

Abstract

Through an exploration of two settings, Qatar and England, this chapter makes sense of women's experiences of miscarriage, particularly the way they are impacted by the social landscape in which reproduction is embedded. I argue that expectations of reproductive agency produce anxiety about uncertain fertility futures and increase notions of culpability. Qatar and England provide an opportunity to compare and explore the tensions between reproductive choice and pregnancy loss because of the variation in reproductive experiences and reproductive agency. Such a comparison furthers analytic understandings of women's responses to reproductive disruption by teasing out the way notions of agency impacts the experience. The chapter demonstrates how perceptions of avoiding miscarriage and being a "good", "pre-conception" parent are situated within a broader cultivation of neoliberal citizens in England, compared with Qatari experiences where miscarriage is framed as reproductive proof. A comparative approach to reproduction exposes the opposing and fluid meanings of 'control,' and when fertility rates are viewed across a continuum.

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God's design; thwarted plans: Women's experience of miscarriage in Qatar and in England

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Miscarriage is a potentially disruptive event, often unanticipated and undesired, yet the perception of disruption varies, both individually and collectively. This chapter explores the social landscape in which fertility is embedded in two settings, Qatar and England, to understand how miscarriage is framed whilst also considering how cultural formulations of miscarriage are in flux. An exploration of EuroAmerican discourse and how it may differ from other approaches is particularly important given the hegemony of what Strathern (1996: 38) defines as 'the largely middle-class, North American/Northern European discourse of public and professional life' through which a 'dominant' language of reproduction has emerged particularly in global policy initiatives (Faircloth et al., 2013). Typically framed in discourses of agency and choice, the expectation is that with freedom, access and empowerment, desired fertility outcomes will be fulfilled (Van der Sijpt 2014: 278). Contained in this is the suggestion that women are individual agents, able to choose their reproductive path; however, this ignores the uncertainty of reproduction and limits to reproductive agency. This chapter makes sense of women's experiences in two contexts, particularly commenting on differences, by exploring notions of reproductive control. I argue that increased expectations around reproductive agency produce anxiety about uncertain fertility futures and increase feelings of culpability. Qatar and England are interesting locations to look at the tensions between reproductive choice and miscarriage because of the variation in women's experiences of reproduction and reproductive agency. Such a comparison furthers analytic understandings of women's responses to reproductive disruption by teasing out the impact of notions of agency on experience. A comparative approach to reproduction exposes the opposing and fluid meanings of 'control,' and when fertility rates are viewed across a continuum.

MISCARRIAGE IN TWO SETTINGS: ENGLAND AND QATAR

People develop individual and collective understandings and responses to illness and misfortune but do so within in a cultural framework; thus, I begin with a brief overview of the two ethnographic settings within which women experience reproductive loss. In 2012 I embarked on an investigation of miscarriage in two of the countries I have called home—England and Qatar. The research was sparked by my own experience: following a missed miscarriage at 13-week's gestation I was intrigued by the silence surrounding miscarriage in England and observed women's responses of grief, sadness, and isolation. Five years after my first miscarriage, I found myself in a clinic in Qatar following a third. The contrasting experiences of my miscarriages and curiosity about the experience in other contexts encouraged me to study this subject formally. Exploring reproduction as culturally contingent, the research explored how the approach, management and experience of miscarriage is impacted by social context including: medical practice, religion, the value and importance of motherhood, indigenous knowledge of pregnancy and the pregnant body, notions of cause and culpability, as well as notions of life before birth. This chapter draws on fieldwork conducted over fifteen months in Qatar and twelve months in England between 2012 and 2016. Based primarily on interviews with 80 (40 Qatari and 40 British) women who had recently miscarried, I also draw from interviews with 20 pregnant Qatari women, religious leaders, and traditional healers in Qatar as well as family members and medical professionals in both England and Qatar (for a full description of methods see Kilshaw et al 2017). The research was a collaboration between a team of four clinicians and two researcher co-ordinators in Doha, the latter of whom conducted most of the interviews in Qatar; and two UCL anthropologists.

Qatar

Qatar is a small country on the northeastern coast of the Arabian Peninsula. It has experienced rapid and dramatic social and economic changes since the mid-20th century as the result of the discovery

