

INTRODUCTION

AMBIGUITIES AND NAVIGATIONS

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A striking feature of accounts of and literature on miscarriage is the trope of silence. The slogan of Baby Loss Awareness Week, which began in the UK sixteen years ago, is 'Break the silence'. Associated with the American Pregnancy and Infant Loss Remembrance Day Campaign, which began in 2002, the week concludes each year on 15 October, International Pregnancy and Infant Loss Remembrance Day. Approaches to miscarriage have changed dramatically and the silence has steadily eroded in much of Euro-America, as evidenced not only by the introduction of such awareness days and other public forums to articulate feelings of loss, but also by recent campaigns to provide certificates of life for miscarried foetuses under 24 weeks' gestation; a growing market for miscarriage memorials; and shifts in medical practice, including changes to disposal practices. In the past, pregnancy tissue would be discarded as clinical waste and routinely incinerated in the UK, but following increased levels of public scrutiny, including a 2014 *Dispatches* programme, the UK Human Tissues Authority (HTA) developed guidance on the disposal of the remains of pregnancy (March 2015). This guidance, which influences national policy, outlines that women should be informed of and have access to a range of disposal options (burial, cremation, incineration¹), the woman's wishes should be carried out and that remains should be 'sensitively' disposed of. In Texas, USA, a 2017 senate bill requiring hospitals and clinics to bury pregnancy remains (miscarried, stillbirth and aborted as well as those from ectopic pregnancies)

regardless of the woman's wishes was passed and it appears that other states may follow suit. While the responsibility rests with the clinic, not the women, the bill will impact the availability of abortion (and early pregnancy) care providers, as they may not be in a position to provide the required disposal services. This law would in effect prevent clinics from providing abortions if a disposal/burial pathway was not established, while placing additional financial burdens on them. The bill was blocked and taken to trial in July 2018, and it remains opposed for the time being, although in September 2019 Texas attorneys asked the courts to revive it. Such shifts in the treatment of these materials have been informed by broader societal changes regarding pregnancy loss in these contexts and in turn this loops back to impact on how women experience a pregnancy ending: the way these entities are considered subsequently informs the nature of interactions with them.

Miscarriage has increasingly been framed as a significant loss of a baby or child that is typically met with distress, grief, post-traumatic stress and depression (Farren et al. 2016). Such a shift has come about in large part due to support groups and charities: in the UK, the Miscarriage Association and campaigns such as Mumsnet's 'Miscarriage Care Campaign' have been influential in shifting public and medical thinking. The medical profession has responded to the call to manage miscarriages with greater sensitivity, including changing the approach to care, and the medical terminology used. Until recently, the surgical removal of pregnancy remains in the case of incomplete or missed miscarriage was referred to as 'Evacuation of Retained Products of Conception' (ERPC); this has now been renamed the more neutral 'Surgical Management of Miscarriage' (SMM). Changes in clinical approach have been informed by broader societal transformation in how society approaches pregnancy loss, whilst also reinforcing understandings of miscarriage as the death of a baby. Framing miscarriage as significant loss may result in frictions in contexts when it is not perceived in this way or is framed more normatively or pragmatically. Furthermore, what impact might this have on the framing of other kinds of pregnancy endings? This book reveals variation and highlights the fluidity of miscarriage definitions, categories, meanings and approaches.

Despite its prevalence, there is very little scholarly social science literature on miscarriage. This book responds to this gap, positioning itself among the impressive body of work on anthropology of reproduction and, particularly, on reproductive disruptions (see Inhorn 2007c). Anthropology provides a means to explore miscarriage as

simultaneously biological, social and cultural and thus provides rich insights. The chapters consider how such an event interacts with kin, marital, gender, religious and political structures and reveal how these vary significantly between cultures. Social and political forces shape miscarriage, adding further evidence to the way in which 'reproduction is always embedded within larger social, cultural, economic, and political relations and forces' (Inhorn 2007a: 10; see also Lock 1993; Rapp 2000; Scheper-Hughes 1992). The first significant anthropological consideration of pregnancy loss, Cecil's (1996) collected volume, responded to the scholarly silence, which Cecil suggests may be because of notions of miscarriage as failure and that it is typically accompanied by mess, blood, pain and embarrassment and, thus, not easy to speak about. Layne's work on miscarriage, most notably *Motherhood Lost: A Feminist Account of Pregnancy Loss in America*, published in 2003, marked the advent of miscarriage as a subject of anthropologists' attention. Revealing how middle-class American women grapple with the two affective political forces of foetal rights and a cultural code of silence, Layne notes an absence of a 'cultural script' to articulate the grief of pregnancy loss (see also Cecil 1996). Yet the efforts of Linda Layne, other scholars and pregnancy loss support groups have meant public disclosures of miscarriage are now more common in northern Euro-America (Kilshaw 2017b; Layne 2003).

Layne's landmark work reflects the broader scholarly focus, which has primarily rested on white, middle-class Euro-American women; meaning that reproductive loss in a large group of women has been ignored, including those from other ethnic backgrounds and non-hetero-normative people. Building on literature such as Wojnar and Swanson (2006), Peel (2010) and Luce (2010), Craven and Peel (2014, 2017) argue that LGBTQ people have an amplified experience of loss due to the challenges in achieving conception and adoption. Indeed, the emotional and financial investment made in quests for motherhood and the heterosexism of health professionals in many cases heightens the distress of miscarriage (Wojnar and Swanson 2006) whilst homophobia intensifies feelings of isolation (Luce 2010). Responding to a significant gap in the scholarship on miscarriage, Craven and Peel's work on non-traditional families is a welcome addition, as is that of scholars such as Berend (2010, 2016), who looks at loss in the context of surrogacy. With the literature primarily exploring Euro-American heterosexual women's experiences (e.g. Layne 1992, 2003; Letherby 1993) and only a few scholars examining the issue from the viewpoint

of women and men outside of these contexts (e.g. Cecil 1996; Rice 2000), a significant absence has been an understanding of how women in other parts of the world experience miscarriage. This book is part of a small but growing body of work that explores miscarriage beyond Euro-America (see also Kilshaw 2017a, 2020; Van der Sijpt 2017, 2018).

