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PLACES

Pregnancy Loss (under 24 weeks) in Workplaces

Informing policymakers on support mechanisms

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PLACES

Pregnancy Loss (under 24 weeks) in Workplaces:

Informing policymakers on support mechanisms

A report submitted to the Department of Children, Equality, Disability, Integration and Youth (DCEDIY) in fulfilment of the requirements of the tender for the provision of a qualitative research study to examine the workplace experiences of people dealing with pregnancy loss

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Foreword

Pregnancy loss before 24 weeks gestation is the most common adverse outcome in pregnancy and is both a deeply personal experience for women and their partners, as well as being a societal reality in the workplace and community.

Pregnancy loss has for generations been experienced and treated as a 'private' event attracting little wider social commentary or acknowledgement. For women and their partners this has contributed to a disenfranchisement of their loss, in addition to an under acknowledgement of the multidimensional reality of the impact of pregnancy loss. In addition to the emotional experience, pregnancy loss has a physical and health related impacts, requiring varying levels of medical care and support – which can include both medical and surgical intervention. This care often requires time off from work and other commitments and has hitherto not been provided for in any statutory or protected way for women in the workplace. For many, there are considerable barriers – personal, collegial, financial, emotional and career related – to sharing their need for leave at what is a difficult time. At best, pregnancy loss support and leave in the workplace has relied on the compassionate support of a manager for the availing of sick or annual leave to provide for recovery. For many women, their physical care and recovery during and following pregnancy loss is further compounded by the emotional reality of bereavement and loss. Bereavement is recognised both as a universal phenomenon and also a deeply personal one. Loss in early pregnancy can also be textured by the fact that the news of pregnancy may not have been shared with family, colleagues or an employer or may have particular sensitivities in the case of termination of pregnancy.

The impact of pregnancy loss on women in the workplace and how women and their partners are supported in the workplace is the key focus of this commissioned report. In addition to a review of the international literature, legislation, and policies, this report captures the lived experiences of women and their partners to make recommendations for supportive, protected and compassionate care in the workplace for those who experience pregnancy loss. The lived experiences of the participants in this study, and the high response rate of just under 1,000 people, are a poignant witness to the importance of this report and the need for legislative change.

The words of participants in this report provide a searingly honest insight into the realities of pregnancy loss and its impact in the workplace, and highlight the

importance of legislative, policy, and culture change to address what has for too long been an underacknowledged loss; one that is deserving of protective workplace support.

For information or support around pregnancy loss, please visit www.pregnancyandinfantloss.ie.

Acknowledgments

This report contains the voices of over 900 women and men with experience of pregnancy loss, without whom this report, and resulting recommendations, would not have been possible. It can be difficult to share experiences of pregnancy loss, and we are indebted to them for doing so. We hope that we have done them justice, and that this work will enhance experiences and supports for people whose pregnancies end in a pregnancy loss.

We also thank the companies who shared information about their policies and supports with us; we cannot name them individually in order to protect their anonymity.

We identified legislation regarding leave for pregnancy loss in ten high-income counties. We are very grateful to the following key informants who verified information on each jurisdiction for us:

- Australia: Samantha Payne, CEO, Pink Elephants Network
- Quebec (Canada): Professor Francine de Montigny, Professor of Nursing and Family Sciences, University of Quebec in Outaouais
- Iceland: Leó Örn Þorleifsson, Director of Rights and Entitlements at the Directorate of Labour
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permitting us to use questions from their surveys within our own qualitative survey.

We are grateful to all those who shared information about our qualitative study through their networks, including via social media, or who supported the work. In particular, we thank the following individuals and organisations:

- Activelink
- A Little Lifetime: (Representative)[1]
- Cork University Hospital
- Cork University Maternity Hospital (Representative)
- Defence Forces: (Representative)
- Féileacáin: (Representative)
- Financial Services Union: (Representative)
- Forsa Union
- INFANT Research Centre (Representative)
- Irish College of General Practitioners
- Irish Congress of Trade Unions
- Irish Federation of University Teachers: (Representative)
- Irish National Teachers Organisation: Maeve McCafferty, Acting Senior Official in the Education, Research and Learning Section
- Irish Neonatal Health Alliance National Women's Council (Representative)
- Leanbh Mo Chroí: (Representative)
- Mandate Trade Union: Eoghan Fox, National Executive Council Member
- Miscarriage Association of Ireland: Jennifer Ui Dhubhgain, Secretary
- Royal College of Physicians of Ireland: (Representative)
- School of Nursing, University College Dublin (Representative)
- Senator Marie Sherlock, Labour Party
- SIPTU: (Representative).

We wish to acknowledge our colleagues within the Pregnancy Loss Research Group who provided advice and guidance throughout the project, including the reviewing of materials and dissemination of information about the study. In particular, we wish to thank Anne Marie Farrell and Tara Woulfe who provided advice on the conduct of the study, assisted with recruitment, and reviewed and

[1] Names of representatives with authors.

inputted into the final report, based on their lived experience insights of pregnancy loss in the workplace.

Finally, we thank the Department of Children, Equality, Disability, Integration and Youth for commissioning and funding this work. In particular, we wish to acknowledge the support of Jamie McCarthy (Research and Evaluation Unit) and Dr Jane Ann Duffy (Principal Officer, Equality and Gender Equality) throughout the project.

Disclaimer

Within this report we use the term 'woman'. However, it is important to acknowledge that people who do not identify as cis-gender women can be excluded from this descriptor, including people who identify as transgender, gender diverse and gender non-binary (Moseson et al., 2020). We also appreciate that there are risks to desexing language when describing female reproduction (Gribble et al., 2022). Workplace supports for pregnancy loss must be appropriate, inclusive and sensitive to the needs of people whose gender identity does not align with the sex they were assigned at birth.

We use terms such as ‘pregnancy loss’, ‘miscarriage’, ‘abortion’, ‘termination of pregnancy’, ‘fetus’ and ‘parent(s)’; however, we recognise that people have different views on the appropriateness of such terminology, particularly when applying it across different types of pregnancy loss experiences.

Executive summary

This research

The PLACES Project - Pregnancy Loss in Workplaces: Informing policymakers on support mechanisms - was funded by the Department of Children, Equality, Disability, Integration and Youth, and conducted by researchers from University College Cork and University of Galway between September 2022 and September 2023. The aim of this project was to examine the workplace experiences of pregnancy loss before 24 weeks gestation, and to identify relevant needed supports.

Background

Pregnancy loss affects approximately one in every four pregnancies, most often before 12 completed weeks of pregnancy. Pregnancy loss at any gestation can have physical impacts on the pregnant woman, and emotional and social impacts on the woman and her partner. Most women of reproductive age are in paid employment; as such, workplaces are an important context to consider in pregnancy loss experiences. In the Republic of Ireland, women are entitled to maternity leave of six months duration if they experience a stillbirth after 24 weeks of pregnancy. There is no statutory leave entitlement for pregnancy loss before this time.

Methods

This project drew on a number of methods to gain a broad and deep understanding of workplace experiences of pregnancy loss. This included a search for relevant research; a review of international statutory leave for pregnancy loss; a sample of pregnancy loss policies across companies in the Republic of Ireland; a national mixed-method survey with 913 participants' responses included; and a qualitative interview study with 13 participants.

Key findings

There is a significant gap between the needs of individuals who experience pregnancy loss and the supports available to them in workplaces. This has an impact on the wellbeing of individuals, their physical and emotional recovery from pregnancy loss, and their return to work.

Most women across high-income countries, including the Republic of Ireland, are without leave entitlements or legal protection which would enable them to take

sufficient leave from work following a pregnancy loss. Women who experience termination of pregnancy, or partners of the woman experiencing the loss, are even less likely to be entitled to time off work. As such, most individuals rely on sick leave or other general leave entitlements to take time off work.

Some individual companies or countries across the world provide leave specifically for early pregnancy loss. Among these policies, there is huge variation regarding who is eligible for this leave, or how long this leave from work is.

Our findings suggest that most women need leave from work. The amount of leave needed depends on a variety of factors, including the physical impact or clinical management of the loss; the gestation of the pregnancy; and personal factors such as history of recurrent loss or emotional response to the pregnancy loss. Women who experience termination of pregnancy, similarly, require time from work, to recover from the physical process, and sometimes the emotional effects, particularly those who experience termination of pregnancy for medical reasons. Partners also need some leave from work, in order to support the woman who has lost the pregnancy, and to deal with their own loss.

Our primary research suggests that there is still a level of secrecy and stigma attached to pregnancy loss, especially earlier losses and termination of pregnancy. This can prevent people sharing their loss or seeking support, particularly in the workplace. Participants across the international literature and in our primary research often described fear of dismissal from work, or discrimination regarding career progression. Indeed, some individuals internationally, and in the Republic of Ireland, did face dismissal or sidelining for promotions as a result of their absence or decreased productivity following pregnancy loss.

Within workplaces, individuals, and particularly managers, are often uninformed about pregnancy loss and ill-equipped to support workers during these experiences. This very often led to negative workplace experiences following pregnancy loss. These experiences include a lack of empathy and support; harsh treatment regarding absence or workload; insensitive comments and questions; and distressing exchanges in the workplace. Across the literature, and our primary research, a small number of individuals left their employment due to their experiences following pregnancy loss.

Policy implications

Based on the above findings, we put forward the following recommendations:

Recommendation 1

A statutory right to paid leave should be introduced for pre-viability pregnancy loss, regardless of the gestational stage or the reason for the loss. This should be subject to medical certification. This would play two roles: first it would allow for a period of recovery, and second it would show societal recognition of the impact of pre-viability pregnancy loss.

Recommendation 2

Any leave introduced should be of sufficient duration to meet the needs of those affected, which are presented in this report.

In the other jurisdictions examined, the model of pregnancy loss leave introduced was influenced by the existing statutory leave frameworks, all of which are more generous than in the Republic of Ireland. The duration and scope of any leave in the Republic of Ireland would have to be considered in the context of existing statutory paid leave provision. Current statutory paid sick leave is three days (to be increased to 10 days by 2026), while the statutory entitlement to leave following a stillbirth after 24 weeks of pregnancy is 26 weeks maternity leave. Payment of maternity benefit is subject to having the requisite PRSI contributions, and there is no statutory entitlement to receive payment from the employer while on maternity leave, although employers can choose to pay employees while on maternity leave. The needs of people experiencing pre-viability pregnancy loss will vary, and any statutory provisions introduced will need to have regard to this.

Recommendation 3

A statutory right to paid leave for pregnancy loss should also be introduced for partners. According to international literature and the findings of primary research detailed in this report, this leave is needed in order to process their own loss and to support their partner (including the care of any children).

Recommendation 4

If, in accordance with the recommendation above, statutory paid pregnancy loss leave is introduced, it should be added to the list of family/care-related leaves which are covered by the Unfair Dismissals Act. The statutory wording introducing any such leave should also make clear that such leave is covered by equality law and less favourable treatment on the basis of taking such leave is prohibited under the gender ground as a pregnancy-related issue.

If statutory paid pregnancy loss leave is not introduced, then guidance should be issued to employers to clarify that any less favourable treatment of an individual for taking existing leave entitlements following pregnancy loss is covered by the provisions of employment equality legislation and would amount to discrimination on the gender ground as a pregnancy related issue.

Recommendation 5

Given the individuality of each person's experience of pregnancy loss, patient and public involvement in the development of policies and practices which promote positive workplace cultures and environments is recommended.

Recommendation 6

The implementation of leave entitlements should be carefully considered by workplaces. Procedures on notification, submitting certification, and requesting leave should be developed with sensitivity to the needs of individuals experiencing pregnancy loss. This includes considering the need for privacy and compassion, as well as allowing reasonable time to notify the employer.

Recommendation 7

Additional supports and accommodations should be made available to workers experiencing pregnancy loss. An organisational framework, including policies and practices regarding how to support employees experiencing pregnancy loss, clearly outlining the organisational ethos/positioning regarding this issue and highlighting the different measures and supports available to staff, should be a priority in organisations.

For this purpose, clear guidance should be provided, by relevant Government Departments, to organisations on how to develop and implement such frameworks, encouraging each employer to apply and adjust these to their workplace contexts in the most suitable way.

Further to Recommendation 5, involvement of individuals with lived experience of pregnancy loss and relevant stakeholders (e.g. external organisations and individuals/groups specialised in this issue) is essential for an adequate development of policies and practices in this field, as well as their successful implementation.

Recommendation 8

Information about leave and support entitlements for pre viability pregnancy loss needs to be clear, publicly available and accessible, to ensure that individuals can easily inform themselves about these, and avail of such supports when needed.

Recommendation 9

Political leadership is needed to drive changes in public awareness and perceptions surrounding pregnancy loss – in general, and specifically relating to workplaces and how to support workers in this regard. This requires various actions, such as the inclusion of education around pregnancy loss as part of overall sexual and reproductive health education within schools, antenatal curricula, and through other channels/settings, and in national policies and action plans (across all Government Departments, including Health; Children, Equality, Disability, Integration and Youth; Education; Enterprise, Trade and Employment; Justice; Social Protection).

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Chapter 1. Introduction

1.1 Overview of the tender process and requirements

In June 2022, the Department of Children, Equality, Disability, Integration and Youth (DCEDIY) commissioned the authors of this report to conduct a qualitative research study to examine the workplace experiences of people whose pregnancy had ended prior to 24 weeks gestation. The rationale for this focus on earlier pregnancy loss was that people who experience pregnancy loss from 24 weeks gestation (i.e. stillbirth or neonatal death) are entitled to full maternity and paternity leave whereas no statutory leave is currently available for pregnancies ending before this gestation.

This study was commissioned within the context of the Organisation of Working Time (Reproductive Health Related Leave) Bill 2021 (Houses of the Oireachtas, 2021) going before the Houses of the Oireachtas. This Bill proposes a period of paid leave consequent upon miscarriage or for the purposes of availing of reproductive healthcare.

The DCEDIY commissioned a three-phase study (Figure 1.1) to establish whether policy interventions are required in the workplace to better support people following pregnancy loss. Support mechanisms could include the provision of compassionate or bereavement leave, flexible working arrangements, or other workplace policies.

