butter and a cooked egg, and is drunk by women after birth. *Mi jiu* "helps to restore blood flow through the body, gives the mother fresh energy, and encourages rest" (Maiden & Farwell, 1997). All of the women in Jackie's family and village had drunk this after their births and advised Jackie to, but she didn't. *Zang hong hua* is a lot more complicated to make; it is an herbal wine made from yak butter, chicken, honey, *zang hong hua*<sup>2</sup>, and *chong cao*<sup>3</sup> (Dr. Yao). Dr. Yao explained that TTM doctors will suggest new mothers drink a little bit of this wine every day to improve their

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<sup>2</sup> 藏红花, *zang hong hua*, is a parasitic fungus that kills and takes over a specific kind of caterpillar (Dr. Yao).

<sup>3</sup> 虫草 DEFINE and explain significance



breastmilk and ability to breastfeed. While *zang hong hua* and *chong cao* are very expensive to buy, they can be found locally and many villagers can forage for their own supply and make the organic solution themselves. Loraine said she drank *zang hong hua* after giving birth, but you can't drink it during pregnancy because it is said to lead to miscarriages. Despite Dr. Yao's explanation of the significance of drinking *zang hong hua*, only Loraine said she had used it. In Yangla, Phoebe and Addie had chosen to let breastfeeding happen naturally and did not use any alcohol. My interviewees who had not used these two alcohols did not extrapolate on why; however, one possible explanation could be a lack of access to ingredients, and another explanation could be the influence of Western medicine on women's perceptions of what is good or bad to use. Yangla is extremely dry and the natural environment might not have the same growth as other areas of Diqing, such as the *zang hong* flower or *chong cao*. In Shangri-La, two out of three women I interviewed within the city did not use either of the alcohols. While there could be many interpretations of this evidence, which in and of itself is qualitatively too small to extrapolate on, one might assume that having all given birth in the PH with Western medicine and living in a more developed area could have influenced their ideas of what is or is not medically effective. However, these alcohols have been used for generations, as Dr. Yao and Jackie explained, and it is clear that to an extent this traditional practice is either in decline or is simply not practiced by everybody. What remains prevalent amongst all Tibetan communities, however, is the usage of yak butter tea in great quantities. While this has general health benefits, particularly for high altitudes, yak butter gives strength to both mother and fetus (Craig, 2009).

Lastly, the tradition of rest, or lack there of, was consistent amongst my interviews and literature. During pregnancy, women go about their daily life and work, without paying much attention to rest. Dr. Briggs spoke of this, commenting on the extent to which women used to work so close up until their due date that sometimes that would simply give birth in

the fields. Tim's wife, who had given birth at home, had worked picking mushrooms during her pregnancy. With Jackie, and presumably other working, city women, they also worked for most of their pregnancies, but for more rural women before the hospital regulations, they would "[perform] all their normal chores, including carrying heavy pails of milk to market, right up to the time they gave birth" (Maiden & Farwell, 1997). While many women work during pregnancy, sometimes without any change in the labor or chores being done, women no longer work right up until their delivery, because they are not delivering within a hospital and have to stop work close to the due date in order to deliver within the hospital. On the flip side of this, however, is the period of rest a Tibetan woman goes through after delivery her baby. This tradition, as described by Lila, keeps a woman inside the house for thirty to forty days, as to keep away from the cold and wind that might have more negative affects when a woman is in a weaker state, post-delivery. Lila said this protection from cold and wind extended so far as to not washing one's body, of which Lila could only handle fifteen days of before she needed fresh air and to go about her normal life, again.

## **Conception**

Within religious texts and the literature on traditional Tibetan birthing and parenting practices, conception is incredibly significant, and still very present, however the topic is not at all present within my findings. This paper is a comparative study between my findings and previous literature, and the lack of such a crucial topic from the literature in my findings is note-worthy and worth exploring. In this section I will detail the importance of conception and hypothesize about why it is absent from my data.

A human life begins at conception in Tibetan culture, because that is when a consciousness enters into material existence. After death, a being exists in a state of existence between the death of their previous life and the birth of their next. This state is called Bardo, where beings are simply "invisible consciousness... a kind of subtle physical form" that can

