

Pregnancy and Miscarriage in Qatar



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Women, Reproduction and the State

Susie Kilshaw

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*For Scarlett and Annabel for thinking that being an anthropologist
is cooler than being a pilot.*



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Reproductive Disruptions: Spectrum of Compromised Fertility

Women's stories reveal the influence of social and political forces on intimate experiences of conception, pregnancy and miscarriage, and how reproductive negotiations are embedded in wider familial relationships, which are themselves influenced by Qatari social structures. The interconnection between motherhood and womanhood informs women's reproductive navigations and experiences. As a result of the high value placed upon having children, women typically have numerous reproductive events with miscarriage as part of a broader spectrum of reproductive disruptions. Furthermore, because of the significance of fertility, miscarriage is interpreted in light of a woman's ability to conceive. It is for these reasons that miscarriage is, on the whole, neither stigmatized nor surrounded in silence. Qatari pronatalism impacts women's reproduction and shapes miscarriage as a normative event. Such an approach is in stark contrast to what one finds in the UK and, indeed, in other parts of northern Europe and North America. Public discourse and scholarly work on miscarriage have focused on the silence surrounding it, framing it as 'the last taboo' whilst also emphasising understandings of pregnancy loss as failure. However, the silence has eroded and it is increasingly being spoken about in public forums, in part to overthrow notions of miscarriage as failure and reduce feelings of culpability. Over the past two decades not only has pregnancy loss become more visible, but the dominant narrative is that of a significant loss that should be acknowledged and memorialized (Kilshaw 2020a). This chapter considers how miscarriage is understood in Qatar and reveals the diversity of expressions of pregnancy loss and undermines assumptions about miscarriage as failure.

Miscarriage unshrouded

Women commonly described miscarriage as ‘normal’, ‘no big deal’, something not particularly unknown or unusual, as Huda did at the opening of this book; her interpretation informed not only by her own experience of five pregnancies and the birth of three children, but also her social context. Huda interprets her experience in light of an understanding of reproduction as inclusive of suffering and difficulty, with particular attention to other women’s experiences of reproductive disruption. When speaking about her view of miscarriage and her own experience, Huda refers to the ways in which other women’s pregnancies have ended. Thus, miscarriage is a sad, if commonplace occurrence. Such an understanding helps women to approach miscarriage with acceptance, as Huda did, realising it is not indicative of reproductive failing.

Huda understands her miscarriage event in the context of the shared experience of other women:

I know many women who miscarried recently; my colleague was pregnant at the same time as me and she miscarried. It was her first miscarriage after three successful pregnancies. My husband’s sister and also my friend miscarried last year, most of the women I know who got married in the last two years had miscarriages.

Huda’s knowledge of ‘many’ other women who miscarried, allows her to contextualize her experience with those of others and as something not particularly unusual. In particular, she focuses on recent cases of miscarriage, further reinforcing commonality. Indeed, ‘most’ of the newly married women she knows have experienced a miscarriage suggesting that it is a normal event in women’s reproductive negotiations. Huda reports that her colleague miscarried at the same time as she did and that this followed a number of successful pregnancies, indicating that miscarriage is something that happens to fertile women and those who are able to produce children. Huda’s awareness of the pregnancy losses of other women meant that hers is not interpreted as unusual or necessarily worrying and does not signify reproductive inadequacies.

Women are aware of the miscarriages of others, suggesting that it is discussed relatively openly (Kilshaw et al. 2017), at least in some social

environments. Jameela, a thirty-eight-year-old interlocutor who miscarried at the same time as her sister 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 who had similar experiences. Interestingly, similar to Huda, Jameela refers 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. Indeed, Huda explains: '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.'

Previous knowledge of her mother's pregnancy loss meant that when Huda first miscarried there was a developed framework for seeing such disruptions as normal. This knowledge provides a context where miscarriage is not seen as indicative of damaged fertility. Of particular relevance, was that her mother and other women known to her had gone on to have children despite previous miscarriages. In fact, Huda's mother-in-law comforted her following her miscarriage by focusing on the likelihood of future pregnancies: 'My mother-in-law told me that it always happens with women because of tiredness and once you had children before you will have again so it is not a big deal.' Huda's mother-in-law focuses on the commonality of miscarriage and minimizes it, particularly by reminding Huda that she had already produced three children. Her mother-in-law focuses on Huda's demonstrated fertility. That Huda has had children previously suggests that the miscarriage is an unfortunate event, likely caused by tiredness, but it means she is fertile and will have more children despite this pregnancy ending. Her miscarriage is not seen to impact future reproduction or suggestive of reproductive failure. These accounts and anecdotes reveal a focus on miscarriage events as embedded in wider reproductive careers: women have miscarriages before or after successful reproductive events and, thus, a miscarriage does not reflect on women's overall fertility. Instead, it is seen as a common pregnancy complication, a not unexpected event in the typically lengthy period of reproduction activity that is common to Qatari women. In general, women experience numerous

reproductive events during their reproductive years and often have complex reproductive experiences. In light of this, miscarriage is often interpreted as one possible adverse experience in a range of reproductive disruptions or complication, but one that is somewhat anticipated.