Unanticipated and often undesired, miscarriage is a reminder that reproduction is disorderly, its misfortune outside our control (Boddy 1989). Scholars have outlined the sense of chaos that arises when reproductive expectations and aspirations are not met (e.g. Inhorn 2003). Reproductive loss has been conceptualized as a major disruption, which potentially causes a crisis in gendered identity, relationships and life plans (Becker 1999). As a theoretical concept, miscarriage provides opportunities to make sense of the discourses and dynamics that evolve in times of uncertainty, ambiguity and reorientation. The uncertainty of miscarriage causation provides possibilities for the negotiations of interpretations. Such flexibility of explanations can make a woman vulnerable to accusations of inducing pregnancy loss, but can also provide opportunities to tailor interpretations to suit circumstances (Jeffery and Jeffery 1996; Jenkins and Inhorn 2003; Van der Sijpt 2010). It is during such moments that explicit 'reproductive navigation' (Van der Sijpt 2018) takes place, providing opportunities to explore social life. Miscarriage engages a woman's relationship with her body, her self, the foetus, as well as past and future children; it features possibility and loss as well as ongoing negotiations of the self. The book explores how miscarriage is framed and understood rather differently in diverse contexts: Cameroon, Romania, Qatar, India, Pakistan and the UK, revealing how social context and cultural norms dramatically impact on miscarriage. And yet miscarriage always involves liminality and uncertainty, engaging core questions of social life. We use miscarriage as a lens through which to explore some of the most central issues within anthropology, including the thresholds of humanity, categories of personhood and the boundaries of life and death. Pregnancy endings provide opportunities to interrogate anthropological assumptions and significant issues of theory and practice in anthropology about personhood and the foetal subject; boundaries around bodies, categories and definitions; and how society understands and frames gender, women and, particularly, motherhood.

Demography and Miscarriage

The demographic contexts within which miscarriage arises also impact reactions: lowering fertility means having a child becomes an exceptional occurrence in the life course and may lead to greater feelings of loss, whereas high fertility rates may mitigate mourning and grieving as will contexts with higher rates of infant mortality. Low fertility rates may increase emotional, financial and other investments in pregnancy, emphasising miscarriage as loss and entailing acts of mourning, which will be similarly felt in contexts of demographic anxieties. Miscarriage is a potential personal and social problem: it may lead to psychological distress, such as parental depression, which in turn may impact family members and lead to marital dissolution. In some contexts, women who miscarry have a higher risk of postpartum depression even after having a child (Blackmore et al. 2011). There may be additional social costs associated with miscarriage such as loss of work or chronic health problems associated with depression. Of course, miscarriage may increase space between children and may reduce the number a woman is able to or chooses to have, although the demographic approach to miscarriage suggests that this is minimal.

Miscarriages are frequent critical events and we might expect quantitative approaches to give them major attention, yet miscarriage has relatively little significance for fertility trends. The historical demography of communities around the world, together with contemporary anthropological research on them, showed a vast range of fertility levels while overthrowing the widespread assumption that women in the past always had many children. Even in the absence of contraception, the completed family size of women was shown to vary by 200 per cent. The old demographic view, following Malthus, according to which delayed marriage was the main factor leading to such variation – and that most people simply did not try to control their fertility – was clearly inadequate to account for such differences. This led demographers to consider more comprehensively the way social and biological aspects of reproduction interact. In addition to the timing and incidence of marriage, and the possible role of abstinence, the main factors in the absence of widespread contraception have turned out to be the role of lactation in inhibiting ovulation, and the impacts of pathological factors (i.e. gonorrhoea and AIDS). Long before the rise of contraceptive technology there were serious and sustained controls on fertility.

However, it is the timing of births rather than quantity that is being controlled.

Studying the dynamics of women's reproductive life courses more carefully, with particular consideration to the length of intervals between births, demographers looked at a variety of factors, including induced abortion, 'waiting time to conception', as well as miscarriage. One purpose of the framework (called the 'model of proximate determinants' [Bongaarts and Potter 1983]) was to specify what influence miscarriage has on changing numbers of children relative to the other factors, revealing two important trends in miscarriage: maternal age and length of the gestation period.² In constructing their model of how length of birth intervals is impacted by these factors, demographers realized that miscarriage refers particularly to the 'waiting time to conception'. On balance, in societies where sustained breastfeeding is practised, most of the interval between births is taken up by lactation, together with the nine months while a woman is typically pregnant. Indeed, the model showed that, on average, intervals including concerted lactation (often supplemented by abstinence to ensure spacing) might regularly reach three years or longer in the absence of contraception. In the context of this finding, we can readily understand why demographers came to regard the influence of miscarriage – which most often occurs in the early stages of gestation – as *not* a major factor shaping the number of births. The model shows that the number of months that miscarriage contributes to birth intervals is much smaller than other factors. While demographers have clarified much by their careful attention to how miscarriage can be measured, the secondary status the subject has played in fertility trend research has done little to encourage attention to the genuine problem that miscarriage creates for many women – a problem that is amplified for those who have repeat miscarriages, a variable not factored into demographers' models.

Boundaries, Definitions and Metaphors

Person Categories

Discussions of miscarriage inevitably lead to questions about the meaning ascribed to the embryo/foetus. Han (2018) points out the centrality of the dilemma of what to call 'it' in the first place: our choice of term (foetus, baby, child) is to refer not only to it in its material existence but also to the social relations that surround it;

to define a foetus is also to describe what is a pregnancy and what is a pregnant woman. In biomedical terms, 'foetus' only comes into effect after the eighth week of gestation (Maienschein 2002). However, the term is often used for earlier gestational ages. Nomenclature neither maps neatly onto clinical gestational stages nor correlates with clinical, physical, legal, religious and cultural distinctions. A foetus is made into being by the different practices around it. Medical, religious, legal, social and personal definitions inform the production of the thing (i.e. baby, tissue, no-thing) and yet such categories may not be coherent, are often ambiguous and open to negotiation. Early pregnancy is often framed as tentative, precarious and uncertain, with ambiguity about what is contained within. Writing about conception and pregnancy in eighteenth-century Germany, Duden (1993: 14) shows that conception was 'an ambiguous stage in a woman's somatic experience'. A delayed period was 'maybe a sign that she was "with child", maybe not', as it could be due to a blockage or retention of menses (ibid.: 16). It was only when a woman felt "'quickenings" that she would perceive herself as being "really pregnant"' (ibid.: 17). Person categories may be rigid or flexible. In their ethnography of pregnancy loss in rural North India, Jeffery and Jeffery (1996: 24) note that if a pregnancy ends before three months gestation, the contents are commonly referred to as 'merely a blob of flesh ... that broke up into blood clots and caused bleeding', with such bleeding framed as a menstrual period. Nearly three months will have elapsed before women speak of pregnancy, referring to a *bacha* (baby) with a spirit; before this point an early foetus is not recognized as such. A distinction is made between early and later loss in Cameroon, with the latter representing the loss of a child. Despite this conceptual distinction, however, the line between them is fluid: foetal development is determined by the strength of one's blood, which varies, meaning a woman will not know when her foetus is formed, viable or at term. A lack of a clear boundary between the end of a pregnancy and the loss of a child leaves space for women to propose what is lost (see Van der Sijpt's chapter in this volume). A miscarriage may represent the death of a baby (Layne 2000), a child (see the chapters by Van der Sijpt and Kuberska in this volume), the creation of a cosmological being (Kilshaw 2017a; Van der Sijpt 2018), but for others in other contexts a miscarriage may be understood as the expulsion of blood, water, dirt, tissue, a 'piece of meat', an assortment of cells, or 'matter out of place' (Jeffery and Jeffery 1996; Kilshaw 2017a; Littlewood 1999; Murphy and Philpin 2010). The development of