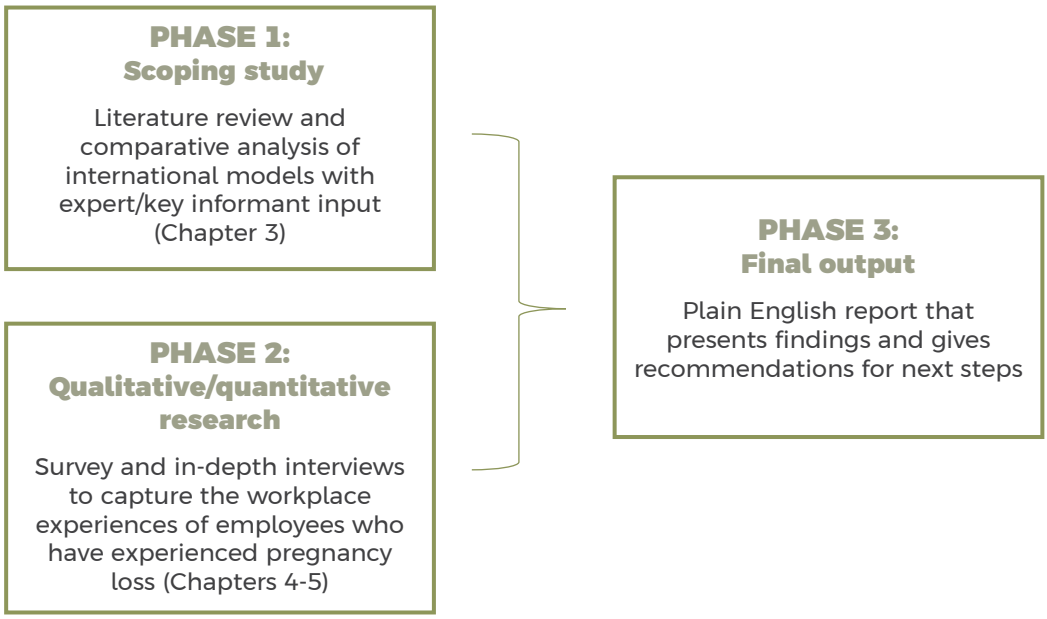


Figure 1.1 The three phases of the study commissioned by DCEDIY

The study was titled 'PLACES: Pregnancy Loss in Workplaces: Informing policymakers on support mechanisms' (Pregnancy Loss Research Group, 2023).

Informed by international best practice, recommendations for formal or informal support mechanisms in the workplace to better support workers who experience pregnancy loss were to be put forward (see Chapter 7). These recommendations, in turn, will help to inform Government policy on this matter, including the development of legislation if required.

Project timeline

A 12-month contract was awarded for the conduct of this work. The timeline, highlighting key activities, is presented in Table 1.1.

Table 1.1 Project timeline

Activity	Time period
Tender advertised	22 April 2022
Tender deadline	20 May 2022
Tender awarded	02 June 2022
Contract signed	19 August 2022
Research Assistant commenced employment	19 September 2022
First meeting of the Research Team	20 September 2022
Application for ethical approval for Phase 2 study submitted to the Clinical Research Ethics Committee of the Cork Teaching Hospitals (CREC)	15 November 2022
Interim report submitted to DCEDIY	04 January 2023
Ethical approval granted for Phase 2 study by CREC	22 February 2023
Qualitative survey launched	06 March 2023
Qualitative survey closed	24 April 2023
Qualitative interviews commenced	08 June 2023
Qualitative interviews ceased	06 September 2023
Final report submitted to DCEDIY	18 September 2023

Key messages

- Pregnancy loss affects many women, with 1 in 4 pregnancies ending in miscarriage
- Pregnancy loss under 24 weeks can include first- and second-trimester miscarriage; molar pregnancy; ectopic pregnancy; and termination of pregnancy
- Some women have repeated or recurrent miscarriages, and some experience more than one type of pregnancy loss during their lifetime
- Pregnancy loss may happen spontaneously or may need to be managed with medication or surgery. This can take time, and can present a range of side effects and problems such as pain, bleeding, infection, or surgery complications
- Pregnancy loss can be associated with a range of emotional and psychological impacts such as sadness, grief, and disappointment; as well as depression, anxiety, or post-traumatic stress disorder
- Most women of reproductive age are in paid employment, as such, most people are workers/working when they experience a pregnancy loss
- Returning to work following pregnancy loss can present a range of challenges such as managing emotions and physical symptoms at work; difficulty in focusing on work; managing other people's reactions in the workplace; and sometimes facing pressure or discrimination from management about work performance
- There is a need for time off work to recover from the physical and/or emotional impacts of a pregnancy loss
- Workplaces need to become more educated and create compassionate and supportive environments for employees to return to following a pregnancy loss.

1.2 Pregnancy loss: Types and management strategies

There are various ways in which pregnancies can end in loss, within and across trimesters. These include first and second trimester miscarriage, ectopic pregnancy, molar pregnancy, termination of pregnancy, stillbirth, and early and late neonatal death. In this section, we provide an overview of each of these, including how they are currently defined in the Republic of Ireland (see overview in Table 1.2) and how they are managed within maternity services and the healthcare system.

Table 1.2 Overview of pregnancy loss types and definitions

Type	Definition
First trimester miscarriage	The spontaneous loss of a pregnancy within the first 12 completed weeks of pregnancy
Second trimester miscarriage	The spontaneous loss of a pregnancy after the 12th completed week and before 24 weeks of pregnancy
Recurrent miscarriage	Two or more consecutive first trimester miscarriages
Ectopic pregnancy	When a fertilised egg implants itself outside of the uterus (womb)
Molar pregnancy	Occurs at the time of conception when the sperm and the egg join together and there is excessive development of the cells that form the placenta with little or no fetal (baby) development
Termination of pregnancy	A medical procedure which is intended to end the life of a fetus[a]
Stillbirth	An infant born after 24 weeks of pregnancy, or with a birthweight of over 500g, with no signs of life[b]
Early neonatal death	The death of a live born baby occurring within seven completed days of birth, with birth occurring at any number of weeks of pregnancy
Late neonatal death	The death of a live born baby occurring after the 7th day and within 28 days of birth

Note: [a]Health (Regulation of Termination of Pregnancy) Act 2018; [b]Civil Registration Act 2004.

1.2.1 Miscarriage

Miscarriage is generally defined as the spontaneous loss of a pregnancy before it reaches viability, and occurs in approximately 15% of pregnancies (Quenby et al., 2021). In this report we explicitly focus on first and second trimesters as distinct categories, as second trimester miscarriages have different pathophysiology and treatments, often more closely aligned with stillbirth (McPherson, 2016; Shields et al., 2020). Often described as the most common complication of pregnancy (McCarthy et al., 2020; Toffol et al., 2013), miscarriage can have a profound physical, psychological and/or social impact on the pregnant woman, her partner, and wider society (Quenby et al., 2021).

First trimester miscarriage

First trimester miscarriage is the most common form of pregnancy loss, occurring before 12 completed weeks of pregnancy (Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland & Directorate of Strategy and Clinical Programmes, Health Service Executive, 2012). Vaginal bleeding and loss of pregnancy symptoms are often the first signs of a miscarriage (Jurkovic et al., 2013). However, some women experience 'missed' or 'silent' miscarriages whereby symptoms such as bleeding and cramping are not experienced, and their miscarriage is only identified on an ultrasound scan near the end of the first trimester (Devall et al., 2021). Very early pregnancy losses which present as a positive pregnancy test but cannot be detected on ultrasound scans are called biochemical pregnancies. These usually occur around or before the 6th week of pregnancy and may account for over half of all miscarriages (Dumitrascu et al., 2019).

Recurrent miscarriage (also termed recurrent early pregnancy loss) can be defined as two or three or more miscarriages, whether consecutive or not (Hennessy et al., 2021). In the Republic of Ireland, it is now defined as two consecutive first trimester miscarriages (Linehan et al., 2023). Recurrent miscarriage affects between 1-3% of women/couples (Quenby et al., 2021).

A variety of management options for miscarriage are available, including expectant, medical or surgical management (Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland & Directorate of Strategy and Clinical Programmes, Health Service Executive, 2012; NICE, 2023). The appropriateness of each will be determined by the availability of advice and support services, the type of miscarriage, the number of weeks of the pregnancy, and the dimensions of the retained pregnancy tissue, as well as the woman's needs and preferences. A Cochrane network meta-analysis reported that surgical and medical methods for managing a miscarriage may be more effective than expectant management or placebo; however, the authors cautioned that the results may be unreliable due to variations in how miscarriage (missed and incomplete) was defined in the included trials, and other methodological limitations (Ghosh et al., 2021).

Expectant (or 'conservative') management involves holding back from further medical intervention and waiting for the miscarriage to happen by itself. This may take days or weeks to complete, and the timing is difficult to predict. If bleeding

and pain cease during 7 to 14 days of expectant management, indicating that the miscarriage has completed, the person takes a home pregnancy test and returns to the hospital if it is positive (i.e. indicating that the miscarriage has not completed).

Medical management of miscarriage involves taking two medications: mifepristone (which must be taken in the presence of a doctor), and misoprostol tablets 24 to 48 hours later. Recognised side effects associated with misoprostol include diarrhoea, nausea, vomiting, hot flushes and chills. Depending on the size of the pregnancy sac and how close the person lives to the hospital, they may be advised to stay in hospital until the miscarriage occurs. Misoprostol may cause heavy bleeding and period-like pains. Most women will experience lower abdominal cramps, heavy vaginal bleeding and passing small clots. This bleeding could be heavier than a period and can last for 7-10 days. Approximately 90% of women will miscarry completely within one week of taking the misoprostol tablets (Creinin et al., 2006). As part of follow-up, women are asked to perform a home urinary pregnancy test two weeks after taking medication. Women may also be given an appointment to attend the Early Pregnancy Assessment Unit for an ultrasound scan 14 days after taking the initial medication. It is possible that there may be a small amount of tissue still remaining in the womb at this stage and this may also require further medical or surgical management approaches.

Surgical management of miscarriage involves gently widening the neck of the womb and removing the pregnancy tissue. It can be surgical management in a theatre under general or regional anaesthetic (electrical, ERPC: Evacuation of Retained Products of Conception), or under local anaesthetic in an outpatient or clinic setting (Manual Vacuum Aspiration). An ERPC procedure by a doctor takes approximately half an hour. Most patients are admitted to hospital in the morning and are discharged later the same day. Some women may experience period-type pain and light vaginal bleeding following the procedure. Manual Vacuum Aspiration involves a clinic visit of about two hours however, the procedure itself – undertaken by a doctor – takes about 10 minutes. The procedure is done while the woman is awake, so they are able to go home shortly after. Period type pain, such as, cramping, will be experienced at this stage, which may be uncomfortable. Bleeding, like a period, will occur and last about 7-10 days.

According to Black et al. (2017), the use of medical management has caused a statistically significant reduction in the number of women undergoing surgical management of a missed miscarriage, and its use as the first-line choice for

miscarriage management will likely increase. Irish data shows that inpatient miscarriage care has changed over the years; these data do not separate first and second trimester cases. Between 2005 and 2016 the risk of hospitalisation for early miscarriage decreased from 70.6 to 49.7 per 1000 deliveries; however, the risk of blood transfusion increased over time (ratio: 2.0). There were less blood transfusions among women who undertook medical treatment (ratio: 0.3) but they had an increased risk of staying over two days at the hospital (ratio: 1.5; 95% CI 1.2 to 1.9) compared to ERPC (San Lazaro Campillo et al., 2019).

Second trimester miscarriage

Miscarriages occurring in the second trimester of pregnancy are uncommon and often unexpected. The incidence of miscarriage in the second trimester varies depending on the gestational age in weeks that is used in definitions, and depending on whether the pregnancy has been dated and evaluated using ultrasound.

In the Republic of Ireland, second trimester miscarriage is defined as pregnancy loss after the 12th and before the 24th week of pregnancy (Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland & Directorate of Strategy and Clinical Programmes, Health Service Executive, 2014). The risk of second trimester miscarriage is approximately 0.5% in women at low risk of miscarriage (Westin et al., 2007). Second trimester miscarriage is associated with higher morbidity than earlier losses and requires inpatient admission (Morris et al., 2016).

Management of second trimester miscarriage may involve awaiting spontaneous miscarriage – especially where this is inevitable when the woman presents to hospital – or planned induction where the second trimester fetus has died in utero (Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland & Directorate of Strategy and Clinical Programmes, Health Service Executive, 2014). Where medical induction of labour is required, a combination of mifepristone and a prostaglandin (misoprostol) is recommended. The side effects of misoprostol include nausea, vomiting, diarrhoea, shivering and fever, and related complications include haemorrhage, endometritis and, very rarely, uterine rupture. Postpartum haemorrhage is often anticipated in women who deliver in their second trimester, and around a third require a separate surgical procedure to remove the placenta after delivery (Morris et al., 2016). Surgical management of

second trimester pregnancy loss is currently not practiced in the Republic of Ireland.

1.2.2 Ectopic pregnancy

Ectopic pregnancy is a rare but serious complication in early pregnancy, involving the implantation of a fertilised egg outside of the uterus (San Lazaro Campillo, Meaney, O'Donoghue, et al., 2018; Spillane et al., 2018). The majority of cases (95%) occur within the fallopian tube, while the remainder can occur in the ovary, abdomen or cervix (Spillane et al., 2018). Between 1-2% of all pregnancies end in ectopic pregnancy (San Lazaro Campillo, Meaney, O'Donoghue, et al., 2018; Spillane et al., 2018). There were 865 ectopic pregnancies reported in the Republic of Ireland in 2021, a rate of 14.6 per 1,000 births (National Women and Infants Health Programme, 2023). Ectopic pregnancy is a cause of major obstetric haemorrhage in 0.9% of cases (National Women and Infants Health Programme, 2023). It also remains a frequent cause of maternal death; in 2018-2020, eight women in the UK and the Republic of Ireland died from ectopic pregnancies (Knight et al., 2022).

Following the process of determining the location of the ectopic pregnancy, treatment options are determined, which may include expectant, surgical or medical treatment depending on the size and location of the ectopic pregnancy, level of pregnancy hormone and the woman's wishes (Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland & Directorate of Clinical Strategy and Programmes, Health Service Executive, 2014; NICE, 2023). With expectant management, women have weekly serum βhCG testing in an early pregnancy unit until levels return to normal; this usually takes approximately three to four weeks. Medical treatment of ectopic pregnancy requires admission; following administration of methotrexate, the woman stays on the ward for observation for one hour and is subsequently discharged, with follow-up appointments in the maternity unit/hospital's Early Pregnancy Unit for serum βhCG on day 4 and day 7. Once βhCG levels are reducing, weekly serum βhCG testing in the Early Pregnancy Unit is required until levels return to normal, which takes approximately three to four weeks. Ectopic pregnancies which have a high risk of tubal rupture or have already ruptured require surgical management (Capmas et al., 2014). Across Irish maternity hospitals from 2005 to 2016, 58% of women with ectopic pregnancy underwent surgical treatment (San Lazaro Campillo, Meaney, O'Donoghue, et al., 2018). This requires general anaesthesia and an inpatient stay, with outpatient follow-up to review surgical recovery.