As Huda's account reveals, following a miscarriage, women are typically reminded by those around them that future pregnancies are possible and, indeed, likely. There is no reason to think subsequent pregnancies will not be successful. That a pregnancy had occurred in the first place is emphasized, which reinforces the woman's status as fertile. Noora, the forty-two-year-old mother of six, introduced in Chapter Three, explains:

They usually stigmatize the infertile woman. People say she is like 'an unplanted Land, *ard bour* (a land where plants do not grow)', not like the woman who had babies or at least gets pregnant: this woman is not stigmatized even if she lost her pregnancy twice or even three times. It is not a problem at all, but they always stigmatize the woman who didn't get pregnant at all.

Noora explains that a woman who has become pregnant but lost pregnancies 'twice or even three times' is not stigmatized; the emphasis is on her ability to conceive, which demonstrates her fecundity. Exhibiting fertility in this way separates her from barren women who are likened to land where nothing grows. Noora's husband, Mohammed, agreed:

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 loses a pregnancy is 'healthy and fertile'; she has successfully conceived and the miscarriage does not imply an impairment in her reproductive status. Miscarriage is a normal event in a range of reproductive possibilities; it is acceptable, unlike infertility. Even those women who experience a number of miscarriages will likely be understood to be reproductively healthy.

Miscarriage is not damaging to fertility or perceptions of the woman as a fertile woman, she is expected to conceive again. Indeed, miscarriage is viewed as a positive demonstration of fertility. This is reflected in women's accounts, as they typically express optimism about future reproduction; they appear confident in their ability to conceive again, as do those around them. Huda's

miscarriage is not a challenge to her fertility; she expresses confidence in her ability to achieve her reproductive aspirations, although such navigations are met with ambivalence. Huda expresses uncertainty about having another child, but despite her reluctance, she decides to try to conceive again:

Look, I myself didn't want to have more kids because I feel that my health is not like before, I mean it takes a lot from the woman's health: pregnancy and raising the kids takes a lot . . . I say *alḥamdulillāh* but I wish to have a boy for his sisters. My husband plans to have many kids but to please him and please myself I say, 'In shā' Allāh, we will have one son.

Despite her reticence, in time Huda becomes more certain of having another child, or, more specifically, a son. She explains that this is to please her husband, but also herself and to provide a protector for her daughters. To this end, her attentions turned to cleansing her body of the miscarriage and preparing for conception. She sought advice from medical professionals and conducted research on the Internet, to learn how best to complete the miscarriage and 'get rid of the dead baby'. Advised to eat pineapple and drink pineapple juice, Huda resorted to her knowledge of herbs and foods and undertook a protocol to expel the pregnancy tissues. Her use of herbs and diet was supplemented by the skills of traditional healers whose treatment Huda sought. Qatari women commonly use herbs and foods to aid menstruation and birth or cleanse the uterus in their aftermath. Al hess, also al hasow and al hesow, a common Arabic sweet dish, similar to custard, is used in the aftermath of a miscarriage to rid the body of retained tissues and blood. The mixture, containing sugar and flour with the addition of *al haba al hamra* (also *hab al Rashad*), red seed or garden cress (Latin: *Lepidium sativum*) is also consumed by postpartum women, those suffering from heavy periods or at the end of menstruation. It 'cleanses the uterus and cause[s] bleeding', clearing the uterus of blood and tissues. Due to the way it acts on the uterus, it is referred to most often as a food to be avoided by pregnant woman (Kilshaw et al. 2016). As Huda explains, Qatari women,

Take it after delivery and after miscarriage. It cleans the uterus because it has laxative effect and it reduces the uterine contractions.

One of the traditional practitioners that Huda called upon to help her 'pass the baby' and avoid 'the induced labour' or the medical management of her miscarriage was *al massada*. The masseuse conducted a series of massages

using oils, in order to relieve pain and to encourage the expulsion of tissues and blood to cleanse the uterus and return it to its previous state. However, despite conducting ten sessions with Huda, *al massada* was unsuccessful in stimulating the completion of her miscarriage and Huda 'had no choice but to seek medical help'. As described previously, Huda returned to the hospital to have her miscarriage managed, at first through a series of medications, but it eventually required surgical intervention.