of natural gas and oil in 1940: a discovery, which led to it becoming the richest country in the world. The state religion is Islam; the vast majority of Qataris are devout Sunni Muslims, as reflected in our cohort who were all Sunni Muslim Qatari women. Sexual relationships are governed by law with relationships outside marriage prohibited, whilst polygamy is allowed. Most marriages are arranged and as in most of the Arab world, consanguineous unions remain most popular: 54% within the family; 34% between first cousins (Bener and Hussain 2006), a statistic supported by our findings. The local Qatari population has grown at a marginal rate whilst the country's population has swelled dramatically in the past decades, reaching 2.6 million, of which close to 90% is comprised of migrant workers (Ministry of Development Planning and Statistics 2016). Concerned about demographic imbalances, particularly their minority status, and eager to increase capacity of the local population, the Qatari Population Policy 2009 focused on promoting fertility amongst Qataris (Gulf Research Centre, 2014: 20) with a continuing emphasis on reproduction and fertility in subsequent development strategies, including the long term "Qatar National Vision 2030". Various direct and indirect pronatalist mechanisms include generous family allowances, high subsidies on housing, food and energy products and state funded Assisted Reproductive Technologies (ARTs). The emphasis on reproduction is also a reflection of the Islamic belief that human reproduction and the need to preserve one's social group are of utmost importance (Tremayne and Inhorn 2012:18). Contraception is available and made use of, however, most women expressed ambivalence about its use with some saying it was *haram* (prohibited) and others suggesting it was only permissible with their husband's consent. The majority suggested that using contraception should only be used after a woman had already given birth and for the use of birth spacing or in the case of illness (See Kridli et al 2013). Abortion is legal in Qatar, but heavily restricted and uncommon. Qatari women experience multiple pregnancy events (Supreme Council of Health 2014) and thus, are at risk of miscarriage and multiple losses, as reflected by the miscarriage rate, the three stillbirths, three neonatal deaths and one death of a one year old due to congenital abnormalities in our cohort. The rate of stillbirth is 5.8, which is higher than the 4.2 per 1,000 births in England and Wales. The elevated rate could be due to higher rates of congenital abnormalities related to consanguineous marriages and low rates of medical terminations (Rahman, El Ansari, Nimeri, et al 2012).

Qatari interlocutors were recruited through the main public hospital and are representative of the overall population. They were generally educated, with more than 50% having achieved at least undergraduate education and the majority (60%) were employed, reflecting the emphasis on education and employment opportunities for women in state development strategies (Kilshaw forthcoming). The average age was 33-years-old and all were married, reflecting the fact that pregnancy is only permissible in the context of marriage. Family characteristics and formation in Qatar have been changing in recent years with women marrying and having children later than they did in previous generations and having fewer children overall. The average age of marrying has risen to 24.1 (MDPS 2016) and the total fertility rate (TFR) has declined from 5.7 in 1990 to 3.9 in 2009, but it remains high compared with other countries and is one of the highest in the Arab Gulf States (MPDS 2016; Toumi 2011). Marriage rates overall have declined in recent years and divorce rates have risen since 2001 (MDPS 2016) and is now one of the highest rates in the region. Women are expected to have children soon after marriage and it is important for them to demonstrate their fertility in this way, which is reflected in our cohort of whom 73 % had children. The model of family promoted is one where couples marry relatively young and begin having children immediately. Families are large and women are encouraged to have children throughout their reproductive years with motherhood valued highly in Islam and Qatari society (Kilshaw, forthcoming).

England

England, part of the United Kingdom, has an overriding ideology of neo-liberalism, which sees competition as the defining characteristic of human relations. Having children is encouraged in public discourse and linked to one's perceived role in society, although there is an increasing visibility and support for those who remain childless through choice or by circumstance. A number of state policies and funding support families including generous maternity leave, the introduction of paternity and parental leave, and government funded childcare and education. However, there is stratified encouragement of having children along certain lines, such as class, in order to cultivate and reproduce ideal reproductive citizens. Those dependent on welfare benefits have to navigate a two-child policy, whereas those not dependent in this way are faced with entirely different options with implications for loss. As Murphy (2019: 37) argues motherhood is seen as something needing disciplining with ideas around who makes appropriate mothers informing policy; such that miscarriage may be perceived as a solution for pregnant teenage women (Brady et al 2008) because of pregnancy in this group seen as a social problem (Cook and Cameron 2015). Notions of appropriate reproduction impact experiences of loss, which is reflected in the cohort of interlocutors of predominantly 'middle class' white women in their 30s.

Although, as in much of Euro-America, England is seeing an increase in "engaged fathers", childcare is often primarily seen as the mother's responsibility and children a site of women's 'identity-work' (Faircloth 2013). The percentage of births outside marriage or civil partnerships was 47.6% in 2016 although many were born to parents who lived together. The family model aspired to by interlocutors is relatively small: 2-3 children born to women in their early 30s. The number of women over 40 having babies overtook the number of women 20 years and under for the first time in seventy years, a trend echoed across Europe. The vast majority of participants were married and almost all were in long-term partnerships with the father of the pregnancy, although three separated within the year following the miscarriage. The TFR in England and Wales was 1.8 in 2014 and the average age of first-time mothers was 28.6 years in 2015 (ONS 2016), which means women typically have fewer children and begin childbearing later than in Qatar. This is reflected in our cohort's demographics: the average age of interlocutors was 34.5 years; 50% remained childless (although 15% were pregnant at the time of the interview) and subsequently went on to give birth; of those who had children, the vast majority had one child, with only three interlocutors having 2-4 children. In the UK abortion common, legal and accessible with approximately 20% of all pregnancies currently ending in abortion; one in three women have had an abortion in their lifetime; and approximately 194,668 abortions took place in England and Wales in 2017.

