Sienna R. Craig DARTMOUTH COLLEGE

"Not Found in Tibetan Society": Culture, Childbirth, and a Politics of Life on the Roof of the World

This article explores the work of culture and politics in the context of health-development interventions, through an analysis of a maternal-child health project conceived and executed in the Tibet Autonomous Region, China. This article illustrates the ways such categories circulate to serve the needs of governmental and non-governmental organizations, and, in the process, how they run the risk of essentializing culture or eliding the complex realities in which people live. Yet such elision is neither a given nor one-sided. Rather, such programs are enmeshed in a ***realpolitik*** in places such as Tibet where the trope of "culture" is both problematic and deeply influential, and where demographics are politicized in particular ways. Health-development efforts such as this project illustrate a "politics of life" (Fassin 2007) even as the technocratic tendencies of development in which such projects are implicated can remove "politics" as a sphere of discussion or engagement. Even so, such efforts can make a difference in people's lives and, at the same time, contribute to a critical, engaged anthropology of global health.

In fact everything suggests that rather than becoming separate, humanitarianism and politics are tending to merge — in governmental, inter-governmental, and non-governmental spheres (Fassin 2007: 16).

INTRODUCTION

This article explores the work of culture and politics in the context of health-development interventions, through an analysis of a maternal-child health (MCH) project conceived and executed in the Tibet Autonomous Region (TAR), China. I have been involved in this work since 2002, [1] In the early stages of this work, I was involvedinitially as an ethnographer. In intervening years, I have served as a co-researcher and advisory board member of the US non-governmental organization (NGO) through which a suite of Tibet-based MCH activities were supported, until 2008. This article situates this maternal-child health project—and my involvement with it—in the context of critical anthropology of development literature. As many scholars have shown, development interventions can (intentionally or unintentionally) render invisible local categories of meaning and experience or ignore the political and historical circumstances that have given rise to the socioeconomic problems "development" aims to address (cf. Ferguson 1994, Gupta 1998, Escobar 1995, Fisher 1997). This article takes inspiration from Pigg's (1997a, b) insights about the ways health-development programs can adopt interpretive lenses that in essence "create" subject positions such as "Traditional Birth Attendants" (TBAs) out of more complex, contested socioeconomic and micro-political contexts. Following Pigg, I argue that such categories primarily serve the needs of governments, NGOs, and global health institutions. In the process of planning, justifying, and raising funds for health-development interventions—no matter how urgent the needs, no matter how poignant the stories, no matter how powerful the statistics—we risk of essentializing culture and eliding the complex realities in which people live.

Yet such elision is neither stable nor one-sided. It is possible to witness and participate in health-development "success stories" even when situated within politically charged environments, and even though they will likely never fully transcend the logic of global capitalism (including twenty-first century philanthropic capitalism and capitalism with Chinese characteristics, in this case) or the social politics that rim universalist human rights discourse (around the fact that scores of women and children die unnecessarily from complications of childbirth, in this case). At the core of this essay is a concern with the ***realpolitik*** of health-development agendas

1. I am chair of the One Heart Worldwide Medical Advisory Board. This article reflects my perspectives and analysis and does not necessarily reflect the views of the organization.

in places in which the trope of "culture" is problematic and deeply influential, and where demographics are politicized in particular ways.

Following Didier Fassin, I argue that such health-development efforts illustrate a "politics of life": a political process that gives specific value to human life through the execution of health-development and humanitarian aid (2007: 500). While connected to Foucaultian ideas of biopower and governmentality—the regulation of populations through techniques of power and technologies of governance, respectively—Fassin's idea hinges more on affective ties. Biopower and governmentality are at play in Tibet, but are often eclipsed by positions that are more impassioned than rationalistic, more tied to conflicting moral claims and competing representations of Tibetan culture, than they are bound simply by bureaucracy or state policy (Adams 2005). As Ferguson (1994) argues, development's technocratic approaches can remove discussions of the politics of development interventions themselves. Such maneuvers take on increasing weight, I argue, in places that are overtly politicized, such as Tibet. Even so, health-development programs such as the one I describe can make a profound difference in people's lives.

This article responds to Janes and Corbett's call for an engaged, critical medical anthropology of global health (2009: 180). My article provides an ethnographic example of structural inequalities that frame the circumstances under which many Tibetan women experience pregnancy, birth, and postpartum life. The program in question is described in the context of global agendas focused on maternal-child health (MCH), and within a growing ethnographic literature that analyzes MCH programs and policies. Next, Pigg's critique of the World Health Organization (WHO) Alma Ata-era assertion that TBAs can be "found in most traditional societies" becomes a springboard to examine the compellingly inverted Tibetan case—namely, the notion that there are no traditional birth attendants in Tibetan culture (cf. Pinto 2008: 29). What does this cultural "lack" accomplish, discursively and pragmatically? How has this presumption—that Tibetan culture lacks traditional birth attendants—helped to justify this organization's work? Where does ethnography fit into this picture? I explore the politics of demography in Tibet: representational discourses framing the premise that giving birth and surviving infancy in Tibetan areas is a risky proposition. Finally, I show how a moment of crisis—the 2008 Tibetan uprisings and the Chinese state's response—have posed radical challenges to this work and pushed necessary reassessments of what this work is about. As such, this article illustrates the ways disparities in health outcomes and the health-development and humanitarian agendas that crop up to address them cannot escape a politics of life. The article also provides an example of the complicated practices of such initiatives, shedding light on the possibilities and limits for an engaged anthropology of global health.

HEALTH EDUCATION AND RESEARCH IN TIBET

The impetus for the organization in question began in the late 1990s when the founder visited the TAR as part of a team conducting reconstructive surgery. During that trip, the founder, a nurse practitioner with expertise in emergency obstetrics, heard stories about the difficulties many Tibetan women face during pregnancy and childbirth, the high rates of maternal and infant death, and that many Tibetan women gave birth at home, often alone. The Maternal-Fetal Medicine Division of the University of Utah Health Sciences Center, where the founder of this organization was employed, then initiated a series of trips to the TAR. The team from Utah, which included high-risk obstetricians and other OB/GYN experts, laid the foundation for a decade of collaboration; they were eventually invited by the TAR government to investigate the MCH situation in Lhasa Prefecture and, in consort with local partners, plan programs to improve MCH education, research, and clinical practice.

From the outset, this effort included collaboration between Tibetan, Chinese, and foreign (mostly US) clinicians and social scientists. This cross-cultural, multidisciplinary network was united around the premise that maternal-child health care could be improved in Tibet, through the provision of more and better basic prenatal care to pregnant women, assistance at delivery, antenatal care, and improved possibilities for referral in emergencies. Health education and equipment for rural village and township clinics to tertiary care centers in Lhasa, could contribute to this effort. As many of the people initially involved in this work were not only seasoned clinicians but also well-respected researchers, and since Tibet was "under-researched" in many areas, including maternal-fetal medicine, there was much to be gained by developing such programs. Yet how to design and structure interventions, at what scale, and with what focus, remained unclear initially. For reasons of geography and politics, Tibet was not an easy place to work.

