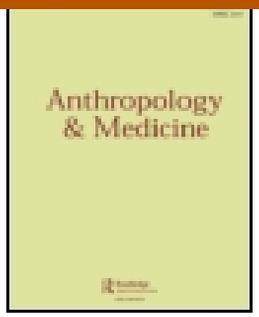

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Birds, meat, and babies: the multiple realities of fetuses in Qatar

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ABSTRACT

This paper explores miscarriage in a variety of Qatari contexts to reveal the multiple realities of the unborn. During 18 months of ethnographic research, a range of settings in which fetuses emerged were explored. The unborn are represented and imagined differently, particularly in relation to the ways they are located, with multiple beings emerging according to the context and position of the stakeholder. This paper considers fetuses produced within these contexts and considers how they can be different beings simultaneously. The paper reveals how categories meant to define these beings are in flux and are constantly negotiated; it reflects moments of ambiguity. The paper serves as an illustration of the way in which value-afforded pregnancy materials affects the contexts in which they emerge; this then loops back as context dictates the significance of the material, hence multiple realities of these beings.

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Introduction and background

Medical anthropology has long focused on multiple realities: of the body, of science, of selfhood, etc.; however, recent scholarship has reinvigorated discussions of multiplicities (i.e. see Mol 2014; Holbraad 2010, 2012). Such writings provide stimulus to move beyond merely reporting on *the experience of* and instead focusing on the materiality of the body – of women's, embryos and fetuses. Such literature emphasizes problematizing categories, both those of interlocutors and one's own, which is particularly beneficial and acutely salient in occasions of shared experience. In this paper, I explore fetuses in a variety of Qatari contexts to reveal their multiple realities and consider how particular entities come into being. The paper discusses fetuses in the ways they are represented or imagined, with this always including the ways in which they are 'located': in the womb, on a scan, on a dissection mat, at the grave site. When considering fetuses, I explore the way they are a combination of what they are and what they may come to be. Additionally, where they are actively positioned and placed leads to very different realities: the fetus is made into a certain reality as much by its specific location in the body, in the social world, and in the cosmology. Thus, this paper describes the entanglements of different places, different forms and different imaginings of the fetus in Qatar.

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Developments in medicine and technology enable us to 'see' the fetus. Seeing, like any other human activity, is as much conditioned by culture and society as by biology: seeing itself *produces* the object that is being seen (Han 2013, 80). A scanned fetus may be alive or dead: it may reassure that it is alive by moving or revealing its heartbeat or the image reveals it to be dead. An unexpectedly small creature may appear, its development ceased and so different from the 'baby' of the woman's imagination. In Qatar, once a fetus is revealed to be dead, it inhabits a reality in *Jannah* (paradise). Thus, a dead fetus *in utero* appearing on a sonogram also has reality in the cosmology. For some, there is a baby, but no fetus; as in the case of a blighted ovum. A baby inhabits the reality of imaginings of its potential. There is no 'natural' or ahistorical fetus: all fetuses are socially, culturally and politically constructed and construction varies depending on who is attributing the meanings (Casper 1998). A number of social scientists have explored the meanings ascribed to the unborn. This paper is situated within a developing discourse around fetuses and embryos (i.e. Franklin 2013; Pfeffer 2008; Pfeffer and Kent 2007; Morgan 2009; Scheper-Hughes 2003; Michaels and Morgan 1999). In particular, it contributes to limited academic literature on miscarriage and fetal death outside of EuroAmerica as well as scholarship on reproduction in the Middle East (Inhorn 2007).

In EuroAmerica, anti-abortion propaganda has been central in presenting images of fetuses to the public (Layne 2000; Michaels and Morgan 1999), but fetuses have escaped these confines and become familiar features of the public landscape. They inhabit the imaginations of pregnant woman and those who wish to be pregnant (see Layne 2000, 2003). Images of fetuses are standard in science journalism, pro-life propaganda, and consumer advertising (Taylor 1992). They are shared on websites, Facebook, Instagram and are used to advertise products. However, in Qatar, fetal images do not have a regular presence, due to an absence of pro-life propaganda and the rarity of representations of the human form. Pregnant women are familiar with fetal images through sonograms, but these are largely clinical interactions with an absence of narration: the focus is on diagnosis. Women did not tend to keep scan pictures to remember lost fetuses. A fetus whose fate was being scrutinized and determined emerged: one whose mother might continue to regard it as a baby, but whose doctors might diagnose as risky, expendable. These fetuses introduced notions of agency of those around them who might make decisions regarding their future, for example whether they will be terminated.

As part of a process of medicalization of pregnancy and birth, which has occurred in Qatar in the decades, homebirth is illegal and women seek medical assistance in the early stages of pregnancy. Close monitoring means that fetal demise is often discovered during regular appointments. Women experiencing pain or bleeding generally present to the hospital and are commonly admitted to undergo monitoring and management. Fetuses that are miscarried elsewhere are often brought into the hospital in order to be examined. This means that both live and dead fetuses are generally managed by the hospital: they are medical objects. Dead fetuses are handled, cut, collected; then wrapped and labeled and wait in the mortuary. From here they travel to the mosque and graveyard where their gestational age informs their treatment. Emerging from the ethnography is an illustration of how value afforded to pregnancy materials impacts the contexts in which they emerge, yet this loops back as context dictates its significance.