1.2.3 Molar pregnancy

Molar pregnancy (also known as 'Gestational Trophoblastic Disease) is a rare pregnancy disorder which often presents with irregular vaginal bleeding in the first trimester and is associated with abnormally high levels of human chorionic gonadotropin (hCG) (Joyce, Coulter, et al., 2022; Lok et al., 2021). It occurs at the time of conception when the sperm and the egg join together and there is excessive development of the cells that form the placenta with little or no fetal (baby) development (National Gestational Trophoblastic Disease Registry, Monitoring and Advisory Centre, 2020). There are two types of molar pregnancy: complete hydatidiform mole and partial hydatidiform mole; both differing in their genetic makeup and development. Molar pregnancy does not result in a viable pregnancy.

Obstetric management of molar pregnancy involves uterine evacuation (ERPC) and histopathological examination of the pregnancy tissue. Follow-up serum or urine hCG monitoring is done until hCG values return to within the normal range (Joyce, Fitzgerald, et al., 2022); this monitoring usually weekly at first and the period of surveillance can last from one to six months. Most women with molar pregnancy do not require further treatment following uterine evacuation of the pregnancy tissue. Some will however develop disease persistence and progress to malignant disease requiring chemotherapy or further surgical intervention, the risk being higher for complete hydatidiform mole (15-20%) than partial hydatidiform mole (0.5-1%) (Joyce, Fitzgerald, et al., 2022).

1.2.4 Termination of pregnancy

Pregnancies can also end through termination of pregnancy, which is defined in Irish law as 'a medical procedure which is intended to end the life of a fetus' (Health (Regulation of Termination of Pregnancy) Act 2018, 2018). In this report, we use the term 'termination of pregnancy', in line with this legislation, rather than the term abortion, though we appreciate that both terms are used across the literature and in public discourses. Across the world, an estimated 29% of pregnancies end in termination (Bearak et al., 2020; World Health Organisation, 2021).

The Health (Regulation of Termination of Pregnancy) Act 2018, enacted on 01 January 2019, provided for several different circumstances under which termination of pregnancy could be legally performed in the Republic of Ireland:

- Section 12 allows termination of pregnancy to be carried out by medical practitioners up to 12 weeks gestation, once a minimum of three days has elapsed from the date of certification. The majority of terminations occur under this section of the legislation; 99.7% in 2022 (Department of Health, 2023).
- Section 11 allows termination of pregnancy to be carried out in the setting of a fetal condition likely to lead to death in utero or within 28 days of birth
- Sections 9 and 10 allow termination of pregnancy to be carried out in the setting of a risk to life or a risk of serious harm to the health of the pregnant person.

In 2022, 8,042 terminations in early pregnancy (up to 12 weeks) were carried out under the grounds set out in Section 12 of the Act; 22 were carried out due to a risk to life or health under the grounds set out in Section 9, four due to a risk to life or health in an emergency situation under Section 10, and 88 due to a fatal fetal anomaly under Section 11 (Department of Health, 2023).

Approximately 3% of pregnancies are diagnosed with a fetal anomaly, a proportion of these are fatal or life-limiting (Miremberg et al., 2023). Following confirmation of a fatal fetal anomaly, women/couples are faced with decisions concerning the remainder of the pregnancy: continuing and giving birth, or terminating the pregnancy (Jackson et al., 2023). There is no agreed definition of what constitutes a fatal fetal anomaly, or agreed list of conditions associated with fatal fetal anomalies in the Republic of Ireland (Power et al., 2020). A recent Irish study found that 40% of women whose pregnancy was diagnosed with a major fetal anomaly travelled outside of the Republic of Ireland for abortion care, mainly to England; mostly due to cases deemed locally as not meeting the legal criteria for termination of pregnancy (Miremberg et al., 2023).

Termination of pregnancy can be medical or surgical, and can occur in primary (medical termination only) and secondary care settings. Medical termination of pregnancy involves taking mifepristone, followed by misoprostol, between 24 to 48 hours later. Medical termination of pregnancy can be provided in a primary care setting up to nine completed weeks of gestation. Surgical termination of pregnancy is performed in a secondary care setting and involves a vacuum aspiration or dilation and evacuation (Boyd et al., 2022); in the Republic of Ireland this is currently available up to 12 weeks gestation (Section 12 cases). Termination is a safe procedure; major complications are rare at all gestations (Boyd et al., 2022).

1.2.5 Stillbirth

In the Republic of Ireland, a stillbirth is legally defined under the Civil Registration Act 2004 as an infant born after 24 completed weeks of pregnancy, or with a birthweight of over 500g, with no signs of life (Irish Statute Book, 1994). It should be noted however that a revision of this legal definition is imminent. The Civil Registration (Electronic Registration) Bill 2023 seeks to amend the definition of stillbirth in the Civil Registration Act 2004 to 400 grammes and 23 weeks to reflect improvements in neonatal survival rates, in line with the clinical guidance from the Department of Health and the Health Service Executive (Houses of the Oireachtas Joint Committee on Social Protection, Community & Rural Development and the Islands, 2023). In 2021, the Health Service Executive National Clinical Programme for Neonatology, the National Perinatal Epidemiology Centre and the National Women and Infants Health Programme defined a pre-viable live born infant as one who is born alive before 23 weeks gestation and shows signs of life as per defined criteria for more than one minute, thereby bringing the threshold of viability under that implied by the definition of stillbirth in the 2004 Act (National Clinical Programme for Neonatology et al., 2021). A review of stillbirth definitions within high-income countries suggested that the stillbirth definition in the Republic of Ireland should be updated to ≥22 weeks gestation and ≥400 g to comply with improved medical developments and survival rates of infants born pre-term (Kelly et al., 2021).

Globally how stillbirth is defined varies, from 20 to 28 weeks gestation, or 350g – 1000g (Kelly et al., 2021). Given the variation in definitions, prevalence rates are difficult to determine (Escañuela Sánchez et al., 2023) but stillbirth occurs in an estimated 3.5 per 1000 total births in high-income countries (Flenady et al., 2016). In the Republic of Ireland, the rate of stillbirth was 4.20 per 1000 births, 240 stillbirths, in 2020 (San Lazaro Campillo et al., 2022).

How stillbirth is defined impacts on legal outcomes regarding maternity and paternity leave entitlements and civil registration of births. In the Republic of Ireland, people who experience a stillbirth are entitled to full maternity and paternity leave (Department of Social Protection, 2023a, 2023c). This includes 26 weeks of maternity leave (with the option to take a further 16 weeks of additional unpaid maternity leave) and two weeks of paternity leave. If a person has enough PRSI (Pay Related Social Insurance) contributions, they are entitled to Maternity Benefit for the 26 weeks basic maternity leave, i.e. paid leave. Stillbirths may also be registered, but it is not obligatory (Department of Social Protection, 2023b; Irish

Statute Book, 1994). This registration process is also under review as part of The Civil Registration (Electronic Registration) Bill 2023, discussed above.

1.2.6 Neonatal death

In the Republic of Ireland, early neonatal death is defined as the death of a live born baby occurring within seven completed days of birth, while a late neonatal death is the death of a live born baby occurring after the 7th day and within 28 completed days of birth (San Lazaro Campillo et al., 2022). In 2020, there were 117 early neonatal deaths and 35 late neonatal deaths in 2020 in the Republic of Ireland, out of the 57,114 births with a birthweight >500g or gestational age of ≥ 24 weeks, corresponding with an early neonatal death rate of 2.06 per 1,000 live births (San Lazaro Campillo et al., 2022).

1.2.7 Scope of this study

This research will focus on pregnancy loss before 24 weeks of gestation. Hereafter 'pregnancy loss' refers to first and second trimester miscarriage, ectopic and molar pregnancy, and termination of pregnancy.

1.3 Psychosocial impacts of pregnancy loss

In addition to the physiological and medical impacts, pregnancy loss can have wider social and emotional implications for women, their partners, families, and society, with recognised and enduring impacts on emotional health and wellbeing (Heazell et al., 2016; Kolte et al., 2015; McCarthy et al., 2020; Meaney et al., 2017; Tavoli et al., 2018). An Irish qualitative study of experiences of miscarriage found that participants experienced devastation, grief, and guilt following pregnancy loss, as well as anxiety and stress in subsequent pregnancies (Meaney et al., 2017). The diagnosis and treatment of ectopic pregnancy can be devastating, with women reporting shock, disbelief and confusion following diagnosis, and lasting impacts (Spillane et al., 2018). A survey of women in the Republic of Ireland who experienced molar pregnancy and other gestational trophoblastic diseases found that women experienced feelings of intense sadness at the time of diagnosis and needed psychological support to help them to deal with the pregnancy loss (Joyce, Coulter, et al., 2022). Pregnancy loss through termination for medical reasons can be associated with additional impacts. A diagnosis of major fetal anomaly in pregnancy is usually unexpected, and causes grief and distress, which can be exacerbated by inadequate care and support, whether a person decides to end the pregnancy or not (Jackson et al., 2023).

Psychological wellbeing can also be negatively impacted by the experience of pregnancy loss. Psychological consequences include increases in the risk of anxiety, depression, post-traumatic stress disorder, and suicide (Broen et al., 2005; Farren et al., 2016, 2018; Heazell et al., 2016; Quenby et al., 2021; van den Berg et al., 2018). In addition to the impact on women, pregnancy loss can also have a significant impact on men/partners, some of whom report many of the same grieving and social experiences as women, following pregnancy loss (Harty et al., 2022; Meaney et al., 2017; Obst et al., 2021). Indeed for men there can be a 'double-disenfranchisement' as they try to remain strong and act in a support role for their partner, and sometimes thereby ignore their own sense of loss (Harty et al., 2022; Obst et al., 2020).

Pregnancy loss continues to be associated with a level of stigma in terms of personal reproductive 'failure' and disappointment. This has partially been shaped by a societal discomfort in acknowledging the reality, prevalence, and existence of pregnancy loss (Nuzum et al., 2019). Furthermore, early pregnancy losses receive a lack of civil recognition – for example, pregnancies which end before 24 weeks are not registered in the way stillbirths are (Irish Statute Book, 1994). This in turn has shaped how early pregnancy loss has been treated as a medical event requiring sick leave with little emphasis on the grief and loss that can be associated with it.

Pregnancy loss has long been considered a 'silent grief', which by virtue of its silence is experienced by many as a disenfranchised loss (Doka, 2008); not fully recognised as a loss (Maker, 2010; Meaney et al., 2017). Indeed, with early loss it is often the case that the pregnancy has not been disclosed yet to family, friends, or colleagues, when the loss occurs (National Care Experience Programme, 2023). This has the potential impact of restricting the ability to share the experience of pregnancy loss and further isolate women and their partners. Raising awareness of the impact of miscarriage may assist society in supporting individuals following loss, alongside reducing the hidden nature of the experience (Bellhouse et al., 2018).

1.4 Workplaces as context

As of July 2023, there were more than 1.24 million females working in the Republic of Ireland, representing a 59% female labour force participation (Eurostat, 2020). Among the 25 to 44 age group, over 67% of women are employed (Central Statistics Office, 2022b). As such, pregnancy loss becomes a workplace issue when most women of reproductive age are in paid employment

at the time of pregnancies and pregnancy losses. As full-time work takes a significant amount of time and energy, and women rely on their income to contribute to their own or their households' livelihoods, workplaces and workplace supports can significantly influence the pregnancy loss experience.

In addition to the primary function of employment (earning an income), a positive mental health model proposes that paid employment provides other functions which are important for well-being: time structure; collective purpose; social contact; status; and activity (Jahoda, 1981; Paul & Batinic, 2009). Jahoda's model of the 'latent functions' of employment proposes that work contributes to a person's welfare by providing structure to their day; a shared purpose and experience; contact with individuals outside their family unit; and activity to engage in. This perspective reiterates the importance of the workplace in a person's life, and further highlights the need for workplaces to be considered in relation to pregnancy loss experiences.

A number of studies have estimated non-health-care costs associated with miscarriage, many of which focused on the economic value of lost work productivity. These studies identified that both absences from work or lower productivity after returning to work result in economic costs, which sometimes exceed direct costs to the health-care system (Quenby et al., 2021). An economic evaluation estimated the mean value of work absences for study participants to be £431 per person (Petrou et al., 2006); while a study in the Netherlands found a similar estimated value (£439), but which was driven by lower productivity upon return to work, rather than the cost of absence (Graziosi et al., 2005). In light of the prevalence of early pregnancy loss, a not-for-profit charity based in Australia called 'The Pink Elephants Support Network' launched a 'Leave for Loss' Campaign, which lobbied for bereavement leave to include miscarriage. As part of this campaign, the charity conducted a cost modelling exercise to estimate the cost of this policy. The estimated cost was between 0$ (based on a paper-only change from other leave to bereavement leave) and $55.8 million AUD as the upper estimate. They compared this to the estimated cost of presenteeism in Australia of $34 billion AUD. Presenteeism is the loss of productivity for those coming to work without full capacity to work (dandalopartners, 2021).

Regarding support for families after a perinatal death, pregnancy loss researchers in Canada also discuss the costs of presenteeism. Costs related to presenteeism are usually higher than absenteeism, as psychological illness or bereavement are related to decreased productivity and more frequent workplace accidents (De

Montigny et al., 2018). As such it is important to consider the costs of current presenteeism when considering future costs of absenteeism.

1.5 Workplace experiences of pregnancy loss

Despite the prevalence of pregnancy loss before 24 weeks (or before viability globally) and the relevance of the workplace to these experiences, there remains a lack of knowledge around workplace experiences of and supports for early pregnancy loss. However, in recent years there have been some empirical studies – including interview (Gilbert et al., 2023; Rose & Oxlad, 2022; Silverman, 2020) and survey (Keep et al., 2021; Miller & Suff, 2022; Obst et al., 2022; Tommy's, 2022) studies; autoethnographies (Boncori & Smith, 2019; Porschitz & Siler, 2017); and scoping/literature reviews (Hackney et al., 2020; Meunier et al., 2021; Musodza et al., 2021). Most of these studies focused exclusively on women, except for Obst et al. (2022) which only included men, and Rose and Oxlad (2022) who interviewed LGBTQ+ men and women. While Meunier et al.'s (2021) scoping review included literature on both women and men, the majority of included articles focused on women. Within this small body of literature, first and second trimester pregnancy loss features specifically and within discussions of all types of pregnancy loss. Five of the aforementioned studies focus on miscarriages (<20 weeks of pregnancy) (Boncori & Smith, 2019; Hackney et al., 2020; Keep et al., 2021; Porschitz & Siler, 2017; Silverman, 2020), the remainder focus on all pregnancy losses and neonatal deaths. In the following sections, common themes or topics identified across this literature are discussed.