Christianity is the most widely practiced religion in England and pervades the official social structure: 59.4 % Christian, 5% Muslim and 3.7% other religions in the 2011 census. Three interlocutors did not reveal their religion, a quarter described themselves as atheist, and the majority of those remaining described themselves as non-practicing Christians. Whilst the interlocutors from the Qatar were representative, the English cohort was not: primarily middle class, educated, white, and, interestingly, non-religious or atheist; with social position contributing to their miscarriage experience. The composition of the cohort in England was due to site and recruitment techniques: interlocutors were recruited through an NHS hospital with ethics approvals demanding a passive form of recruitment. Additional participants were recruited through a popular miscarriage support forum as well as through social networks. Such recruitment techniques meant that the group was self-selecting; whilst not representative of the population of England as a whole, this group is representative of the dominant voice in popular discourse around miscarriage and, thus, provides an important insight as well as an opportunity for comparison with Qatari women.

MODELS OF NORMATIVITY AND REPRODUCTION

Qatar: Expectations of disruption

Women understand having children as a significant aspect of their role as a Muslim and a Qatari

woman. Interlocutors consistently spoke of the expectations of pregnancy and motherhood with this tied to a woman's social role as well as religious and national identity. State discourse emphasises the importance of family and, particularly, motherhood, in the development of the country; women consistently spoke about the extreme pressure to produce children. Women spoke of pregnancy as an expected and "normal" state for a married woman. Pregnancies were not planned; they were a natural outcome of sexual relations with their husband. Qatari women similarly described miscarriage as "normal," unexceptional; a possible outcome and one of a number of possible reproductive difficulties. Miscarriage is managed with relative openness within cultural frameworks of modesty: women referred to being aware of the miscarriages of others (Kilshaw et al 2017), at least in some social environments. Jameela, a 38-year-old interlocutor describes miscarriage as:

Something normal, I saw that lots of women miscarried this month. Also, my sister, just yesterday, she miscarried. The heartbeat also stopped. I saw a lot [of miscarriages] this month. Many women miscarry.

Describing miscarriage as "normal", Jameela refers to other women she was aware of that had similar experiences. Interestingly, Jameela and Huda, below, refer to other women who had miscarried recently and by so doing emphasizes commonality: this is something that happens to women like her, in the immediate time frame and to contemporary women. Miscarriage is familiar to Jameela as it is to Huda, a thirty-five-year-old working mother with three children, who knew other women, including her sister-in-law, a number of her friends, as well as her mother; who had miscarried:

The first miscarriage was normal for me because my mum miscarried and many women who I know also had miscarriages and then they had kids.

Knowledge of her mother's experience meant that when Huda first miscarried there was a framework normalising it. In light of high fertility rates, it is anticipated that some pregnancies may not result in the birth of a healthy child¹.

There has been a process of medicalisation of pregnancy and childbirth in Qatar, which has meant a sharp significant decline in maternal, neonatal and perinatal mortality rates since the 1970s (Salameh et al. 2009). Between 1990 and 2012 Qatar's maternal mortality rate dropped by 80% and between 1975 and 2011 the Relative Risk of Neonatal Mortality in Qatar decreased by 87%, despite the fact that the population increased by 10-fold, and number of deliveries by 7.2-fold (Rahman and Badreldeen 2013). As part of a process of medicalisation women seek medical assistance in the early stages of pregnancy; the country's antenatal coverage is 94%; 99.45% of Qatari women have hospital deliveries (Rahman and Badreldeen 2013; see Green and Smith 2006 for similar in UAE), largely due homebirth being illegal. Close monitoring means that foetal demise may be discovered during regular appointments. Women experiencing pain or bleeding generally present to the hospital and are commonly admitted for monitoring and management. With improvements in maternal and child mortality rates being relatively recent, the cultural memory of pregnancy as precarious likely persists.

Miscarriage does not make women vulnerable to stigma or shame in most cases: the husband of Noora, a 41-year-old Bedouin mother of six who had recently miscarried for the first time, explained,

When the woman doesn't get pregnant and doesn't have kids at all, we call her *Aqueem*, (infertile). but when the woman miscarries once or twice, we consider her healthy and fertile.

A woman who miscarries is “healthy and fertile;” she is compared positively to infertile women, who are seen as particularly problematic and stigmatized because of their inability to produce children. Miscarriage demonstrates fertility, for conception was achieved. Similarly, Varley describes miscarriage in Gilgit, Northern Pakistan, as ‘half the battle won:’ two or three miscarriages viewed as normal, but more than five was “too much”, signalling cosmological imbalance (2008:313). Miscarriage is not viewed as damaging to fertility, or harming perceptions of the woman as such; she is expected to conceive again. In Qatar there is a standard method of handling the remains, with all pregnancy remains buried just as all human tissues and body parts are buried (Kilshaw 2017a) with most women not memorializing beyond this. Miscarriage is a normal event in a range of reproductive possibilities; women's typically express optimism about future reproduction and confidence in their ability to conceive again, as do those around them.