The project

The research upon which this paper is based set out to explore local configurations of miscarriage in Qatar. The research involved 18 months ethnographic research in Qatar where we followed women, their pregnancies, miscarriages, and fetuses through the different clinical and non-clinical sites they inhabited (for a detailed description of methods, see Kilshaw et al. 2016). The ethnographic research combines a study of 60 Qatari women who are experiencing pregnancy (n = 20) and recent miscarriage (n = 40), key interviews with those involved in lives of these women, and participant observation. The project utilized in-depth, embedded and analytic ethnography (Lofland et al. 2004) with the gradual accumulation of data through observation and the slow inductive analysis of these data (Lofland 1995, 47). During the course of the fieldwork, observation of selected clinical and non-clinical sites provided additional information and contextualised the interview data. Fifty-five secondary participants provided additional material on Qatari pregnancy, birth and loss: interviews and interactions with husbands, family members, health professionals, religious leaders, and Qatari traditional healers were included. The research collected and analysed in-depth data about the way in which cultural context impacts notions and experiences surrounding pregnancy and loss in Qatar.

Interviews were conducted in Arabic using a semi-structured interview script, each lasting 1–2 hours. The interview scripts explored general thoughts about motherhood and women's role in Qatari society as well as more specific information about miscarriage causation, health in pregnancy and reproductive experiences. Participant observation included: attending clinical and sonogram sessions with the Qatari pregnant participants, visiting participants in their homes, attending prenatal appointments, participating in Qatari mothers' groups, and accompanying women to traditional healers. Analysis of the qualitative data generated by the research was through a process of thematic coding and analysis. The basis of analysis was deep familiarity with the data and involved reading and re-reading the interviews and a dynamic process of organizing, describing, and interpreting raw data in order to make sense of the information. Emerging understandings and identification of key knowledge gaps shaped further interviews and fieldwork interactions. Ethics approval was granted by Weill Cornell Medicine-Qatar; Hamad Medical Corporation, Qatar; and University College London, London.

Qatari context

A constitutional monarchy headed by Emir Sheikh Tamim bin Hamad Al Thani, Qatar is a small country occupying the Qatar Peninsula on the northeastern coast of the Arabian Peninsula. A British protectorate in the early twentieth century, the country gained independence in 1971 and has experienced rapid and dramatic social and economic changes since the mid-twentieth century as the result of the discovery of natural gas and oil in 1940: a discovery that turned it from a largely Bedouin society dependent on fishing and pearl fishing to the richest country in the world. The state religion is Islam and the main source of legislation is Sharia law; the vast majority of Qataris are devout Sunni Muslims with most adhering to strict Salafi interpretation of Islam. Premarital relationships are prohibited and polygamy is allowed. Most marriages are arranged and as in most of the

Arab world, consanguineous marriages remain the most popular form of marriage (54% within the family; 34% between first cousins) (Bener and Hussain 2006). Despite its conservatism, the country has endeavoured to be an influential link between the Arab world and the rest of the world and to develop a reputation as a progressive nation in terms of education, research and politically. Qatar's total population is 2.2 million, with Qataris comprising only 10% of this number (Qatar Statistics Authority 2013). Thus, the majority of the population is composed of migrant workers from all over the world. In recent years, the treatment of these workers has been the focus of criticisms.

The Qatari state encourages high fertility amongst its citizens through various direct and indirect pronatalist mechanisms including generous family allowances, high subsidies on housing, food and energy products and state-funded Assisted Reproductive Technologies (ARTs). The emphasis on reproduction is a reflection of Islamic belief that human reproduction and the need to preserve one's social group are paramount (Tremayne and Inhorn 2012:18) and in response to Qataris minority status in the nation. While the overall population has rapidly grown since the late twentieth century, the Qatari population has only marginally increased. The Qatari fertility rate has been decreasing in recent years, but at 3.6 in 2010 it remains high compared with other countries and remains one of the highest in the Arab Gulf States (Qatar Statistics Authority 2012). Qatari women experience pressure to produce children and their social status is closely related to procreation potential. Sarra, a 27-year-old pregnant interlocutor:

> Every woman wants to be a mother and have kids. [*What happens if she had health problems or was infertile*?] They would look badly upon her because she can't have kids and she is not useful… they will talk. After the first month [of marriage] the questions start.

In Qatar, like in most of the Arab world, reproduction is largely seen as a woman's domain and, thus, women are largely blamed for reproductive problems (see Van Balen and Inhorn 2002; Inhorn 2007). Our research explores unsuccessful pregnancies to better understand whether such an event results in a potential personal and/ or social problem. This paper explores the fetus as it is entangled in these cultural forces to reveal the multiplicity of the reality of fetuses in a variety of places, forms and imaginings in Qatar.

Miscarriages and fetuses

We encountered living and dead fetuses in different places, imaginings and materialities: in bodies (both pregnant and miscarrying), on 'TV' screens, in plastic containers, on dissection mats, as sonogram images, as pictures on smart phones. Varying states played a role in different realities: a fetus, a dead fetus, an at-risk fetus, flesh, tissue. The way these are represented or imagined is always informed by the ways they are 'located': in the womb, on a scan, being prayed over in the mosque. Where they are positioned and placed leads to different realities: the fetus is made into certain realities by its specific location in the body, in the social world, and in the cosmology. In this paper, I consider cultural definitions of pregnancy and miscarriage and the ways in which the multiple realities of its subject are manifest in relations between local values and practices in medical settings. Mol emphasizes that the point of the use of the word 'ontology' was that it makes it possible to address what the sciences made of their *object*. The focus is on performing, or doing, or enacting:

> The idea was that there are not just many ways of *knowing* 'an object', but rather many ways of *practicing* it. Each way of practising stages – performs, does, enacts – a different *version* of 'the' object. Hence, it is not 'an object', but more than one. An object multiple. (Mol 2014, 1)