exist in many places all at once and are able to move through space with no barriers such as we know in our state of existence (solid substances, etc). A being's experience in Bardo can be pleasant or it can be particularly painful and what Western, Christian ideology might think of as hell-like; the experience in Bardo is dependent a being's karma. The epicenter to the rebirth philosophy of Buddhism is karma. Karma determines the form in which you will be reborn, and to be reborn human "is considered by Tibetans to be a rare opportunity – far preferable to being reborn as a god. For only in human life, Tibetans explain, is there the proper admixture of pleasure and pain that serves as a catalyst on the spiritual path" (Baker, 1997). It is extremely fortunate to be reborn as a human being, as it is so rare that there is a Tibetan saying "comparing the chances of being reborn as a human to the chances of a blind turtle putting its head through a golden ring floating on the surface of the ocean... which it does about every five hundred years" (Maiden & Farwell, 1997). If you have enough merit to be reborn as a human, the next step is finding a couple to be reborn into. The paring of a being with parents is neither accidental nor competitive, it is purely and simply based on karma. "Everything in the birth process is linked with karma... the mother, the father, and the baby are all connected by karma," says a woman within Maiden's study of Tibetan parenting. All of the beings in Bardo are constantly surrounding couples while they are engaged sexually, but only one will have the correct karma to be born into a specific couple. The karmic sync-up of the being in Bardo with parents depends on each of their individual karmas, the couple's relationship, and the couple's preparedness for bringing a human into the world. If a being is karmically attracted to a couple during intercourse: "the consciousness joins the egg-sperm complex at the moment of conception... there is a great deal of spiritual activity at the time of conception, and 72,000 energetic channels in both the mother and father are powerfully activated" (Maiden & Farwell, 1997). At this moment, when the consciousness combines with the egg and sperm, the consciousness takes material, human form and a

woman conceives. It is not uncommon for the mother to feel her senses especially heightened at the moment of conception and know that she is now pregnant. It is also not uncommon for pregnant women to have dreams that show them the sex of their fetus. (Maiden & Farwell, 1997)

The extent to which Tibetan Buddhist and medical texts details conception and the rebirth process, as depicted in Maiden's work, suggests the magnitude of such phenomena both spiritually and tangibly for Tibetans, particularly women. Why, then, did none of the women I interviewed speak on the topic of conception? I believe the answer is that there are many reasons that this information might either not be known, not understood within my interview questions, or very private and personal. Whether or not an understanding of the religious significance of conception was known to my participants will never be known to me, however reasons as to why they might not have that specific body of knowledge will be discussed briefly in the conclusion of this paper. As to the interview process, I believe this is the most likely place for certain knowledge to be not properly communicated or completely missed. I asked my participants if they knew of any traditional Tibetan birthing practices. Practices and beliefs, first of all, are very different. Additionally, I did not include any questions about conception specifically, as I did not want to lead my questions in any forced directions based solely on literature I had read. Lastly, as most of my interviews were in Chinese or through the double language barrier or Tibetan to Chinese, questions and answers about conception would have been extremely complex and most likely lost on me. And if it wasn't the language barrier and set up of my interview, the absence of the topic of conception could very well have been due to the private nature of conception, which has to do with both sex and a very complicated, personal spiritual experience. All of these factors could have contributed to the lack of information on conception from my participants, however, it is also possible that people I interviewed had nothing to say about conception, not because they

didn't know about it, but perhaps because it was not important or relevant to their experiences.

While not about conception, I would like to add here a brief context of abortion within Tibetan Buddhism and culture as one of my interviewees, Lila, explained it. My paper is not about abortion, however any conversation about birth must include the cultural and participant perceptions of abortion. Because a human being comes into existence at conception, abortion is seen as one of the worst things you could do, as paraphrased from Lila. She continued, saying that as retribution, you would have to circle around nine snow mountains if you got rid of your baby. This is not the case for miscarriage, the natural loss of the baby. Dr. Briggs, from his medical experience and observations, believes that while Tibetans are less likely to have abortions, it is more likely for a Tibetan woman living in the city to abort than other Tibetan women, assumedly more rural women.

### **Preparation and Support**

Jackie's older sister has two children who were both delivered at home, before hospital regulations. For her first child, she was past her due date and worried that something was wrong, because she wasn't going into labor. Her husband ran to the village lama to seek help. The lama told her husband to kill a pigeon, cook it, and feed it to his wife. Her husband followed these instructions, and after she had finished eating the pigeon, she soon after went into labor. Stories of spiritual or ritual preparations and assistance leading up to labor are common within the previous research on Tibetan birthing practices. Apart from Jackie's story of her sister's birthing experience, I found no other women's experiences of spiritual or ritual preparation before labor. Below I will detail both the textual instances of traditional preparation for birth as well as the preparations made by my participants, including who is present for the birth and preparations.