spirit or soul may be part of the continuum of development, in most cases conception, pregnancy, birth and early life, a series of stages of strengthening personhood and humanity.

Miscarriage has been absent from feminist scholarship because of the political nature of the questions involved in the foetal subject: something worth grieving accedes it to personhood (Layne 1997: 305). The concern has been that to focus on the foetus surrenders to the pro-life movement its major premise and forecloses the feminist insistence of reproductive freedom for women (Michaels and Morgan 1999: 1). Indeed, the meanings ascribed to foetuses and the history of efforts to grant social identities to them is a problematic topic in current feminist thought (see Michaels and Morgan 1999). Research is scant precisely because of the surrounding ambiguity: living but not yet alive, an embryo falls between the categories of 'human' and 'non-human'. We have difficulty in articulating exactly what these beings or materials are, making scholarly analysis difficult. As Rapp (2018: xiv) eloquently notes:

[The] foetus, a foetus, and the differential life chances of foetuses everywhere constitute a perfect storm of what the feminist theorist Donna Haraway would call material-semiotic objects. Liminal in the most profound sense, foetuses serve as lightning rods for any ontology you'd care to imagine, providing our meaning-making species with a continually self-reproducing nature-culture, a biosocial or material-vitalistic entity to which every generation must necessarily address itself.

Uniquely symbolic and yet innately flexible, the foetus "matters in so many dimensions of our experiences and expectations because it is both materially and metaphorically a product of the past, a marker of the present and an embodiment of the future" (Han, Betsinger and Scott 2018: 1). Scholarly reluctance to engage with the foetus is compounded with unsuccessful pregnancies: the miscarried foetus is a source of the profoundest ambiguity and yet the meanings ascribed to it are not value-free and have significant implications for a variety of practices, such as abortion; embryo creation, storage and disposal; the use of such material for research purposes; and fertility treatments.

While scarce, anthropologists' work on embryos and foetuses, particularly in relation to new technologies such as Assisted Reproductive Technologies (ARTs), has been influential in thinking about issues around person categories, personhood and potential. Work such as Cromer's (2018) on embryos 'left over' following in

vitro fertilization (IVF) reveals they are not inherently valuable; it is the considerable efforts at framing, defining and classifying that transform them into waste, preborn persons or frozen assets. Berend's (2010, 2016) research on surrogacy in the USA has shown that surrogates often mirror the rhetoric of anti-abortion activists despite their own stance on abortion, in terms of their conviction that life begins at conception. For many surrogate mothers, chemical pregnancies are considered miscarriages despite the lack of presence of an embryo or foetus because of the focus on the imagined and potential child; indeed, the distinction between egg, embryo, foetus and baby is often erased. Such understandings of personhood developing at conception with little distinction in relation to gestational age emerge in the USA, which may have as much to do with technology as it does with religious perspectives. American understandings of the foetus as 'bare facts of biological life' are the result of specific historical and social processes with the same moral, political or medical importance and meaning not necessarily ascribed to these entities in other contexts (Han 2018). Miscarriage provides an opportunity to explore the foetal subject: categories, such as legal, medical and religious classifications, grapple with definitions of life before birth, the boundaries of humanity and what value is attributed to an embryo, foetus or pregnancy residues. A plethora of relational values inform what these materials are, how they are regarded, and meanings ascribed to them. The landscape around miscarriage shifts: in many contexts, legislation continues to change, categories around foetuses, their value and notions of personhood are in flux. The meanings attached to life before birth vary considerably from culture to culture (Conklin and Morgan 1996; Morgan 1989), with the boundaries in relation to the thresholds of humanity and personhood informing how miscarriage is framed and appropriate responses. Knowledge of the foetus may become contested terrain with conflicting claims structuring debates about reproduction (Newman 2018: 201).

Definitional Boundaries and Language

A recent article in the UK's *Guardian* newspaper argued that 'language matters' when it comes to miscarriage (Lindemann 2018). Influencing practices as well as shaping experience, definitions and concepts of pregnancy ends are multiple, often drawn around considerations of what is lost as well as intentionality; boundaries around miscarriage are contingent and open to renegotiation and vary depending on cultural and historical context. Murphy (2019:

35) points out that scholarly literature tends to conflate various forms of pregnancy loss into one category, with miscarriage often considered alongside neonatal death and stillbirth, making for an imprecise literature. This book focuses specifically on miscarriage and considers the impact of definition categories. Miscarriage may be described in terms of falling: in Arabic, miscarriage is referred to as *Isqat* or *Tasqeet*, both originating from *saqat* (to miscarry), which means to ‘drop something from up to down’. Conveying a drop or a fall is similarly found in Urdu (‘a baby falls’) (Shaw 2014; Qureshi’s chapter in this volume), Hmong (Rice 2000), and in early gestational pregnancy in Cameroon (*abum ia song*, ‘the pregnancy has fallen’). The *Oxford English Dictionary* (OED) defines miscarriage in general terms: ‘a failure, blunder or mistake’; ‘a mishap or disaster’; ‘an instance of misconduct or misbehaviour’; before coming to ‘the spontaneous expulsion of a foetus from the womb before it is viable’. The usage thus partakes inevitably of the wider implications of wilful human agency *and* mere accident, of culpability and chance, and of failure. Definitions and understandings typically suggest an event of bleeding and (swift) emission of tissue. However, this rarely tallies with women’s experience of an extended process, unfolding over days if not weeks, with women commonly expressing alarm when their experience does not correspond with common perceptions.