Like most interlocutors, Huda focuses on moving forward from the miscarriage. Related to this is not dwelling on the experience; she describes not saving anything to remind herself of the pregnancy:

No, I didn't keep anything because if it is abortion, I don't like to keep anything because every time I see it, I will feel *atab nafseyan* (emotionally unwell).

By far the majority of interlocutors do not keep mementos of the pregnancy, such as scan pictures of the foetus or items bought in preparation for the birth. Some women who had bought items of clothes or other goods for the baby say they might keep them, but with the intention of using them for subsequent pregnancies and babies, not as a form of commemoration, suggesting they are not imbued with meaning linked with that particular pregnancy. Most women say they will give them to charity or to someone they know who is having a baby. Huda suggested that keeping items will cause upset and make one 'emotionally unwell'. Remembrances are unwanted or inappropriate, with women suggesting that, instead, one must accept the miscarriage as part of God's plan. The framework for finding meaning in miscarriage as part of God's will and an understanding of the being as a 'bird in heaven', who maintains a presence in the cosmology provides comfort. Dwelling on the lost pregnancy implies not accepting it as God's will.

This approach to miscarriage is markedly different from many women in Euro-America who, in part and in response to societal silence, now eroding, insist on public displays of commemoration to acknowledge their loss. There are growing opportunities to do so, such as International Pregnancy and Infant Loss Remembrance Day, which closes with a day of remembrance ceremonies and candle lighting vigils including the global Wave of Light, where participants light a candle in memory of babies lost through miscarriage, stillbirth and infant

death, illuminating social media platforms with images. Women often keep baby items, pictures and other objects to remember and memorialize a pregnancy that ended in miscarriage (Layne 2000, 2003; Kilshaw 2020b, 2017b) or the imagined child contained within. The temporal shift backwards to pre-pregnancy and even pre-conception in the context of anxious reproduction (Faircloth and Gurtin 2017) leads to an emphasis on each pregnancy as containing a child whose loss must be acknowledged and grieved. This is likely linked to lower fertility rates, meaning women experience fewer pregnancies, delayed reproduction, what has been termed 'anxious' reproduction (Faircloth and Gurtin 2017) as well as increasing expectation of medicine. The normativity and lack of sensitivity around miscarriage in Qatar was reflected by our research experience in that whilst IRB approvals were rigorous, but relatively straightforward in Qatar, in England there was a great deal of concern about asking women to speak about what is deemed as such a sensitive and distressing topic.

Multiple miscarriage: towards infertility

Huda was not particularly worried about her first miscarriage, seeing it as a relatively common event, which did not threaten her fertility. However, when she experienced her second miscarriage, those around her became concerned that there was something wrong and her fertility was questioned. For Huda, it was her second miscarriage that attracted concern but, in most cases, a small number of losses was not seen as cause for alarm. One, two or three miscarriages is typically seen as acceptable and unlikely to be seen as indicative of reproductive failure. However, each miscarriage seems to have a cumulative effect, adding to potential concern. The woman's specific situation will also be taken into account as those around her consider reproductive possibilities and aspirations. Numerous miscarriages result in dwindling confidence in a woman's fertility moving her through the spectrum of perceived fertility toward suspected infertility. In this way a miscarriage, if it follows a number of previous miscarriages is problematic not so much in itself, but when considered in relation to previous disruptions, may be interpreted as an indication of infertility.

A miscarriage does not indicate reproductive failure, but numerous miscarriages accumulate concern, which may be seen as reproductive

inadequacy and failure. Reem, a thirty-five-year-old woman with five children who had recently miscarried for the first time describes, 'For us [miscarriage] is normal, but for someone who miscarries a lot they feel sorry for her.' This indicates that multiple miscarriage is seen as deviating from the norm and is worthy of pity; thus, whilst miscarriage is relatively normalized, it may be potentially problematic, particularly with each additional loss or reproductive failure. Additional losses accumulate apprehension, placing a woman in dangerous proximity to a wholly negative category: infertility. Multiple reproductive losses place a woman in a vulnerable position as it casts doubt over her reproductive status, moving her across the spectrum towards deficient fertility. This resonates with Varley's findings that miscarriage in Gilgit, Northern Pakistan, is proof of a woman's ability to conceive – 'half the battle won': two or three miscarriages over a woman's reproductive life were viewed as normal, but more than five was "too much," and signaled cosmological imbalance or "black magic" (2008: 313). Similarly, whereas miscarriage in Qatar was likely to be seen as caused by evil eye or other factors, infertility might be attributed to possession or black magic.

Challenges to a woman's ability to reproduce may put her in a vulnerable position and leave her open to threats of divorce or polygamy, as Mohammed explained:

Most women worry that if she miscarries once or more, her husband may marry another woman, even if the idea is not present in his mind, the people around him will make him think of it. [*Who are those people?*] His family, his mother, his brothers and sisters, and his friends . . . This is the most fearful thing for women. I mean even if she has children; no matter how many one or two or three and then she miscarried once or twice or more, she will assume that her husband is still young and nothing can prevent him from getting married again.