The most prominent rituals within the literature are for encouraging the labor and chanting. Chanting is such a large part of daily life, that it is not surprising that at major life events such as birth more specific prayers might be done. Prayers were often done by important members of the family, such as the husband, and often coincided with other rituals done for helping delivery along. If there were more serious issues with delivery, or needing to induce labor, the help of a lama might be sought out. A lama or monk would never be present or directly involved in the birth, due to its unclean nature and the importance of monks or lamas to remain unpolluted from such proximity and exposure. However, a lama or monk might bless certain things, such as the butter that the mother might need later, before labor begins, or do special prayers for the birth from the monastery. If a birthing condition was serious enough, a lama might be asked to use divination to understand exactly what rituals needed to be done. For simply helping the labor along and trying to make it as quick and easy as possible, rituals such as this one might be employed:

there is an elaborate ritual in which a small piece of butter is molded into the shape of a fish with two eyes. A monk or respected family member recites a mantra over it two thousand times and blows the energy of the prayer into the butter. The butter fish is then given to the mother to swallow head first, without biting into it... (Maiden & Farwell, 1997)

This is said to make a woman go into labor and to make the delivery smoother. In other women's experience within Maiden's research, the butter need not be in the shape of a fish, as long as a specific mantra is said enough times and blown into the butter and fed to the woman, she will have a much faster and easier birth. This is corroborated by midwives, who have seen it work time and time again. (Maiden & Farwell, 1997)

My participants' experiences, or others' experiences whom my interviewees shared, included the preparation of certain food or drink, but lacked the spiritual component present in the traditional preparations above. Certain foods or drinks were prepared for the labor and post-delivery. Jackie spoke of the preparation of honey, and the meat from a goat or sheep, as well as scissors that would be needed to cut the umbilical cord, to be ready when a woman

finishes giving birth. These foods were said to have a lot of nutrition, which would help women replenish strength after birthing. Phoebe, during the delivery of her children –and what she knew of other women’s births , they went similarly – drank yak butter tea throughout the birth in order to give her the energy to push. These were all highly practical and less religious ways to prepare for the delivery of a child. And now, for women giving birth in hospitals, women will check into the hospital before their due date to prepare for the birth. The time a woman checks into the hospital before her due date is primarily based on a combination of the woman’s feelings towards the birth, whether those feelings might be apprehension or ease, and the distance at which she lives from the PH. For instance, Addie had to plan the roughly six hour drive from Yangla to Shangri-La for her second birth, so that she would arrive with time before the due date as to ensure that she did not go into labor before she arrived, such as on the road. At Dr. Briggs’ clinic, I met the father of a woman who had traveled from Yangla to give birth in Shangri-La, but had gone into labor midway. This woman and her family had stopped on the side of the road and called for a doctor from Shangri-La to come assist them in the road-side delivery. Lila, on the other hand, who lives in Shangri-La, could have arrived at the hospital on her due date or at the first contractions and made it to the hospital smoothly, however she was so nervous about giving birth and being prepared that she arrived twelve days early. The accessibility of care and the physical distance between one’s home and the hospital you are giving birth would effect how early or late a pregnant woman may come in; the farther away a woman lives, the more she would have to plan ahead of time when and how she would get to the hospital before going into labor. This will be expanded upon in an analysis of the differences between rural and city women’s experiences.

Who provides the most help for women leading up to and during delivery, and who is or is not allowed to be present? Here we find some similarity between previous studies and

my own. Before hospital birthing, women's most trusted attendant and advisor leading up to and during labor was her mother, or her husband's mother, and/or a midwife. It can be said, however, based on Maiden's work and my own findings, that a woman would take whatever help and support that she could, based on who was available. Most often, a woman's mother is the main source of support, as she herself had given birth and thereby knows how to help her daughter through the process. While Dr. Yao explained that previous to hospital births, every village had a local midwife, based on the inconsistencies of the presence of midwives within my home-birth interviewees or the stories they told of their relatives, midwives were not always available. If neither a woman's mother nor a midwife were accessible to her, she might deliver with the help of an older, experienced woman in the village, or sometimes with nobody at all. Graham, a man who had been raised in a nomadic family in Amdo, but who had moved later in life to Shangri-La, explained how a nomadic woman might give birth. Because of the remoteness one chooses to ensure good pastureland for your herd, a nomad family is likely to live far away from any town or city, and perhaps far from even their closest nomadic neighbor. When a nomadic woman is near to giving birth, her husband might go and bring back her mother, if she is alive and nearby, or the next closest woman in the area who has experience giving birth. If there is nobody nearby, a husband will assist his wife, often being guided and taught by her before and during labor. While this system was based on the practicality of living nomadically, families living in rural areas often had similar experiences. Gathered from my interviews, men are not typically present at birth, unless they very much want to be or unless necessity dictates a man help in any way possibly if nobody else can. Through all the information told to me by interviewees about themselves or those they knew, aside from Graham's knowledge on nomadic birth, only one husband was present at his wife's birth, and this was because he was a village doctor. In Maiden's work, however, a husband's presence was important and in some cases considered a "sacred responsibility"