We are not merely onlookers: we are actors who have an impact; not just on the perception, but on reality itself. Reality is never simply 'there' for us to observe, instead it is constantly *being enacted through* practice (Mol 2014). Thus, I ask: how is a fetus made into being by the different practices around it? The medical and legal definitions of miscarriage inform the production of the thing (i.e. baby, tissue, no-thing). Miscarriage and stillbirth, abortion, and infant death are distinguished in biomedical discourse, with different implications for the management of the loss (Shaw 2014); the definitions are defined by the fetus produced: its weight and ability to survive outside its mother's body, but definitions are multiple. The ambiguity of categories adds to the multiplicity, as reflected in an interview with a clinician in Qatar:

> Miscarriage is the expulsion of uterine content below 24 weeks of gestation… The most important thing… is the weight of the foetus more than the gestational age because generally any foetal weight less than 500 g should be regarded as abortion. They said neonatal care is improving that's why they changed the date [from 24 to 20 weeks gestation] but the foetal weight [was] fixed at 500 g.

The clinician then emphasised 'the definition should be less than 500g' rather than linked to gestational age. There is no sharp limit of development, age, or weight at which a human fetus becomes viable; however, viability is rare for a fetus of less than 500 g. Definitions of viability and, thus, of miscarriage, shift in relation to medical knowledge, technology as well as locale. The World Health Organisation (WHO) defines miscarriage as expulsion or extraction of an embryo or fetus weighing 500 g or less and recommends that any baby born without signs of life at greater than or equal to 28 weeks' gestation be classified as a stillbirth (WHO 2016). Others use greater than any combination of 16, 20, 22, 24, or 28 weeks gestational age or 350, 400, 500, or 1000 g birth weight (Nguyen and Wilcox, 2005). There is 'probably no health outcome with a greater number of conflicting, authoritative, legally mandated definitions' (Nguyen and Wilcox 2005).

Interlocutors describe these beings using different terms: *tefel* (child/ baby), *janeen* (fetus), baby, *qetat lahem* (piece of meat), *Toyoor fe al Jannah* (bird in heaven). Some women indicated a lost *hemel* (pregnancy) rather than a lost being. 'Janeen' and 'baby' were most commonly used and were often used interchangeably, the latter often referring to later stages of pregnancy. In Arabic, the root letters *jeem* (j) and a double *nuun* (n) form words that generally relate to things that are covered and concealed. These include *janeen* (a fetus in the womb, 'dimunitive hidden one'), *junoon* (insanity), *jannah* (the gardens of Paradise), *jinni* (an intelligent spirit). Parkhurst, working in the United Arab Emirates (UAE), comments on the ways in which meaning and associations can be made manifest through the physical, suggesting the word for fetus indicates a 'concealed' or 'secret' human; but also hinting that the sex of the child remains unknown; the fetus remains a mystery (2014, 68). Throughout the paper, I use the term 'fetus' in the way women use 'janeen' to refer to entities regardless of gestation, thus my use of the term attempts to incorporate a range of beings/entities.

In biomedical terms, 'fetus' only comes into effect after the eighth week of gestation (Maienschein 2002); however, the term is often used for earlier gestational ages. Nomenclature neither maps neatly onto clinical gestational stages nor correlates with clinical,

physical, legal, religious and cultural distinction. A Qatari clinician expressed category ambiguity:

> Until [the] first trimester we call it missed abortion- up to 16 weeks. After that… we call it intrauterine foetal death. Some people consider intrauterine foetal death after viability at 24 weeks; but for us [it is] once the baby is developed at 16 weeks. [At 16 weeks] you can recognise [a] male baby… you can see this is boy and this is girl. [At this stage] we consider it IUFD.

She emphasizes that in Qatar 'we call it miscarriage up to the first trimester', but in other locations miscarriage is defined 'up to 20 weeks', revealing shifting categories. She refers to the development of the fetus including its sex: a fetus that is sexed becomes more recognised as a human being, something we found in interlocutors accounts. She refers to the 16-week threshold, which is informed by Islamic law, referring to both the religious and medical categories in the definitions. I will now discuss the treatment of fetuses within Islamic practice in a broader discussion about Qatari fetuses.

Alive fetuses: in the womb, at risk, unwanted, projected on a scan

Live fetuses inhabit the space within their mother's womb and her imagination, they are projected onto the screen of a sonogram machine or fill the room with the sound of their heartbeat. Some fetuses are at risk and objects to be investigated. A religious leader, an expert in fertility and reproduction, explained the importance of thresholds around whether a fetus was considered 'alive' or 'a human':

> In Qatar we follow *Madhab Al Hanbali* and so the borderline between living and non-living human being is four months. In other *madhabs* this is not the case, a foetus or baby will not be treated like an adult unless he came out screaming and shouting.

Such definitions give rise to different realities and impact their possibilities. The Sheikh quoted from a well-known hadith (Hadith 6390, Book 33, Muslim):

> Verily the creation of each one of you is brought together in his mother's belly for forty days in the form of seed, then he is a clot of blood for a like period, then a morsel of flesh for a like period, then there is sent to him the angel who blows the breath of life into him and who is commanded about four matters: to write down his means of livelihood, his life span, his actions, and whether happy or unhappy.