Boundaries separate miscarriage from other pregnancy endings. This may be in relation to intentionality, attributes of the pregnancy (i.e. gestational age) and/or what is lost. The interrelationship between categories around foetal death is a key feature of the first chapters of this book and emerges in subsequent chapters too, with particular attention given to the way in which abortion (induced pregnancy ending) influences how miscarriage (spontaneous pregnancy ending) is framed. Miscarriage, stillbirth, abortion and infant death are distinguished in biomedical discourse, with different implications for management (Shaw 2014) and perception of the event. However, distinctions are not always concise. Miscarriages are distinguished from medically induced abortion in local Urdu and Panjabi idiom, where in the former the pregnancy ‘becomes’ wasted or ‘a baby falls’, whereas the latter are events that involve human agency (Shaw 2014). The circumstances and cause of a pregnancy ending often remain unknown, which may lead to vulnerability to accusations of wilfully ending the pregnancy, but also provides flexibility in how the event is presented. Ambiguity may extend to language around categories, lending itself to uncertainty around intentionality. The moral associations of labels may generate

navigations as miscarrying women try to disprove their culpability (see Van der Sijpt's chapter in this volume; see also Erviti, Castro and Collado 2004; Van der Sijpt 2017). Women and carers may choose particular language or descriptions of events as they navigate uncertainty, as Suh (2014) describes among health care providers in the Senegalese medico-legal domain where abortion is illegal. Categories of pregnancy endings take shape in clinical practice with health providers obscuring induced abortion in medical documents in a number of ways, including using terminology that does not differentiate between spontaneous and induced abortion (Suh 2014). Medico-legal-religious constraints define these categories and inform women's experiences; reproduction occurs within these constraints but there are opportunities for subversions, as women and their carers navigate ambiguities and resist particular framings.

In some contexts, there is little linguistic distinction between induced and spontaneous endings, such as in Qatar where *Ijhad* (abortion) is used interchangeably with *Isqat* or *Tasqeet* (miscarriage). With abortions rare due to legal, social and religious prohibitions, there is little requirement to linguistically distinguish from miscarriage. Elliot (Chapter 2, this volume) describes how the historic conflation of abortion and miscarriage in the UK has shaped how miscarriage has been approached in medical and public contexts, with the two entwined in terms of language, medical practice and ethical discussion around viability and personhood. The conflation can be seen in legal definitions where the law in the UK (and former colonial jurisdictions) makes it a crime for a woman to 'procure her own miscarriage' (<https://www.legislation.gov.uk/ukpga/Vict/24-25/100/section/58>, last accessed 14 June 2019). 'Spontaneous abortion' has traditionally been the term used for miscarriage in UK medical settings. In 1997 a Royal College of Obstetricians and Gynaecologists study group recommended that the word 'abortion' be avoided in cases of spontaneous early pregnancy loss, noting that 'abortion' was associated in the public mind with planned termination of pregnancy (RCOG 33rd Study Group 1997). Legal and commonplace in the UK, with one in three women undergoing an induced abortion, the study group recognized that cultural associations deemed the term inappropriate for the loss of a wanted pregnancy. It adopted this in its guidelines in 2006, noting the 'historical terminology ... distressing' (RCOG 2006: 1). 'Miscarriage' or 'pregnancy loss' have now become the favoured terms in both public and medical settings, and linguistically separated from abortion, with the latter implying intentionality. Thus, by referring

to their loss as a 'miscarriage', women in the UK convey clearly that the loss was unintended; women typically refer to abortions as 'terminations', denoting their active component.

Boundaries drawn around miscarriage may be defined by the object produced, its weight and ability to survive outside its mother's body, but definitions are multiple and fluid. Primarily a legal distinction to do with the death of a human being, classifications of stillbirth versus miscarriage revolve around viability in global policy initiatives, but viability shifts in relation to medical knowledge, technology as well as locale. There is no clear limit of development, age or weight at which a human foetus automatically becomes viable, and thus categories defining when the end of a pregnancy constitutes the end of a life are variable. The World Health Organisation (WHO) recommends that any baby born without signs of life at greater than or equal to 28 weeks' gestation be classified as a stillbirth (WHO 2016), which means that those under 28 weeks' gestation are considered a miscarriage. This definition is used in a variety of settings, including in the UK until 1992 and in present-day Romania. In other contexts, a combination of less than 16, 20, 22, 24 or 28 weeks gestational age or 350g, 400g, 500g or 1000g birth weight are used as the boundary: there is 'probably no health outcome with a greater number of conflicting, authoritative, legally mandated definitions' (Nguyen and Wilcox 2005: 1019). There are eight different definitions of stillbirth by combinations of gestational age and weight in the United States, and at least as many in Europe (Nguyen and Wilcox 2005).

Advances in medical technology have increased survival rates of previously unviable foetuses, bringing forward the threshold between miscarriage and stillbirth. The British Parliament supported a change to the stillbirth definition from 'after 28 weeks' to 'after 24 completed weeks' in 1992, following consensus from the medical profession about the age of viability. The Stillbirth (Definition) Act 1992 meant that a foetus born dead at or after 24 completed weeks of pregnancy is recognized in law as an individual: the baby's death must be registered in person by one or both parents at a register office, and a stillbirth certificate issued. However, definitions are not always straightforward: late gestation pregnancies terminated due to congenital abnormalities are registered as stillbirths in the UK. While the boundary between miscarriage and stillbirth has shifted to an earlier gestational threshold in the UK, others have called for further changes that would incorporate and legally recognize earlier pregnancy losses. In 2014, Conservative MP Tim Loughton³

introduced a bill that would have enabled parents to register a pre-24 weeks' gestation death by basing the definition of stillbirth on the experience of giving birth. The bill did not proceed, but there have been a number of petitions calling for the law to be changed, with a recent campaign led by Labour MP Sharon Hodgson calling for optional birth certificates or registration for miscarried pre-24 weeks' gestation babies. Such categories and the legal mechanisms around them impact social perceptions of the importance of the loss by defining whether or not it is considered the death of a human being.

The 2016 *Lancet* series 'Ending Preventable Deaths by 2030' (de Bernis et al. 2016) situates pregnancy loss on the global health agenda, specifically by outlining the stillbirth rate as a marker of quality of care in pregnancy and childbirth which should be integrated within initiatives for women's and children's health and women's rights and empowerment (de Bernis et al. 2016: 707). This raises questions about interventions for what we might call 'avoidable loss' and the right to reproduce, but also about protecting the rights of the unborn and rights to protection – similar to the abortion debate. Discourses of reproductive governance (Morgan and Roberts 2012: 241) are increasingly framed through contestations over 'rights', including the 'right to life' of the unborn, the latter found in emerging policies, laws and tactics of surveillance. The entanglement of women's reproductive rights and foetal rights is evident when a woman is recast as a potential threat to her foetus; with whomever is classed as the foetus's protector in command of her body. Marshae Jones' provocation of an altercation in which she was shot while pregnant in Alabama, US, was interpreted as wilful endangerment of her foetus and led to her being indicted for manslaughter. Being shot, consuming drugs or blue cheese, or losing a pregnancy may be interpreted as a failure by a woman to protect her body, or, more succinctly, the environment of the foetus.