(Maiden & Farwell, 1997), but not necessarily in the role of birth attendant. One superstition in Tibetan culture, explains that if a man is present during labor, the infant might be too shy to come out and this can make the delivery a lot longer and harder (Maiden & Farwell, 1997; Chophel, 1983). It is very important for a woman to receive help and support during labor, but it is not always the case that they do. In theory, a woman should know how to give birth from the experience of observing and learning from her own mother's births (of her siblings) or perhaps neighbors' births (Maiden & Farwell, 1997). In reality, however, it is unclear how much women actually knew, but often they were thrust into the situation alone and having to figure it out for themselves. Loraine's grandmother gave birth to her mother alone, as did one of the Yangla patients that Dr. Briggs saw. In some cases, as was Phoebe's, her mother was present, but did nothing but watch and wait for the baby to come. Although it varied, there was definitely a tradition of more experienced women helping women in labor through the birth process. Now that women are no longer giving birth at home, the circumstances have changed. While family members are in the hospital with women during delivery, nobody is actually in the delivery room, save the doctors, nurses, and other women also delivering. Most of my interviewees had nothing to say on this, however Lila mentioned that after it was over she wished there could have been someone in the delivery room with her for comfort and support. Despite the hospital regulations, nomad women do not always give birth in hospitals. Nomad women are giving birth in hospitals more so than in the past, but the regulation does not seem to extend to the full extent to them, because of their unique situations in very remote areas.

### **Delivery, Safety, and Medical Care**

Historically, Tibetans have experienced very high rates of infant mortality and maternal mortality. Data on these rates are very inaccessible and not very accurate, however one statistic mentioned in Maiden's work from a health agency in 2007 stated that "as many

as 20-30% of Tibetan children die within their first 12 months of life” (Maiden & Farwell, 1997). There are a few speculated reasons for this particular height of infant and maternal deaths during childbirth or infancy in Tibetan communities: poor hygiene, lack of medical knowledge or access to medical care, and environmental and social factors. These three things are incredibly intertwined. For instance, because of the very high altitudes and the cold temperatures most Tibetans live in, bathing is a rare occurrence, happening perhaps a few times a year, particularly for those living rurally with few amenities. Another large overlap is the ways in which social factors of poverty and structural violence imposed onto Tibetans have historically limited access to medical care (Maiden & Farwell, 1997). These three issues are intertwined, and it would be hard to say whether one more than another created these rates of mortality. Hygiene in many Tibetan areas was not at the forefront of peoples’ minds; people did not fully understand what infection was, nor was sanitation of high value in Tibetan life (Maiden & Farwell, 1997; Dr. Briggs; Dr. Yao). Because of this, infection has always been a large issue and attributed within Tibetan culture not to a lack of sanitation but to some spiritual force such as a spirit. Within Tibetan villages, there might be a local lama, TTM, or perhaps more recently TCM or Western, doctor, or a village midwife available for the medical care of mothers and women delivery children, however these medical figures would have varying degrees of competency as well as medical resources (Dr. Doug, Maiden & Farwell, 1997). Every woman I spoke to about their or their mother’s or grandmother’s birthing experiences said that there was no medicine or medical procedures involved, unless a complication was serious enough to go to a hospital. Finally, environmental and social factors such as altitude, remote areas with no transportation or infrastructure for transportation, as well as a general rurality to much of Tibetan areas, presently and more so in the past, that made hospitals and more developed medical care very inaccessible. Losing children is not uncommon in the literature nor the experiences of women I spoke to. Only one of the women

I interviewed had lost a child, or had told me that they had, through miscarriage, but whilst in Dr. Brigg's clinic or site visits to different villages in Yangla, I met women who lost babies through miscarriage as well as death in infancy. One woman in Yangla had given birth to a total of six children in her life, three of which had died within a year. This kind of ratio is not uncommon; a doctor within Maiden's study had told her that his mother had given birth to fifteen children, only to have nine survive (Maiden & Farwell, 1997). With a history of this kind of death and lack of stability and safety for mothers and infants, it is not surprising that the new hospital regulations are so welcomed. (Maiden & Farwell, 1997)