At this time, a small yet expanding group of foreign development organizations were operating in the TAR. The organizations varied, from Euro-American state development agencies and INGOs to a private NGOs and philanthropic organizations. Working in Tibetan areas of China required each organizations partner with branches of government. These partnerships and the work contracts they produced were built on a combination of hard currency (proving that one had the capital to invest in development activities) and "soft" social capital and connections. In other words, none of these development organizations were exclusively ***non-governmental,*** although some of these organizations operated under such designations in their country of origin. While some organizations ran programs on improving health outcomes (e.g. child malnutrition, safe drinking water, Tibetan medicine, and sanitation projects), none were exclusively dedicated to maternal-child health. This fact, combined with the group from Utah's ties to a network of Tibetan friends and colleagues as well as their quite personal realizations about

a form of Tibetan suffering—the loss of mothers and wives, newborns and infants—morphed into an effort to design and implement a program that focused on unmet MCH needs in Lhasa Prefecture.

Exploratory collaboration between 1999-2001 took place through efforts to author a National Institutes of Health (NIH) and Gates Foundation grant proposal and, when funded, to begin implementing a research project that focused on maternal and neonatal outcomes. A University of Utah obstetrician, the nurse practitioner who founded the organization in question, and a medical anthropologist who had worked in Tibet for many years drafted the initial proposal, which suggested the creation of a Skilled Birth Attendant (SBA) training program and other health education work, including continuing medical education for Lhasa-based physicians. As a precursor to commencing such work, the organization founder and others from Utah forged institutional partnerships with the Lhasa Prefecture Health Bureau, the TAR Health Bureau, and the Mentsikhang (traditional Tibetan medical hospital). In addition, colleagues from Utah established relationships with medical institutions in Beijing—a diplomatic process that was uncharted in the TAR and that required time, good will, and efforts at cross-cultural communication on all sides.

The group was given permission to work in four counties in Lhasa Prefecture, selected by TAR government partners. The concept behind the initial proposal was to implement SBA trainings and provide technoscientific assistance in one or two of the four counties and then to compare, over time, key indicators between these "control" and "intervention" counties, such as number of prenatal visits, locations and outcomes of births, etc. However, little baseline data existed in these areas, particularly with respect to information about women's knowledge and experiences, beliefs and behaviors, surrounding pregnancy and childbirth as well as socioeconomic possibilities and constraints with respect to maternal and child health care. As such, ethnographic interviews were prioritized: interviews and focused discussions with women in these counties and rural health care providers. This research commenced in 2002. I became involved in this project by the fall of that year. Results of this ethnography are described in Adams et al 2005a. These data served, in part, as a basis for the SBA curriculum developed by Tibetan and US clinicians.

By late 2002, the project bifurcated into the NIH/Gates-funded clinical research project, whose history and outcomes are described elsewhere,[2] and the programs and activities of a newly formed non-governmental organization, OneHeart, wherein the "heart" initially stood for "Health Education and Research in Tibet." Between 2002-2004, OneHeart worked with its institutional partners, international health care professionals, and Lhasa-based staff to develop, execute, and evaluate programs. A four-month SBA training became the organization's hallmark. The training was taught collaboratively by US certified nurse midwives and a Tibet-based committee of biomedical and Tibetan medical physicians. This model allowed cohorts of government health workers from rural areas—who had a mandate to assist with MCH care but had limited training and virtually no support—to benefit from didactic courses and hands-on internships in Lhasa hospitals. Other programs included physician trainings taught by OB/GYNs from the US and geared toward expanding the medical repertoire and improving skills of Lhasa doctors—the same people who were also "master trainers" and members of the organization's Curriculum Committee. OneHeart initiated a village outreach program in 2004, co-facilitated through the Women's Federation (the rural, gendered arm of the Communist Party). This program aimed to expand knowledge about danger signs in pregnancy, encourage birth preparedness, distribute birth kits, and incorporate SBAs into home and clinic-based births.

Between 2004-2008, these programs became more refined and integrated, eventually articulated as a "network of safety." This model, guided by the Continuum of Care (COC) framework, acknowledges the health and well-being of women, newborns, and children should be managed comprehensively across levels of care, ***and*** across time and geography, and in ways that are attentive to cultural and socioeconomic realities (Sines et al 2006). OneHeart's work came to include an explicit research component. Data collection systems were developed in parallel with, but with support from, prefecture and county-level health bureaus. Research endeavors included a Center for Disease Control (CDC)-funded project on the relationship between nutrition and maternal-child health outcomes and programs on neonatal resuscitation and birth defects. This period also saw an increased level of educational exchange between US and Tibetan collaborators: US-based medical, MPH, and social science students participated in OneHeart's activities, while Tibetan collaborators came to the US for educational opportunities, facilitated by State Department- and privately-funded support. The joint Tibetan-US team began plans for a new MCH training center in Lhasa, inaugurated in 2008. However, the trajectory of OneHeart's Tibet-based work changed radically in the wake of the March 2008 protests in Lhasa and the political activity and state repression to follow—issues to which I turn below.

OneHeart's approach in Tibet was in its infancy at the same time as the United Nations introduced its Millennium Development Goals. OneHeart's core mission falls within the purviews of Goal 3 (promote gender equity and empower women), Goal 4 (reduce child mortality) and Goal 5 (improve maternal health). OneHeart has "grown up" in an era of increasing attention to MCH indicators worldwide, a rise in private, state, and bilateral funding for programs that focus on women and children, and a rise in prominence of "Safe Motherhood"—as a strategy, a slogan, a set of policy guidelines, and a web of individuals and organizations working across local-to-global scales. The rise of non-

2. See Adams et al 2005a, b and 2007; Miller et al 2007, 2009, Tudor et al 2006.

governmental organizations, private charities, and bilateral partnerships is part of a larger trend, including the NGO-ization of development, the shifting roles of nation-states and other geopolitical realignments, and the increasing neoliberalization of the global economy (cf. Igoe and Kelsall 2008). Timing is significant.