1.5.1 Challenges in returning to work

Much of the qualitative data described participants' difficulties in returning to work following their pregnancy loss. Productivity was often affected, through a loss in ability to concentrate, being distracted by emotions or thoughts of the loss (Obst et al., 2022; Porschitz & Siler, 2017; Silverman, 2020), and/or a decline or absence of motivation or care about their work (Porschitz & Siler, 2017). A qualitative interview (Gilbert et al., 2023) study found that a common experience was encountering grief triggers at work, which brought up memories of their pregnancy loss. Engaging in the emotional labour of hiding their grief was also described by participants (Gilbert et al., 2023). Some participants experienced physical symptoms or pain at work, which added further challenges to returning to work (Silverman, 2020, p127). Participants in Gilbert and colleagues' (2023) interview study described their physical experiences of loss – blood clots,

cramping, surgery, and sometimes labour and delivery and production of breast milk. These emotional and physical effects can negatively impact the well-being of employees and lead to decreased cognitive ability, which can decrease the overall productivity of workplaces.

1.5.2 Time off work

Across the literature a need for time off work following a pregnancy loss was expressed. Most studies reported how much time participants took off work, if any, or what kind of leave was taken. The length of leave taken varied from one day (Silverman, 2020) to one year (Keep et al., 2021), and most commonly took the form of sick leave (Gilbert et al., 2023; Keep et al., 2021; Obst et al., 2022; Rose & Oxlad, 2022). Across studies, participants faced a variety of reactions from their workplaces with regards to taking time off work. Within Silverman and Harris-Britt's (2020) interview study, some women were supported in taking as much time as they needed, while others were pressured to return to work or even carry on working through their miscarriage. Guilt arising from increased pressure on colleagues through absence was sometimes a factor (Gilbert et al., 2023; Silverman, 2020; Tommy's, 2022). Rose and Oxlad (2022) identified barriers to accessing leave, such as pregnancy loss not being viewed by HR staff as sufficient for bereavement leave, while a male participant in another study was fired after requesting an extended period of leave (Obst et al., 2022). An issue faced by participants across the literature was needing to take sick leave for pregnancy loss, which reduced future entitlements to leave. This was particularly problematic for Silverman's (2020) participants in the USA, whose sick leave reduced future maternity leave entitlements; and Rose and Oxlad's (2022) LGBTQ+ participants, whose sick leave reduced what could be taken for future Assisted Reproductive Technology (ART) treatments. In addition to insufficient leave entitlements, a lack of specific leave sometimes led to ambiguity around what was a justifiable length of leave to take (Gilbert et al., 2023). Other types of leave such as bereavement leave were preferred to sick leave as they more appropriately acknowledged the pregnancy loss experience (Rose & Oxlad, 2022).

1.5.3 Disclosure

A common part of pregnancy loss experiences discussed across literature is the decision to disclose the pregnancy loss to the workplace, or not. In their autoethnography (Porschitz & Siler, 2017), both authors, who experienced first trimester miscarriages, kept their pregnancy losses a secret, and told nobody in

their workplace. They describe their nondisclosure as automatic, something that happened in response to cultural norms, rather than a conscious decision on their part. They highlight how pregnancy loss is not discussed in society but is especially not discussed in workplaces, where the emphasis is placed on being professional. Boncori and Smith (2019, p81) also discuss the silence of miscarriage in academia, where the 'maternal body remains unwelcome or rejected' and there is a lack of healthy work-life balance.

Across studies, the majority of participants shared their loss with their workplace to access support and understanding (Keep et al., 2021), to gain practical accommodations (Rose & Oxlad, 2022) or to normalise the topic (Silverman, 2020). Sometimes pregnancies were simultaneously disclosed with pregnancy losses, in cases where participants had not revealed their pregnancy (usually before 12 weeks gestation) (Gilbert et al., 2023). On the other hand, some participants did not disclose their loss because they did not feel comfortable sharing (Silverman, 2020), it was a private matter (Miller & Suff, 2022), they were afraid of judgement (Rose & Oxlad, 2022), or because the topic was too painful to discuss and often not met with adequate support or understanding (Keep et al., 2021). Certain workplaces were especially non-conducive to disclosure as participants were concerned that it would impact their career progression or employment security (Keep et al., 2021) or where workplaces with male-dominated management (Keep et al., 2021; Silverman, 2020). One survey examined who, in the workplace, the disclosure was made to, and found that just over half of participants told their manager, while just 6% told HR (Human Resources) (Miller & Suff, 2022).

1.5.4 Organisational supports

When employees return to work, either immediately after a pregnancy loss or following a period of leave, there are many ways in which employers can facilitate an easier reintegration to the workplace. Across the literature, participants highlighted supports they experienced and valued, or accommodations they would have liked to have been offered. These included being allowed to work from home (Keep et al., 2021; Silverman, 2020); modified duties or work arrangements (Keep et al., 2021; Rose & Oxlad, 2022; Silverman, 2020); access to counselling or occupational health (Miller & Suff, 2022); and overall flexibility with workload or schedule (Keep et al., 2021; Miller & Suff, 2022; Obst et al., 2022; Rose & Oxlad, 2022).

1.5.5 Emotional supports

Employees included across the literature also highly valued and expressed a need for emotional support in the workplace. In Keep et al.'s (2021) survey study, 87.6% of women felt somewhat or well supported by colleagues, and 73.5% were somewhat or well supported by managers. Feeling that their loss was recognised and acknowledged by people in their workplace was important to participants (Gilbert et al., 2023; Obst et al., 2022). It was important for managers especially to prioritise their employees' wellbeing over productivity on their return, which some participants did experience: 'My health and wellbeing came first, work came second (Silverman, 2020, p124). Many participants found it helpful when their colleagues shared their own pregnancy loss experiences, which helped to normalise the topic and make employees feel less alone (Silverman, 2020). Participants in a study conducted in the UK were asked to share what they needed to hear from their manager, and responses emphasised acknowledgement and compassion – "It would have been nice for them to acknowledge the situation" (Tommy's, 2022).

1.6 Summary

Pregnancy loss affects many women and couples, with one in four pregnancies ending in miscarriage. Pregnancy loss under 24 weeks includes first and second trimester miscarriage; molar pregnancy; ectopic pregnancy; and termination of pregnancy. Pregnancy tissue may pass spontaneously in earlier pregnancy loss, but more commonly medication or surgery is required to manage pregnancy loss. The physical impacts of pregnancy loss can include cramping, bleeding, fatigue, or surgery complications. Many women and partners go through a period of sadness, grief, or sometimes depression, anxiety, or post-traumatic stress disorder following pregnancy loss.

Despite the prevalence and impact of early pregnancy loss, there is still a level of stigma, secrecy, and lack of understanding surrounding the topic on a personal, professional, and societal level. Though the majority of people who experience pregnancy loss are in paid employment, there remains a lack of awareness on this issue and poor support for employees and families experiencing these losses. There has been a recent increase in empirical research in this area which has identified key difficulties faced when returning to work following pregnancy loss, in addition to the importance of time away from work, and the need for provision of supports on return (Keep et al., 2021; Obst et al., 2022; Rose & Oxlad, 2022; Silverman, 2020).

Chapter 2. Project Aims

2.1 Overall aim of the project

The overall aim of this project is to examine the workplace experiences of pregnancy loss and determine what formal or informal support mechanisms could be introduced in the workplace to better support people who experience pregnancy loss. The specific aims and objectives for each of the three phases of the project are outlined below.

2.2 Phase 1: Scoping study

The aim of the scoping study is to:

- Examine international models in order to identify international best practice in terms of compassionate workplace policies and statutory leave provisions to support parents experiencing pregnancy loss – as well as workplace-based supports and support systems.

Specific objectives are to examine:

- Statutory leave provisions in terms of pregnancy loss/bereavement leave (and potentially statutory maternity leave provisions, for context) in high-income countries – criteria for receipt (e.g. types of losses covered – including any limits on timing of gestation, whether medical confirmation required or not, application process and level of certification needed, and by whom)
- Supports / systems in the workplace.

2.3 Phase 2: Qualitative and quantitative study

The aim of the qualitative and quantitative study is to:

- Explore lived experiences of pregnancy loss (before 24 weeks gestation) in the workplace.

Specific objectives include, to:

- Examine the risk and protective factors in terms of working conditions that can affect return to the workplace following pregnancy loss
- Explore the factors that encourage/discourage people from disclosing (formally/informally) pregnancy loss at work
- Elicit experiences (personal and professional) of workplace support (formal/informal) after pregnancy loss
- Investigate experiences across various demographics and types of workplace

- Establish whether there is a need to introduce formal support mechanisms for employees coping with pregnancy loss, including, but not limited to, the provision of a statutory entitlement to leave.

2.4 Phase 3: Reporting

The aim of this phase is to generate recommendations and implications for workplace supports, including policy interventions, to better support people following pregnancy loss.

The specific objectives are to:

- Provide a full write-up of the overall research project, along with an executive summary and summary notes, in plain English
- Draw on/integrate the findings from Phases 1 and 2 to produce recommendations for formal or informal support mechanisms that could be introduced in the workplace to better support working parents experiencing pregnancy loss. Support mechanisms may include, but are not limited to, the provision of compassionate or bereavement leave, flexible working arrangements, or other workplace policies
- Seek input from patient and public involvement contributors to refine these recommendations.

Chapter 3. Phase 1: Scoping study

Key messages

Overview of international legislation on early pregnancy loss leave

- 10/81 high-income countries/jurisdictions provide specific leave to women when they experience a pregnancy loss before viability
- There are three broad categories of leave available in these countries:
    - Compassionate or bereavement leave
    - Maternity (and paternity) leave
    - Miscarriage or pregnancy loss leave
- Length of leave available varies from 2 to 60 days and is determined mostly in three ways:
    - All individuals are entitled to the same maximum amount of leave
    - Longer leave is provided to people with a pregnancy loss at a later gestation
    - Medical personnel decide the length of leave based on need
- Nine of the ten countries provide paid leave. It is most common for employers to pay this leave, but some countries also use social insurance funds or state treasuries
- Four out of the ten countries provide leave to partners experiencing pregnancy loss
- Five of the ten countries provide leave for termination of pregnancy under any circumstance, with a further two providing for it under certain circumstances.

Workplace policies available in some organisations/companies in the Republic of Ireland

- Of 179 of the 'best' companies in Ireland which were contacted, just 20 shared whether they had a policy on pregnancy loss or not
- Of these, almost half (9 out of 20) confirmed they have a specific pregnancy loss policy in their workplace
- All 9 companies provide paid leave to employees who experience a pregnancy loss
    - This leave ranges from 3 to 20 days and is either named compassionate / bereavement leave or miscarriage / pregnancy loss leave
    - Most companies provide leave to partners and those who have experienced termination of pregnancy
    - Other supports within pregnancy loss policies include free counselling and flexible working.

3.1 International legislation

3.1.1 Background

In the Republic of Ireland, women and their partners are entitled to full maternity and paternity leave following a stillbirth (Department of Social Protection, 2023a, 2023c). This includes six months of maternity leave and two weeks of paternity leave. To qualify for maternity or paternity benefit, workers must have paid at least 39 weeks of PRSI (Pay Related Social Insurance). Maternity benefit is €262 a week and can be 'topped up' by an employer to match normal wages. However, there are no statutory provisions for pregnancy losses before 24 weeks of pregnancy. People who experience the loss of a pregnancy during this timeframe are either faced with an immediate return to work, or using other leave entitlements. The latter can include sick leave, pregnancy-related sick leave, bereavement or compassionate leave, and/or annual leave.

Sick leave: Since January 2023, workers in the Republic of Ireland have a statutory right to three days' paid sick leave per year, as a legal minimum (Sick Leave Act, 2022). Employers must pay 70 percent of normal pay, up to a maximum of €110 a day. Beyond the statutory three days, employees who have sufficient PRSI contributions may apply for Illness Benefit. Employees must have been working at least 13 weeks with their employer before gaining this entitlement. Employers may demand certification from a general practitioner in order to provide this leave. Employment contract in individual workplaces may offer a greater amount or higher pay than the statutory entitlement (Citizens Information, 2023b).

Pregnancy-related sick leave: Some employees who work in the public sector, for example, school teachers, or Health Service Executive (HSE) staff, are entitled to pregnancy-related sick leave. If an employee has a medically certified pregnancy-related illness which renders them unfit for work they must first use their normal sick leave allowance. If they exceed this allowance, they can then take pregnancy-related sick leave which provides at least half-pay and is not counted on sick records (ASTI, 2021; HSE, n.d., 2015; Irish Nurses and Midwives Association, n.d.) However, pregnancy loss is not explicitly included as a pregnancy-related illness.

Compassionate leave: Compassionate or bereavement leave may be given to employees on the death of a close family member. However, this is not a statutory entitlement and is subject to employer's discretion (Citizens Information, 2023a). Furthermore, pregnancy losses may not be considered as a death of a close family

member, depending on how this is interpreted by employers and/or HR personnel.

Annual leave: Employees in the Republic of Ireland are entitled to paid annual leave equal to four working weeks in a leave year in which at least 1,365 hours are worked (Organisation of Working Time Act, 1997). Employers pay this leave at the normal weekly rate. Employers can decide/influence when this leave is taken.

Other types of leave include three days of paid force majeure leave for a family crisis or five days unpaid leave for serious medical care of a family member or cohabitant (Citizens Information, 2023a).

Pregnancy loss is not specifically catered for by any of the above leave types. Access to bereavement, compassionate, or force majeure leave for pregnancy loss is at the employer's discretion, while statutory sick leave is limited and requires medical certification.

In 2021, the Labour Party brought forward a Private Members' Bill, entitled The Organisation of Working Time (Reproductive Health Related Leave) Bill 2021 (Houses of the Oireachtas, 2021) to establish a period of paid leave consequent upon miscarriage. This proposes that an employee be entitled to 20 days leave, paid by the employer.

In order to understand how leave can be introduced to support women and partners following a pregnancy loss, it is necessary to explore leave provisions in countries of similar economic standing. Thus, we conducted a review of high-income countries' legislation pertaining to statutory leave following pregnancy loss.

3.1.2 Methods

The World Bank (2022) definition of high-income countries was used to define the group of high-income countries included in this review. The term 'country' is used here to describe jurisdictions listed as high-income countries by the World Bank, which sometimes includes territories or autonomous regions (e.g. St Kitts and Nevis, Macao).

Extensive internet searches were undertaken to identify pregnancy-loss related leave before viability in each country. Sources of information considered included government information websites, international reports on maternity and related

leave, and original legislation. Search terms included 'miscarriage', 'maternity', 'leave', and the name of the country. Where multiple sources of information were available for each country, these were cross-referenced to ensure accuracy of information. These searches were conducted between October and December 2022.