Alabama, Georgia, Ohio and Missouri have all recently passed restrictive bills on abortion which may lead to suspicions that a woman is responsible when her pregnancy ends spontaneously and make women vulnerable to investigation in the case of a miscarriage, leading to a situation where she would have to prove she lost her baby through miscarriage. The interrelationship between categories of miscarriage and abortion and how they relate to legal and religious understandings informs women's experiences. A 1998 blanket ban on abortion in El Salvador (including cases of rape, incest, when a woman's life was at risk, or the foetus was fatally

impaired) led to the prosecution of women who were assumed to be guilty of abortion when their babies were miscarried or stillborn.

Reproduction is disciplined, with certain forms of motherhood valued while others are discouraged, perhaps characterized as social problems, with such framings informing policy and impacting experiences of loss. Recently, Ellie Lee (2017) has reflected on how sex-selective abortion became institutionalized as a social problem in Britain and problematized as associated with perceived problems of religion and ethnicity, presented as a form of violence against women. By placing pregnancy loss on the global health agenda, the 2016 *Lancet* series pointed to the heavy psychosocial burden and economic cost of stillbirth on families and nations. Similarly, miscarriage is a significant negative life event for many, affecting physical and emotional welfare, and may lead to psychological distress for a woman and others around her. In the UK, miscarriage accounts for fifty thousand hospital admissions annually (<https://www.northdevonhealth.nhs.uk/wp-content/uploads/2016/04/Guidelines-for-Management-of-Miscarriage-V1.0-30Mar16.pdf>, last accessed 14 June 2019), and there are additional social costs associated with miscarriage such as loss of work and further impacts on health. Miscarriage is thus a potential personal and social problem.

Body Boundaries

Body boundaries are problematized in miscarriage: pregnant bodies are often thought to be vulnerable, at risk, permeable; body boundaries need to be monitored and protected during pregnancy and miscarriage results when boundaries are traversed by diffuse dangers, as Qureshi (this volume) describes. Social networks and borders around groups are engaged in such events and may represent lines of tension or networks of care. A pregnancy is typically embedded in social relationships: the sperm donor may have claims on the foetus and/or the body of the woman in which it grows, but wider kin groups may also be invested (Qureshi, this volume). Mitra (this volume) extends this discussion further by illustrating that miscarriage in the context of surrogacy impacts relationships beyond kin groups to include intended parents and those involved in the business of surrogacy. In the case of traditional surrogacy the woman is genetically related to the foetus; or as described in Mitra's chapter, gestational surrogacy involves a foetus that is not genetically connected to the gestating woman, further problematizing lines between kin and non-kin. In such cases, Berend (2010)

found the primary bond was between the intended parents and the woman rather than the foetus and the woman.

The foetus has its own genome, but that genome is the collaborative output of two other individuals, including their input from past generations (Rutherford 2018). Revealing complexities of temporality and materiality, Rutherford (2018) discusses the foetus as a biological entity with labile boundaries, its signature reaching into the past and extending beyond gestation into the future, requiring a more inclusive and expansive approach. A foetus and pregnancy materials are both separate and part of the woman as well as having genetic ties to the father. ARTs and other developments in reproductive medicine such as in utero foetal surgery, artificial womb creation, and research into fetomaternal microchimerism challenge assumptions about body boundaries and pregnancy. Research showing that cells from the foetus have been found to pass through the placenta to establish cell lineages with the woman that may persist and multiply in the mother for several decades forces us to question notions about bodily boundaries between foetus and woman. Miscarriage provides an opportunity to more fully explore cultural assumptions about pregnancy and the relationship between bodies of foetuses, of women and those beyond.

Technology

Advances in biomedical technology have had a significant role in shaping the way pregnancy and miscarriage are understood and experienced, as foregrounded in this volume by Melo and Granne (Chapter 1) and further developed by Elliot (Chapter 2), Qureshi (Chapter 4) and Mitra (Chapter 7). Developments in biomedicine, such as sensitive and inexpensive pregnancy tests, have reduced ambiguity around early pregnancy by making it detectable with a high degree of certainty just over a week following conception, meaning that women who experienced early miscarriage as late menstruation are now more likely to experience it as the loss of a pregnancy. Early detection informs imaginings of the foetus and developing personhood, which is further strengthened by ultrasound technology that enables us not only to discern its presence, but to 'see' it (Mitchell 2001; Rapp 2000). Seeing, like any other human activity, is as much conditioned by culture and society as by biology: seeing itself produces the object that is being seen (Han 2013: 80). The meaning of foetal images has been explored by anthropologists

Taylor (2008) and Mitchell (2001), revealing how the interpretations of sonograms are commonly structured to lend weight to foetal personhood, with an interlinking between such technology, the social construction of foetality and the politics of reproduction more broadly (Mitchell 2001). Technologies influence expectations of and meaning invested in life before birth, as have developments that have increased the possibility of survival for earlier gestation foetuses.

Ultrasound scans are commonly used to date, detect and monitor pregnancy and may be framed as a means to develop foetal–parental relationships. They may also be the means to diagnose miscarriage: discovery may precede embodied knowledge in the event of a missed miscarriage (when the foetus stops developing without any outward signs of bleeding or passing tissue). Howes-Mischel (2018) reminds us that materiality as a body is not only seen but heard, as explored by Middlemiss (Chapter 6, this volume). Foetal Dopplers and other medical technologies are used to make social claims about foetal presence: they reiterate expectations about forms of ‘proof’ offered by technological mediation that displace women’s sensed and bodily relationship with their foetuses as authoritative (Han, Betsinger and Scott 2018; Howes-Mischel 2018). Scholars have discussed such technology and its impact on the recession of the authority of women’s somatic knowledge. Middlemiss shows how women embrace and take ownership of this in light of previous experiences of their own somatic ignorance of foetal death, contributing to feminist debates over whether reproductive “technologies allow women to exert agency and control over their own reproduction, or whether they represent new forms of control over pregnancy (Ginsburg and Rapp 1991; Murphy 2012; Neyer and Bernardi 2011; Rothman 2014)” (Middlemiss, this volume).