Every young mother I spoke with spoke highly of the hospital services and if given the choice, would prefer to give birth in a hospital and not at home. The medical care provided in hospitals for women delivering is highly developed and regulated, with very little room for error or other medical techniques. All obstetrics departments must be up to specific standards of Western medicine and there is a very low threshold for how many infants can die within the department before punishments are administered (Dr. Yao, 中华人民共和国母婴保健法实施办法). Hospitals offer a high level of security for mothers, with facilities and experts available if anything should go wrong. All the young mothers I interviewed – Loraine, Lila, Jackie, and Addie – said that the hospitals were much better and safer than home births. Money was not always mentioned by the women I spoke with, however Dr. Briggs gave some details about the current costs of giving birth in hospitals. C-sections are 800 yuan and natural birth is 1,400 yuan. If this is your first child, though, and you pledge to not have another baby after the first one (more pertinent with the one-child policy), the hospital, or government, would help pay for the birth of that first child. Additionally, if you continue to not have an additional child, the government will give an annual stipend to the family (Dr. Briggs). Dr. Briggs also mentioned that because women often come to the hospital before

their due date to await labor, oftentimes hospitals will decide when the woman goes into labor. If a woman waiting in the hospital passes her due date, after a few days the hospital will attempt to induce her labor with the use of Pitocin and are more likely to get C-sections. Pitocin will induce a stronger labor than a natural one and you lose around 1000mL of blood from a C-section, versus 500mL for natural delivery. The earlier you check into the hospital before labor, the more likely it is that the doctors will decide when you go into labor through the use of Pitocin and/or C-section. Because of the distance one must travel to get to the PH if you live more rurally or in other parts of Diqing, it is often the case that more rural Tibetan women receive C-sections. This, again, ties into the differences between rural and city women's experiences with birth, which will be discussed shortly. (Dr. Briggs)

In the literature on traditions during the actual delivery of children, it seems that far more is done spiritually and ritually before and after birth than during. As mentioned earlier about diet, giving women yak butter tea or other beverages to help give energy and strength during delivery is important as well as serving women good meat after the birth (Phoebe, Maiden & Farwell, 1997). Midwives, and presumably women who had already given birth and were helping the woman in question, would know exactly how to cut the cord and handle the placenta after the baby had been delivered (Maiden & Farwell, 1997). Oftentimes the tools, mostly scissors and knives, used to the cord were not clean; one woman even said that the knife she used was not cleaned before, but rather afterwards to clean the pollution off (Craig, 2009). This, particularly from a Western medical perspective, might account for some cases of infection and possibly infant death. Placenta is important and has many superstitions attached to it in Tibetan culture. The placenta was always buried after birth in a place where no animals would dig it up, because if an animal found it and ate it the mother could become sick (Maiden & Farwell, 1997). In Tibetan hospitals they made sure to put the placenta somewhere clean, and not just anywhere like the trash (Dr. Yao, Dr. Xie), and some TTM

physicians might even carry on the tradition of burial (Maiden & Farwell, 1997). It is unknown to me how the hospitals women now have to give birth in, such as the PH, handle the placenta. Based on the standards to which these hospitals have function and the fact that they only use Western medicine leads me to believe that whatever they do with the placenta has no specific cultural significance. While most aspects of the traditional birthing process, from conception to infant rituals, seem based in spiritual and cultural significance, the actual period of time where the woman is delivering does not seem to have many spiritual aspects. This might be due to the fact that the spiritual aspects of birth were mostly written within monastic institutions; celibate monks, while very knowledgeable about Tibetan Buddhism and Tibetan Medicine, were not wholly familiar with the female body and biology due to both its pollution and association with sexuality (Craig, 2009). Due to the possible dangers associated with home births in Tibetan culture, it is somewhat expected that given the access to hospital care, mothers would much prefer a hospital birth over a home birth. In theory, it would also be possible to still keep traditions involved in pregnancy, preparations, and infant care even if you had a hospital birth. While this seems possible, to have the security and comfort of a hospital birth, while still being able to practice Tibetan birthing traditions, it didn't arise in my findings. There were very few traditions involved in the birth process that went along with both the hospital births and the home births I was told about.

### **Infants, Family Structure, and Men's Roles**

Apart from praying, chanting, blessings, and naming for infants, my findings did not include the rituals and ceremonies depicted in the literature. A human life is incredibly sacred and important in Tibetan Buddhism and culture, thus the traditions after the birth of a child “may be found in the most ancient Tibetan texts” (Maiden & Farwell, 1997). Purification rituals are some of the most important after-birth traditions, as the blood and in many ways the entirety of the delivery, is considered polluted and impure (Maiden & Farwell, 1997,