Through this process, countries were identified as providing statutory leave in the case of pregnancy loss before the point of viability / stillbirth as defined by that country (if such a definition existed and was available). Countries were considered as one jurisdiction as defined by the World Bank; however, in the case of federal countries in which one state or region provided pregnancy-loss related leave where their country did not, this state or region was included in our review.

Following establishment of the countries which provided statutory leave relevant to this review, original legislation was sourced and analysed. In particular, information pertaining to the following aspects of leave were sought:

- Type of leave (e.g. bereavement leave, miscarriage leave)
- Length of leave and determinants of length given
- Eligibility requirements for taking this leave (inclusion of partners and women who experience termination of pregnancy; requirement of certification)
- Payment during leave.

In addition to reviewing legislation, experts from these countries were contacted and invited to act as key informants for this review. These informants were asked to verify findings and provide information about this legislation which was not available online. These experts worked in the country where this leave was given, and their expertise ranged across the disciplines of obstetrics, midwifery, law, politics, and human rights. Experts were contacted between March 2023 and August 2023.

Though the focus of inquiry was on high-income countries as per the requirements of this project, throughout the course of this research several middle-and-lower income countries were identified which also provide pregnancy-loss related leave. Though the legislation from these countries was not analysed and verified with the same rigour, the leave provisions are noted later in this chapter (Table 3.2). Furthermore, while a review of draft legislation was outside the scope of this research, countries which are considering introducing statutory pregnancy-loss leave are also presented.

3.1.3 Results

Information was available for 80[2] of 81 high-income countries. This search ascertained that nine countries and one provincial jurisdiction provide statutory leave in the case of pregnancy loss before viability. The jurisdictions providing this leave are: Australia, Québec, Iceland, South Korea, Macao, New Zealand, Panama, Portugal, Puerto Rico, and Taiwan. Leave entitlements are summarised in Table 3.1 and discussed in further detail, by country, below.

[2] No information on maternity, paternity, miscarriage, or parental leave was found for New Caledonia

Table 3.1 Summary of statutory leave provisions in high-income countries

Country / Jurisdiction	Type of leave	Duration of leave	Payment	Partners included	Termination of pregnancy included	Certification requirement
Australia	Compassionate leave	2 days	Yes; employer	Yes	No	If requested by employer
Iceland	Parental bereavement leave	2 months	Yes; state treasury	Yes	Yes	Yes
Macao	Maternity leave	21- 70 days	Yes; employer	Yes	No; illegal in Macao	Yes
New Zealand	Bereavement leave	3 days	Yes; employer	Yes	No	No
Panama	Maternity leave	Determined by medical certificate	Yes; employer or Social Security Fund	No	Yes	Yes
Portugal	Pregnancy loss leave	14 – 30 days, determined by medical certificate	Yes; social welfare and employer	No	Yes	Yes
Puerto Rico	Maternity leave	Determined by medical certificate	Yes; employer	No	Yes	Yes
Québec	Special maternity leave	3 weeks	No	No	Yes	Yes
South Korea	Miscarriage / stillbirth leave	5 – 60 days, depending on gestation	Yes; employer or employment insurance fund	No	Depending on reason for termination	Yes
Taiwan	Maternity leave	5 – 30 days, depending on gestation	Yes, if pregnancy ends after 3 months; employer	No	Yes, if termination was legal	Yes

Australia

Statutory leave entitlements are covered by the Fair Work Act 2009. In 2021, the Fair Work Act 2009 was amended by the Sex Discrimination and Fair Work (Respect at Work) Amendment Act (2021) to expand employees' entitlements to 'compassionate leave' of two days to those experiencing a spontaneous abortion (i.e. miscarriage) before 20 weeks. This leave is granted in recognition of employees' bereavement following miscarriage, and to give employees time away from work to grieve.

This leave is paid by employers. Casual workers are only entitled to unpaid leave. Employers have the right to request evidence of the miscarriage, for example, a medical certificate. However, in practice, most employers do not require certification before granting compassionate leave[3]. The employee must give notice to their employer as soon as is practicable.

This leave can be taken by the employee who had the miscarriage and the employee's spouse or de facto partner. The former spouse or de facto partner is not entitled to take this leave. Employees who have had a termination of pregnancy are not entitled to avail of this leave.

In Australia, women who experience a stillbirth (400g birthweight or 20 weeks gestation) can take up to 12 months' unpaid parental leave (Fair Work Act 2009, 2009; Fair Work Ombudsman, n.d.).

Canada (Québec)

Canada does not provide statutory miscarriage leave at a national level. However, the province of Québec has amended the Labor Standards Act (2002) to allow citizens time off work in the event of 'termination of pregnancy' or pregnancy loss.

According to the Labour Standards Act, s. 8.5.2 (Labor Standards Act, 2002), an employee is entitled to 'special maternity leave' in the event of a pregnancy loss before 20 weeks. The leave period is three weeks, unless extended by a medical certificate.

[3] Key informant: Samantha Payne, Co-Founder and CEO of the Pink Elephants Support Network, Australia

This leave is unpaid. Employees must provide a medical certificate attesting to the event, and provide written notice with the expected date of return to work section 8.5.2 of the Labor Standards Act (2002).

Employees are entitled to this leave in the case of termination of pregnancy or abortion. This entitlement does not extend to spouses or partners of the woman who has experienced a pregnancy loss are not entitled to this leave.

In Canada, a pregnancy loss is considered a stillbirth if the pregnancy ends after 20 weeks gestation. In this case, women are entitled to 18 weeks of unpaid maternity leave and partners are entitled to five days of absence, the first two of which are paid (Loi sur les Normes du Travail, 2020).

Iceland

Employees in Iceland are entitled to leave from work in the event of a miscarriage after 18 weeks of pregnancy. This leave can be from two weeks up to two months; it must be taken at least two weeks at a time; and can be taken in the period up to 24 months after the miscarriage.

This entitlement comes under Law on bereavement leave, Law No, 77, Article 8, which applies since January 2023 (77/2022: Lög Um Sorgarleyfi., 2022) and is classed as 'parental bereavement leave'. Previously, this entitlement was classed as maternity and paternity leave.

This leave is paid at 80% of average total wages based on the six-month period preceding two calendar months before the miscarriage. Payments are financed by the state treasury. Self-employed workers are entitled to this benefit if they have paid monthly income tax and social security contributions. Students, unemployed, and part-time workers are entitled to bereavement grants.

Medical certification must be submitted to the Directorate of Labour, confirming the length of pregnancy, in order to access this leave.

Partners of the woman who has experienced the miscarriage are also entitled to this leave. If they are not married or in a registered partnership at the time of miscarriage, details of parenthood must be included on the medical certificate in

order to access leave. This leave is granted in the case of termination of pregnancy or abortion[4].

Employees who experience a stillbirth from 22 weeks of pregnancy are entitled to three months of parental bereavement leave (77/2022: Lög Um Sorgarleyfi., 2022).

South Korea

Pregnant workers are entitled to 'miscarriage or stillbirth leave' in South Korea since 2012. The length of leave depends upon the gestational age as follows:

- Up to 11 weeks of pregnancy: 5 days
- Between 12 and 15 weeks of pregnancy: 10 days
- Between 16 and 21 weeks of pregnancy: 30 days
- Between 22 and 27 weeks of pregnancy: 60 days
- At least 28 weeks of pregnancy: 90 days.

As such, leave is based on gestational age, rather than a distinction between miscarriage and stillbirth.

This leave is legislated under Article 43 (Request, etc. for Miscarriage or Stillbirth Leave) Presidential Decree No. 23868 (2012) (Enforcement Decree of the Labor Standards Act, 2012).

Wages are paid during this leave. Employers in medium and large companies pay wages for the first 60 days, after which point the employment insurance fund covers the remainder. In the cases of small companies, the employment insurance fund covers wages for the first 60 days, after which the employer is responsible. The definition of a small company depends on the industry (e.g. less than 500 employees in the manufacturing sector; less than 200 employees in the hotel and restaurant sector). Employees and self-employed workers are eligible for this leave following a six-month and three-month period of income activity prior to taking leave, respectively[5].

Partners are not entitled to miscarriage or stillbirth leave. Employers are not obliged to provide miscarriage or stillbirth leave to employees who have

[4] Key informant: Leó Örn Þorleifsson, Director Rights and Entitlements at the Directorate of Labour
[5] Key informant: Eunkyung Shin, Director, Ministry of Health and Welfare, Republic of Korea

experienced a termination of pregnancy or abortion, unless for reasons laid out in Article 14 of the Mother and Child Health Act (2015) as follows:

- The pregnant woman and her spouse have given consent
- She or her spouse suffers from any eugenic or genetic mental disability or physical disease
- She or her spouse suffers from a contagious disease
- She is impregnated by rape or quasi-rape
- Pregnancy has taken place between relatives
- Maintenance of the pregnancy severely injures or might injure the health of the pregnant woman for health or medical reasons.

Macao

Female employees in Macao are entitled to maternity leave if they have an involuntary miscarriage after more than three months of pregnancy. The length given is between 21 and 70 days, depending on the employee's condition of health, as determined by a medical certificate. Female employees who experience an involuntary abortion before three months of pregnancy are entitled to sick leave only[6]

This was introduced as an amendment to Law No. 7/2008 "Labour Relations Law" (Law No. 8/2020, 2020).

This leave is paid by the employer if the employee has worked for one complete year before the miscarriage. If the employee has worked for less than a year, this leave is unpaid.

Male employees are entitled to paternity leave of five working days, which may be taken consecutively or separately, during the period from three months of pregnancy until 30 days after the birth of the child. Those working more than one year are entitled to receive basic renumeration during the leave period.

Termination of pregnancy or abortion is not legal in Macao and therefore leave would not be granted in this case.

[6] Key informant: representative from Labour Affairs Bureau, Macao

New Zealand

Employees in New Zealand are entitled to three days of 'bereavement leave' if they experience a miscarriage before 20 weeks of pregnancy.

This leave was introduced in 2021 as an Amendment to the Holidays Act 2013 by the Holidays (Bereavement Leave for Miscarriage) Amendment Act (2021).

Those planning to have a child through surrogacy or adoption are also eligible for this leave if that pregnancy ends in miscarriage. Employees become eligible for bereavement leave after working for six months.

This leave is paid by the employers. Partners are also entitled to this leave. Certification or proof of miscarriage is not required. Employees who have experienced a termination of pregnancy are not eligible for bereavement leave; however, as aforementioned, certification of pregnancy loss is not required[7].

Women who experience a stillbirth after 20 weeks of pregnancy are entitled to primary carer and parental leave (Parental Leave Eligibility, n.d.).

Panama

Employees in Panama are entitled to a period of 'maternity leave' following a pregnancy loss. The length of leave is not set out in legislation and is instead determined by the attending physician.

This leave is legislated under Article 112 of the Labour Code and Law 51 of 2005 (Social Security Law) (Código Del Trabajo, n.d.).

This leave is paid by the employer and the Social Security Fund. Employees who have nine monthly contributions in the previous 12 months receive a maternity allowance equivalent to the average weekly wage. The rest of the salary is paid by the employer. Where employees do not qualify for maternity allowance, 100% of the salary is paid by the employer. Self-employed workers are not entitled to paid leave[8].

[7] Key informant: Robin Cronin, Research Midwife Specialist, New Zealand

[8] Key informant: Mario A. Rognoni H., Associate Lawyer, Arosemena Noriega & Contreras, Panama

Medical certification is required to determine if, and how much, leave is granted. Employees are entitled to this leave following a termination of pregnancy. Partners are not entitled to paid leave after a pregnancy loss.

A pregnancy loss is considered a stillbirth in Panama if the pregnancy ends after seven months (Lawn et al., 2016). However, as pregnancy loss leave is set by the attending physician, this definition does not automatically grant different leave entitlements.

Portugal

Employees in Portugal are entitled to 'pregnancy loss leave'[9] from work following a miscarriage or abortion, upon the recommendation of a medical doctor.

This is legislated for under the Labour Code (Código Do Trabalho, n.d.), Article 38 ° (Pregnancy Termination Leave). Pregnancy loss leave can be between 14 and 30 calendar days, the length decided by medical recommendation.

This leave is paid to public sector workers by social welfare, and to private sector employees partially by social welfare and partially by the employer.

Partners are not entitled to pregnancy loss leave.

Parents in Portugal who experience a stillbirth after 22 weeks are entitled to share 120 days leave (Seguranca Social, 2023).

Puerto Rico

In Puerto Rico, employees who experience a miscarriage or abortion which "produces the same medical effects as childbirth" are entitled to maternity leave.

This comes under Article 9 of Fringe Benefits (Government of Puerto Rico Human Resources Administration and Transformation Act, 2017).

This leave is paid by the employer.

The length of leave can be up to four weeks. Medical certification is required as evidence that the pregnancy loss has produced these medical effects. In practice,

[9] Key informant: Judicial Assistant in the Judicial Council, Portugal

the gestational age at which the pregnancy loss occurs and the treating physician's recommendation determines the length of leave.[10]

Partners are not entitled to statutory leave under this law. Women who experience a termination of pregnancy or abortion are entitled to this leave.

Taiwan

Employees in Taiwan are entitled to maternity leave in the case of miscarriage before 20 weeks of pregnancy. The length granted is dependent upon gestational age, as follows:

- Up to two months of pregnancy: five days
- Between two and three months of pregnancy: one week
- At least three months of pregnancy: four weeks.

This leave is legislated for by Article 15 under Measures for Promoting Equality in Employment (Act of Gender Equality in Employment, 2022) as amended by Presidential Order No. 11100001911 on January 12, 2022. Only employees whose miscarriage occurred after three months of pregnancy are entitled to payment during this leave[11]. This leave is financed by the employer. Those who have been employed for at least six months are entitled to full pay, while those employed for less than six months are entitled to half pay.

Employees are required to provide a 'certificate of diagnosis' in order to take this leave.

Partners are not entitled to paternity leave in cases of miscarriage.

Women who have experienced termination of pregnancy or abortion are entitled to this leave. However, in Taiwan, under Article 9, Chapter III of the Genetic Health Act (Genetic Health Act, 2009), abortion is only legal in specific circumstances including: the diagnosis of genetic, infectious, or psychiatric disease detrimental to reproductive health in the family; pregnancy as a result of rape or coercion, or by a man prohibited to lawfully marry the pregnant woman; when pregnancy or

[10] Key informant: Mariela Rexach, Littler, San Juan, Puerto Rico

[11] Key informant: Peiyuen Tsai, Associate Professor, Graduate Institute of Social Work, National Chengchi University

childbirth is likely to affect the woman's mental health or family life; or where there is risk of teratogenesis for the fetus.

Women who experience a stillbirth after 20 weeks of pregnancy can take eight weeks of maternity leave[12].