Ultrasound technology has been influential in producing images of foetuses, with anti-abortion propaganda central in presenting such images to the public (Layne 2000; Michaels and Morgan 1999), but the images have escaped these confines and become unremarkable features of the public landscape. They are found in medical journals and on television, used to advertise products (Taylor 1992), shared online via Facebook and Instagram and inhabit the imaginations of pregnant woman and those who wish to be pregnant (see Layne 2000, 2003; Rothman 1986). A foetus may be introduced to family, friends and the wider public on social media accounts, having an online presence before it has an outer utero one; they may be used as artefacts in order to support the

legitimacy of grief in the face of miscarriage (Layne 1992). Such images have become sites of intense politicization, particularly in the UK and US: fetuses are the raw material onto which hopes, fears and political and religious views are projected. Despite their ubiquitousness fetuses remain ambiguous entities that take on value and meaning dependent upon the context in which they reside.

Rituals and after Death

Interrogating what happens following a pregnancy ending and how the resulting tissue, material, body or being are handled reveals what society makes of them. The ritualization of pregnancy loss and ensuing cultural responses provide further opportunities for interrogating societal notions of personhood. In some contexts, fetuses are granted full burial rites suggesting their status as persons, yet in other contexts pregnancy loss, whether through miscarriage or elective abortion, is not necessarily recognized as the loss of a human child or life. Scholars have written about foetal death and surrounding rituals and memorializations, including their increasing popularity (Gammeltoft 2003, 2010; Hardacre 1997; Harrison 1999; Kilshaw 2017b; Kuberska, Chapter 8, this volume; Layne 2003; Peelen 2007; Van der Sijpt 2017, 2018) in a number of contexts, including Romania, Qatar, Japan, Taiwan, the USA and the UK. The aim of rituals may be to appease the spirit of the foetus or to attend to feelings of guilt (Gammeltoft 2003; Hardacre 1997; Moskowitz 2001; Van der Sijpt 2018), most commonly in the case of aborted rather than miscarried fetuses.

Scholars have shown how we can approach pregnancy remains as cultural artefacts from which we can glean how fetuses were imagined and cared for in the past. Practices including preservation and disposal help us to infer what a society made of these materials and overthrow assumptions that interest in and care for the foetus is primarily an interest of modern humans as a result of reduced risks of pregnancy and foetal death (Han, Betsinger and Scott 2018). Respect given to perinates in Neolithic graves in Egypt suggests they were considered part of the social group (Kabacinski, Czekaj-Zastawny and Irish 2018), and a lack of significant differences in the treatment of fetuses compared to older children in the mortuary context of seventeenth-century Poland suggests a similar identity ascription (Scott and Betsinger 2018). In contemporary Romania, all remains are sent to the laboratory and then incinerated,

reflecting that official personhood is granted by religious status as either baptised or unbaptised, rather than by gestational age or the reason for its demise. However, that some women who miscarry perform their own practices to commemorate babies reflects that they acknowledge them as having person status and, thus, do not share the official position (Van der Sijpt, Chapter 3 in this volume, and 2018). In Qatar, all remains are buried with specific practice depending on gestational age and ensoulment (Kilshaw 2017a) and, thus, burial practices are informed by religious and cultural notions of personhood. The changes in recent years in British disposal practices, including 'sensitive disposal' and hospital-arranged shared cremation services that Kuberska details in this volume (Chapter 8), reflect shifting cultural approaches to pregnancy loss, the value afforded to foetal remains, and notions of personhood. Classifications are context dependent: remains of pregnancy are handled and managed in ways that are informed by duration and location in the body of their mother. The way these entities are considered subsequently influences how they are interacted with, and yet practices around their disposal may subsequently inform how we value them, impacting our experience of their loss.

Motherhood

Miscarriage provides opportunities to investigate cultural understandings of motherhood: how we approach miscarriage tells us about what a pregnant woman or mother is to be. Scholars have explored children as a site of 'identity-work' (Faircloth 2013) and motherhood as highly moralized (Faircloth 2013; Gammeltoft 2007; Taylor 2008), and valorized, documenting the resulting disorder when expectations of motherhood cannot be achieved (e.g. Inhorn 2003). Practices that commemorate lost babies enact ongoing care and demonstrate 'good' parenting (Van der Sijpt, Chapter 3 in this volume), asserting the woman's identity as a mother, even if she does not have a child to parent. Acts of memorialization may help to resolve the crisis of life plans, gendered identity and relationships that reproductive loss creates (Becker 1999).

Developments in and the global spread of reproductive technologies, including widely available birth control and ARTs, have informed how we imagine fetuses, babies, children, parents and families and how we think of reproduction, informing a broader rhetoric of choice. This has led to a prevailing view, particularly

among middle-class, educated, predominantly white women, that pregnancy timing can and should be chosen (Elliot, this volume). Those seeking fertility treatments engage with and commit to parenting long before becoming parents, with new forms of ARTs such as egg freezing demanding they be forward thinking, reflexive reproducers in advance (Faircloth and Gurtin 2017). Self-improvement and self-monitoring have become central to fertility and pregnancy in contemporary Euro-America, part of a broader trend of what Faircloth and Gurtin (2017) have termed 'anxious reproduction'. These technologies create new choices, but also more burdens, accountabilities and anxieties (Faircloth and Gurtin 2017). The implication is that by following expert guidelines and engaging in this discourse, you are keeping your foetus safe; hence it is unsurprising that women in such contexts experience shock and feelings of culpability in the face of reproductive loss, perceiving miscarriage as a failure of successful monitoring or appropriate planning (see the chapters by Kilshaw and Middlemiss in this volume). Such experiences highlight the innate contradiction in the discourse of control and responsibility in pregnancy/conception versus miscarriage.

Feelings of personal guilt and failure may accompany miscarriage, particularly in neoliberal and medically technologically sophisticated settings and where a sense of responsibility, accountability and agency dominate reproductive experiences (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 (Layne 1997); it can be seen as an 'instance of failed production' or 'moral failing' (Layne 2003: 148). Miscarriage as failure may be particularly acute in pregnancies conceived through ARTs and in the case of surrogacy experienced as a lack of success in giving a baby to its intended parents, as well as the failure of the surrogacy 'journey' and loss of membership to the community (Berend 2010). A sense of loss may include an important financial or status forfeiture, as described by Mitra in this volume (Chapter 7). ARTs further influence the production and framing of this experience because of the hope of success that they breed, the role of early constant monitoring adding weight to notions of responsibility, accountability, pregnancy as success, and foetal personhood (Berend 2010, 2016; Mitra, this volume). Yet miscarriage may not always be framed as failure; it may be a positive demonstration of fertility (Kilshaw, this volume; Varley 2008) or a sign of the body acting as it should by preventing the ongoing development of an unviable foetus. Framing miscarriage as the

body functioning normally is found in biomedical interpretations (Layne 1997: 291; Melo and Granne, this volume), where miscarriage is a natural process of quality control.