England: Rejecting normalization

Interlocutors in England spoke about the “decision” to get pregnant, taking into account age, career, relationship status and/ or financial situation. They planned pregnancies, often around weddings, holidays, work commitments and purchasing homes; describing a desire to be secure financially as well as romantically. Some plan conception around the academic year to avoid having a “summer baby” due to the perception that these children will be at a disadvantage as the youngest in the year group. Regular income, suitable housing, having a partner and father for the child and “feeling ready” were important elements of planning and being in a suitable position to have a child. Dow found amongst her interlocutors in Scotland, UK “deliberations about becoming a parent demonstrate the assumption that parenthood can, and should, be planned- that planning parenthood is a sign that one intends to be a *good* parent” (2013:37). The commonality and accessibility of birth control, abortion, and ARTs adds to the discourse of reproductive control and agency. An emphasis on planning resonates with the dominant ideology of socially appropriate childrearing in much of EuroAmerica, including England, characterized as “intensive parenting” (Hays 1996; Faircloth 2013; Faircloth, Hoffman and Layne 2013) and which has reached backwards in time so that “parenting ought more properly to be viewed along a temporal continuum, extending even to the pre-conception period, as mothers attempt to perform ‘ideal motherhood’ and in fact achieve ‘mother’ status through pre-conception efforts” (Faircloth, Hoffman and Layne 2013: 6). Relentless demands are placed on “pre-conception parents” to optimize their lifestyles, bodies and environment to ensure the welfare of their children (Faircloth and Gurtin 2017:13). It logically follows that those who feel they have fallen short of such demands may experience feelings of failure or worries of culpability when reproduction does not go to plan. Women's efforts, which suggest motherhood status at the early or pre-conception stage, inform feelings of grief and loss. English interlocutors typically commemorate their miscarriage through a variety of means including: tattooing their body; creating a burial site; planting a tree or plant; participating in remembrance ceremonies or awareness events, such as Baby Loss Awareness Week. Heloise describes miscarriage as a feminist issue, noting the need to oppose the silence around miscarriage, which led to her being unfamiliar its commonality because of a lack of dialogue about it. Women typically experience miscarriage as a silenced event, which they endeavour combat with acts of remembering (Kilshaw 2017b; Layne 2000).

English interlocutors understood their miscarriage as rare and unusual and likely signifying underlying problems (see also Bardos et al 2015). Liv, a 25-year old mother of a two-year-old daughter and living with her partner of seven years, was aware that medical professionals were pointing to the commonality of miscarriage in an attempt to “make her feel better” and assuage

feelings of guilt, but this did not resonate with her reproductive experience, which included two miscarriages and a previous difficult pregnancy. Interlocutors focused on the unusualness of their particular case, such as a history of reproductive problems, including previous miscarriage. They resisted notions of (their) miscarriage as normal, as Liv explained:

[They said:] ‘This is normal, it’s fine, it happens to one in four pregnancies.’ You don’t want to hear that when you’re 25. I don’t drive, I don’t smoke, I follow the book when it comes to pregnancy... and I eat fairly healthily. You don’t need to hear these things saying, ‘This is fair, one in four, this is fair.’ It’s like no, no, no. ... [The nurse] just kept saying, ‘Normal.’ ... ‘This is not normal!’

For Liv, the statistic was general, not applicable to her, as a relatively young woman and one who had managed risk by following guidelines and not partaking in certain behaviours such as smoking, driving or eating unhealthy foods. Expectations around pre-conception and pregnancy in England are relentless with risk a central discourse, with a focus on containing risks to one’s own health, and those threatening the well-being of the foetus (Lupton 1999: 59), which is linked to wider discourse of individualization and risk-consciousness (Beck and Beck-Gernsheim, 1995, 2002). In a ‘neo-liberal’ era, with its emphasis on self-management, ‘good’ mothers are reflexive, informed consumers (Murphy, 2003) who constantly monitor themselves and their environment. Such understanding implies that pregnancy can be made risk-free (Rothman, 2014) and that risks can be effectively managed. Liv rejected the normalization of her miscarriage with particular reference to risk management by being a “good” “pre-conception” parent. A commitment to planning pregnancy is key to this, which itself is suggested as a means to minimize risk.