Based on this hadith, classical scholars theorise that the *ruh* (soul) is breathed into the fetus at 120 days gestation: at this point it is a human being. This central Islamic belief is pivotal to the treatment and management of fetuses and informs certain practices, such as legal abortion. However, the views of different schools of Islam vary as to the interval and reasons for permissible abortions; there can be dissonance between the categories that construct fetuses as social, legal and religious entities. In Qatar, an abortion can be performed at any stage if necessary to save the life of the woman; or if the baby would be born suffering severe, permanent mental or physical deficiencies, but only prior to ensoulment. The medical context gives rise to a being that is tissue and flesh, and thus disposable. However, the Sheikh described a different fetus:

> They have to differentiate between before and after the soul is blown, after that she can't abort the baby because he is considered as a human being… So if the pregnancy reaches four

> months, it is not allowable to abort him. [He can be aborted] only if he threatens the mother's life.

We asked the Sheikh if abortion was permissible following a diagnosis of abnormalities:

> Many times we face such cases. [The hospital asks] about our *fatwa*… our *fatwa* says that we should not abort him: leave him until he is out then we will deal with him. Where is mercy? God has created him and chose this for him, so we leave it for God.

For this Sheikh, once a fetus becomes a human being, it should be left regardless of potential for its death or disability.

Despite knowledge of the period of ensoulment, most interlocutors reported that a fetus becomes 'a baby' at five months gestation. Pregnant for the ninth time, 38-year-old Noor explained that the fetus became a person,

> From the fifth month… because he starts moving… you feel there is a spirit in your tummy. There is a big creature that exists. When he is small you feel there is something, but you don't know what. … . [M]y feeling about the baby starts when he starts moving. Whenever he moves or jumps I put my hand on my tummy and mention God's name, I feel there is a soul.

Similarly, pregnant with her eighth child, Houda thought of the fetus as a 'baby':

> From the fifth month, *Subhan Allah,* because you feel that it is complete *Ma Sha'allah* [*Does it have to do with the soul is breathed into it*?] No, because the soul is breathed into it from the fourth month… When it starts to move, *Subhan Allah,* I felt that the soul was blown into it.

Both Houda and Noor began to think of the fetus as a 'baby', a person separate from them, once it began to move at around five months gestation: its individual existence mediated by its movements.

Zina babies

Pregnancy is illegal for unmarried women in Qatar and, thus, such a fetus is neither legitimate nor acknowledged. An unmarried pregnant woman risks jail or deportation and may receive physical punishment. Access to maternity care is dependent upon producing a marriage certificate. Thus, the foetus of an unmarried woman is problematic, which has difficulty emerging in a Qatari medical setting, perhaps not even seen to exist. Unmarried migrant women who find themselves pregnant are advised to leave the country, ensuring the absence of such fetuses in the Qatari context. The Sheikh said:

> Women are of two types: a married woman and a single woman. The married woman should not abort her baby only in exceptional cases… she is the origin and the baby is the branch, so if the branch is threatening the origin we have to sacrifice the branch to protect the origin, not the opposite and not for other reasons such as having many children.

He then continued to say that an unmarried woman's fetus is 'haram', and, thus,

> Some scholars allow [abortion] before he turns into a human being and before having a soul. [Because the foetus is created] by shame [this baby will] remain a *zina* baby… if the soul is not yet blown, then she is allowed to abort the baby because of the shame that will follow her…

The Sheikh suggests a married woman's fetus is legitimate and sacred and must not be destroyed unless its presence threatens the life of its mother. An unmarried woman's fetus, however, is not recognised and, according to some scholars, can be legitimately aborted. Islamic law has a strict taboo on sexual relations outside wedlock (*zina*): the taboo is designed to protect paternity (i.e. family), which is designated as one of the five goals of Islamic law (Clarke 2009, 3). *Zina* threatens the entire framework of Islamic society because it confuses the lines of *nasab* (lineage), which is the foundation of the system. *Nasab* accrues to those conceived within a union of marriage; it is that which gives one full membership in society (Clarke 2009, 96). Thus, these fetuses are particularly liminal, practically invisible, and are not accorded legitimacy.

Scanned fetus; risky fetuses; liminal fetuses

Fetal images do not have a regular presence in Qatar, due to an absence of pro-life propaganda and the rarity of representations of the human form. Fetal images are, however, familiar to pregnant women due to numerous routine sonograms. Women typically undergo monthly monitoring ultrasounds from an early stage of their pregnancy. More frequent scans are common: if a pregnancy is deemed high risk, it will be more closely observed. Monitoring at the public hospital is often supplemented by additional investigations at private clinics. These may be sought for 'second opinions' about potential complications or to observe the baby for reassurance. In some cases, women seek additional scans to allow husbands to attend, as they are unable to do so in the sex-segregated public hospital.

Fetuses are located in the medical realm almost immediately and are regularly observed. The sonography sessions I observed had a clinical atmosphere. Women asked simple questions about sex and fetal size, but otherwise there was little discussion between those present: in all cases those present were the sonographer, the woman and myself. High rates of diabetes meant that women were often concerned about the fetal size, as the condition can result in growth restriction, growth acceleration and fetal obesity. Fetuses emerging in the 'scanning room' were often at risk, risky or problematic: they are observed, diagnosed; their fate considered. Hamda, a 41-year-old pregnant mother of seven, experienced her fetus as at risk because of her diabetes and age:

> I am old and as you know the chances that a woman may give birth to an abnormal baby increases after the age of 35. I am honestly scared and if it happened that my baby has any problems or deformities I will terminate my pregnancy… . I saw many Mongolian children when I was working in [the hospital] and I know how much they and their parents suffer. This is why I think it is better to get rid of the baby in this case rather than watching him or her suffering.