Despite previously suggesting that a small number of miscarriages should not cause concern, Mohammed recognizes that women who miscarry may worry that such an event leaves them susceptible to their husband marrying again. Even if the husband is not thinking of responding in this way, he argues that those around him may encourage him to marry again to ensure more children. This, he suggests, is 'the most fearful thing' for Qatari women. The fact that they have already produced children does not necessarily protect

them from worry. Mohammed's description of women's anxieties in relation to polygamy is reflective of what we found in other conversations. Women often spoke about the possibility of their husband taking another wife in the guise of having more children, but this was most often associated with problems conceiving rather than miscarriage. Indeed, women do have cause for concern. Statistics show 95.9 per cent of divorces occur between childless couples often within the first four years of marriage (MDPS 2016: 25). Feelings of vulnerability in the face of not fulfilling reproductive aspirations and expectations informs women's experience of miscarriage.

The threat of polygyny certainly impacted Noora's experience of miscarriage, as she was particularly worried that Mohammed would take another wife when it was no longer advisable or possible for her to produce more children. Noora confirms Mohammed's assertion that miscarriages make a woman vulnerable:

Definitely a woman who miscarries will be scared because this is considered a weakness, if I miscarry it means I can't have children, so definitely I will be scared.

Whilst Noora and Mohammed previously suggest miscarriage is not a cause for concern and is a demonstration of health and fertility, further discussion reveals that they suggest that miscarriage may be regarded as 'weakness', casting a woman in a vulnerable position. This apparent contradiction is likely informed by Noora's particular situation: she is forty-two years old; her miscarriage occurred towards the end of her reproductive years. She miscarried after becoming pregnant despite medical advice warning her not to due to her age and health. Of course, the pregnancy and its ending occurred against the backdrop of Mohammed's continuing desire for more children and his admission that in order to fulfil this desire, he will marry again with Noora's permission. Noora feels she is running out of time, thus, a miscarriage is more likely to suggest the end of fertility.

Whilst most women spoke about miscarriage as not something particularly worrying or shameful and many suggested it was spoken about somewhat openly, others suggested that concealing miscarriage is common practice in Qatar. Dana explained:

I think [women] avoid talking about it, to avoid being a topic of conversation because people feed on gossip like this. Miscarriage is usually a good topic of

gossip and they would avoid it, they don't want to be a topic of gossip. And whether it happened again . . . and they count how many times it happened to someone. People, some people, tend to collect and analyse even add some spices to it, so to avoid this we do not want to share.

According to Dana, women avoid disclosing miscarriages to avoid being the subject of gossip. Dana refers specifically to the risk of others knowing that one has experienced numerous miscarriages. Women may not discuss their miscarriage for fear of future reproductive disruptions and others noting their accumulation. The suggestion is they keep miscarriage secret to avoid future miscarriages being tallied by others, which may lead them to be labelled infertile. According to Dana, gossips also 'add spice' to stories, perhaps intimating more reproductive difficulties.

Twenty-eight-year-old mother of two Khadija also suggests miscarriage is something about which others gossip. Having recently experienced her second miscarriage at twelve weeks' gestation, Khadija thinks miscarriage attracts ignominy:

They say: 'This woman always miscarries.' For example, you may be sitting in a place with your friend and your friend points at a lady and says, 'This lady has no children because they always die' or 'She always get pregnant but her babies die in her stomach,' – like this.

Khadija explains that some women are known to lose pregnancies and may be pointed out as such. Khadija's husband adds:

There is another social stigma; for example, if a woman always miscarries, men don't propose to her sisters because they think it may be genetic.

Khadija's husband suggests that there is a stigma associated with a woman who 'always miscarries' and that this may impact a woman's family members, as recurrent miscarriage extends the stigma to the woman's female relatives. However, what these quotations reveal is that whilst the speakers are reporting that miscarriage is seen as shameful, in fact, they refer to *multiple* miscarriages. A woman 'who has no children because they always die' is suffering from miscarriage, but the emphasis is on her inability to produce children at all. Whilst able to conceive, she remains unable to continue a pregnancy and, thus, she moves along the spectrum towards infertility.