Craig, 2009). The new mother must be cleansed by washing with warm water, because “whatever she touches will wear out or be quickly lost” (Maiden & Farwell, 1997). The infant will undergo a purification ceremony a certain number of days after birth to free the infant from the delivery’s impurity (Chophel, 1983). A common superstition in Tibetan Buddhism is sex change; that people are able to, most likely unintentionally, change sex. While a sex change from a female to a male is prayed for and welcomed, a male changing into a female is greatly feared. When a male is first born, the mother should place a gold ring onto the top of the baby’s penis in order to prevent him being changed into a female (Maiden & Farwell, 1997; Chophel, 1983). After this, a baby is bathed in a cleansing, warm bath of clean stream water and saffron and then dressed in clean and soft, incense-infused clothing to ward of evil forces. A baby will then be given the “power of wise speech” by a member of the family, often the father, by putting saffron water onto the infant’s mouth in the syllable of Manjusri, the deity of wisdom (Maiden & Farwell, 1997). Finally, the infant will have its first feeding, a “mixture of butter and barley flour” (Craig, 2009). None of my interviewees had any rituals or ceremonies for their children after birth, and contrary to the above-mentioned cleaning of a woman after birth, Lila said that it is tradition not to encounter any cold, including washing one’s self. One ritual mentioned in Maiden’s as well as from Dr. Xie is the use of an oil or solution including zang hong hua that is brushed onto the child’s lips and tongue to improve oral health, particularly gums (Maiden & Farwell, 1997). A very important component to the start of a Tibetan life is the naming of a child. Every single Tibetan I interviewed had gone to a lama for the name of their child. This is a significant tradition that stays consistent within the literature and my findings.

Within Tibetan families, mothers are the primary caretakers of children and responsible for household chores, with help from grandparents if they are available to them. As discussed earlier, Tibetan men are not usually involved in the delivery of their children,

and participate less in the raising of children than their wives. Jackie describes how she works outside the home, cooks all the meals, and then takes care of her son; the extensive labor she puts into the raising of her son on top of her previous household and professional duties put extreme stress onto her. What helped Jackie ease her stress was sharing the responsibility of raising a child not with her husband, but her mother. Jackie lives in Shangri-La and her mother and rest of her family lives in a village about an hour away. Jackie's mother does not live with her full-time, however to help with the care of her son, her mother would stay with them in Shangri-La for semi-extensive periods of time and go back and forth between Jackie's home and their home village. When I visited villages in Yangla, I witnessed this shared responsibility of raising children with the grandparents, sometimes to the extent of only seeing the baby with its grandparents and almost never with its mother. This shared responsibility seems to give great amounts of love and attention to the children, as well as helping to ease the amount of responsibilities mothers have. This large family structure of multiple generations within a home and the majority of the family living within the same village creates a very strong support system of care for mothers, children, and the oldest generations. The home I stayed in in Yangla had four generations living in one house, spanning the ages of one to roughly seventy. Additionally, the practice of polyandry and polygamy has been common within Tibetan communities, although less common within modern Tibetan communities. In two of the homes I visited in Yangla, the middle generations of women (between forty and fifty years old) were married to two and three husbands, respectively. This is a long-standing custom, and can improve the productivity of a family by delegating different responsibilities to different husbands. It can also be extremely complicated, however, in the familial dynamics within a home. The family with two husbands, who were brothers, found that this family structure worked well, because one husband worked outside the home and the other took care of the internal affairs and live stalk

of the home. The family with three husbands, however, had complicated relationships that created negative dynamics within the home, as told to me by Dr. Brigg's nurse, a relative of both Tibetan homes in Yangla. Tibetan family structures, however, seemed to differ based on location; in rural villages, large families are the norm and exist similarly to those families in Yangla described above, but in cities, the family unit within a home is often much smaller and might be farther away from the parents' hometowns. One major difference between the rural families and urban, Shangri-La families I observed was the access to a large support system in the raising of children. In rural areas where families are large and living in close proximity to each other as well as having many generations within one house, the responsibilities for taking care of children are shared and does not rely as solely on the mother. In Shangri-La, however, it was more likely that parents were not near to their parents, and therefore lacked the support in many areas of life including childrearing.

### **Rural versus Urban Experiences**

As a small boy, Graham, a Tibetan nomad from Amdo, witnessed his aunt's near death during childbirth. His aunt, who lived nearby to his family, went into labor, but the placement of the child in her womb was wrong and caused serious complications. As there were no doctors, hospitals, or experienced physicians or midwives in the area, they resolved to try and take her to a hospital. They first tried to put her onto a horse, but this did not work, so four men fastened a make-shift stretched together and started carrying her in the direction they believed would eventually have some sort of town. In the front of this caravan was a man carrying a torch for when they continued through the night, and in the back Graham walked behind with a horse. They walked across immense expanses of grasslands for a very long time before they came up on a road. At this point the group waited with his dying aunt until a truck came by and agreed to take her to the hospital. The doctors were able to save both her and her child.



