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Conceptualising reproductive loss: a social sciences perspective¹

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Introduction

In general, the study of human reproduction focuses on reproductive ‘success’ or – at the very least – on the struggle to achieve reproductive success, rather than on reproductive ‘failure’. Social scientists have noted that the discourses which surround pregnancy and childbirth focus on positive outcomes and happy endings without acknowledging common, sometimes repeated experiences of reproductive loss. Layne, a feminist anthropologist, argues:

... emphasis on happy endings, whether believed to be the result of medical intervention or women’s natural inborn powers to reproduce, exacerbates the experience of those whose pregnancies do not end happily. (Layne, 2003, p. 1881)

Reproductive loss refers to experiences of miscarriage, stillbirth, perinatal and infant death, as well as maternal death – and defined more broadly - to the loss of ‘normal’ reproductive experience such as that associated with infertility and assisted reproduction.

In spite of the fact that reproductive loss is a relatively common experience, there is

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comparatively little literature which explores the concept of reproductive loss within the wider study of human fertility. Indeed, a search for the terms, miscarriage, loss, stillbirth, neonatal death and infant death in this journal produced only 1 hit (see Bahadur et al., 2000). This paper explores a social sciences perspective on reproductive loss and reflects on the implications of this for practice, policy and research in human fertility.

Reproductive loss, social exclusion and the social structure

In the nineteenth century, rapid industrialisation and urbanisation across much of Europe lead to a crisis in public health; this crisis, together with the public health reforms of that century, highlighted the relationship between poverty, deprivation and health (Hodgkinson, 1973). It was only in the early twentieth century that infant mortality became seen as a public health problem and, since then, infant mortality and child health has been widely accepted as an important indicator of the present and future health of a nation (Armstrong, 1986).

Although changes in classification make longitudinal epidemiological comparisons quite complex, the World Health Organisation (WHO) (2006) notes that in developed countries rates of perinatal (including stillbirth) and infant mortality have declined over time and are falling. Whilst this is, of course, encouraging, it is important to note that reproductive loss is unequally distributed; for example globally, there are considerable disparities between developed and developing countries (WHO, 2006). The most recent evidence from the WHO indicates that those regions of the world with the highest infant mortality rates are also those with the lowest gross national income per capita (WHO, 2006).

A recent perinatal mortality survey in England, Wales and Northern Ireland (CEMACH, 2007) also indicates that there are continued inequalities in the major maternal risk factors for perinatal mortality, notably these are: social deprivation, ethnicity and maternal age. For example, mothers living in the most deprived areas are twice as likely experience stillbirth compared to women living in the least deprived areas. The babies of women living in the most deprived areas are also 2.2 times more likely to die in the first month of life (CEMACH, 2007).

Mothers from some minority ethnic groups are also more likely to experience reproductive loss in comparison to women whose ethnicity is recorded as White (however, the recording of data is incomplete therefore statistical analyses should be treated cautiously). For example, in England, women of black ethnicity are 1.9 times more likely to experience a stillbirth and 2.2 times more likely to have a baby die within the first month of life compared to women of white ethnicity (CEMACH, 2007).

Experiences of reproductive loss are quite clearly located, and must be understood within the context of the social structure. As noted in a recent enquiry of maternal deaths in the UK:

the underlying root causes of maternal deaths are often underlying social and other non-clinical factors. The link between adverse pregnancy outcomes and vulnerability and social exclusion are nowhere more starkly demonstrated than by this Enquiry. (CEMACH, 2007, p. 44)

The recommendations put forward by the CEMACH report include the provision of more welcoming and accessible antenatal care, as well as improved sensitivity to the clinical and social needs of migrant women. In order to inform policy, put such recommendations into practice and enhance patient care, a greater understanding of the way in which experiences of human fertility and reproductive loss are socially structured is required.

Difference, diversity and reproductive loss

Reproductive loss – in all its forms – can be experienced as devastating; indeed, reproductive success is often seen to be a crucial part of the life course (Busfield, 1987; Earle, Komaromy, Foley and Lloyd, 2007; Earle and Letherby, 2007). For women, in particular, losing a baby or not being able to biologically mother children challenges the normative expectation that all women are, or want to be, mothers. Although it could be argued that fatherhood is still not as key an identity for men as motherhood is for women it is probably much more significant than it is believed to have been in the past (Earle and Letherby, 2002). It is increasingly being recognised that disruptions to the reproductive lifecourse are significant for men, as well as other family members such as siblings and grandparents. For example, McCreight's (2004) sociological study of male narratives of stillbirth and neonatal death in Northern Ireland suggests that mothers and fathers may well experience and express their grief differently following the death of a baby. A psycho-social study of grandparents' grief in Israel (Nehari, Grebler and Toren, 2007) also highlights how the loss of a grandchild can be a devastating blow but that grandparents often feel isolated in their grief. SANDS (The Stillbirth and Neonatal Death Society) highlights the special information and support needs of fathers and grandparents

following the death of a baby. They argue that mothers are usually the focus of attention, leaving fathers and other family members feeling ignored and unable to express their grief (SANDS, online).