One or two miscarriages do not reflect negatively on a woman's fertility and, thus, does not typically impact her social or marital standing. However, individual circumstances may result in a woman's position being more or less vulnerable in the face of miscarriage. In Huda's case, her miscarriage at advanced maternal age and in light of her husband's eagerness for more children mean that her marital standing may be impacted. Despite previously speaking about how her mother-in-law minimized her miscarriage in light of her having three children, Huda feels that, after her second miscarriage, her past demonstrations of fertility were forgotten:

Look, abortion is very common now . . . once you miscarry, oh my God! You have a problem and they start telling the husband 'What are you going to do now?' So they ignore that you had babies before. My husband's parents are waiting for a baby boy . . . No, but also abortion! 'You are facing a new problem' . . . They make things worse. Unfortunately, we have so many wrong beliefs and our men believe in this even if they are well educated.

Not fulfilling expectations of producing a son puts her in a difficult position, but when she then miscarries a 'new problem' appears. Huda complains that her previous successful pregnancies have been discounted in the face of her recent miscarriages. The requirement to produce a son had been the focus of concern, but the miscarriage creates 'a new problem' in the eyes of her in-laws, which lead her to 'feeling emotionally unwell'. Reproductive disruptions of different forms accumulate vulnerability.

Infertility

Miscarriage, as the premature ending of a known pregnancy, primarily demonstrates fertility and, thus, does not necessarily place women in a problematic position. Pregnancy loss, when seen in a broader context of women's reproduction and what is deemed 'normal', does not automatically make a woman vulnerable. Experiencing a miscarriage sets a woman apart from those who are barren, for it shows that she is able to conceive. Unlike those who experience miscarriage, infertile women emerge constantly in discussions as targets of stigma and anxiety. Infertility and, particularly,

infertile women are seen as anathema. With the emphasis on pronatalism and on women's role in producing children, those who are unable to do so are seen as failures. With womanhood and motherhood being so entwined, those who are unable to become mothers may be seen as not fully women.

Despite remaining childless having recently experienced her second consecutive miscarriage, twenty-nine-year-old Kareema feels blessed in comparison to her sister-in-law who has never become pregnant in her seven years of marriage. Unlike her sister-in-law, Kareema feels secure in the knowledge that she can become pregnant and thus is fertile. Achieving pregnancy is positive, as conception, even one that ends in miscarriage, provides protection from concerns about her fertility, if only temporarily. It is those who have not conceived, like her sister-in-law, who are truly vulnerable, for it is more likely that they will not produce children. Seven years without conceiving demonstrates a lack of reproductive health and suggests the woman is barren. For this reason, Kareema thanks God for the opportunity to experience pregnancy even if it ended prematurely. She feels she has 'tasted motherhood'.

Wafa describes infertile women as the source of gossip: 'Because she can't have kids and she is not useful . . . they will talk.' A woman's 'use' is tied to her ability to produce children. Those who are unable to do so will be objects of derision. Wafa explains that such women are viewed negatively. With reproduction being central to a Qatari woman's status, social standing and identity those who are unable to produce a child are considered inadequate and lack value in society. Infertility presents a threat to social norms of reproduction. A barren woman is particularly problematic as she is unable to fulfil her role as reproducer. As a result, a newlywed woman is the source of intense interest, with those around her awaiting evidence of her fertility. Interlocutors describe the first months of marriage as a tense period during which they experience scrutiny, particularly by their husband's family, with whom they now live. Newly married women feel pressure to conceive immediately; if they do not do so, concerns about their fertility swiftly develop. Her fertility is of interest, to the extended family with observations and remarks made about her reproductive status, particularly by the mother-in-law. At times, passive commenting becomes more active: women describe being instructed to seek medical intervention, often after only a few months of marriage. Typically, these stories feature anxious mothers-in-law. Women

are encouraged and cajoled to seek assistance from medical practitioners to improve their chances of becoming pregnant. Women are held responsible for their fertility and are expected to be proactive in seeking investigations and enhancements, if necessary. The aforementioned hadith, which informs understandings of illness 'Allah has sent down both the disease and the cure, and He has appointed a cure for every disease, so treat yourselves medically, but use nothing unlawful' (Abu Dawud), extends to infertility. Women's responses are derived from such framing: God caused the misfortune and it was meant to be, but medical care and treatment may be required to rectify it. God ensures a cure, leading women to be optimistic about their future reproduction. This means that women experiencing reproductive problems seek treatment – both biomedical and alternative therapies. Indeed, particularly with infertility, it was seen as a woman's responsibility to seek treatment whilst maintaining faith in God as the ultimate arbiter of cure.