Summary of Chapters

The impetus for this book was a seminar series of the Fertility and Reproduction Study Group (FRSG), Institute of Social and Cultural Anthropology, Oxford University that brought together material on diverse historical and cultural contexts to explore societal approaches to miscarriage. At the outset a key aim was to take up the challenge of questioning the language and categorization of 'miscarriage' and its implications. Melo and Granne's opening chapter presents the (primarily UK National Health Service (NHS)) biomedical framing of miscarriage, providing an excellent overview of miscarriage definitions and categorization, treatment protocols, as well as risk factors and causes. Melo and Granne establish the fluidity of definitions and approaches to miscarriage; the chapters that follow continue to grapple with shifting and negotiable category boundaries. Revealing just how inefficient humans are at conception, with miscarriage one aspect of this, they challenge assumptions about notions of control over reproduction. The authors question whether or not miscarriage should be viewed as failure; according to biomedical understandings, miscarriage is instead framed as the body responding in a healthy way to an unviable pregnancy. Elliot's comprehensive and fascinating exploration of the history of miscarriage in twentieth-century Britain provides evidence for the medical view of miscarriage as beneficial. Advances in biomedicine altered the way pregnancy and loss were understood, including the discovery by the 1960s that there are forty-six human chromosomes. The recognition that chromosomal abnormalities are a significant cause of miscarriage means it begins to be framed as a natural, healthy and positive process. This established the foundation for therapeutic screening and abortion in the 1970s as a means to reduce birth defects. As Elliot argues, there was a significant shift from a desire to avoid 'foetal wastage' and 'salvaging' the foetus to seeing miscarriage as a beneficial process of rejecting unsavoury foetuses or 'products' and a process of quality control.

Attempts at defining types of pregnancy endings and their unclear boundaries emerge throughout the book, with Elliot's discussion of the relationship between abortion and miscarriage particularly

striking. Classifications are not always clear, and the shadow of abortion continues to be cast over miscarriage. In the second half of the twentieth century, while the types of pregnancy loss were increasingly seen as distinct medical and social phenomena, they remained entwined in terms of language, medical practice and ethical discussion around viability and personhood. The boundaries around miscarriage and, particularly, the delineation around intentionality are further explored by Van der Sijpt's (Chapter 3) deft comparison of miscarriage in two settings: Romania and Cameroon. Van der Sijpt shows how the broad social forces including historical memories profoundly shape experience: cultural and historical resonances, particularly the history of suspicion surrounding pregnancy loss in the aftermath of Communist Romania's strict abortion prohibitions, continue to inform women's experience of miscarriage. While the settings differ in many ways, women's navigations reveal similar dynamics, she argues. The emphasis on having children in these two settings contributes to an environment in which pregnancy loss becomes silenced and shrouded in suspicions. In Cameroon, it is the shifting nature of sexual relationships and the knowledge that women may not wish to keep all their pregnancies that is particularly relevant. Like many of the chapters, the boundaries around categories are explored, yet what is particularly novel is how Van der Sijpt shows how women are able to navigate in a way that best suits their situation: miscarriage produces ambiguity and uncertainty, but the opportune flexibilities contained within reveal miscarriage to be a potential for reorientation.

Moral discourses entailing agency and blame are often evoked in the face of miscarriage and attempts at explanation made. The cause of miscarriages is rarely determined (Melo and Granne, Chapter 1), which can frustrate attempts at understanding. Elliot's (Chapter 2) historical account reflects on how medical knowledge around the cause of miscarriage influenced how it is framed more broadly. The aetiological repertoire is typically broad: the ethnographic chapters suggest a range of possible causes, including God's will, witchcraft, evil eye, food consumed or not consumed, stress, emotional upset, carrying heavy objects, exhaustion, age or anatomical problems of the woman, and genetic problems with the embryo. Each society will have notions of how best to protect a pregnancy and reduce risk of miscarriage: women in early twentieth-century Britain were advised to 'avoid riding, dancing, golfing, tennis, cycling, falls, blows, excessive coitus, lifting, pushing, walking too far, standing too long, and, in fact, everything that causes great and often sudden excess

in the intra-abdominal pressure' (Horrocks 1901: 946); as Elliot (Chapter 2) surmises, such avoidance advice is likely social stricture and a comment on respectable femininity. The burden of prevention and possibly guilt is placed on women, as it is throughout a variety of social contexts. Considered causes may be contradictory and changeable: possible causes provide a flexible idiom that can be differently employed in different social situations (Van der Sijpt and Notermans 2010) and may be used to divert attention away from or direct attention to culpability. The lack of a consensus about cause increases uncertainty and ambiguity.

Miscarriage causation is considered in most chapters, but it is Qureshi's contribution that explores this in depth. In Pakistani Punjab, miscarriages demand accountability: while they are deemed God's will, Qureshi reveals how space for human action is opened, where culpability is passed from women's natal families to their marital families, who directly influence their workload, diet and care during pregnancy. The relationships between women's natal and marital families represent common fault-lines, but 'there is more to miscarriage than the anthropological story about accusations following lines of social tension', she argues. Providing a dramatic illustration of the shifting nature of miscarriage and person categories, Qureshi argues that the distinction reported by Jeffery and Jeffery (1996) between *bacha girna* (the falling of a baby) and a *maas-ka-pinda* (blob of flesh) has eroded, mainly due to the availability of medical technologies. Qureshi describes collapsing boundaries around classifications of pregnancy endings and their understandings, but she also speaks of other blurred boundaries – those of the pregnant body. Informed by Pinto's (2008) account of visualization, Qureshi describes the 'intensely personalizing gaze of the sister-in-law', which penetrates the pregnant body and causes anxiety. In her discussion of *athra*, a particular form of spirit contagion, Qureshi provides entirely novel and nuanced material on this precise ethnomedical diagnosis, which is activated in cases of recurrent miscarriage. The dominant explanation for reproductive misfortune and a preoccupation among the women she met, Qureshi reports an almost complete gap in the scholarly literature. In her account of *athra*, Qureshi comments upon anxieties around body boundaries and the need to be vigilant in protecting and maintaining them against diffuse threats. Despite the increasing medicalization of pregnancy and access to inexpensive diagnostic tools, which shift notions of uncertainty, pregnancy

continues to be seen as precarious and concealment a means to protect fragile early pregnancies.