3.1.4 Additional information on low and middle income countries

Although outside the scope of the review, details of the length of leave provided and need for certification in low- and –middle-income countries was acquired during the searches for this study. This information is worth noting, and is presented in Table 3.2. Often, New Zealand is talked about as the first or second country in the world to introduce miscarriage leave (Frost, 2021; Mellen & Pannett, 2021; 'New Paid Miscarriage Leave for Public Sector Workers', 2022), whereas some low- and middle-income countries have had miscarriage leave for decades. For example, miscarriage was included in India's 1961 Maternity Benefit Act, and employers must allow six weeks of leave following miscarriage (Ministry of Labour & Employment, 1961). In China in 1951, a woman worker was entitled to 15 days' leave for a miscarriage before three months and 30 days' leave for a miscarriage between three and seven months (Labour Insurance Regulations of the People's Republic of China, 1951).

Table 3.2 Provision of statutory leave in lower-and-middle income countries

Country	Provision of Leave	Certification
Brazil	2 weeks paid maternity benefit (Koslowski et al., 2022)	Not specified
Columbia	2 to 4 weeks paid maternity leave (Ahmad & de Leon, 2021)	Yes
China	15 days of maternity leave up to four months of pregnancy 42 days of maternity leave beyond four months of pregnancy (Mao, 2020)	Not specified
India	Six weeks paid maternity leave (Ministry of Labour & Employment, 1961)	Yes
Nicaragua	Paid maternity leave in accordance with the requirements of the medical certificate; duration not specified by law (*TRAVAIL Legal Databases*, 2011)	Yes
Mauritius	3 weeks paid maternity leave (Addati et al., 2014)	Yes
Indonesia	Up to one and a half months paid miscarriage leave (Addati et al., 2014)	Yes
The Philippines	60 days paid maternity leave (*Republic Act No. 11210*, n.d., p. 11)	Not specified

[12] Key informant: Peiyeun Tsai

3.1.5 Countries considering the implementation of legislation

During the course of the scoping study, the team became aware of other countries/jurisdictions which were drafting legislation for workplace leave for pregnancy loss: Northern Ireland, Alberta, Nova Scotia and Catalunya.

Northern Ireland

On 7th January 2022 the Northern Ireland Assembly passed the (Parental Bereavement (Leave and Pay) Act (Northern Ireland) 2022, 2022) (the 2022 Act). This Act, and the subsequent regulations, introduced a statutory entitlement to two weeks parental bereavement leave, together with a statutory payment for eligible working parents who experience a stillbirth from the 24th week of pregnancy, or the death of a child under the age of 18. The two weeks can be taken consecutively or non-consecutively over a period of 56 weeks (split into two defined periods), from the date of the stillbirth or the child's death. These new entitlements were effective from 6th April 2022.

From 24th October to 22nd December 2022, a public consultation was held on dedicated legislation for Miscarriage Leave and Pay in Northern Ireland which would be incorporated under the 2022 Act (Department for the Economy, 2022). The proposed legislation would extend the entitlement of two weeks leave to people who experience miscarriage up to the end of the 23rd week of pregnancy. There will be no qualifying period before an eligible worker or employee could avail of parental bereavement leave and/or pay following a miscarriage, but–as with existing parental bereavement pay–there would be a minimum qualifying earnings threshold. Termination of pregnancy is not covered by the proposed legislation. The consultation sought views on whether it would be desirable, in all the circumstances, to require medical evidence for eligibility to be provided by a person intending to claim miscarriage leave and/or pay. The outcomes of the consultation were not publicly available at the time of writing this report.

Alberta

An amendment to Bereavement Leave legislation is proposed which would allow for three days' leave (in a calendar year) in any pregnancy that does not end in a live birth. The employee must give the employer as much notice as is reasonable and practicable n the circumstances ('Alberta Government Alters Bereavement Leave Legislation amid Abortion Debate', 2022; Bill 17 Labour Statutes Amendment Act, 2022, 2022, p. 1).

Nova Scotia

An amendment to Chapter 246 of the Revised Statutes, 1989, the Labour Standards Code (Bill 203 - Labour Standards Code (Amended), 2022, p. 203) will introduce pregnancy loss leave in Nova Scotia. An employee will be entitled to unpaid leave of absence up to five working days if they or their partner experience an 'end of pregnancy' up to the 19th week of pregnancy.

Catalunya

The Government of the Generalitat of Catalunya has agreed to provide public sector workers with three working days bereavement leave, if a woman or her partner loses a pregnancy between the 6th week and 179th day of pregnancy (workers who experience a pregnancy loss after 180 days are already entitled to maternity leave) (*El Govern de La Generalitat Incorpora Un Permís per Dol Gestacional En l'àmbit Laboral*, 2022; 'New Paid Miscarriage Leave for Public Sector Workers', 2022).

3.1.6 Summary

Only 10 out of 80 high income countries/jurisdictions assessed in this review provide statutory leave from work in the case of pregnancy loss before viability. As such, in most of high-income countries, women and their partners face either an immediate return to work or reliance on sick, annual, or other leave, while experiencing the physical, psychological, and social impacts of pregnancy loss.

The statutory leave provided in these 10 jurisdictions varies significantly in terms of length, eligibility, and conditions of leave. There are strengths and weaknesses of legislation that can be seen in each jurisdiction. Comparison is further complicated by differing legal systems, cultural attitudes towards pregnancy loss, and economies.

Across these high-income countries, the length of leave ranges from 2 to 60 days. Those who legislate for this leave under compassionate or bereavement grounds tend to offer short leave periods (Australia, New Zealand) or only to those with a later loss (Iceland). Countries with tiered leave based on gestation generally provide the upper range of leave (South Korea, Taiwan), but only for later losses. Countries whose leave is determined by medical staff exclude fathers and potentially fail to recognise the psychosocial impacts of pregnancy loss (Panama, Puerto Rico, Portugal).

Leave is usually paid, and most commonly by employers, at a full rate. Social welfare payments or use of the state treasury may alleviate financial strain on employers in some countries. Eligibility of employees who have experienced termination of pregnancy varies significantly between jurisdictions. The inclusion or exclusion may be reflective of legality or cultural attitudes towards termination of pregnancy in each jurisdiction.

3.2 Workplace policies in the Republic of Ireland

3.2.1 Background

There are no statutory workplace supports in the Republic of Ireland if a pregnancy ends before 24 weeks gestation; however, workplaces can develop and implement their own pregnancy loss policies. In recent years, many companies have introduced paid miscarriage or pregnancy loss leave for their staff, which has received coverage on social media and news outlets. For example, Bank of Ireland introduced early pregnancy loss leave this year (Walsh, 2023); Lidl recognised early pregnancy loss and miscarriage in their compassionate leave policy (three days of full pay) in 2021 (Neville, 2021); Vodafone introduced pregnancy loss leave for women and partners in 2022 (O'Callaghan, 2022); Pinterest offers four weeks of paid leave for miscarriage since 2022 (Darmody, 2021); and Diageo launched Pregnancy Loss Guidelines including paid leave in 2022 (Diageo, 2022).

We wanted to systematically explore what types of policies, if any, were available in workplaces in the Republic of Ireland, which support people following a pregnancy loss. Learning the extent of existing policies will provide another layer of understanding of workplace experiences of pregnancy loss and highlight if there is a need for legislative provisions. Additionally, existing policies could provide a framework from which statutory supports could be built on or around.

3.2.2 Methods

Sample selection

There is no central database or information source for workplace policies in the Republic of Ireland. Though some company policies are publicly available through news reports or social media (as highlighted above), it was beyond the scope of the project to conduct a media search of pregnancy loss policies. Furthermore, a systematic sampling method was necessary to increase transparency and replicability. Therefore, we used a purposive sampling strategy in order to identify and examine pregnancy loss policies across companies in the Republic of Ireland

within the time limits of the agreed programme of work. We selected two publicly available lists of 'best' companies or employers in Ireland as our sampling frame: (1) Best 150 Employers in Ireland, and (2) Best Workplaces - Small. We chose these as it could be argued that such companies have a greater likelihood of having a pregnancy loss policy given their recognised strong reputation for employee satisfaction and good employment conditions. In addition, these lists cover a range of public, private, and third sector organisations, and industries. The two lists are as follows:

The list of Best 150 Employers in Ireland 2021 (hereafter 'Best 150 Employers') was produced in collaboration between the Irish Independent newspaper and statistics company Statista, and published in the former in May 2022 (English, 2021; Irish Independent, 2022).This list ranks employers, in order of best employer, from 1 to 150. All companies employing more than 200 people in the Republic of Ireland (n= >800) were eligible for inclusion. Employees working for eligible companies (N= >6,500) evaluated their employer through online panels. Evaluations related to work environment, employer's reputation, and work conditions. The strength of this list is that the ratings are independent and confidential from employers; however, a limitation is that smaller companies (those employing <200 employees) are not included or represented. We therefore supplemented this list with another.

A list of great workplaces (hereafter, 'Best Workplaces') categorised into small, medium and large companies was compiled and published by Great Place to Work™ (Great Place to Work, 2022). Companies who participate in the Great Place to Work programme were eligible for inclusion in this list. The programme includes an employee experience survey, a company culture audit, a data report, and certification for those companies which score 65% or higher in their survey – and these are also included in the Best Workplaces list (Great Place to Work, n.d.). The employee experience surveys are distributed through the workplace and therefore are open to bias. Furthermore, only companies which pay to participate in this programme are eligible for inclusion. However, this list includes small companies (fewer than 250 employees) unlike the 'Best 150 Employers' list. The inclusion of small companies is vital to explore whether pregnancy loss policies are feasible for companies with fewer employees.

We included all companies on the 'Best 150 Employers' and 'Best Workplaces – Small' in our sampling frame. This comprised of 182 employers / companies in the

Republic of Ireland, with a range of 26 to over 28,000 employees, from a variety of industries such as pharmaceutical, retail, healthcare and hospitality.

Data collection procedures

Following the compilation of this list, a systematic approach was taken to contact these companies in order to learn about their pregnancy loss policies. Companies were contacted by a member of the research team between 19th October and 19th December 2022, inclusive.

First, the company's website was searched to find contact information for Human Resources (HR) personnel, or general contact information if the former was not available. There was a variety of communication forms available across companies including email addresses, phone numbers, live chat functions with virtual assistants, live chat functions with support staff, postal addresses, or webpage 'contact us' forms.

Initial contact was made, where possible, with each company who provided contact information. This initial contact consisted of an introduction to the research team, a brief overview of the research study, and a request for communication with HR personnel. Where HR contact details were not found, a second contact attempt was made. Where any member of staff refused to participate on behalf of their company, no further contact attempts were made.

Where no reply was received, a period of at least one calendar month was given before a repeated contact attempt was made. Where possible, an alternative form of communication was used for follow-up.

Where communication with HR personnel was established, a policy request email was sent directly to them. Details of the research, including hyperlinks to the Pregnancy Loss Research Group website, the PLACES Project webpage (Pregnancy Loss Research Group, 2023), and the Department of Children, Equality, Disability, Integration and Youth website. HR personnel were asked to share if their company had a policy on pregnancy loss under 24 weeks gestation. It was made clear that individual/company names would be kept confidential outside the research team; only pseudo-anonymised information would be publicly reported. Communication with informants included emails or phone calls, according to the preference of the informant.

Companies which had specific pregnancy loss policies were asked to share the following details:

- What type of leave does this fall under? (e.g. compassionate / miscarriage / family leave)
- What is the duration of this leave?
- Is this leave paid?
- Is an employee required to provide certification in order to access this leave?
- Is this leave available in the case of termination of pregnancy?
- Is this leave available to employees whose partners have experienced a pregnancy loss?

3.2.3 Results

Out of 182 companies on this list, the research team was able to contact 179. Within this sample, 13% (n = 23) responded to an information request. Of these, 17% declined or were unable to share policy information, and 83% (n = 20) responded with information.

The final sample included in this study comprised 20 companies, ranging from small (26 employees) to large (over 3,000 employees), and inclusive of industry types (e.g. retail, construction, research, healthcare).

Nine companies in this sample (45%) had a specific pregnancy loss policy in place, details of which they shared with the research team. An overview of these policies is displayed in Table 3.3.

Table 3.3 Details of pregnancy loss policies in companies based in the Republic of Ireland

Company Size	Leave type	Length of leave provided	Certification required to take this leave	Leave for partners	Termination of pregnancy included	Leave paid
> 250	Compassionate	5 days	No	Yes	Case by case	Yes
> 250	Bereavement	15 days	No	Yes	Yes	Yes
> 250	Bereavement	5 days	No	No	Yes	Yes
> 250	Miscarriage	20 days	Yes	5 days	Open to interpretation	Yes
> 250	Compassionate	Varies by gestation of loss: 1-3 months: 5 days 4+ months: 20 days	No	Unknown	Unknown	Yes
> 250	Compassionate	3 days	No	Yes	Yes	Yes
50 - 249	Parental bereavement	No specific limit	No	Yes	Yes	Yes
< 50	Miscarriage, stillbirths, and neonatal death	2 weeks	No, but can be extended with medical certification	At the discretion of company	At the discretion of the company	Yes
> 250	Compassionate	5 days	No	Yes	Yes	Yes

Conditions of leave

Of the nine companies that had a specific pregnancy loss policy, all provided paid leave. The length of leave provided ranged from 3 to 20 days. One company provided a longer duration of leave to those who have lost a pregnancy after four months gestation than for those who have experienced earlier losses. Over half (n = 5) of companies did not stipulate a timeframe in which the leave must be taken, while the remainder (n = 4) indicated that the leave should be taken immediately following the loss. No company imposed a limit on how many times an employee could access this type of leave.

Termination of pregnancy

Most (n = 5) also provided this leave to women who had experienced a termination of pregnancy. One company indicated that leave for termination of pregnancy was not specified in the policy, but discretion would be applied on a case-by-case basis. Another company indicated that their policy was open to interpretation on this matter, and a third reported that this could be given at the discretion of the company. One company did not report whether leave is available in the case of termination of pregnancy.

Partners

Two-thirds (n = 6) of companies had policies which included provision for partners to take a period of leave following their partner's pregnancy loss. One company explicitly did not, while another left it to discretion. One company provided 20 days of miscarriage leave to the woman who was pregnant, and five days to her partner.

Additional supports offered

Seven of the sample shared other supports they offered to employees who had experienced pregnancy loss under 24 weeks of pregnancy. Employee assistance programmes which provide counselling was the most common form of this support (n=6). One company allowed, where possible, employees to work flexibly on return; another emphasised that management should implement their policy with flexibility and compassion. Another company worked with an Irish miscarriage advocacy and support group to develop a guidebook for workplace supports for pregnancy loss, and introduced a buddy system for support. Direct leader support was introduced alongside EAP in one company, though the exact

details of the support provided were not elaborated upon by the company informant.