Pregnant Abeer describes how in the first months of her marriage her mother-in-law had been concerned that she was infertile; the absence of pregnancy heightened by a comparison with her sisters-in-law who produced children soon after their weddings. Despite only being married for two months, Abeer's mother-in-law escorted her to the hospital where she underwent investigations into her fertility. Her mother-in-law also arranged for *al massada* to come to their home to provide fertility enhancing treatments. In Abeer's case, her marriage had not been in the family, making the relationship with her mother-in-law distant. With pressure mounting on her, Abeer fell to the floor in front of her husband and cried. Seeing her crying on the floor, her husband assumed the worst and thought tests must have revealed a problem with her ability to conceive. Abeer explained to him that she was not upset over the status of her fertility, but instead her distress was due to her treatment at the hands of his family: 'you people make me feel that I have a problem'. This seemed a turning point for the couple, as her husband, who Abeer often refers to as kind, honest and loving, realized how much pressure she was under and how upset it was making her. Indeed, despite the family making her feel as though there was something wrong with her, medical investigations revealed no physical problems that might indicate reproductive problems. This was further demonstrated by the fact that Abeer soon became pregnant. Delighted by the news, her husband bought her a generous gift of gold.

Infertile women hold a problematic and liminal status, as they transgress social roles and expectations. They are a the source of anxiety and concern and, thus, it is unsurprising that they are also most common source of evil eye. This is particularly relevant for discussions of miscarriage, for evil eye is seen as a common cause of pregnancy loss. Thus, not only are infertile women to be pitied and seen as failing in their duty and role as a Qatari woman, they are also to be feared. They are doubly stigmatized: unable to produce children themselves, they are also sources of risk for other women's pregnancies. The sheikh introduced in the previous chapter explains:

But definitely, a woman with many births could be cursed especially if another woman who is infertile looked at her belly, so she may eventually miscarry. Absolutely, the evil eye is like an arrow that comes out of the eye of the jealous person.

A specialist in reproductive issues, the sheikh echoes the comments of other interlocutors: pregnant women are not only vulnerable to evil eye but also likely to attract it. Those who are jealous of their fertile state are most likely to be infertile women. Due to the importance of reproduction, a barren woman is likely be jealous of another's pregnancy and, thus, should be feared. Khadeeja leaves us in no doubt as to the source of evil eye:

[Evil eye is] from an infertile woman. Nowadays infertility has increased and the chances to become pregnant have decreased, therefore, someone who is not getting pregnant may be *yeseeb bel ain* (hit by the eye) of a pregnant woman.

Infertile women, jealous of another's fertility may cause harm. With contemporary Qatar facing decreased fertility, according to Khadeeja, women are more likely to suffer infertility and, as a result, cases of evil eye in pregnancy are increasing. Barren women are to be pitied, but also feared, for they can impact the pregnancies of women and cause them to miscarry. Infertility is a problematic state for a society that prizes fertility so highly.

Childbirth and childrearing are key elements of the role of women in Qatari society. Motherhood is entwined with women's role in Qatar: women are reproducers of children and of society and thus, it is unsurprising that women who fail to produce children espouse an ambiguous and problematic status.

Government discourse makes the 'Qatari family' the basis of Qatari society and the heterosexual family as the 'reproductive unit'. This creates a liminal character, which has become the focus of state anxiety: the single woman. As sources of societal anxiety, barren married women are related to single women for they are both seen as reproductively useless. The state's concern with the 'sharply rising proportion of Qatari women who never marry and steadily increasing divorce rates' (QNDS 2011:166) is acute. The local press has anxiously reported that a quarter of marriageable Qatari women remain single with Arabic newspapers publishing articles about the negatives of the 'spinster problem' (Rajakumars 2014). As sex and reproduction are only legal and sanctioned when they occur between a married man and his wife, the wombs of single women are unproductive. The QNDS 2011–2016 (165–77) provided detailed 'targets' to 'Implement a programme to strengthen family cohesion' including to 'reduce the proportion of Qatari women who are unmarried by ages 30–34 by 15%'.

The wombs of single women, unable to reproduce legitimately (at least for the time being) and barren women are wasted: they are not available for the state's mission to swell the Qatari population. These women are the source of anxiety, their value for population enhancement and reproduction of Qatari society is limited; they problematize the interdependence of the role of women and motherhood. Stigma associated with infertility has parallels in other societies and is particularly acute in pronatalist contexts, such as Israel where infertility is seen as a tragic fate for a woman (Inhorn 1996). The barren woman is an archetype of suffering in the Israeli/Jewish imagination and particularly problematic for religiously observant Jews for whom reproduction is understood as an imperative religious duty that is foundational to their entire way of life (Kahn 2000). Similarly, procreation is part of one's religious duty and entwined with one's role as a Qatari woman. One's religious obligations around reproduction reinforce national expectations to become a mother.