Concomitant with this increased transnational attention to MCH issues, I note an increase in critical development studies literature on the politics of reproductive health care in the context of modernity. This work includes engagements with how regimes of authoritative knowledge play out in health-development interventions focused on pregnancy and birth. It also includes analyses of how biomedical and more local or "traditional" systems of knowledge around pregnancy and childbirth become disarticulated, and the social and medical impacts this can have. Such impacts include increased medicalization of birth including the devaluation or lack of attention in health-development programs to the diverse roles that women play and social categories that women occupy around pregnancy, birth, and postpartum care (van Hollen 2002, Gutschow 2010), as well as social hierarchies in the context of care (Shiffman and Garces de Valle 2006, Pinto 2008), problems of transport (Davis-Floyd 2003), and Safe Motherhood interventions (Berry 2010). OneHeart's programs were attentive to many of these critiques and caught up in others.

In Lhasa circa 2002-2004, this convergence of increasing transnational funding, a focus on SBA/midwife training programs, and the rollout of Tibet-specific Integrated Management of Childhood Illness (IMCI) protocols was notable. At this time, at least seven foreign organizations in the TAR were working on MCH. Yet OneHeart was the only organization in the TAR exclusively devoted to these issues. In concurrent and subsequent years, foreign organization-sponsored MCH programs commenced in other Tibetan areas of China. These social facts—increasing national and global attention to maternal and child health, corresponding increases in local and regional MCH programs, and concomitant increases in critical social science exploring the impacts of such work—are not unique to Tibet. However, the truism that there are no traditional birth attendants in Tibet is exceptional—an issue to which I now turn.

"FOUND IN MOST TRADITIONAL SOCIETIES"

In an essay that bears the same title as this sub-section, Stacy Leigh Pigg reminds us that no discussion of "beliefs and behaviors" with respect to health-development programs is socially neutral. Through her analysis of midwife trainings and related interventions in Nepal, Pigg examines the ways such programs (as well as the institutions and individuals that underwrite them) can adopt specific interpretive lenses that create categories of being and experience such as "Traditional Birth Attendants." If one's developmentalist mandate is to fashion a training program for birth attendants attentive to "local realities" or deemed "culturally sensitive," then one is often compelled to find individuals within a "community" who seem capable of meeting such criteria. The problem is, through the process of locating TBAs, power-laden translations take place, including a concept Pigg calls "side switching." Side switching involves "processes of social differentiation, placement, and displacement that occur in and through development activities" (1997a: 260). In Pigg's ethnography, we encounter Nepalis who reject the idea of "culturally appropriate" development and development experts who pine for a certain kind of "traditional" person to become the first object and later the socially-modified product of health-oriented development interventions.

In another article, Pigg (1995) reminds us about the power dynamics inherent in the types of socio-linguistic and political translations that make it possible to "find" TBAs in so many "traditional" societies. These dynamics involve understanding acts of translation are "as much a matter of social positioning as it is of language (1995: 47). Acronyms such as TBAs efface or de-politicize these power relations. Universalizing principles inherent in much development discourse can systematically de-contextualize sociocultural experiences in the course of attempting to account for them. We might note this as the penchant to display "cultural competence" in global health work in ways that can lead to profiling patients and their families. In her analysis of the ways the term ***sudeni*** becomes a gloss for "TBA" in Nepal, Pigg shows how the act of "finding" TBAs to be recruited for SBA training programs can actually collapse a range of Nepali women's knowledge, social positions, and expertise, co-opting a Nepali linguistic marker to stand for something that it often does not mean in the vernacular (1997a: 271).

Pigg's work encourages a sharp evaluation of how terms like "traditional" and "indigenous" have been wielded by anthropologists and development workers alike. Such terms are wrapped up in the work of anthropology and development in complex ways. Pigg unravels not only how and why health-development practitioners are capable of "finding" all those TBAs, but also why anthropologists critique these renderings of identity and question the inattention to power dynamics and social relationships in which the practices of TBAs are embedded (1997a: 275). Attention is placed on incommensurability and the power dynamics at play in the translation of authoritative knowledge (Jeffrey and Jeffrey 1993). Yet, when faced with evidence that some rapid efforts at building socio-linguistic bridges across gulfs of culture, medicine, and power result in health programs that are "effective" in social, epidemiological and perhaps even political senses, Pigg asks the question: "Can bad social analysis result in good development programs?" I continue to ponder this question, and return to it in the conclusion.

First, though, an important point must be addressed: namely, in Tibet we are confronted with the inverse of the truism that TBAs are "found in most traditional societies." Studies of Tibetan medicine reveal that this "science of healing" (*gso ba rig pa*) includes textual references and pharmacopeia

on which to draw, which address obstetric and gynecological issues and, to a lesser extent, children's illnesses. In practice, though, Tibetan doctors rarely participate in births. Taboos around menstrual blood and the polluting effects of childbirth are realities I have encountered first-hand and have been documented elsewhere (McGranahan 2010, Rozario and Samuel 2002, Adams et al 2005a). Qualitative research conducted in Tibetan areas of China, Nepal, Ladakh, and Tibetan exile communities in India discuss ritual practices performed during and after birth and, as such, engage questions of Tibetan women's agency and conceptualizations of pregnancy and birth experiences. However, none mention a specific ***category of person*** known for attending or assisting birth, and some specifically note this absence (Pordie and Haricart forthcoming, Vorndran 1999, Chertow 2008, Gyaltsen et al 2007, Heydon 2011). This absence ***may*** reflect the fact that there exists no commonly identified ***linguistic marker*** for a person who assists with labor and delivery. Some recent work from Qinghai province indicates this may well be the case—at least in parts of northeastern Tibet (Tsering forthcoming).

Regardless of ethnographic "exceptions," clinically trained colleagues with whom I worked in the TAR—Tibetans, Chinese, and foreigners, alike—reiterated this assertion. At first, I was comfortable with this generalization—a generalization whose implications, if not its empirical truth, I am impelled to reexamine now. As Pinto (2008: 32) puts it, I have begun "to sense that the idea that 'there are no midwives here' offers lack to a situation that is all about abundance." But an abundance of what? I argue that it is an abundance of lived experience around pregnancy and birth, a (relative) abundance of suffering and loss around these same lived experiences, and an abundance of discussions about Tibetan "culture" in health-development programs, such as those carried out through OneHeart.

The problematic only begins here, though. More prescient are the suppositions that can follow. One runs the risk of assuming that this cultural "lack" is somehow causal, that it can ***explain*** the high maternal and infant mortality experienced across the high Himalaya and Tibetan Plateau. This acknowledgment is a cautionary tale. As Pigg notes, "Arguments about differing points of view, grounded in relativism, slide with alarming ease into highly essentialized depictions of innate differences. Discussions of local context are readily reduced to a cataloging of discrete factors or customs of a "culture" (1997a: 264).[3] Farmer (1999) echoes these comments when he notes how "culture," when combined with a narrow epidemiology, does not adequately interrogate the structural parameters in which such "cultural" realities play out. This is a "politics of responsibility" in which tropes of culture and cultural difference can be used to deflect attention from structural violence and social inequalities and engage in "blame the victim"-type discursive and policy practices (Nichter 2008: 135).