She explained she would consult a Sheikh to obtain a fatwa to allow her to terminate the pregnancy. Sonography sessions produced fetuses that were investigated and diagnosed which might reveal or inform their fates as to whether their termination could be legally and/ or religiously sanctioned.

Thirty-one-year-old Mashael had given birth to a stillborn child, lost a daughter when she perished a week after her birth and had suffered four miscarriages. Her recent loss unfolded over a number of days and involved numerous scans and investigations. Mashael came to the hospital upon discovering bleeding: the doctor explained that she might be

experiencing a miscarriage but that there was nothing to be done. He advised her to go home and wait. However, anxious Mashael requested a scan, which revealed her twins to be alive, so she refused to leave the hospital despite the clinician saying, 'believe me we will not interfere at all'. Two days later, a scan revealed the death of one twin and a lack of amniotic fluid around the other. She was told she would have to abort 'the babies', but was later instructed to wait for a week in order for another scan could be performed. This scan confirmed the lack of fluid. The decision was made to terminate the pregnancy because 'if they didn't abort the baby he may be disabled or paralyzed'. Mashael was induced, went into labour and delivered the fetuses. However, the miscarriage was incomplete leading to surgical intervention to remove the pregnancy remains from her body.

The fetus produced by the sonography equipment may be different to that which the woman has come to know: a different sex or unlike the healthy baby she imagined. One pregnant interlocutor was surprised to find that instead of the imagined and experienced fetus, a scan revealed an empty uterus: the clinician diagnosed a blighted ovum. A pregnant woman's fetus may be revealed to be dead, its demise remaining unknown until a medical professional scrutinizes the image. I now move on to discuss these fetuses that are not alive and discuss the multiple realities of these beings.

Fetuses that are not alive: miscarried, as meat, in the graveyard

When we met Noora she had miscarried the previous day. She told us quietly about her miscarriage and its medical management. Having discovered her miscarriage during an ultrasound scan, Noora had experienced what is known as a 'missed miscarriage': when the fetus dies *in utero* undetected, the fetus and pregnancy materials remain in the woman's body. Noora had waited for the miscarriage to complete naturally, but this did not occur. She was subsequently admitted to the hospital and given a combination of pills and vaginal pessary to induce labour. As she passed tissues and blood, she saw the fetus, which was then dispatched to the histopathology lab. After speaking to Noora, we were curious about the path fetuses travel after they leave the woman's body. We went to the lab and were welcomed by women in white coats who removed a fetus from a white plastic container and laid it carefully out on a blue mat as they explained how they would examine the body. Where would this fetus go after it had been investigated? We were directed to walk a few yards to the mortuary. Here we met Dr Ali, who led us into the mortuary. He showed us a number of small, neatly wrapped, blue and white plastic encased packages, which were labelled with a woman's name (the mother) or 'baby of' and the woman's name. The latter, fetuses of over 22 weeks gestation, require official documentation: a birth and death certificate, as well as a burial request. The family must name it, claim the body and are responsible for its burial.

Describing the contents of the other packages, Dr Ali said: 'the fetus is not a living thing so is sent as a sample or tissue of the mother'. The tissues/fetus waited for collection by the family, but if not collected within two to three weeks, the hospital would bury it. Once enough body parts, tissues, and fetuses amass, they are collected and taken to the graveyard, accompanied by an official hospital request form, which says: 'Kindly bury the dead fetuses and the remnants of body parts that are listed in this letter'. Every body part is listed with the name of the person. A separate list details the fetuses: 'baby of', the gestational age and sex, if known. The Mortuary Department in the hospital has exclusive

authority to issue burying requests and, thus, if a woman miscarries elsewhere, the remains should be delivered to the hospital for management. Fetuses regardless of gestational age will be buried, just as all remains, tissues and body parts are buried.

A few months later, we secured permission to visit the graveyard. We received a call from Dr Ali informing us that an ambulance was preparing to go to the graveyard and would we like to accompany it? Dr Ali explained that we would need to cover ourselves with *abayas* and our hair with *shaylas* and told us to avoid attention. We quickly went to the hospital and navigated the corridors to the mortuary. Greeting us, Dr Ali invited to travel in the ambulance, but as there were four of us we decided to follow separately. We sped through the city, but soon lost the ambulance. Typical of Doha driving there was confusion around changed and reconstructed roads, the lack of street signs and the chaotic and busy traffic. After a series of phone call from the driver, we found our way to the graveyard where we were reunited with the ambulance and its consignment. Eager to heed the directions of Dr Ali, we tried to keep a low profile; however, our presence immediately attracted the attention of a group of curious men who were bemused by the sight of our group in a location rarely visited by women. We were approached in a curious but friendly manner by the sheikh responsible for the mosque. He was happy to explain the burial practices. A fetus of 120 days or more gestation will be handled in the same manner as an adult: it is washed according to Sharia. The body is washed with water and cleaned with *kafour* (Camphor) and then rinsed with water scented with *Sidr (*Ziziphus*)*. The body is dried and perfumed with *Oud* and Rose scents before enshrouded in white clean sheets called *Kafan*. *D'ah* (prayer) takes place and the body is buried in a hole, leaning to the right side and covered with a layer of strips or rock tiles and soil.

A fetus of less than 120 days gestation is treated as tissue and not covered with a shroud or prayed over. Reflecting their non-human status, they are buried in an area of the graveyard reserved for body parts and tissues. Fareeda, a 38-year-old woman with six children after eleven pregnancies, who had recently miscarried explained her experience of fetal burial, first touching on the uncertainty about the definition of miscarriage:

> It is not related to an age [of the foetus]. They say whenever the soul is there it is considered miscarriage. I think from the beginning when it is a *nutfa* until he is formed.