Due to the high value placed on reproduction, infertility produces significant difficulties for Qatari men and women, but it is particularly devastating for women. Infertile women may be subjected to adverse consequences such as abuse, coercion, pressure, divorce, polygamous remarriage or abandonment, and are more likely to be the recipients of social stigma and ostracism by the community (Van Balen and Inhorn 2002; Inhorn 2007b: 186). Women are

particularly concerned about divorce or their husband taking another wife if she is unable to conceive. If a couple has problems conceiving, it is likely the woman will be seen as responsible, regardless of where the difficulties lie. Indeed, throughout the world, women typically bear the burden of infertility, often blamed for any reproductive problem regardless of source. In Qatar, like most of the Arab world, reproduction is seen as a woman's domain leading to women being held responsible for any related problems. As Fareeda explains, infertility is 'always' blamed on the woman:

No one will admit that the problem is from their son! The mother-in-law will say that the problem is from the wife if she didn't get pregnant: this is the tragedy.

Culpability is often placed on the woman and she typically bears the brunt of stigma. For a couple having difficulty producing a child there are options available: ARTs are readily accessible and commonly used. Yet these technologies are not 'immune to culture' but are adopted in complex ways (Inhorn 2006; see also Inhorn 2005; Inhorn 2007b), often with 'patriarchal paradoxes' surrounding them, particularly in certain cultures (Inhorn 2003 in Faircloth and Gurtin 2017). In Qatar, as with other Sunni branches of Islam, such patriarchal paradoxes include a ban on third-party donation, which limits possibilities for infertile women. Whilst ICSI has helped to alleviate problems of severe male infertility in patients, providing greater options for infertile men who previously would not be able to produce 'biological' children, this technology only further increases infertile women's vulnerability (Inhorn 2007b: 191). Polygyny provides opportunities for men who can take another wife in an attempt to produce children. Adoption is not socially sanctioned, so for Qatari women, the only means to produce a child and fulfil societal expectations is by giving birth to her husband's child. If she does not do so, she faces social stigma and is at risk of divorce or her husband marrying another woman.

Normativity and silence – thoughts on the comparative

Whilst the dominant trope surrounding miscarriage is its ordinariness and something not entirely hidden, a small number of interlocutors refer to

miscarriage as ‘taboo’ and something to be kept private. According to Nada, one should not speak to others about one’s miscarriage:

There are some people who hide this and don’t talk about it. In our society they hide miscarriage, however, in other societies such as in USA they sympathize with the woman. Here in Doha, it is a (taboo) *aeb!* The woman who miscarries shouldn’t talk about it and shouldn’t tell anybody.

Twenty-three-year-old Nada’s opinion that miscarriage should be kept private is possibly informed by her status as a new bride whose first and only pregnancy had ended in miscarriage. Having not produced a child, Nada’s position is more vulnerable than other interlocutors who have more fully demonstrated their fertility by producing children. Recently married, Nada is likely unfamiliar with discussions of pregnancy and reproduction in keeping with Qatari social mores, which dictate that sex and sexuality are not appropriate topics for the unmarried and amongst certain groups. Nada has only recently moved into the realm of womanhood and has likely not experienced open discussions with other women about pregnancy. Her comments are striking in that most suggest that miscarriage isn’t something particularly taboo, particularly in comparison to infertility. Nada’s comment that other societies, like the USA, are more sympathetic to miscarrying women and her suggestion that miscarriage is taboo in Doha unlike in other contexts is particularly interesting. As Nada acutely notes, miscarriage is typically responded to with sympathy in North America (also the UK), however, this is a relatively recent development. Historically, miscarriage has garnered little attention let alone sympathy. Scholarly work on miscarriage (i.e. Cecil 1996, Layne 2003, van der Sijpt 2017) has focused on the trope of silence surrounding it. Notions of miscarriage as failure as well as discomfort with its associations with blood, mess, death, and pain (Cecil 1996), or ‘matter out of place’ (Murphy and Philpin 2010) has made miscarriage a silenced subject. In more recent years, this absence has been challenged with more public spaces opening for women to document and articulate feelings of loss and grief.

Accounts of miscarriage in much of Euro-America have focused on its social silence and how this emphasizes feelings of inadequacy, isolation and shame. Yet the sheer volume of discussions around pregnancy loss demonstrates that there is silence no more. Women are actively and publicly sharing

experiences of pregnancy loss, thus dismantling silence, shame and stigma around all forms of pregnancy endings; as the 'break the silence' slogan of British Baby Loss Awareness Week so clearly articulates. Approaches to miscarriage have changed dramatically in much of Euro-America, as evidenced not only by the introduction of awareness days and other public forums to articulate feelings of loss, but also the market for miscarriage memorials, and shifts in medical practice, including changes to disposal practices, which now treat pregnancy materials as something needing sensitive disposal (Morgan 2002; Kilshaw 2020a; Kuberska 2020). Such activities frame miscarriage as a significant loss of a baby or child for which the appropriate response is distress and grief. Informed by broader social transformations and understandings, updated clinical approaches reinforce understandings of miscarriage as the death of a baby.