While twenty or so years ago and perhaps slightly outdated, this story illustrates a common example of how isolated much of Tibetan life and peoples are from the development of cities. The differences between rural life and city life is important analyze within my paper, because much of my research was conducted in Shangri-La, which, although small and relatively isolated as far as cities go to, is a fairly developed city compared to many areas that Tibetan communities live in. Shangri-La holds the prefecture hospital in which women give birth in, making the accessibility between those living six hours away in Yangla and those living maybe ten minutes to an hour away in Shangri-La very different. It is much more convenient for women in the Shangri-La area to go to the PH for checkups, and go to the hospital right before their due date or perhaps once they experience contractions. Women living farther away, who also might have minimal access to transportation or the money to afford to make many trips, are significantly less likely to go to the hospital for checkups and are therefore less likely to know if there were complications and how to deal with them. That being said, for many women in rural areas, having the access at all to a hospital as developed as the PH is comparably a lot better to the complete lack of medical care that their own mothers experienced during the birthing process. This is not to say that living rurally is the issue, but rather that there isn't more funding or resources being placed into smaller clinics in more rural areas. An example of this kind of clinic was depicted in Maiden's research in Dharamsala:

the clinic is accessible and convenient; it is familiar with the health needs of the families it serves; the staff is part of the community and so knows those who come and is trusted by them; and the birth time is relatively short before the family walks home with their newborn. And, as in all Tibetan medicine, the relationship between helper and family is sacred.

I don't know how a clinic like this would work under the strict hospital birthing regulations, but a more community-oriented clinic would be able to blend more traditional Tibetan beliefs about birth with the medical resources and expertise of doctors also trained in western medicine.

## **Conclusion: Why do discrepancies between previous studies and my findings exist?**

As I entered this month of field work with my limited studies of Tibetan Buddhism, culture, and Tibetan women's roles within the religion and culture, I had preconceived notions of the kinds of topics that would be present within women's experiences. These notions were folly and based in a presumption that I might somehow know a group of people and their experiences through learning about them in a class halfway around the world. While I worked carefully to address the fact that I held certain biases, particularly biases about governmental control of Tibetan life, and worked to avoid influencing my methods of interviewing and observation, it is impossible to eliminate bias completely. On that note, I would like to explicitly label the ways in which I believed that, because I had read certain studies about Tibetan birthing experiences and practices, I assumed and to a degree hoped that I would be able to learn about all the traditional methods of birthing and the ways in which Tibetan Buddhism influences those experiences and practices. I felt discouraged when my interviews and observations were not turning up any spiritual or traditional practices within the birthing process, particularly ones I had read about. However, as my field work started coming to an end, I gained a new perspective; it is incredibly interesting that many Tibetans' experiences within the existing literature about birthing traditions are not present in my participants. I had assumed, to a degree, that because women were giving birth in hospitals and no longer at home with support of their communities, families and religious figures, there might be a loss of birthing traditions, but what I had not expected was that even the pre-hospital generation and stories from younger women about their mother's births did not include almost any birthing traditions. In conclusion of my field work and this paper's study of the differences between previous bodies of literature on the subject and my own findings, I would like to analyze and theorize why these discrepancies might exist.

The three avenues of inquiry that I look at as to possible explanations to the differences depicted in this paper are as follows: the influences of Western and Han culture, particularly in the tourist industry; the location of Shangri-La and Diqing as it relates to epicenters of Tibetan culture; and finally that Tibetan culture and identity is neither homogenous, nor static, and the traditional Tibetan birthing traditions depicted in the literature is simply representative of *some* Tibetans, and that the discrepancy between the literature and my findings actually holds little deeper meaning. These hypotheses, however, are not the topics of my paper, nor researched to the extent that one would need to make definitive claims. My thoughts detailed below are not claims or conclusions, but rather further inquiries I have about why my findings turned out the way they did.

The influences of Western and Han culture are apparent not just in the medical sphere, but in the daily life of Shangri-La. In the last two decades, Shangri-La has seen incredibly fast developments, particularly an ever-growing tourist market. As depicted, in much depth, in *Mapping Shangri-La: Contested Landscapes in the Sino-Tibetan Borderlands*, China has capitalized on small towns with large Tibetan populations outside of TAR in order to give tourists a destination in which they can indulge in Tibetan culture and lifestyle, without going to the more controversial TAR. The tourist market in places such as Shangri-La make Tibetan culture marketable, palatable, and “authentic” for the tourist masses. Shangri-La now attracts both the Western back-packing type, the eclectic groups of Western expats, including some of a more mission-oriented agenda, and the Han tourists who get bussed in wearing matching, giant red jackets and toting small oxygen canisters. With this kind of tourist market comes both the more permanent influences of Western culture, such as the mass amount of cafés and guest houses, and Han culture in the form of Han Chinese who decide to move to Shangri-La and open up businesses, profiting off of the new tourist attractions of “Tibetan life”. While I have not studied the tourist industry in Shangri-La and greater China, I believe that these