On the ground in the TAR, this notion that Tibetans did not have traditional midwives gave way to a range of other narratives. For some, it provoked discussions of Tibetan "backwardness" and how traditional "beliefs" made the tasks of improving health outcomes among rural Tibetans difficult.[4] At other times, this lack redoubled a commitment to "best practices" and improve the "safety" of Tibetan birthing environments—even though ethnography revealed that ideas about what "safety" entailed were often contested (Adams et al 2005a). Sometimes urban Tibetan and Chinese colleagues voiced such sentiment; other times, foreigners involved in the project spoke in these terms. When asked why he was compelled to work with Tibetans on these issues, one American obstetrician said he was in Tibet to "push back the tide of ignorance" he saw in Lhasa hospitals and in county and township clinics. Among some foreigners, such narratives hinged, at least in private moments, on the notion that Tibet was in need of "saving" (Adams 2005). I say all this, but I also acknowledge that my fellow American collaborators' positions, while infused with the convictions of biomedical superiority, were also coupled with a real desire to provide a "preferential option" (Farmer 1999) for Tibetan women and children, to address standards of care that might cause unnecessary harm, and to do so in ways that respected and listened to Tibetans they worked with.

For Tibetan administrators and clinicians involved in the project, the positioning of culture was even more complicated. Part of why TBAs might not be "found" in Tibet may actually have to do with the problematic nature of "the traditional" in contemporary China, especially within the context of a "minority nationality" (C. ***minzu***) with a troubled political history and for whom religion plays such a powerful role — as an organizing principle of society and, equally, as a foil for all that is in need of "liberation" and social reform. For some of the Tibetan, Chinese, and multi-ethnic doctors and staff, maternal and child mortality was only "cultural" inasmuch as this could serve, in sympathetic moments, as a proxy for the effects of poverty, rural/urban divides, and lack of education, or, in unsympathetic moments, as a proxy for stubborn, superstitious streaks within Tibetan consciousness that refused to be "modernized" in line with Chinese policy. In Pigg's terms, side switching occurred here, too.

Beyond this—and to be quite frank—the "social fact" that Tibetans have no traditional birth attendants served as a powerful entrée into a much more complex political, socioeconomic, and historical milieu. Specifically, I note experiences of political repression and state violence, patterns of economic exclusion intimately tied up with China's

3. Interestingly, the ***presence,*** rather than the ***absence,*** of TBAs have been viewed as a causal factor contributing to high maternal mortality. When the WHO initially engaged TBAs, they were trained in basic biomedical obstetrics (Verderese et al 1975). This was followed by a policy shift ***away*** from TBAs and, instead, the characterization of such individuals as ***obstacles*** to the delivery of good care (WHO 1992).

4. See Fischer (2008a, b) and Yeh (2007) for accounts of this trope of "backwardness" in state-driven development discourses in Tibet.

infrastructural and military investments in Tibetan areas, its desire to quell ethnically-based social unrest at any cost, and its visions of state's growth, including its now well-established agenda to "develop the West". These circumstances were nearly impossible to discuss openly. In contrast, the dearth of traditional midwives was something around which OneHeart and its partners could coalesce. The perpetuation of the idea that Tibetans had no TBAs gained OneHeart traction in China and abroad with supporters of right motivation, some of whom had little direct knowledge of Tibet or the politics of health-development work, but who sought to contribute to a good cause, and who were move by OneHeart's founder—her dedication to this work and her charismatic ability to convey Tibetan realities.

The ethnographic research we conducted helped diversify our understanding of Tibetan cultural practices around pregnancy and childbirth—at least as they articulate in this area of central Tibet—and to inform program development. We learned that rural women sometimes deliver in an animal pen, so as not to offend household protector deities and other spirits or pollute the hearth. Women we interviewed rarely prepared a layette. Some said things like "when there is too much preparation, the baby may die at birth"; for others, this lack of preparation was simply described in economic terms. Distances between homes and clinics, lack of knowledge about the biomedical signs of complicated labor or high risk pregnancies, a lack of transport, and insufficient money for such transport or hospital fees all played into decisions about where and how to give birth. Likewise, women noted fears—comprehensible in both cultural and epidemiological terms—about hospitals being places of pollution, death, and cycles of disease. We learned some health care workers felt ashamed to assist with birth or they desired to help but felt completely unqualified to do so. We met some health care practitioners who had been delivering babies for years, and who incorporated elements of folk knowledge, biomedicine, and Tibetan medicine into what they offered women, but who eschewed the idea they were "birth attendants" per se. We learned about dietary desires and taboos, and about ideals related to postpartum recovery ("women should rest for one month after delivery") and realities ("I went back to work on my household's farm one week after delivery").

Some aspects of the "beliefs and behaviors" identified through our ethnography were classified as "unsafe" in biomedical terms, in that they put women at risk of dying from what biomedical providers and public health experts would consider "manageable" complications such as pre-eclampsia, sepsis, or postpartum hemorrhage. It is important to note here, though, that the starting points for management, from a biomedical perspective, are these complications themselves. A woman has pre-eclampsia, so we must manage pre-eclampsia. However, this is not necessarily how women we interviewed thought about "complications." Likewise, from a biomedical perspective, practices such as giving birth in animal pens, cutting the umbilical cord with an unsterilized knife or feeding infants roasted barley flour placed Tibetan women and newborns in harm's way. This research not only highlighted such points of dissonance, but also possibilities for cross-cultural synergy around the idea of "safe" birth which informed program development. Here, OneHeart's experiences fall within a tradition of using applied social science to improve health-development interventions (cf. Nichter 2008, 1991). Yet, on reflection, while our efforts to enumerate "beliefs and behaviors" of Tibetan women with respect to pregnancy and childbirth offered an ethnographic contribution to a sparse literature and were useful from a program perspective, they may have contributed, even inadvertently, to the notion that "Tibetan culture" was a seriously agentive force with respect to maternal and neonatal death. It is worth being self-critical about the ways an ethnographer's attention to detail can morph into the types of essentialisms against which Pigg warns. Yet these were not the only representational discourses at play.

DEMOGRAPHY AS REPRESENTATIONAL DISCOURSE

After more than twenty years of health-development resources being poured into safe motherhood campaigns by NGOs, national and regional governments, the WHO and others, between 350,000 and half a million women still die each year in the world during pregnancy or childbirth (Hogan et al 2010, WHO 2007). This roughly translates into one maternal death every minute—the equivalent of a jumbo jet filled with people crashing several times daily. the vast majority of these deaths occur in so-called "developing" countries. Beyond these trends, mortality rates for delivering women and newborn children in Tibetan areas of China, as well as among culturally Tibetan communities in India and Nepal, are difficult to access, or assess for accuracy. This is due to the lack of baseline and longitudinal data, as well as the politics of demographic reporting for this population (Childs 2008: 196-204, 211-227).