Just over half of the companies (n = 11, 55%) did not have a specific or formal policy for pregnancy loss in their workplace. Within this group some HR personnel explained that in lieu of a specific policy, employees may be able to access sick or compassionate leave, or be referred to the company's employee assistance programme.

3.2.4 Summary

Though an extensive list (N = 179) of companies were contacted, the sample who responded with information was small (N = 20), only 11%. Within this small sample, less than half of companies had a policy specifically for pregnancy loss under 24 weeks of pregnancy. While a number of companies that did not have a specific policy indicated that employees may be entitled to compassionate leave or other supports, a lack of specific policy may lead to confusion, stress, or inequality following a pregnancy loss. Though the final sample was insufficient size for statistical analysis, the presence or absence of a pregnancy loss policy does not appear to differ based on company size or industry type.

Within the nine companies which had a pregnancy loss policy, it was most common to provide at least one working week of paid compassionate leave to women and partners, without needing certification, each time an employee experienced a pregnancy loss. Most companies had an employee assistance programme which can be accessed for counselling support following a pregnancy loss.

Chapter 4. Phase 2: Survey study

Key messages

- This survey study included data from 913 participants
- Many women experienced physical effects of their pregnancy loss, including cramping, bleeding, fatigue, postpartum effects, or surgery complications such as infection
- Many women and partners went through a period of emotional upheaval, sadness, or grief
- The emotional and/or physical impacts of pregnancy loss affected individuals' ability to work, to carry on with normal life, and/or manage social interactions in the workplace
- Many participants took some time off work, which was important for physical and emotional recovery
- Often participants felt they had to return to work before they were ready, due to:
    - Lack of paid leave and cover
    - Pressure from their workplace
    - Feelings of guilt about being absent
- Most participants told somebody in their workplace (most often their manager or immediate colleagues) about their pregnancy loss mostly because of the need to:
    - Explain or access leave or supports
    - Talk about the loss for emotional support
    - Remove stigma, normalise the topic and create more supportive and understanding work environments
- Some people did not disclose their loss in their workplace (or only told select trusted people) as they felt it was a private matter or they did not want to get upset at work
- Many participants anticipated negative reactions or repercussions relating to disclosing their loss, ranging from insensitive comments or questions to discrimination at work in the form of dismissal or limited career progression or opportunities
- A need for statutory, protected, paid leave was expressed by most participants, who highlighted that:
    - Time away from work is needed to recover from pregnancy loss, without financial strain or fear of repercussions

    - There should be no limit placed on the number of times leave can be taken
- Workplace supports for employees on their return after a period of leave related to pregnancy loss are needed. These can involve:
    - Pregnancy loss policies and clear guidance on how to support workers who experience pregnancy loss
    - Training for management and staff about pregnancy losses, to facilitate an understanding and supportive environment
    - Flexible working arrangements, aligning with the employee's needs and requirements of the role
- There is a clear need for further dialogue, awareness and understanding on pregnancy loss in workplaces and wider society, to remove/reduce stigma, shame and confusion and enhance support.

4.1 Background

Though research on the topic of workplace supports for early pregnancy loss has increased in recent years (Brewis et al., 2023; Keep et al., 2021; Miller & Suff, 2022; Obst et al., 2022; Rose & Oxlad, 2022), no Irish studies have specifically focused on this topic. As countries have different legal structures, workplace cultures, and societal responses to pregnancy loss, this is an important knowledge gap to address, to ensure that future supports are relevant to the Irish context.

Qualitative data collection allows for greater insights into the phenomena explored and is particularly useful in under-researched areas. Quantitative data collection provides an opportunity to gather experiences from a wide range of people, increasing the generalisability and representation of the data. Mixed methods research allows for both broad and deep knowledge of a phenomenon. Given the relatively small number of studies regarding pregnancy loss in the workplace, and different experiences reported between workplaces and types of pregnancy losses, a survey tool adopting qualitative and quantitative approaches was employed to explore lived experiences of pregnancy loss in workplaces in the Republic of Ireland.

4.2 Methods

4.2.1 Survey design

A survey was purposefully developed for this study, drawing on items from pre-existing surveys: pregnancy loss experiences and supports in the workplace

(Brewis et al., 2023; Keep et al., 2021; Obst et al., 2022; Russell et al., 2011), types of pregnancy loss experienced (Flannery et al., 2022), participant demographics (Central Statistics Office, 2022a), and workplace characteristics (Central Statistics Office, 2022b). Though initially proposed as a primarily qualitative survey, a mixed methods survey was utilised, drawing on quantitative and qualitative measures used in recently conducted surveys in Australia (Keep et al., 2021) and the UK (Brewis et al., 2023). This enabled us to seek the views and experiences of a broad range and number of participants giving us depth of insight (Braun et al., 2021) - we did not seek to gather 'representative' data per se, as is typical in quantitative research.

The survey comprised both quantitative and qualitative questions. Demographic variables collected include age, educational attainment, sexual orientation, and ethnicity. Details of employment and roles were gathered (e.g. full-time/part-time or self-employed; public, semi-state, private, or third sector; size of organisation (small, medium or large); main activity/product of their employer; management/leadership role, if any; trade union membership; as well as pregnancy loss experiences including type of loss(es) experienced and how the most recent loss was managed. Participants were asked if they took leave after their loss and if there were any other supports available. Open-ended questions addressed the reasons they did or did not share their loss with their workplace; what made their return to work easier or harder; and what type of supports they felt were needed in the Republic of Ireland, including the potential provision of statutory leave and what they thought about this, including how long it should be and if there should be a limit on the number of times it could be taken.

This survey was hosted on the online survey platform Qualtrics. Responses to multiple choice questions were configured as forced response (i.e. compulsory to answer) to minimise risk of missing data. Open ended questions were optional, to enable people to move freely through the survey, providing a response to these questions if and when they wished to do so.

The survey tool was piloted with members of the Pregnancy Loss Research Group, including those who work directly with women affected by pregnancy loss, and people with lived experience of pregnancy loss. Phrasing of questions was refined based on feedback and discussions with members of the Group.

4.2.2 Sample selection and survey distribution

Women and men across the Republic of Ireland who met the following criteria were eligible to participate in the survey:

- aged 18 and over;
- lived experience of pregnancy loss under 24 gestational weeks (including miscarriage, termination of pregnancy, ectopic pregnancy, and molar pregnancy);
- most recent pregnancy loss (under 24 weeks gestation) occurring in the last five years;
- in employment/paid work; public/private sector, employed/self-employed, full/part-time or casual work, at the time of the loss;
- living in the Republic of Ireland at the time of their loss.

Online and paper posters were designed for this study and adapted to target specific populations (e.g. men and self-employed workers). These posters, alongside a hyperlink and QR code to the study, were shared on social media platforms (Twitter, LinkedIn, Instagram) through accounts managed by the Pregnancy Loss Research Group, as well as research member's personal and professional accounts. A number of stakeholders (e.g. trade unions, advocacy groups, support groups) assisted in recruitment by sharing via social media or their group's network. Physical posters were displayed across Cork University Hospital, Cork University Maternity Hospital, and University College Cork. Purposive sampling was employed as recruitment progressed to access groups who were under-represented within the sample (e.g. those who experienced termination of pregnancy, partners/fathers, self-employed, diverse ethnicities and sexualities, and people in precarious employment). Recruitment took place between 6th March and 25th April 2023.

We aimed to achieve a minimum sample size of 100. Based on previous research we felt that this would provide a rich dataset to address the research questions. Sample size is shaped by: the scope of the study and breadth of the topic; the research question (e.g., focused on experiences, perspectives, practices, or discourses); the characteristics of, and diversity within, the population; the motivation of participants; and, relatedly, the depth and detail of the individual responses (Braun et al., 2021; Malterud et al., 2016). Some of these cannot be entirely anticipated in advance, and dataset richness and ability to address the questions become more important considerations than reaching an exact number.

4.2.3 Ethical considerations

Ethical approval for the study was granted by the Clinical Research Ethics Committee of the Cork Teaching Hospitals [Reference number: ECM 4 (h) 13/12/2022 & ECM 5 (5) 21/02/2023]. Participants self-selected to take part in the survey. After clicking the online link or scanning the QR code, participants were presented with a participant information leaflet detailing the purpose of the study, potential risks and benefits of participation, and what was involved in participation. Hyperlinks to pregnancy loss supports and contact details of the research team were included. Participants were informed that they would be free to withdraw from the survey up to the point of completion. It was explained that responses were anonymous unless they left their names and contact details, and that results would be pseudonymised.

Following this information sheet, participants were presented with a consent form. Selection of 'Yes, I consent' brought the participant to the first survey question; selection of 'No, I do not consent' displayed the end of survey page, which included a list of pregnancy loss supports and contact details for the research team.

4.2.4 Data analysis

Incomplete responses (those who did not respond to the final question) were removed.

Quantitative data

Survey responses were downloaded from Qualtrics into IBM SPSS V28 (2021). Incomplete or ineligible responses were removed from the dataset. Participants were considered ineligible if they were outside the study inclusion criteria (i.e. did not experience a pregnancy loss under 24 weeks gestation within the preceding five years) or if their responses indicated that they were granted maternity leave, as this may have altered their pregnancy loss experiences significantly. Data were checked to ensure consistency across variables and no duplicate cases. Many of the survey questions were multiple choice questions, with the additional option of selecting 'other' and typing a unique response. These 'other' responses were manually re-categorised by the research team. Where a typed response had a suitable corresponding category, it was added to that category. Where multiple responses could be grouped, new categories were created. All remaining responses were reported as 'Other'. Certain multiple-choice questions allowed participants to select more than one option. Where applicable, these multiple

responses were reported. SPSS was used to analyse quantitative data. Frequency reports were presented using descriptive statistics, and further cross-tabulation analyses with chi-squared testing for association was carried out.

Qualitative data

Open-ended survey responses were downloaded from Qualtrics and imported to data analysis software – NVivo 12 (QSR International Pty Ltd., 2018) for analysis. Incomplete or ineligible responses were removed from the dataset. Participant names and contact details were removed from the dataset to protect their anonymity; however, a key was generated which would enable the research team to re-identify participants if needed, e.g. to make contact about interviews, resulting in a pseudo-anonymised dataset.

Reflexive thematic analysis of qualitative survey data was led by two members of the research team (RKH and MH). This involved a process of data familiarisation, data coding, and theme development (Braun & Clarke, 2022). A theme is a pattern of shared meaning underpinned by a central concept or idea. Each open-ended question was analysed separately, with themes generated by questions rather than across the entire qualitative dataset. Firstly, all responses were read and re-read by RKH and MH for familiarisation and any observations noted. RKH and MH then met to discuss these observations and how to proceed with the analysis. Subsequently, they each coded responses to particular open-ended questions, reviewing and revising codes as analysis proceeded. Initial themes were then actively generated for each question by examining the codes and reviewing the data excerpts. Themes were then written up for each question, checked against the coded data, and shared within a sub-group of the research team (RKH, MH and SL). The team reviewed these summaries and further developed the themes through discussion. A detailed analysis and write-up of each theme was then undertaken and final theme names agreed. RKH, MH, SL and KOD had frequent discussions about the data, preliminary codes and categories and reflected on their positionality in relation to these. Themes were also reviewed and discussed by the PLACES Project Team, and PPI contributors within the PLRG.

4.3 Results

A total of 1,434 people consented to participate in the survey. Of these, 277 were automatically excluded for ineligibility, for reasons including: no experience of pregnancy loss under 24 weeks in the past five years (n = 122); not engaged in

paid work at the time of loss (n = 10); loss before January 2018 (n = 62), not living in the Republic of Ireland at the time (n = 13); aged less than 18 years or above 55 years (n = 20). A further 288 participants did not complete the survey. Six participants were excluded due to qualifying for maternity leave.

In addition to the quantitative questions, participants were asked a number of open-ended questions where they could write as much detail as they wished to provide. This provided a deeper understanding of participants' workplace experiences and the kind of supports which could be provided.

From participants' responses to each open-ended question, themes were generated, with illustrative quotes from the survey provided. To contextualise these quotes, participants IDs are presented alongside the type of loss they experienced. Quotes from partners or fathers are also identified. Where responses differ between demographics, these differences are documented. Please note that the quotes are taken verbatim from participants' survey responses; they have not been edited for grammar or typographical errors. Where partial quotes are presented, text which has been removed is represented with an ellipsis (…). In cases where the meaning of words is unclear or acronyms are unlikely to be understood by the general population, an explanation is provided in square brackets. Expletives have been censored in this report. These qualitative results are presented alongside the quantitative questions to which they relate, where applicable.

Participants who had experienced multiple pregnancy losses were asked to answer survey questions based on their most recent loss under 24 weeks gestation. It should be noted that some participants reflected their experiences across the different losses that they experienced, not just their most recent one – often comparing and/or contrasting the type of loss, physical and emotional impacts, and workplace experiences.

4.3.1 Participant characteristics

In total, data from 913 participants were included in the analysis. The majority of participants carried the pregnancy (95%), were between the ages of 35 – 44 years (69%), had completed a university degree or higher award (88%), were heterosexual (98%) and were white Irish (96%) (Table 4.1).

Table 4.1 Participant demographic characteristics (N = 913)

Demographic	Response option	n (%)
Person who carried the pregnancy or not	I carried the pregnancy	863 (94.5)
	Partner / Father	47 (5.1)
	Other	3 (0.3)
Age (years)	18-24	9 (1.0)
	25-34	232 (25.4)
	35-44	630 (69.0)
	45-54	42 (4.6)
Education (highest level completed)	Secondary school	44 (4.8)
	Post secondary school training	69 (7.6)
	University Degree	261 (28.6)
	Postgraduate Certificate	214 (23.4)
	Postgraduate Degree	325 (35.6)
Sexual orientation	Heterosexual / straight	893 (97.8)
	Homosexual / gay / lesbian	2 (.2)
	Bisexual	13 (1.4)
	Pansexual	3 (.3)
	Prefer not to say	2 (.2)
Ethnicity	White Irish	876 (95.9)
	Any other White background	21 (2.2)
	Asian	3 (.3)
	Hispanic or Latino	5 (.5)
	Arab / Middle Eastern	2 (.2)
	Other	6 (.6)

Almost two thirds had at least one living child at the time of data collection (65%) and 42% of all participants had experienced more than one pregnancy loss in their lifetime (Table 4.2). Though not specifically asked, 15 participants mentioned in their survey responses that they were pregnant at the time of the survey.