influences impact the way culture is defined, interpreted, and retained. Li-hua Ying writes, “for Tibetans in the Sino-Tibetan borderlands, this means that PRC state incorporation and global tourism, which come together in shangrilazation, have generated new forms of Tibetan unity,” which I believe is highly possible, but the flip side to this might be a frayed effect (Yeh & Coggins, 2014). While there might be more unity amongst Tibetans, that doesn’t necessarily mean that Tibetan culture and traditions are being more vigilantly preserved. In the face of powerful cultural, and in many ways colonial, forces, as are Western and Han cultures, is there a possibility that it is becoming harder to preserve or upkeep traditions? I have no conclusion as to the answer to this question, or whether or not this particular phenomenon is directly impacting Tibetan birthing traditions. However, it is a very prevalent and strong influence within Shangri-La that one way or another impacts the lives of those who live there, including Tibetans. This dynamic has been written about, and due to the ever changing scene of Shangri-La, might be an interesting topic for later SIT students to further investigate.

The location of Shangri-La is outside of the TAR and distant both physically and, in many ways, mentally from other culturally Tibetan areas, such as TAR or exile communities. This is integral to understanding some of the differences in my findings and the main bodies of work I am comparing it to. Maiden’s study of Tibetan parenting, including traditional birthing practices, was conducted in Dharamsala, Craig’s work was done in many different areas, including Nepal and TAR and Chophel’s study was also in Dharamsala. These are not the only sources I pull from, however they are the most detailed accounts I read and use on Tibetan birthing practices, particularly Maiden’s work. It is important to recognize that these previous studies have been conducted in highly concentrated areas of Tibetan culture. In Diqing Tibetan Autonomous prefecture, only about 33% of the population is Tibetan (Dr. Yao; Yeh & Coggins, 2014). There are many different minority groups living in Diqing,

along with Han Chinese. Could this distance from other Tibetan areas and peoples have an impact on how Tibetan birthing practices are known or preserved? Is spread of or access to cultural information and practices impacted by such a distance?

The term “Tibetans” includes “a range of human communities which are not necessarily united politically, but who are linked through common languages (or regional dialects thereof), a common religion (with much local and regional variation) and a common area of origin (the greater Himalaya/Tibetan Plateau)” (Craig, 2009). Why would literature done in Dharamsala, in 1997, represent the experiences of Tibetan women in Shangri-La, in 2017? While Tibetan Buddhism and language might be relatively similar throughout the greater Tibetan region, that does not mean that there would necessarily be consistencies in the cultures of different Tibetan communities;

for the truth of the matter about Tibet is that there was no one truth of the matter. The Tibetan world as a whole was too big, too diverse, and too poorly centralized for social conventions and practices to have been well standardized throughout. (Kapstei, 2006)

In conclusion, there might be influences of tourism or Western and Han culture, or a lack of influence from cultural Tibetan centers, but there are also, simply, very different peoples, histories, and cultures within the larger Tibetan area who identify as Tibetan. While this paper is a study of the comparisons between my collected, qualitative data, and previous studies, particularly Maiden’s, it is not to say that all Tibetans should be culturally or traditionally similar, but to see in what ways they are actually different.

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## Appendices

### Appendix A: Human Resources

Name	Gender	Age	Children	Ages of Children	Place of Residence	Location of birth
Dr. Yao	Male	40-50	-	-	Shangri-La	-
Dr. Xie	Male	25-30	-	-	Benzilan	-
Dr. Briggs	Male	56	3	-	Shangri-La	-
“Lorraine” <sup>4</sup>	Female	29	1	9	Shangri-La	PH
“Theo”	Male	21	2	7; 1	Shangri-La	-
“Ingrid”	Female	20	-	-	Shangri-La	-
“Lila”	Female	29	1	1	Shangri-La	PH
“Graham”	Male	30-35	-	-	Shangri-La	-
“Tim”	Male	30-35	1	13	Benzilan	-
“Phoebe”	Female	47	2	--; 24	Yangla	Home
“Jackie”	Female	31	1	4	Shangri-La	PH
“Ruth”	Female	38	1	20	Yangla	Home
“Addie”	Female	24	2	7; 1	Yangla	Yangla Clinic; PH
“Margaret”	Female	70	1+	47	Yangla	Home
“Betty”	Female	65-70	1+	45-50	Yangla	Home
“Lucy”	Female	45-50	1+	20-30	Yangla	Home
“Katherine”	Female	20-30	2	5;1	Yangla	PH

### Appendix B: Hours Logged

Volunteer hours at Shangri-La Handicraft Center – 47 hrs

Interviews and Observation – 53 hrs

Research – 20 hrs

Write-up – 60 hrs

Contextual, experiential study – 15 hrs

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<sup>4</sup> Names within quotations have been changed for the sake of anonymity.