However, for the sake of argument, let us consider that the maternal mortality rate (MMR) for some regions of the TAR was estimated to be as high as 400/100,000 in 2002 (Adams et al. 2005), while in neighboring Qinghai Province the MMR in 2005 was estimated at 280/100,000 (Gyaltsen et al 2007). In contrast, one Chinese source (Zhang 1997) places the MMR at 143/100,000 in 1985, 71/100,000 in 1989, and 57/100,000 in 1994. This is compared with the following MMRs circa 2008 in neighboring countries: 280/100,000 in Nepal, 40/100,000 in China as a whole, and 17/100,000 in US (Hogan et al 2010). Some health-development agencies in Tibetan areas of China have reported as many as 20-30 percent of Tibetan children die within their first 12 months of life; other statistics put the numbers at approximately 90 neonatal deaths per 1000 live births (TIN 2002). The 1982 Chinese census is likely the first "semi-reasonable" estimate of IMR of 155/1000, while research based on 1990 census data put IMRs at between 92-97/1000 (Childs 2008: 196).

These numbers help to make the case for the need to

improve MCH care in Tibetan areas. These statistics become differently meaningful when we consider socioeconomic causes and conditions that give rise to these realities, and then work to address these realities. But such statistics ***must*** be contextualized with respect to how these numbers are produced, and with respect to the demographic politics regarding Tibetan populations. This politics involves the Chinese state, exile Tibetan institutions, researchers and health-development personnel such as those of us involved in this MCH intervention, and a more public arena in which popular support for Tibet and Tibetans is voiced.

As Geoff Childs points out in his extensive studies of fertility, family planning, and demographic change among Tibetan populations in India, the TAR, and highland Nepal (2008), one of the biggest problems in discussing Tibetan mortality rates—or Tibetan demographics generally—is the dearth of data that predate the 1950s. Historical accounts, social science research, and limited census data reveal that Tibetan populations experienced economic hardship during the commune era (roughly 1973 through the mid 1980s), which registered as decreases in fertility and life span. The Great Leap Forward (1958-1961) and the Cultural Revolution (1966-1976) created hardship that adversely affected the lives of many Chinese citizens, including Tibetans. The institution of the Household Responsibility System (T. ***'gan gtsang***) in Tibetan areas beginning in 1980 in the TAR has begun a trend of steady economic improvements in Tibetan lives (Goldstein et al 2006, Goldstein, Childs, and Wangdui 2008), even though most indices of economic growth emerge from state subsidies that disproportionately benefit economic migrants as opposed to overall increases in production. With respect to family structure, Tibetan polygamous kinship systems have changed over time; there has been an upswing in polyandry (especially in central Tibet) since the end of the commune era (Jiao 2002, Goldstein et al 2002). This is significant maternal and child health in that increased rates of polygamy bear on which and how many Tibetan women are marrying and/or giving birth.

With respect to mortality rates, Childs notes, "Virtually nothing is known about levels of mortality in Tibet prior to the 1980s" (2008: 196). He explains that pre-1959 IMR of 430 deaths per 1,000 live births, ritualistically cited by Chinese sources, is likely due to a "mutant statistic" (2008: 220) in which infant (under 1 year) and child (under 5 years) mortality was combined. IMR figures also show much variation. Although a Lhasa-based hospital study of maternal and neonatal outcomes (n=2540) reported a neonatal mortality rate of 42.9/1000 (i.e., deaths within three months of birth, Yangzom et al. 2008: 319), sources above suggest higher rates of infant mortality (i.e., deaths within one year of birth) throughout rural TAR. Childs notes that between 1989-1999, infant mortality and child mortality rates declined; maternal mortality also seems to have declined in the 1990s (2008: 199-200). In addition to the lack of baseline data, any discussion of mortality must take into account declines in the total fertility rate (TFR) and increased use of contraception. Longitudinal data from rural Tibetan villages show an estimated decline in the TFR from around six births per woman in 1986 to under three by 1997 (Childs et al 2005:343). In sum, the fertility transition is well underway among Tibetan exiles and in Tibetan areas of China.

Population demographics for rural culturally Tibetan areas of Nepal remain most comparable to rural Tibet—areas where labor demands are great, population density is low, and family planning services are sparse. In contrast, fertility rates for Tibetan exiles living in India and those living in more accessible regions of the TAR have declined in an ***uncannily parallel*** fashion (Childs 2005, Fisher 2008b). This has occurred ***despite*** exile government rhetoric around the need to grow the Tibetan population, negative moral and karmic effects of abortion voiced by some Tibetans, and the desire to regulate fertility as a means of poverty reduction, in line with state family planning policies in China (Schrempf 2008). These policies include the highly controversial, if relatively localized, Chinese state efforts to sterilize Tibetan women (often after their third child) as part of the implementation of family planning policies (Goldstein and Beall 1991, Goldstein et al 2002, Childs 2008: 208), even though the one-child policy does not apply to minority nationalities officially allowed 2-3 children. Chinese government statistics and social science research since the late 1990s report high rates of contraception use (about 60 percent) with methods including IUDs, pills, implants, and diaphragms (Childs 2008: 207).

At its most extreme, demographic politics between the Chinese state and the exile government is one that vacillates between narratives of cultural genocide on the part of the exile government, and population growth and health improvement, on the part of the Chinese state. The latter is tinged with Malthusian arguments about birth control as a precondition for economic development and correlations between family size, Tibetan "backwardness," and poverty in ways that do not skillfully account for patterns of subsistence, educational improvements, and off-farm income earning strategies noted among many Tibetan populations (Fischer 2008a, Goldstein et al 2008, Childs 2008: 210). Exile Tibetans tend to argue that Tibetan populations have been decimated by the Chinese presence. Yet the Tibetan exile government bases many of its arguments about the number of people who died as a result of Chinese "liberation" on data extrapolated from a relatively small number of personalized, qualitative accounts (Childs 2008: 214-216). Chinese sources, in equally polemical ways, argue that prior to 1959 Tibetans were poised on the verge of extinction due to the Lamaist state's policies of celibate monasticism, the allowance of polygamy, and the overall lack of public health. As is often the case with polemics, neither extreme is reliable. We know that Tibetan populations in China continue to grow, particularly in rural high-altitude areas where they have been and remain dominant, even as patterns of urban socioeconomic exclusion persist (Fischer 2008b).