MISCARRIAGE, AGENCY AND CONTROL

Notions of reproductive choice and control are part of the broader landscape in which reproduction is embedded, subsequently informing women’s experience of miscarriage; including feelings of culpability and perceptions of fertility and future reproductive possibilities. Having planned her life including her pregnancy with meticulous care, thirty-four-year old lawyer Dulcie, “found things not going according to plan very difficult” when her twelve week “dating scan” revealed that the foetus had died. Dulcie grieved for the loss of a life planned with her “child.” Interlocutors commonly spoke of shattered futures, lost dreams, and unfulfilled plans; miscarriage seen as a breakdown in expected life intentions and trajectory. Dulcie found the lack of control over the miscarriage and its aftermath particularly challenging, as did thirty-three-year old Heloise, who spoke about the miscarriage at seven week’s gestation of her baby with her live-in partner as an experience of a lack of control:

I mean the other thing I realised ... I have control over a lot of things in my life and this was just something I had no control over...

Heloise’s choice to have a baby was associated with a desired transformation of her life, to travel and work less and become more settled. Interlocutors described the “decision” to get pregnant; they planned and negotiated timings of conception, which suggests expectations of a high degree of control. A “good mother” in England plans her pregnancies with miscarriage seen as a failure of losing control over her body, plans and aspirations. Medical technology has increased expectations around pregnancy, with some believing advances in biomedicine have eliminated pregnancy loss (Layne 1992; Melo and Granne, this volume); the realization that medicine cannot overcome adding to feelings of uncertainty and lack of control.

“Failure” emerges repeatedly as a trope in interviews with English women who commonly interpret miscarriage in this way, as Vicky, a 35-year-old married woman now twenty-three weeks pregnant explained that following her third miscarriage:

I felt like I was failing... I had this real sense that there was something wrong with me and, yes, something just wasn't right... It certainly felt to me that Josh had done his part, and he was alright, there was nothing wrong with him and it was me letting the side down, really.

Vicky perceives her miscarriage to be a sign that there is something wrong with her; her partner had successfully contributed to the conception, but she was unsuccessful in sustaining the pregnancy. Vicky had counseling and learned relaxation techniques to overcome depression and anxiety and had been signed off work for this pregnancy in order “to get to the 12-week scan.” Miscarriage is typically framed as failure of: one's body, one's femininity and womanhood, self-regulation, plans and control. In contrast, Qatari women's understanding of miscarriage is informed by understandings of reproduction as not something one plans and further embedded in broader societal understandings of one's life as mapped out by God. Qatari women understand miscarriage as being God's will and part of God's plan for them. Samia, a 33-year-old mother of four sons, explained that following her recent miscarriage:

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.

Samia's is initially upset and unaccepting, but is comforted by the doctor's reminder that it is due to God's will. Interlocutors commonly express solace in the knowledge of miscarriage as part of God's plan; Kholoud explained the role of Islam in such understandings:

We believe in Allah “*Subhanaho Wa taa' la*” (The most glorified, the most high) 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 ... 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.

Kholoud's faith is central to her framing of miscarriage and its acceptance, for it is God's will that this pregnancy began and his will that it ends. Had her baby been born he may have caused more pain; the miscarriage is a form of God's protection from further heartache. Women commonly explain miscarriage as part of God's plan and a trial, which shows God's love and provides meaning in the loss, which is reinforced by those around her, including doctors and nurses. Whilst God's will is the ultimate cause of miscarriage, more concrete aetiological notions may also be suggested or explored.

Frameworks of meaning, notions of reproductive control, and ideas around culpability are informed by notions of destiny, fatalism and/ or religion or their absence. Interlocutors in England typically did not refer to religion in making sense of their miscarriage or its cause nor did they reach for religious discourse to provide comfort. Whilst religion did not play a significant role in the lives of the majority of interlocutors in England, religion played a dominant role in Qatar where faith enabled women to find meaning in their miscarriage, deflect feelings of culpability or blame, and provided a sense of certainty in reproductive futures. Faith provided an overarching framework in

Qatar, which informed all aspects of the experience. Miscarriage is embedded in a broader system of agency/ fatalism in the unfolding of one's life. 'Fate' in Southern Arabia is a complex construction, but is often incommensurable and sometimes even congruous with deep personal agency (Parkhurst 2014).

Culpability and blame

Whilst women in both contexts followed certain proscriptions around protecting their pregnancy and ensure their health and safety (Kilshaw et al 2016), for the English cohort the advice, guidelines and expected behaviours were far more detailed, numerous and unrelenting. As Murphy (2019) notes, for women seeking to make sense of reproductive loss, there is much fodder: UK NHS advice suggests pregnant women should not eat: soft cheese with white rinds, soft blue cheeses, raw or partially-cooked eggs; pate; liver; game; and some types of fish (NHS 2017) and women are also given advice about how much they should eat, exercise, drugs and alcohol consumption, and smoking as well as taking certain vitamins. English women described such preparations and behaviours as typically extended to before one conceived. In most cases, the cause of a miscarriage remains medically unknown (Melo and Granne, this volume), leaving women and others to contemplate possible contributing factors. The majority of interlocutorsⁱⁱ (56%) in England referred to "chromosomal abnormalities" or "genetic problems" with the foetus, with these being seen as free from culpability; with women reporting that health professionals emphasized this cause and linked to the lack of blame or control in miscarriage. However, this did not prevent women in England excavating their memories in an attempt to identify possible causes, a search associated with feelings of culpability. Similarly, other scholars have found women interrogating their behavior whilst pregnant to determine whether they were culpable for stillbirth (Murphy's 2012) or their child's disability (Landsman 2000).