For Fareeda, a miscarried fetus is defined not by its gestational age, but by the presence of a soul, referring to a particular stage of development of the embryo: *Nutfa* meaning 'very little water' or 'a drop of water' and linked to men's ejaculate. Sadly, Fareeda was familiar with the ensuing process: once miscarried, the fetus was taken to the histopathology lab for analysis before being returned to her for burial. She explains, 'it was a piece of meat', and so would not be prayed over during the burial process as is customary because at less than 120 days gestation it was without soul. Her description and experience of her fetus reflect the medical and religious categories that define it as a body part or tissue. A number of interlocutors described early fetuses as *qetat lahem* (piece of meat); however, the majority referred to them as *tefel* or *janeen*, suggesting that their reality was not of tissues or flesh. Thus, medical and religious categories did not necessarily match experience.

Lost fetuses and social standing

Producing a child increases a Qatari woman's social standing. In light of the pressure to produce children and the fact that women are largely blamed for reproductive failings,

what impact does a miscarried fetus have on a woman's social position? Najah, who remained childless after one miscarriage, commented that her position is better than that of her brother's wife who despite being married for seven years has not conceived. She thanks God that she can bear children and was given the opportunity to experience pregnancy. Despite not producing a live child, a woman who miscarries has demonstrated her fertility. A dead fetus secures a woman's position through demonstrating of fertility and being a mother. An aspect of this is the being maintains a position in the cosmology. The fetus is made into a certain reality by its specific location, in this case in the social world and in the Qatari cosmology.

Birds in heaven

The most common way people spoke about fetuses was as 'birds in heaven': doctors, religious leaders and interlocutors referred them in this way. Fareeda revealed the way a fetus can be a variety of things:

> The doctor in the operation room told me, "You have four *toyoor fe al Jannah* [birds in heaven]." I said "I hope I will see them in heaven." She said, "No they will make you enter heaven"… . When I tell them I had four miscarriages they say, "you are lucky, there is someone who will protect you in the judgment day." I told them my first miscarriage was about 40 days only. They say "this bird will come alone in heaven and hold your hand and say to God, 'this was my mother'" … It should be this way because we are suffering a lot in miscarriage… . It relieves the pain, *alhamdullah*.

Samia, a 33-year-old woman, the mother of four sons, had recently experienced her first miscarriage:

> When they informed me… I cried and I didn't accept it … the doctor said; "this is from Allah." So, though I was shocked at the beginning, but being a Muslim and our faith that whatever happens to us is God's will… . God rewards. My baby will be a bird in heaven and he [will act on behalf] of his parents

Rouda was focused on caring for her six-month-old daughter and was pregnant again. She spoke about her previous experience of miscarriage, stillbirth and loss. She explained that her lost babies were with prophet Mousa in heaven.

> Our Prophet said any child that dies will be with our Prophet Mousa until his family comes to the heaven…so this is reassuring… They will be birds with Prophet Mousa in heaven, I don't know if they will be in the form of birds or children until their family dies and comes to heaven.

Rouda had given birth to a stillborn baby girl and later gave birth to a daughter with Down's Syndrome who died when she was 20 months old. These beings and her miscarried fetuses had a presence in the cosmology, which provided compensation for her suffering and brought her comfort:

> You feel if you believe in God you will let it go, we don't guarantee how long we will live for a year or two, at least if we die someone will be there for us.

She continued to explain that they will protect her and ask God to forgive her on judgment day: 'this is what we get from these situations'. Thus, these are ethereal beings and are rewards for fertility and suffering.

When Haleema discovered she was miscarrying, she became very upset and shouted at the hospital staff who then tried to calm her. One nurse said, 'It's ok, *in sha'allah* he will be an intercessor for you to paradise'. Haleema found the knowledge that her lost babies would be in heaven comforting:

> I think that I will meet the babies again in the afterlife and they will be my intercessors. I don't think that I want them to come back again to me. I just think that they will seek forgiveness for me in the judgment day.

As one clinician explained:

> Because in Qatar we are Muslims: we believe God gives and God takes, and we believe that this will be a bird in heaven. [For] any mother that loses a baby; this will be a bird and she will see him in the afterlife, so she will not be very depressed that she lost that baby.

Fetuses are ultimately gifts from God; the loss was destined as part of God's plan. Women are reminded that the fetus is in heaven and will be seen again when it acts as an intercessor. The fetus plays a role in a woman's future cosmological status. Kholoud explained the afterlife and the role that deceased children played in this:

> We believe in Allah "*Subhanaho Wa taa' la"* and we work for the afterlife. This life is transient and what we do in this life should be intended for the afterlife. I kept my baby with Allah and *Inshallah* I will meet him later … On the day of judgment [this child] will hold his mother and father's hands and pass them to heaven. He will be a mediator for his parents … You don't know what your child will grow up to be: he may grow up to be disabled or a corrupted person or disobedient or he may kill his parents. So Allah didn't want him to be born because he wants the best for you. We believe in this and this is why we stay strong when we have such experience.

The handling of dead fetuses reveals the way in which there are a plethora of relational values that inform how this matter is regarded. Categories meant to define them are in flux and are constantly negotiated: the value-afforded pregnancy materials affect the contexts in which they emerge; this then loops back as context dictates its significance.