Aside from being interesting indicators, statistics always encounter issues of validity. Childs notes the Chinese state "has a less than exemplary reputation for handling empirical data" (2008: 190). Long-term data gathered by independent researchers such as Goldstein and Childs are incredibly valuable yet ultimately limited in scope. Added to issues of validity are patterns of reporting, or underreporting. Fischer (2008b) states—and I have experienced first hand—that infant and maternal deaths are not always reported in official registers because health care workers fear retribution in the form of fines or other political-economic punishment if "good" numbers are not recorded. Household members may under-report births, deaths, and numbers of children. Even sterilized women can be considered potentially unreliable "because local officials tend to inflate figures in order to satisfy government mandates" (Childs 2008: 207). This statistical landscape—a political minefield of sorts—leads us to the conclusion that no account of life and death in Tibetan communities, whether singular or population-based, is apolitical.

Let us locate this reality within other MCH statistics. Up to half a million women die each year from pregnancy related complications. WHO defines maternal mortality as deaths that result from pregnancy, childbirth, or postpartum complications; more than 60 percent of these deaths occur during or just after labor and delivery; over half are viewed as being caused by manageable complications such as postpartum bleeding, infections, pregnancy-induced hypertensive disorders, and obstructed labor (WHO 2007). I qualify this statement because of the need to consider what ***causes*** these causes. Each year, more than 60 million women worldwide give birth at home, alone or without skilled care (Sines et al 2006). Governmental and nongovernmental sources report that 80-90 percent of rural Tibetan women deliver at home. A female relative, often a mother or mother-in-law, often assists during childbirth (Gyaltsen et al 2007, Adams et al 2005b). When it comes to children, each year nearly ten million children die before their fifth birthday, with more than 40 percent of these deaths occurring in the first four weeks of life (UNICEF 2008). Most of neonatal deaths occurred due to asphyxia, preterm delivery, sepsis, and tetanus (Jones et al 2003). Intrapartum-related neonatal deaths ("birth asphyxia") are a leading cause of child mortality globally, outnumbering deaths from malaria (Lawn et al 2009). Birth asphyxia or "breathlessness" (***'ug pa me ba***) as it is described in Tibetan vernacular, is common.

According to WHO, the most effective ways to decrease maternal and neonatal mortality is to a) have a skilled birth attendant (SBA) present at a birth and b) have timely access to emergency obstetric services. Sidestepping for a moment the question of what qualifies an attendant as "skilled" (Gutschow 2010), and the politics of child survival (Justice 2000), meeting either of these parameters is often not possible in Tibetan communities. To make a Farmer-esque comment, these are only "manageable" complications if one has access to medicines, knowledge, transportation resources, and technologies. It is fair to say some practices we observed ethnographically may ***contribute*** to high maternal and infant mortality among Tibetans, it is, again in Farmer's words, "immodest" to stop here, when it comes to claims of causality. We must recognize how structural inequalities figure in the premature deaths of Tibetan women and children.

Furthermore, if we don't consider the micro- and macro-politics of using people's stories of suffering to promote awareness about crucial experiences of inequity, and to raise funds and design programs to help address them, we run the risk of the "suffering stranger"—a stranger who is marked as an "other" and further marked by culture—to help galvanize global health work (Butt 2002). In Leslie Butt's critique of the use of short personal narratives of suffering to frame broad global health issues—a discursive strategy common in the work of Farmer and his Partners in Health co-founder (and my college's current president) Jim Y. Kim –the use of such stories of suffering and an appeal to universal human rights to validate broader theoretical claims and activist agendas "can mask the real absence of the poor and their suffering on the world stage" (2002: 1).

So, let's get specific. I argue that early and formative ethnographic work as well as ongoing program assessments in Tibet revealed a set of structural and social parameters that conspire to work against good outcomes for women and children in Tibet. These parameters are: a) ***geographic***, with reference to poor roads and other infrastructure, high-altitude, extreme weather, and limited dietary options; b) ***micro-political and micro-economic***, with reference to how patients and health care providers interact, how both embody and/or resist state policies at a very local level, and how or if patients can afford health care; c) ***macro-political and macro-economic***, with respect to the increasing privatization of health care in China, the dynamics of socioeconomic exclusion in Tibetan areas, and the risks Tibetans bear in working with foreign organizations such as OneHeart, even when these organizations work very hard to eschew any "political" agendas; and d) ***cultural***, including gender-based inequalities, lack of education, and aspects of specific cultural practices that can predispose women and children to poor health outcomes. Tibetan "culture" is only one piece of the puzzle.

Consider these experiences. A nomad woman bleeds to death on the concrete steps of a county hospital for lack of funds to pay for an emergency cesarean section. This registration fee, printed up on forms that require a degree of literacy (in Tibetan and/or Chinese) are beyond the capacity of this nomad family, linking the fate of this woman to central government health policy reforms that, since the late 1990s, have shifted away from socialized medicine toward the privatization of health care. A Lhasa obstetrician recounts how some Tibetan women come to her in labor, with stories of financial hardship or alcoholic, abusive spouses (themselves often subjects of socioeconomic exclusion) and plead: ***pu gu me ba so***, literally "unmake" this child. The doctor may proceed with full term

abortions, and these events are recorded as stillbirths. A county-level health official intimates the "official" approved numbers of neonatal deaths he has been told he can report, and how this differs from baseline data he's been collecting as part of OneHeart's monitoring and evaluation system. As I reflect on this reality, I note that these, too, are "arrested" and "dispossessed" Tibetan histories, though of a different sort than those of which McGranahan (2010) writes, with respect to the history of the Tibetan resistance movement.

SPACES OF MANEUVER

I now turn my attention to several of the spaces within which this project was able to maneuver during its tenure in the TAR, and what happened therein. By a "space of maneuver" I mean the places, literal and figurative, in which health-development work productively, interacts with, and acts within, the parameters of politics, geography, and culture in Tibet. How is it that something, which began as a poignant slogan about saving lives of Tibetan women and children, transformed into a pragmatic and well received set of programs in which ethnography existed alongside health care delivery, clinical research, and continuing medical education? In what follows, I outline several spaces of maneuver: first, in the dramatic moments of on the ground intervention by American clinicians working with OneHeart; second, through the ***longue durée*** of maintaining partnerships with government officials, and the spaces for policy change (or at the least critical reflection on state policies) this engendered; and third, spaces of maneuver that emerged through efforts at "behavior change." These latter efforts took seriously aspects of Tibetan "culture" but also came to understand that these specific ways of being in the world were flexible and contingent, bound up with the culture of biomedicine as it is enacted in places like Tibet, and influenced by the "beliefs and behaviors" of urban Tibetan doctors and US clinicians.