As Liv pointed out, either the medical professionals were "lying before" by emphasizing preventative proscriptions or were "lying now" when suggesting that miscarriage was beyond one's control and not due to any misdemeanors. Women described a struggle between a guilt-inducing "irrational" search for cause and "rational" thoughts of the miscarriage being blameless, caused by bad luck, and/ or by faultless congenital abnormalities. Liv articulated such feelings of culpability:

I still blame myself. I know I shouldn't and I've had doctors, nurses, family, friends, everyone tell me not to blame myself, but I think I will until I die.

Jennifer, a thirty-five-year old married woman with no children after one miscarriage and two previous terminations, sifted through her memories to identify possible cause: focusing on instances where she had transgressed the risk-conscious behaviours and self-management of a good pre-conception or pregnant woman:

Over Christmas I was quite poorly. I'd taken quite a lot of Sudafed and other cold and flu medication. And then, on the day before New Year's Eve we'd gone to a friend's house for a dinner and I had drunk rather a lot of champagne with my female friends, and then two days later found out I was pregnant. Then, of course, when we found out I'd miscarried and then they went, 'We think the baby didn't develop properly,' immediately I started going, 'Well, there we go, I was just pregnant and I'm flooding my body with medication and alcohol. No wonder this didn't develop properly,' and I tortured myself for a good couple of days.

In most cases, as we see with Jennifer, women worry about behaviour prior to knowledge of the pregnancy despite being model pre-conception mothers. Jennifer's desire to understand is linked

with attempts at making sense of her miscarriage and to exert control over her reproductive future through the management of risk:

Because there is so little understood about what the causes really are, for me it's that classic thing of you really want to find something. ... I think that unknown... fed into those fears: 'Well, if we don't know what's caused it, how do we stop it happening again?' 'I can't fix this unless I know what caused it to begin with...

For Jennifer the uncertainty of cause is particularly problematic and informs anxieties about future reproduction. Understanding the reason for the miscarriage would mean an ability to prevent another in the future: identifying cause is a means to manage uncertainty.

Interlocutors in England suggested a number of possible causes of miscarriage, with half submitting problems with the woman's body such as a misshapen uterus or the presence of fibroids, or problems with the cervix. Whilst women acknowledged that problems in reproduction could be due to either partner's contribution, most emphasised miscarriage as due to problems with her body, as Emma did:

I'm faulty and I can't do what women are supposed to be able to do. ... You just feel that fundamentally you are broken as a woman.

Emma suggested that something was wrong with her body: it did not function in the way it should; it failed at producing motherhood. British women typically understood miscarriage to be their fault either the result of something they had done, such as consuming alcohol, being stressed, or because of a problem with their bodies or their selves. The aging body was a significant concern, with 41% suggesting advanced age was a likely cause of miscarriage.

There was some overlap in understandings of cause in England and Qatar, with both cohorts seeing stress or lifting a heavy object as a common cause. This resonates with research revealing Americans understand miscarriage as being caused by a stressful event (76%) and lifting a heavy object (64%) (Bardos et al 2015). Twenty-five percent of Qatari interlocutors cited foetal and/ or chromosomal abnormalities as the cause of miscarriage, which was further linked to ideas of destiny and God's will. There were, however, significant differences in notions of causation, such as those that saw problems with the woman's body as a causal feature: 5% of Qatari participants suggested problems with the uterus were a cause of miscarriage. English interlocutors did not discuss diabetes as a risk, whereas 12% of Qataris did, reflecting the high prevalence of the condition in Qatar, with 16.7% incidence in the adult Qatari population (Bener, Zirie, Janahi et al 2007). Advanced age did not emerge as a major concern or dominant theme in Qatar. Supernatural forces play a dominant role in miscarriage causation in Qatar, but were entirely absent from discussions with English interlocutors: 33% of Qatari interlocutors referred to evil eye and all referred to God's will as a common cause. Qatari interlocutors suggested that ultimately, miscarriage is part of God's plan and, thus, out of their hands. Women found comfort in the knowledge that the miscarriage was destined for them and, thus, beyond their responsibility. This helped to deflect accusations that they were to blame, as some reported that they had been indirectly blamed for causing their miscarriage, as was the case with Dana, a twenty-nine-year-old mother of two children who had suffered a miscarriage and a stillbirth before experiencing a second miscarriage. Dana's mother explained:

[Dana] was telling us that her husband's family accuses her of the miscarriage in an indirect way. Her mother in-law said; "what's wrong with women nowadays? We used to get our babies without having any problems!"