Discussion

Classifications are informed by context, and they may be around time: remains of pregnancy are handled and managed in ways that are informed by duration and location in the body of their mother. Gestational age informs treatment: remains of less than 120 days gestation are handled as though they were a body part or tissue of the woman. Some interlocutors referred to them 'pieces of meat'; however, most referred to them as *tefel* or *janeen*, revealing categories did not necessarily match women's experiences. As the fetus has no soul and was never meant to be more than it was, women are advised to find comfort in the fact that one has not really lost anything. A small number of interlocutors reported that if the remains were less than four months gestation, they could be buried anywhere; one interlocutor referred to remains buried in her backyard. Fetuses of 22 weeks gestation or more are classified as stillbirths: they are human and social beings needing birth, death and burial documentation. They must be named and their families take responsibility for them. The stillborn fetuses are defined by government law, but differ slightly from those categorised by clinicians who defined the distinction between

miscarriage and stillbirth as at 24 weeks gestation. Those beings between 120 days gestation and 22 weeks gestation are ensouled, and are thus human beings, and will be buried in the same manner as an adult.

A fetus of less than 120 days is not human, but is a sacred tissue in that it should not be discarded unless the mother's life is at risk, according to the religious scholar to whom we spoke. Abnormality is not sufficient to justify its sacrifice. A *zina* fetus is not similarly sacred; however, we were told that different schools have differing positions on this. In the medical context, such pre-ensouled fetuses are tissue, flesh to be discarded if abnormal or risky. Despite this, women commonly suggested the fetus became a 'baby' when they began to feel it move. Amongst British Muslim Pakistani interlocutors, Shaw (2014) found that women also focused on fetal movement as an important threshold of personhood, but movement was seen to be animated by the moment of ensoulment. Miscarriages prior to this are described as 'lost' or 'wasted' pregnancies; women refer to lost pregnancies, a loss of blood or tissue, rather than lost babies (Shaw 2014). The moments when a woman first begins to perceive fetal movement is sometimes referred to as 'the quickening' in Canada, the US and the UK. Historically, quickening was sometimes considered to be the beginning of the possession of 'individual life' by the fetus, with the word being epistemologically linked with 'quick' meaning 'alive' (Han 2013). According to Christian tradition, this equates with the moment of ensoulment, in which a human spirit comes to animate the human body (Duden 1999). However, in Qatar, women did not experience ensoulment as simultaneous with movement.

This paper has considered the multiplicity of fetuses and their locations: in the body, on a dissection mat, wrapped in plastic in the mortuary, buried with other body parts in the graveyard, prayed over by the sheikh, an image projected on a screen. Some fetuses inhabit multiple realities simultaneously. A woman might experience a miscarried fetus as a piece of meat and a child, whereas certain realities are mutually exclusive: lost fetuses or birds in heaven and alive, *in utero* fetuses cannot exist simultaneously. A *zina* fetus is mutually exclusive to a scanned fetus or any fetus emerging in a medical context. A dead fetus is lost potential, but demonstrates fertility and enables its mother to experience motherhood. A bird in heaven with a cosmological reality it produced. The woman will be reunited with this bird and it will help to secure entry into *jannah*.

Conclusions

Research into terminations, miscarriage and the fetus is scant, not just because of sensibilities of it as taboo, but precisely because of their ambiguity. Uncertainty surrounding the embryo and fetus abounds: living but not yet alive; it falls between category of 'human or non-human' (Casper 1994). Fetuses occupy a liminal category somewhere between person and human tissue (Squier 2004): an ambiguity with which social science struggles. We have difficulty in articulating exactly what these beings or materials are, making such material all the more difficult to examine, question and hold up for scholarly analysis. From my British context (and similarly in other parts of Europe and North America), legislation continues to change, and our categories are in flux: we revise categories and meaning around these materials. There is an inherent instability of this tissue, the embryo, and the fetus, which is perpetuated by a lack of attention by anthropologists. Our ethnography is deliberately focused on an entity that escapes categorization.

Social scientists have shied away from the miscarried and aborted fetus: an unsurprising reluctance, given the political nature of the questions involved. The meanings ascribed to human fetuses and the history of efforts to grant social identities to them is a problematic topic in current feminist thought (see Michaels and Morgan 1999). Such scholarly reluctance is compounded with unsuccessful pregnancies. The miscarried fetus is a source of the profoundest ambiguity because of the way its context determines it; yet such entities can illuminate issues central to a society: the boundaries of life and death, the thresholds of humanity, categories of personhood, kinship and the role of the dead in the lives of the living. Exploring and problematizing categories is particularly significant when exploring globally common, but deeply personal experiences such as pregnancy endings. The multiplicity of these beings is salient when one considers how such claims are not value-free and have significant implications for a variety of practices, such as abortion; embryo creation, storage and disposal; the use of such material for research purposes; stem cell research; and fertility treatments.

There are always categories, such as legal, medical and religious categories, that grapple with definitions of these materials. There are a plethora of relational values about what these materials are, how they are regarded and what they mean. The practices around these materials (tissue, remains, bodies, fetuses) feed back and determine what they are. There is a looping relationship: the value afforded these materials impacts their locale and the context in which they emerge; but context then dictates value. An exploration of fetuses in Qatar illustrates that essentialist thinking about such entities and attempts at definition produce different realities. This ethnographic paper serves as an illustration of categories constantly in flux and continually negotiated. It hints at contestation around these categories. Despite a desire to define the boundaries, categories are messy; boundaries overlap and are always context dependent, and, hence, multiple realities.

Ethical approval

The research upon which this paper is based has been approved by all of the appropriate ethics committees in both UK (UCL) and Qatar (HMC, WCM-Q).