Although direct intervention in rural deliveries by US clinicians working with OneHeart was a relatively rare, such moments of cross-cultural medical encounter ***did*** happen, with range of effects. The project team (comprised of Tibetan staff and US clinicians on routine visits) was at times called into a home or a clinic in which a labor was in progress, and sometimes in trouble. In some cases, the problem was obstructed delivery or prolonged labor; in other cases, it was a botched manual removal of a placenta, the signs of sepsis, or postpartum hemorrhage. In some instances, the problem could be managed locally. The insertion of American biomedical expertise into the equation, with locally trained SBAs assisting, inspired local confidence in the SBAs and in the program more generally. In other instances, local intervention was insufficient to save a life, so the US-Tibetan team would rally financial and logistical support, sometimes bringing a woman to Lhasa in the back of the program's hired car. These spaces of maneuver were dramatic. The founder and other clinicians sometimes ended up fervently advocating, as only a foreigner or a high-level Party Cadre could, for an emergency cesarean section or a blood transfusion for someone who might otherwise be lost to the sea of maternal mortality statistics.

In these spaces of maneuver, a politics of life was at work, as were American and biomedical cultural assumptions and practices. These direct interventions were not conceived of as "political" acts, but rather actions to counter a nexus of structural inequalities and to prevent an unnecessary death. Yet these moments of foreign biomedical heroism had longer-term effects, including, but not limited to, new patterns of (inter)dependency and new desires for similar interventions in the future. There is a price for, and a currency of, such actions. Such moral and medical decisions contribute to a politics of life in that they are explicit statements about the value of these women and their children, against narratives about their demise that would, perhaps, be silenced by the state or chalked up to ***karma***. These acts of skillful means and compassion ran the risk of reproducing power dynamics that have so mired and defined "development" over the years. But such acts also emerged from an iterative process of building rapport with specific people in specific places over many years—often a hallmark of anthropological method. This way of working was, in part, personality-driven and based on affective ties. Yet these acts of radical intervention were meaningful in great part because they were coupled with a long-term commitment to provide structural and technoscientific inputs and to keep returning to work in a difficult place. Within the larger programmatic approach to research and health education, these direct interventions were respectful, if complicated and political, exchanges.

A second space for maneuver occurred through the more painstaking process of maintaining partnerships with government officials. These domains of action took a good deal of conscious effort and warranted different types of approaches. They included the creation of new consensus around what having a "safe" birth meant, what a "skilled" birth attendant knew, and how she (or, much more rarely, he) acted. Further methodological questions emerged as we considered how (or if) to position "culture" in the midst of structural inequalities experienced on the ground that, in some cases, were reinforced through government policy or sub-optimal standards of care. Representational discourses mingled in compelling ways as the project unfolded. In the early days, our ethnography produced a range of reasons why women avoided government health facilities. Program evaluations and the implementation of several research projects augmented initial data. We learned that some women were afraid of being treated roughly at health care facilities: deemed "dirty" or "backwards" by people whose skills they did not trust. Others were afraid that the frightening and painful death that befell a sister, a cousin, an aunt, or snatched the soul of a newborn, would also become their story or the story of their child, should they give birth in hospital. Some stories pointed to the fact that the delivery room, such as it was, in a township clinic was neither staffed nor stocked with

medicines.

Official state policy was pushing women to deliver in hospitals or clinics, with monetary incentives both at the household level (in the form of subsidies) and for institutions (in the form of revenue) to do so. While OneHeart was not in a position to argue against this policy directly, over time the organization was able to encourage a reconsideration of this push toward hospital or clinic-based births through the evidence of improved home-based outcomes in cases where a SBA they trained was in attendance. These realities gave way to a multi-pronged approach that did not preclude home births, but that also provided techno-scientific inputs—more comfortable delivery beds, newly painted walls, birth kits, etc.—to existing rural health care facilities. OneHeart strengthened (through training and technical inputs) referral possibilities between rural and urban environments. In this case, spaces of maneuver included hybrid NGO-government support for improved rural-to-urban referral services, and a greater sense among the health care workers who participated in the OneHeart-led SBA trainings that they would have follow-up support and opportunities for further education. Slowly, over a decade of work, the organization was able to advocate for home-based interventions, rather than push a strict or normative perspective that uncritically equates facility-based births with better outcomes. Not only were more women using health facilities, but the organization had also succeeded in showing the prefecture-level health authorities that "normal" deliveries could be successfully managed at home. As such, the project's documentation of reasons why Tibetan women give birth at home has helped to complicate, if not dispel, vague yet pervasive notions that "superstition" or "cultural backwardness" was the reasons for reticence to access hospitals. This, in turn, helped to inform—and, in a few cases, reform—prefecture-level health policies.

These spaces of maneuver at the policy-level would not have been possible, I argue, without OneHeart's direct investment in Lhasa's hospitals and in education and overall life experiences of its practicing physicians. This included effort on the part of OneHeart to bring key personnel from the organization's partner institutions to the US for study tours and direct experiences of the US health care system, in rural and urban settings. Here, geographic and social similarities between Utah and Tibet, for instance, (high altitude environments with rural populations who, in some cases, harbor cultural beliefs that might interfere with or complicate health care delivery) facilitated unexpected understanding between Tibetan and American clinicians.

The third type of space in which OneHeart endeavored to maneuver takes us back to this sticky concept of culture, and ways the organization engaged with local "beliefs and behaviors". These spaces of maneuver were structured not only by official partnerships and the more overt politics of life in Tibet, but also by US and international obstetrical "best practices" and previously established parameters for "what works" in MCH interventions generally and what is predicted to be workable in a place like Tibet. This space of maneuver did not escape and could even reinforce the valuing of biomedical knowledge—specifically that produced through the international Safe Motherhood community, evidence-based obstetrics, and lessons learned from previous maternal child health-development interventions—over more localized biomedical practices and forms of Tibetan cultural and medical knowledge.

Some of the interventions aimed at behavior change focused on the biomedically defined problem of birth asphyxia and Tibetan as well as biomedical conceptions of the types of "pollution" that can negatively impact birth outcomes. Health care workers and laypeople, alike, commonly used the euphemism "breathlessness" to describe children who died soon after birth. Qualitative research, combined with direct intervention in the form of village-based health trainings, reinforced the fact that such concepts were neither stable nor uniform; they changed once families and local health workers were exposed to relatively simple technologies (plastic suction devices) and, in some cases, new vocabularies, including asphyxia, for deciphering the outcomes of a birth. Even concepts as central as ***grib,*** spiritual pollution or defilement, which our ethnography showed to be linked to giving birth in animal pens or other places away from the hearth, was positively incorporated into home-based programs. It took no grand cultural leap for families to imagine the benefits of ***containing*** pollution of birth by using a birth kit: placing a plastic sheet under the laboring woman and using a disposable, sterile razor blade to cut the umbilical cord.