Dana had described to her mother that she felt her in-laws held her responsible for her miscarriage in an “indirect” way, suggesting there was something “wrong” with her along with her contemporaries. Notions of miscarriage cause are linked to wider discourses of Arab modernity its impact on reproduction (Kilshaw, forthcoming). Typically, indirect or general suggestions of culpability are linked with suspicions that a woman may have transgressed norms of pregnancy or acted “carelessly” by not resting or not effectively avoiding exhaustion. The mother of twenty-three-year old Nada who had no children following a miscarriage stated that in general a woman is considered culpable when she contributes to the miscarriage by not heeding medical advice or common guidelines for pregnancy health:

If she carried something heavy, in this case she is guilty, or if she took a medication that may harm her and the baby; she is guilty, or if she didn't follow the doctor's recommendations; she is guilty too. But if she did all what she can and followed the doctors' recommendations and took the medications; in this case she is not guilty.

Carelessness, particularly around fatigue and exertion emerges as a trope around culpability. Whilst a number of Qatari women reported that they felt others (typically their husband's family) might think they caused their miscarriage, expressions of self-blame were uncommon, which differs from the English context where narratives of miscarriage typically include feelings of responsibility.

Feelings of culpability amongst interlocutors in England focus on particular behaviours; but also wider life choices around planning reproduction, including a focus on advanced age. Age was commonly the factor as to why women decide to try to conceive and a concern when problems are experienced. Women expressed anxiety about the relationship between age and fertility, questioning whether miscarriage was linked to their decision to delay conception, expressing concern that their increasing age limited opportunities for reproduction. “Are we running out of time?” worried 35-year-old Vicky. As Heloise explained,

The other kind of fear...is how long will it be before I get pregnant again? Was that my only chance? ... Am I going to be one of those people who has multiple miscarriages? It just opens a door to all kinds of uncertainties.

“Uncertainty” appears repeatedly: miscarriage results in ambiguity, particularly over one's reproductive future. English interlocutors were anxious and pessimistic about their future fertility. They worried that this was their last opportunity to have children, reflecting the milieu of “anxious reproduction,” which emerges as new reproductive choices, burdens, responsibilities and accountabilities increases anxiety (Faircloth and Gurtin 2017). Qatari women had confidence in their fertility and a sense that their life is mapped in a way that is somewhat beyond their control. Qatari women's lives are lived within a religious and cultural framework, which limits notions of reproductive choice, and, as a result miscarriage is seen as ultimately out of their control.

Approaches to miscarriage: practices in flux

Understanding the shaping of women's experience of miscarriage is relevant given the hegemony of the Euro-American ‘dominant’ language of parenting and reproduction, which has begun to frame miscarriage as a significant loss to which grief and memorialization are the appropriate response. Health policy and medical practice in Qatar are influenced by EuroAmerican discourses and professionals in these fields come to the country from all over the world. Parenting has become a subject of state concern and has become tied to narratives of national identity and discourses of modernity as articulated in the main state development strategies, including the Qatar National Vision 2030 (QNV), and as evidenced by a number of government initiatives (i.e. Doha International Family Institute, The Qatar Nanny Academy). Qatari women's experiences of

miscarriage may change as dominant discourses continue to infiltrate as well as with societal changes, which see Qatari women marrying and having children later, producing fewer children and experiencing fewer pregnancies. Furthermore, with an emphasis on “women’s empowerment” (Qatar National Development Strategy 2011) in state discourse including increased expectations and aspirations around work and education, it is possible that opportunities and requirements for reproductive choice will accompany such transformations. One cannot but note that Hays (1996) noted the intensification of motherhood in EuroAmerican settings was coterminous with women’s increased participation in the workforce and in Qatar the state focus on motherhood and parenting has accompanied strategies to increase women’s participation in the workforce. However, forces in Qatar will contain, resist, and shape these discourses for example, the centrality of faith in the aftermath of miscarriage minimizes not only feeling of culpability and accusations of blame, but also reduced anxiety and feelings of uncertainty.

The way miscarriage is framed is not stagnant just as other aspects of fertility and reproduction may be in flux. There are a range of responses to miscarriage and differences within settings as well just as there are similarities across contexts. In both contexts the approach to miscarriage is in flux: both seem to be shifting, but perhaps in opposite directions. The more individual the model of health and illness, the more one becomes culpable. The rise of women’s empowerment is, of course, a good thing, but there may be an impact in unexpected ways. As new reproductive choices, burdens, responsibilities and accountabilities increases, so does anxiety about one’s reproduction (Faircloth and Gurtin 2017). It appears that whilst miscarriage is normalized in Qatar, it may be becoming less so. In England, there seems to be a shift away from seeing miscarriage as individual and something to be experienced in silence to something more social through public acts of commemoration; women are rejecting the medicalization of miscarriage are moving towards seeing it as more normalized.