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References

Bener, A., and R. Hussain. 2006. "Consanguineous Unions and Child Health in the State of Qatar." *Pediatric and Perinatal-Epidemiology* 20: 372–378.

Casper, M. J. 1998. *The Making of the Unborn Patient: A Social Anatomy of Foetal Surgery*. New Brunswick: Rutgers University Press.

Casper, M. J. 1994. "At the Margins of Humanity: Fetal Positions in Science and Medicine." *Science, Technology and Human Values* 19 (3): 307–323.

Clarke, M. 2009. *Islam and the New Kinship*. Oxford: Berghahn Books.

Duden, B. 1999. "The Fetus on the 'Farther Shore'" Toward a History of the Unborn." In *Fetal Subjects, Feminist Positions*, edited by Lynn Morgan and Meredith Michaels, 13–25. Philadelphia: University of Pensylvannia Press.

Franklin, S. 2013. *Biological Relatives: IVF, Stem Cells and the Future of Kinship*. Durham, NC: Duke University Press.

Han, S. 2013. *Pregnancy in Practice: Expectation and Experience in the Contemporary US*. New York: Berghahn Books.

Holbraad, Martin. 2010. "Ontology Is Just Another Word for Culture: Against the Motion (2)." *Critique of Anthropology* 30 (2): 179–185.

Holbraad, M. 2012. *Truth in Motion: The Recursive Anthropology of Cuban Divination*. Chicago, IL: University of Chicago Press.

Inhorn, M. C. 2007. "Preface in Reproductive Disruptions." In Gender, Technology and Biopolitics in the New Millenium, edited by Marcia Inhorn, ix–xiii. New York: Berghahn Books.

Kilshaw, S., D. Miller, H. Al Tamimi, F. El-Taher, M. Mohsen, N. Omar, S. Major, and K. Sole. 2016. "Calm Vessels: Cultural Expectations of Pregnant Women in Qatar." *Anthropology of the Middle East* 11 (2): 39–59.

Layne, L. 2000. "He Was a Real Baby with Real Baby Things: A Material Culture Analysis of Personhood, Parenthood, and Pregnancy Loss." *Journal of Material Culture* 5 (3): 321–345.

Layne, L. 2003. *Motherhood Lost*. New York: Routledge.

Lofland, J. 1995. "Analytic Ethnography: Features, Failings, and Futures." *Journal of Contemporary Ethnography* 24 (1): 30–67, 47.

Lofland, J., D. A. Snow, L. Anderson, and L. H. Lofland. 2004. *Analysing Social Settings: A Guide to Qualitative Observation and Analysis*. 4th ed. Belmont, CA: Wadsworth.

Maienschein, J. 2002. "What's in a Name: Embryos, Clones, and Stem Cells." *The American Journal of Bioethics* 2 (1): 12–19.

Michaels, M. W., and L. M. Morgan. 1999. "Introduction: The Foetal Imperative." In *Foetal Subjects, Feminist Positions*, edited by M. W. Michaels and L. M. Morgan, 1–10. Philadelphia: University of Pennsylvania Press.

Mol, A. 2014. *A Reader's Guide to the Ontological Turn Part 4*. Somatosphere.

Morgan, L. 2009. *Icons of Life: A Cultural History of Human Embryos*. Berkeley: University of California Press.

Nguyen R. H., and A. J. Wilcox. 2005. "Terms in Reproductive and Perinatal Epidemiology: 2. Perinatal Terms." *Journal of Epidemiology & Community Health* 59 (12): 1019–1021.

Parkhurst, A. 2014. "Genes and Djinn: Identity and Anxiety in Southeast Arabia." PhD diss., Department of Anthropology, UCL.

Pfeffer, N. 2008. "What British Women Say Matters to Them About Donating an Aborted Foetus to Stem Cell Research: A Focus Group Study." *Social Science & Medicine* 66 (12): 2544–2554.

Pfeffer, N., and J. Kent. 2007. "Framing Women, Framing Foetuses: How Britain Regulates Arrangements for the Collection and Use of Aborted Foetuses in Stem Cell." *Research and Therapies BioSocieties* 2: 429–447.

Qatar Statistics Authority. 2012. *Vital Statistics, Annual Bulletin: Marriages and Deaths 2012*.

Qatar Statistics Authority. 2013. Accessed 4 May 2016. http://www.qsa.gov.qa/eng/populationstructure.htm

Scheper-Hughes, N. 2003. *Commodifying Bodies*. Co-edited with Loic Wacquant. London: Sage Publications.

Shaw, A. 2014. "Rituals of Infant Death: Defining Life Islamic Personhood." *Bioethics* 28 (2): 84–95.
Squier, S. 2004. *Liminal Lives: Imaging the Human at the Frontiers of Biomedicine*. Durham: Duke University Press.
Taylor, J. 1992. "The Public Foetus and the Family Car: From Abortion Politics to a Volvo Advertisement." *Public Culture* 4 (2): 67–80.
Tremayne, S., and M. Inhorn. 2012. "Introduction: Islam and Assisted Reproductive Technologies." In *Islam and Assisted Reproductive Technologies: Sunni and Shia Perspectives*, edited by Marcia C. Inhorn and Soraya Tremayne, 1–21. Oxford: Berghahn.
Van Balen, F., and M. Inhorn, eds. 2002. *Introduction. Interpreting Infertility: A View from the Social Sciences*. In *Infertility Around the Globe: New Thinking on Childlessness, Gender, and Reproductive Technologies*. Berkeley: University of California Press.
World Health Organization. 2016. *Stillbirths*. Geneva: World Health Organization.