Women in many parts of Euro-America have reported silence about miscarriage and typically understand it to be rare, unusual and indicating more serious reproductive problems (Kilshaw 2020b, 2017b; see also Bardos et al. 2015); remaining pessimistic about their future fertility and concerned a miscarriage points to damaged fertility (Kilshaw, 2020b). 'Uncertainty' appears repeatedly in their accounts: miscarriage results in ambiguity, particularly over one's reproductive future (Kilshaw 2020b), reflecting the milieu of 'anxious reproduction', which emerges as new reproductive choices, burdens, responsibilities and accountabilities increases anxiety (Faircloth and Gurtin 2017). Miscarriage in this context is typically understood as failure and is accompanied by feelings of personal guilt particularly in neoliberal and technologically advanced settings where a sense of responsibility, accountability and agency dominate reproductive experiences (Kilshaw 2020a and b; McCabe 2016; Rapp 2000; Thompson 2005). The emphasis on individuality, choice and agency contributes to an assumption that women may be responsible for their miscarriage much as they are held responsible for infertility (Layne 1997). Miscarriage as failure may be particularly acute in the context of ARTs (Berend 2010, 2016; Mitra 2020). However, miscarriage is not always viewed as failure, but instead evidence of health because of its demonstration of conception and/or the body acting as it should by preventing the ongoing development of an unviable or undesirable foetus. Such a framing of miscarriage as the body operating as it should rather than pathologically is found in biomedical

interpretations (Layne 1997: 291; Melo and Granne 2020), where miscarriage is a natural process of quality control. Qatari miscarriage suggests fertility and, thus, a (partial) success; there is optimism about future reproduction. Qatari women retain 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 choice, including about reproduction, and, as a result miscarriage is seen as ultimately outside their control. Exposed to more reproductive events, miscarriage is normalized.

Exploring miscarriage in a range of contexts, such as Qatar, provides opportunities to question commonly held assumptions around the experience. Although the discourse of miscarriage as significant loss of a baby is a recent development in Euro-America, it has become part of the 'dominant' language of parenting and reproduction (Faircloth et al. 2013a), itself informed 'the largely middle-class, North American/Northern European discourse of public and professional life' (Strathern 1996: 38). Yet such a framing of pregnancy loss may be at odds in some contexts, where miscarriage is framed more normatively or is more likely to be approached with pragmatism. Indeed, the influence of such dominant discourses may impact Qatari women's experience of miscarriage, particularly in light of global flows of knowledge in this cosmopolitan context. Increasing individualization of Qatari society may make such interpretations of and reactions to miscarriage more persuasive.

Conclusions

Miscarriage is a sad, if relatively commonplace, occurrence. Awareness of other women's reproductive experiences mean that it was not interpreted as unusual or necessarily a worrying event, reflecting the biomedical view of miscarriage. In biomedicine, miscarriage is understood as a natural process of quality control through which the body recognizes an abnormal pregnancy (Benagiano et al. 2010); a view which resonates with the understanding of miscarriage as God's will to end a pregnancy that would have ended in disability or some future problem. Following a miscarriage, women are reminded of their fertility and typically remain optimistic about future reproduction. The focus is on

cleansing the body often with the help of traditional healers. A small number of miscarriages does not necessarily damage a woman's status or call her fertility into question; however, numerous miscarriages become a source of anxiety and concern. Women who suffer multiple miscarriages evoke damaged fertility, moving them on the spectrum towards the state of an infertile woman. Deviations from the expectation that women will become pregnant easily, soon after marriage; will continue to regularly conceive; and will produce a son places the woman in a difficult position. Her status will only worsen with each additional loss or reproductive failure. With the centrality of fertility and reproduction in Qatari society, those whom are unable to produce children fall short of social expectations. Infertility presents a threat to social norms of reproduction, with the infertile woman being the cause of anxiety, pity but also fear. Qatari interlocutors see miscarriage (in small numbers) as a demonstration of fertility and, thus, it is compared favourably against infertility and an absence of conception. Women and those around them interpret miscarriage by using knowledge from other women as well as from their own reproductive histories. Qatari women often spoke of other women they knew who had miscarried and saw their experience from this perspective, interpreting their experience as not particularly unusual. Because of the specific social landscape in Qatar, which includes extreme pronatalism, high fertility rates, polygyny, accessibility of ARTs but without third-party donation there is a particular configuration of reproductive problems and stigma. Women who are unable to conceive and/or produce children are highly stigmatized; those who have hope of conception and/or who have demonstrated their fertility are protected from this stigma. This differs from much of Euro-America where, in the era of anxious reproduction, any stigma around miscarriage and infertility seems to be collapsing.