In her discussions of risk and threat, Qureshi notes similarities between women who suffer from recurrent miscarriage or ongoing reproductive misfortunes and infertile women. Kilshaw (Chapter 5) also explores the relationship between miscarriage and infertility in her discussion of how choices and notions of control impact a woman's experience of miscarriage in two settings: Qatar and England. Like Van der Sijpt (Chapter 3), Kilshaw illustrates that uncertainty arises from miscarriage, but argues that wider social factors, particularly notions of control over reproduction, exacerbate feelings of anxiety. She demonstrates how perceptions of avoiding pregnancy loss and being a 'good' 'pre-conception' parent are situated within a broader cultivation of neoliberal citizens in England, compared with the experience in Qatar where miscarriage is more about reproductive proof than loss. Middlemiss (Chapter 6) provides another example of the impact of anxious reproduction: uncertainty features heavily in pregnant women's home Doppler use in Cornwall, England; here it is the management of uncertainty in the aftermath of miscarriage. Miscarriage may be diagnosed by a health professional during antenatal visits by use of medical technologies such as ultrasound. Diagnoses are often unexpected by women, as the foetus may stop developing without the woman experiencing bleeding or pain (yet). A lack of awareness of the death of the foetus may lead to women feeling that they failed as mothers by not effectively monitoring or being aware of the status of the pregnancy. In some cases, it is the *missed* element of the experience of a missed miscarriage that is significant. Women may then embrace further technology and surveillance, such as the use of foetal Dopplers or non-indicated ultrasounds, to manage risk. Using a Doppler at home is a means to manage not risk, as Middlemiss's interlocutors were aware a miscarriage could not be prevented, but control over knowledge.

Throughout the book, the impact of advances in and increasing access to biomedical and reproductive technology on women's experience of miscarriage is discussed, including Mitra's (Chapter 7) exploration of surrogacy in India, where the financial and contractual aspect of the surrogate pregnancy further shapes miscarriage experience. Miscarriage is a social event that, in this case, breaks ties between people and due to its contractual nature bears financial consequences and hardship. Contributing to the literature on the labour and market economy surrounding commercial

surrogacy in India (see Pande 2014; Rudrappa 2015; Sama 2012), Mitra provides a welcome and novel addition by exploring those instances when the process is disrupted. Miscarriage presents a particularly problematic challenge to the narrative of success (Berend 2016; Mitra and Schicktanz 2016) that dominates commercial surrogacy in India. Mitra provides additional insights, particularly to the cultural meanings assigned to reproduction and miscarriage in India elucidating surrogates' experience of miscarriages. In a context where miscarriages are culturally silenced and shamed, surrogate miscarriages are doubly so in order to deflect from the inability of the technology to overcome fertility problems. Mitra argues that miscarriage is proactively silenced by the surrogacy industry, leaving women unprepared when one occurs. Technology plays a key role in this performance by contributing to confidence that the process will be successful and establishing the reality of pregnancies through visual technology of ultrasound and regular reports. What is striking in Mitra's account, and differs dramatically from the accounts described by Berend (2010, 2016), is the gravity of the financial loss as well as the emotional and identity loss. Not only do surrogates lose the financial rewards for this particular pregnancy, but they also lose the opportunity to act as a surrogate again, eliminating possible future financial gain as well as inclusion in a community of surrogates. Indeed, a miscarriage could place a woman in a financially precarious position due to costs of treatment for the miscarriage, instead of securing her family's future. Thus, miscarriage results in complex loss that goes beyond the loss of a foetus and has ongoing implications for the woman and her future aspirations. In this way, Mitra's discussion reveals the tentativeness not only of pregnancy, but also of a woman's identity (as a surrogate, as a mother) and how a woman may be dependent on a foetus for a particular role or identity.

Exploring the way pregnancy remains following a miscarriage are managed in England, Kuberska (Chapter 8) illustrates the moral ambiguity around that which is produced by a miscarriage with practices pointing to the liminal nature of these beings. In her discussion of the disposal of pre-24-week pregnancy remains, Kuberska contributes to the discussion about the contingent and potentially fractious nature of boundaries around miscarriage. In particular, she reveals contradictions in legal categories, institutional practices and national guidance, and also suggests that these may differ still from lived experience. While English law requires the registration of stillbirths but not miscarriages, guidance around

disposal frames miscarriage as a death of a baby. Through a focus on the funeral arrangements that accompany hospital-arranged shared cremations and how these are shaped by notions of 'respect' and 'sensitivity', Kuberska reveals a certain view of foetal personhood contained in these practices. Rather than relying on what the woman thinks of the material, unwitnessed ceremonies for pre-24-week fetuses presuppose a miscarriage as a death deserving of a funeral. Such a discussion is particularly welcome given the way practices around the handling and disposal of remains are imbued with meaning and loop back, informing what we think of these materials.

With one in four pregnancies ending in miscarriage, it is unsurprising that a number of the authors have personal experience of miscarriage. Indeed, the subject of pregnancy loss has often been initiated by such scholars: Layne (2003), Letherby (1993), Davidson (2008) and Murphy (2012, 2019). During the production of this book, this issue of personal, political and professional entanglements emerged, shedding light on the complex negotiations when it comes to miscarriage. A number of contributors grappled with whether or not to include their own experience and how to disentangle it from scholarly investigations. Women may feel the need to conceal pregnancy and motherhood from professional realms, and so speaking about one's experience in this way feels transgressive, which may also account for the absence of scholarly work on the subject and the more general silence around the topic. This book is intended to further impede such silences by populating the landscape of miscarriage with a diversity of voices and perspectives. The book explores shifting and negotiable category boundaries around miscarriage and the foetus, exploring medico-legal-religious constraints that inform women's experiences as well as provide opportunities for subversions. By exploring miscarriage in a number of different contexts, we aim to reveal multiple possibilities of approaches to and framings of this common women's health experience.

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Notes

1. This is the case excepting Scotland where incineration is not allowed.
2. As Bongaarts and Potter (1983: 40) remark, these patterns have to be viewed as hypotheses, as the number of representative sample studies on which they are based is small. Their work has, however, been widely accepted as the trends are consistent with aetiology.
3. Loughton has been an activist on reproductive health issues, leading an All-Party Parliamentary Group on conception to childhood. See <https://publications.parliament.uk/pa/cm/cmllparty/190102/conception-to-age-two---first-1001-days.htm>, last accessed 14 September 2019.

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