Conclusions

Women in Qatar and England describe sadness and suffering around miscarriage. Societal approaches to miscarriage and perceptions about its normativity impacts women’s experience, including feelings of responsibility. With the tradition of silence surrounding EuroAmerican miscarriage, women are less exposed to other’s miscarriages, although with the increase in public disclosures of pregnancy loss this is now changing. In contrast, Qatari women report being aware of others who have miscarried or experienced other negative reproductive outcomes, particularly referring to mother’s, sister’s, sister-in-law’s, and friend’s pregnancy losses. High fertility rates mean that there is greater exposure to unsuccessful reproductive events, with miscarriage being understood as not uncommon and not particularly anxiety producing, unlike infertility. Demographic anxiety in the face of declining fertility rates, changes in family formation and overwhelming demographic imbalances as well as Islamic emphasis on procreation means fertility is highly prized informing a view of miscarriage as a positive demonstration of fertility. Whilst fertility rates have been declining, the TFR remains high, which informs understandings of miscarriage as relatively normative. Whilst both settings stress the importance of having children and infertility is the source of profound anxiety, in England there seems to be the collapsing of miscarriage and infertility with both pointing to pathology, in Qatar the miscarriage is understood as evidence of fertility and health.

The different landscapes of fertility within which pregnancy loss is embedded informs experience of miscarriage. English interlocutors were more likely to be childless than those in Qatar: the lower TFR in England, higher average age at time of the birth of the first child, the increasing rates of women having children after 40 and the smaller family model promoted means that women are exposed to fewer pregnancies and have a wider sense of control over their reproductive lives and likely to invest heavily in each pregnancy. Furthermore, children have become a site of women’s

‘identity-work’ (Faircloth 2013) further informing feelings of grief and acts of memorialization. The latter are likely informed by performances of and the achievement of ‘mother’ status through pre-conception efforts and those of early pregnancy. As reproductive choices expand, the burdens, responsibilities and accountabilities around reproduction increases resulting in anxiety (Faircloth and Gurtin 2017). Despite awareness of its commonality, English women saw miscarriage, or at least *their* miscarriage as unusual, perhaps understanding miscarriage as something that happens to other women: those who are not “good” pre-conception parents or pregnant women. In the English neo-liberal context reproduction is seen in terms of success or failure and with its emphasis on self-management, women typically blame themselves when a pregnancy does not continue as planned. Interlocutors in England experience a high degree of control over their reproduction: the use of birth control is common, and women have access to a wide range of reproductive choices and technologies; as reflected in our cohort with four having had one or two terminations including Liv and Jennifer, and six becoming pregnant following ARTs. Women plan conception and pregnancies, understanding their behaviours as having a high degree of influence on the outcome.

Opportunities for choice and notions of fatalism impact the way miscarriage is understood and experienced. The commonality of arranged marriage, the legal and cultural prohibitions around sex and sexuality, pressure to produce children, lack of commonality of birth control and the rarity of abortion all inform notions of (a lack of) reproductive agency. Perceptions of choice and agency impact how reproductive disruptions are experienced. A context that emphasizes choice and control over reproduction has the unintended consequence of heightening feelings of responsibility, accountability and anxiety when reproduction goes awry. Miscarriage is experienced as a lack of control resulting in feelings of uncertainty. Whereas women in England suggested their miscarriage was a failure in their role as a woman and in their bodies, Qatari women did not: instead a miscarriage demonstrates fertility and they express confidence that another pregnancy will occur in the near future. Qatari interlocutors reflected biomedical interpretations of miscarriage not as failure, but rather a normal process of reproduction: the elimination of a something unviable or disordered (see Elliott; Melo and Granne, this volume). What is a comfort in Qatar - a suggestion that one will soon be pregnant again - is often an injury in England: words meant to comfort such as, “at least you got pregnant” and “you can get pregnant again” were hurtful: in England this experienced as minimizing loss, disregarding the uniqueness of the baby, and not resonating with their uncertainty about future fertility. In the English context there appeared to be a collapsing of infertility and miscarriage with little differentiation between the two, which differs from the Qatari context where the two are seen as significantly different.

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ⁱ Amongst the Qatari cohort there had been 3 stillbirths, 3 neonatal deaths and one death of a one year old due to congenital abnormalities. 40% of miscarriage cohort had experienced 1 miscarriage; 30% had two miscarriages; 15% had 3; 15% had 4-6; 30% of pregnant cohort had experienced a miscarriage (one 3 miscarriage and one 5 miscarriage), two had experienced stillbirths

ⁱⁱ Of the 40 women interviewed, six did not comment on causation and, thus, these figures are based on the 34 women who did choose to discuss miscarriage causation