Another space for maneuver existed in the issue of transport in the case of obstetric emergencies and its relationship to differential ideas of "preparedness" for a birth. Fears about preparing for a birth, linked to concerns about jealousy, gossip, and their possibilities of harming a mother, a fetus, or a newborn were common in many of the communities in which OneHeart worked. Yet so were systems of community-based labor, which, combined with support from Tibetan and foreign OneHeart staff, pushed a new model of birth preparedness plans that encouraged people to consider strategies for getting a laboring woman to a health facility in advance of delivery. The language of "preparedness" also brought with it new conceptions of "risk" and causality, in some cases. This, in turn, may have contributed to an increased number of women referred from the village or township level straight to Lhasa—essentially skipping the county level facilities altogether, even though these were institutions in which OneHeart had also invested significant material and educational support.

It is important to note that spaces of maneuver did not simply mean American clinicians coming to Tibet and introducing new ways of doing things, although at times they did just this. Spaces of maneuver also surfaced as Tibetan clinicians struggled with the question of how—or if—they should incorporate Tibetan medical knowledge

into the SBA curriculum. Early iterations of the curriculum included sections that discussed basic Tibetan medical theory as well as approaches to embryology. However, the Tibetans shaping the curriculum eventually chose to limit space in the curriculum devoted to Tibetan medicine or other concepts that could be conceived of as overtly "cultural." They made this decision in consort with feedback from the first few cohorts of SBA trainees. The reasons behind this decision remain complicated, even though Tibetan and US clinicians tended to discuss these changes as "practical" revisions to a packed, intellectually demanding program. I argue these shifts reflect a range of cultural assumptions: assumptions rooted in the culture(s) of biomedicine and anthropological assumptions that Tibetan ways of knowing the body, understanding processes of becoming human, and practicing medicine matter in the context of health-development work. Furthermore, these shifts occurred within politically charged environments that delimited how this program operated.

Finally, these spaces of maneuver echo another of Stacey Pigg's analytical contributions, namely what she calls the "social production of commensurability" (2001). This phrase references the ways communicative difficulties are "resolved" in the process of designing and implementing health interventions through particular types of language work. Pigg writes, "This concept is useful for helping us think about the actual presence of technoscience, including medicine, in out-of-the-way parts of the world, for it takes us beyond discussions of systems of knowledge that tend to come to rest in an overly static, binary and implicitly hierarchical vocabulary of difference" (2001: 482). She shows how scientific knowledge produced in one context can come to be accepted in another, and asks what the consequences are of these "routinized conceptual paths of connection" (ibid: 483). Pigg explores how the relationship between sex and HIV/AIDS come to be understood in Nepal. In the case of OneHeart's interventions in Tibet, this production of commensurability occurred around what having a safe birth entailed, and, conversely, what to do if things went wrong during labor and delivery.

CONCLUSION

From 2001-2008, several hundred Tibetan health care workers received intensive, practical instruction in obstetrics and gynecology through OneHeart. Many participated in "refresher" trainings that include opportunities to discuss tricky deliveries, conduct verbal autopsies, collect and analyze data, and evaluate problems they have continued to encounter in an effort to do their jobs well. Tibetan and US colleagues refines, redesigned, and improved curricular materials. Although statistics are slippery signifiers, in the nearly ten years OneHeart worked in two counties in the TAR, unattended home births dropped from 85 to 20 percent and newborn deaths dropped from ten to three percent. Indeed, 2008 was the first year on record when the county in which the organization had been working the longest reported *no* maternal deaths.

While small on a global scale, these outcomes are noteworthy not only because of the difficult physical and political conditions involved in working in Tibet, but also because of the overall failure of so much health-development aid to make a dent in the lives of mothers and children. With only five years to go before we are supposed to meet the Millennium Development Goals, we are faced with assessments such that offered by Larson and Reich (2009: 208), who state that persistently high maternal mortality statistics "speak to the ***limits*** of real progress" with respect to international efforts aimed at improving health, alleviating poverty, diminishing gender inequality and promoting human rights since the 1994 UN Conference on Population and Development in Cairo.

Unfortunately, none of these positive experiences were strong enough to stem the exertion of state power in Tibetan areas of China beginning in spring 2008. Like a number of other foreign organizations working in Tibetan areas, OneHeart's contract was not renewed after March 2008, despite the fact that Lhasa-based authorities had, just months earlier, actually requested the organization to ***expand*** their programs into four new counties. Without a contract, OneHeart's foreign staff members were required to leave the TAR, the future of the programs became uncertain, and the Tibetan staff faced a loss of livelihood. The founder's quest for answers regarding why the contract was not renewed led, somewhat predictably, down a labyrinth of political supposition, insinuation, and affect between Lhasa and Beijing.

But here is where the story gets even more interesting. Galvanized by their work and the meaning they found in it, the organization's Tibetan staff refused to stop working. Instead, they formed their own social service organization, registered with Lhasa authorities, under which they have continued to run the SBA training and the village-based community health programs. The very fact that they have been able to do this speaks to the implicit state approval for their work; if the political will were not there, this request for such registration would have been denied. It is no longer feasible for this new Lhasa-based organization to accept foreign funds. Instead, they have secured governmental and private Chinese support, including some from cosmopolitan Han who have an interest in things Tibetan—yet another twist on the place of Tibetan "culture" in health-development work. A developmentalist truism that rarely materializes — namely that "development" entails foreign "experts" working themselves out of a job — was an outcome, in part, of acute political unrest. From the beginning, the Americans and Tibetans behind the project envisioned a future in which the programs would be completely Tibetan-run. Politics pushed the envelope. In spring 2009, the first cohort of SBA trainees to be instructed by the entirely Tibetan staff commenced; activities continue to this day. These realities provide strange yet fitting commentary on the politics of development and of life, revealing the affective contours of structural inequality,

and the realm of the possible in contemporary China.

Now renamed One Heart Worldwide, the organization is working in new countries. This has been a painful process of trying to develop "replicable" models of intervention from the particular nature of work conducted in TAR, and to do so in ways that incorporate ethnography and participatory research methods into its assessments, program development, and evaluation. Given what we have learned about the trope of culture with respect to experiences of pregnancy and childbirth, reshaping programs that were beneficial in one context to others is an important and a tricky task. To me, it reiterates the need for anthropology to engage health-development work — to look "culture" squarely in the eye and to see where it succeeds and fails as an organizing principle, a methodological stance, or an explanation for human suffering and resilience. I return to Pigg's prescient question: ***Can bad social analysis result in good development programs?*** Maybe. But let me rephrase this. Can assumptions about culture — including categories of being and experience that a particular population seems to "lack"— be productively reworked into health-development projects that make a difference in people's lives? Here, I think the answer is yes.

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