The limited social science literature that exists suggests that reproductive loss may not be experienced and understood in the same way by different groups of people. These diverse needs pose challenges for the practitioners who are charged with their care and the next section focuses specifically on their role.

Loss, taboo the role of practitioners

Social scientists have argued that the medicalisation of human fertility contributes to the illusion of omnipotence within reproductive healthcare. Whilst the lives of many mothers and babies are undoubtedly saved through medical, technological and pharmacological advances, this illusion is difficult to reconcile when things go wrong. Within the context of reproductive success, managing experiences of reproductive loss can be challenging, as well as being regarded as distasteful and taboo. This perspective influences those who experience reproductive 'failure', as well as the practitioners who provide care when things go wrong.

Bolton (2005), writing specifically about gynaecological nursing (which often involves dealing with reproductive failure), argues that it is often regarded as tainted, 'dirty work'. Drawing on qualitative interviews with 45 gynaecology nurses in the UK, Bolton

explores how nurses must cope with the most distasteful and ‘perilous’ of tasks, such as the handling of a dead foetus. For example, one of her respondent’s states:

When I first started this job I would do anything not to have to deliver the dead foetus and dispose of it or have to dress it etc. My stomach would heave and I’d feel a sense of despair for each and every one. I thought this is one of the worst jobs I’ve ever done in nursing – the touch, the smell, ugh, just everything about it ...

(Bolton, 2005: 176)

Other studies highlight the disparities between the needs of patients and the care provided by professionals. For example in a qualitative narrative analysis of 172 accounts of miscarriage in the UK, Simmons et al (2006) report that women often complained about the level of care they received by healthcare workers highlighting, in particular, the importance of emotional support. They argue that practitioners can play a key role in defining miscarriage experiences and have the opportunity to reduce the trauma of such an event and the potential psychological sequelae.

Traditional models of grief and bereavement place emphasis on ‘letting go’ and severing the bonds with those who have died. However, whilst this is a model that continues to dominate practice amongst those who work with bereaved people (Walter, 1999), newer models challenge this approach (Riches and Dawson, 2000). In the context of reproductive loss, the importance of creating and maintaining bonds with a dead baby –

for example, within the context of a stillbirth or infant death – is increasingly recognised. In many hospitals it is now protocol for bereaved parents to be allowed to touch and dress their baby and memorialisation – using artifacts and photographs – is encouraged (Layne, 1992; Letherby, 1993; Riches and Dawson, 2000). However, an assessment of guidelines for care of mothers following stillbirth indicates that, for some individuals and families, such protocols may actually increase distress (Hughes et al., 2002). McCreight's (2004: 345) study of men's narratives of stillbirth and neonatal death describes how fathers were often faced with the situation where 'the deceased baby was abruptly thrust into their arms by staff ... [with] no preparation for such a traumatic event ... [and] no prior knowledge concerning how to handle a deceased baby, nor any cultural guidelines as point of reference'. Further research is needed to explore these issues further to help inform policy and practice.

Conclusion

This paper has highlighted the importance of reproductive loss within the study of human fertility. It is not intended to provide a systematic review of the literature but to outline how a social sciences perspective can be usefully applied to explore the implications for policy, practice and research within this relatively under-explored area. Experiences of reproductive loss – especially when broadly defined – are not uncommon. However, such experiences are not equally distributed amongst the population and reflect wider inequalities in reproductive health, and health more generally. The literature draws attention to the importance of gender, culture and ethnicity in understanding the meaning and significance of reproductive loss although further research is required to understand

these issues fully. The role of professionals is also vital in ensuring that policy and practice meet the diverse needs of such groups.

Conceptualising reproductive loss is significant, but it is also important to remember that this includes a range of experiences and experiences of loss, and reactions to it, can be diverse. While every experience is unique, the level of skills that are available to professionals will depend on education and experience; and their ability to provide compassionate, integrated, skilled care will, among other things, also rest upon the existence of a specific body of social sciences research that has yet to emerge fully.

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