Table 4.2 Participants' number of living children and pregnancy losses over lifetime (N = 913)

	Number	n (%)
Living children[a]	0	318 (35.0)
	1+	591 (64.7)
First-trimester miscarriage[b]	1	444 (48.6)
	2+	343 (37.6)
Second-trimester miscarriage[a]	1	123 (13.5)
	2+	26 (2.8)
Ectopic pregnancy[b]	1+	83 (9.1)
Molar pregnancy[b]	1+	38 (4.2)
Termination of pregnancy (<12 weeks)[c]	1+	40 (4.4)
Termination of pregnancy (>12 weeks)[c]	1	34 (3.7)
Stillbirth[c]	1	22 (2.3)
Neonatal death	1+	9 (1.0)
Infant death	1	3 (.3)
Embryo / IVF transfer failures / (HCG levels with no positive test (N = 1)	1	4 (0.4)
	2+	7 (0.8)
Pregnant at time of survey	-	15 (1.6)

[a] Missing data for 4 participants
[b] Missing data for 3 participants
[c] Missing data for 1 participant

4.3.2 Workplace and role characteristics

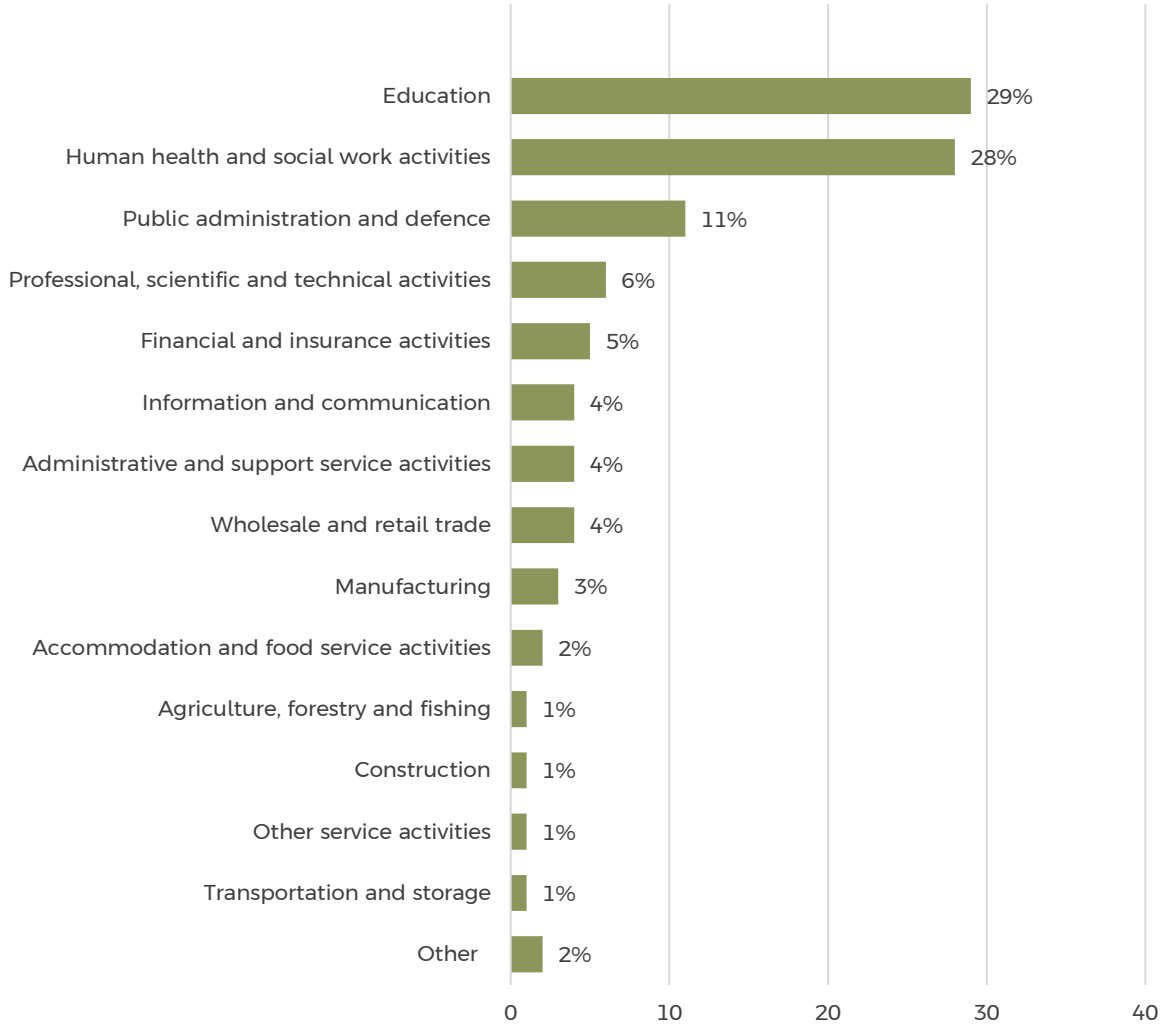
Details of participants' workplace and work role characteristics are provided in Table 4.3. Most participants worked on a permanent and full-time basis (89%) in the public sector (67%). Participants worked in a diverse range of company sizes. 41% of participants earned over €50,000 and 30% occupied a leadership or management role.

Table 4.3 Participants' workplace and work role characteristics (N = 913)

		n (%)
Type of Work	Permanent full-time	808 (88.5)
	Permanent part-time	63 (6.9)
	Temporary full-time	18 (2.0)
	Temporary part-time	1 (0.1)
	Casual basis	3 (0.3)
	Fixed period / fixed task contract	8 (0.9)
	Self-employed (no paid employees)	4 (0.4)
	Self-employed (with paid employees)	8 (0.9)
Sector	Public Sector	613 (67.1)
	Semi-state sector	18 (2.0)
	Private sector	243 (26.6)
	Third sector	31 (3.4)
	Unsure	8 (0.9)
Size of business	Small (<50)	234 (25.6)
	Medium (50 – 249)	126 (13.8)
	Large (250+)	540 (59.1)
	Unsure	13 (1.4)
Trade Union membership	Yes – I am a member of a trade union	545 (59.7)
	No – there was a trade union but I was not a member	133 (14.6)
	No – there was no trade union for my workplace	224 (24.5)
	Unsure	11 (1.2)
Gross income	< €20,000	36 (3.9)
	€20,000 - €35,000	186 (20.4)
	€35,000 – €50,000	307 (33.6)
	€50,000 - €70,000	274 (30.0)
	€70, 000 - €100,000	81 (8.9)
	> €100,000	29 (3.2)
Management role	Yes	276 (30.2)
	No	637 (69.8)
(If yes) No. of people under their management[a]	0	20 (7.2)
	1 – 10	180 (65.2)
	11 – 20	32 (11.6)
	21 – 50	21 (7.6)
	51 – 100	6 (2.2)
	100 +	5 (1.4)

[a] Missing data for 12 participants

The most common economic sectors where participants worked were education (29%) followed by human health and social work (28%) (Figure 4.1).



"Other" = Arts, entertainment and recreation; Water supply: sewerage, waste management and remediation; Electricity, gas, steam and air conditioning supply; Real estate activities; Activities of extraterritorial organisations and bodies; Mining and quarrying

Figure 4.1 Main activity / product of participants' employer / organisation (N = 913)

Most participants worked in a shared indoor space and did not have to travel regularly for work, outside of commuting. Those who carried the pregnancy were asked if they typically stood up for a long time at work – over two-fifths (42%) responded that they did. Many participants had regular contact with groups such as patients, customers, or students (Table 4.4).

Table 4.4 Work characteristics (N = 913)

		n (%)
Main space of work	Own space	171 (18.7)
	Shared space	583 (63.9)
	Own home	103 (11.3)
	Other people's homes	12 (1.3)
	Outdoors	7 (0.8)
	On the road	15 (1.64)
	Hybrid	19 (2.08)
	Other	3 (0.2)
Standing at work for a long time[a]	Yes	379 (41.5)
	No	481 (52.7)
Regular travel for work required	Yes	155 (17.0)
	No	758 (83.0)
Regular contact with:	Patients	184 (20.2)
	Customers	154 (16.9)
	Clients	191 (20.9)
	End users	66 (7.2)
	Students	303 (33.2)
	Parents of students / children[b]	21 (2.3)
	Babies / children	10 (1.1)
	Members of the public	4 (0.4)
	Other	17 (1.9)

[a] Only participants who selected 'I carried the pregnancy' were asked this question (N = 860)

[b] The following responses were typed by participants and grouped

Participants often had some or a lot of influence over their work tasks, and fewer had control over their break, starting, and finishing times (Table 4.5).

Table 4.5 Level of influence over daily work (N = 913)

	None at all / A little n (%)	Some / A lot n (%)
What kind of tasks you did	347 (38.0)	566 (62.0)
The pace at which you worked	353 (38.7)	560 (61.3)
How you did your work	267 (29.2)	646 (70.7)
The order in which you carried out your tasks	224 (24.6)	689 (75.4)
The times you started and finished work	513 (56.2)	400 (43.8)
When you could take breaks	442 (48.4)	471 (51.6)

4.3.3 Pregnancy loss experiences

Participants were asked about their most recent pregnancy loss under 24 weeks gestation. The most common pregnancy loss experienced by participants was a first-trimester miscarriage (75%), and 84% of losses occurred within the first 12 completed weeks of pregnancy (Figure 4.2).

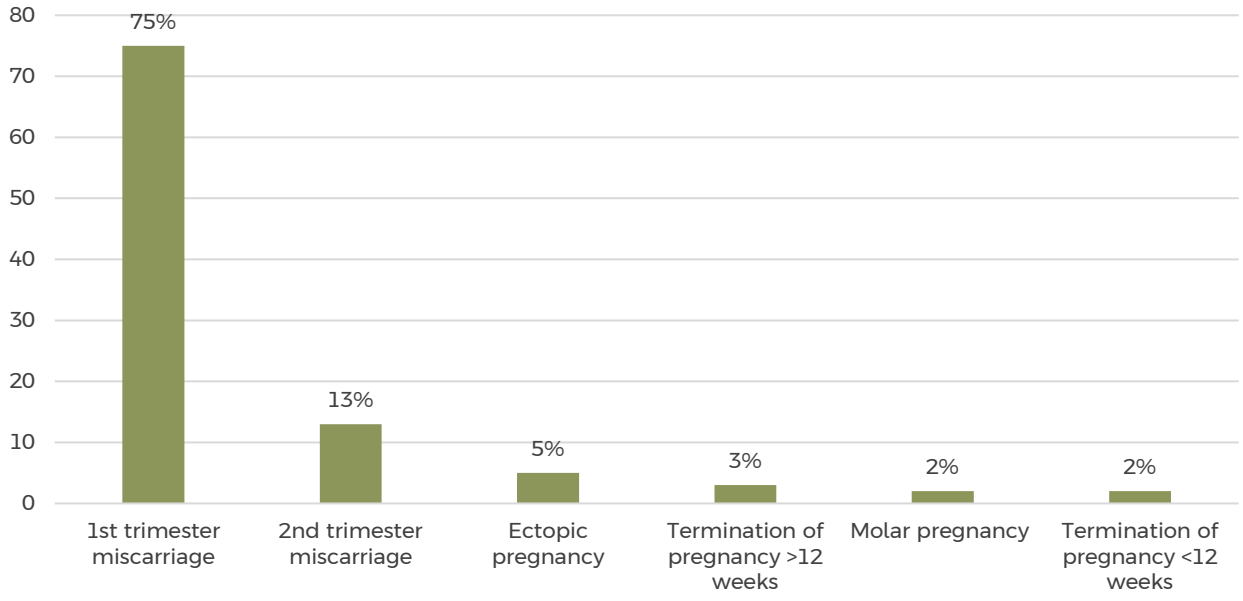


Figure 4.2 Participants' most recent type of pregnancy loss (N = 913)

Just over one-third (39%) of pregnancy losses were managed expectantly (i.e. no medical or surgical treatment), while almost one-third (29%) required surgical treatment; 6% of losses required multiple forms of management. These pregnancy losses were mostly managed at the hospital (41%), followed by at home (29%), and many were managed between both (17%). Ten participants mentioned that they travelled to the UK for a termination of pregnancy – of these,

nine participants experienced their loss since January 2019, when termination of pregnancy was legalised in the Republic of Ireland (Table 4.6).

Table 4.6 Participants' most recent pregnancy loss experiences (N = 913)

		N (%)
Weeks of loss[a,b]	$0 - 5^{+6}$	55 (6.0)
	$6 - 7^{+6}$	193 (21.1)
	$8 - 9^{+6}$	236 (25.8)
	$10 - 12^{+6}$	286 (31.3)
	$13 - 17^{+6}$	76 (8.3)
	18 – 24	61 (6.7)
Confirmed by ultrasound	Yes	574 (62.9)
	No	331 (36.3)
	Unsure	8 (0.9)
Type of management[c]	Expectant	355 (38.9)
	Medical	225 (24.6)
	Surgical	267 (29.2)
	Expectant + Medical	10 (1.1)
	Expectant + Surgical	2 (0.2)
	Medical + Surgical	37 (4.1)
	Expectant + Medical + Surgical	4 (0.4)
	Unsure	13 (1.4)
Location of management[d]	Home	263 (28.8)
	GP	5 (0.5)
	Hospital	377 (41.3)
	Home + GP	12 (1.3)
	Home + Hospital	127 (13.9)
	GP + Hospital	7 (.8)
	Home + GP + Hospital	24 (2.6)
	(Abortion clinic) in the UK	10 (1.1)
	Unsure	2 (0.2)
	Other	6 (0.6)

[a] There were 6 missing data points. Participants typed out responses which were subsequently categorised

[b] Timing of pregnancy loss is presented in weeks + days

[c] This question was not asked to those who experienced ectopic or molar pregnancy (N = 837)

[d] There were 4 missing data points / unclear responses

4.3.4 Pregnancy loss experiences at work: Disclosure

Participants were asked several questions relating to whether they disclosed their pregnancy and/or pregnancy loss within their workplace, and, if so, to whom and what their reactions were. Their responses are outlined in Table 4.7. While under half of participants (45%) had told their workplace about their pregnancy, 85% shared that they experienced a pregnancy loss with somebody in the workplace. Participants most frequently told their supervisor or direct manager (91%) and their colleagues (69%). Only 21% of participants disclosed their pregnancy loss to the HR manager / team. Of those who told somebody in their workplace about their loss, participants experienced a range of reactions, from supportive and understanding (71%) and helpful (43%) to criticism (2%), a lack of confidentiality (5%), or embarrassment (3%). Some participants reported that the people they told in their workplace did not know how to support them (14%) or were not well informed about pregnancy losses (9%). Furthermore, 8% of people were not offered any support from their workplace following disclosure of their loss (Table 4.7).

Table 4.7 Disclosure of pregnancy loss at work (N = 913)

		n (%)
Disclosed pregnancy	Yes	412 (45.1)
	No	493 (54.0)
	Not applicable	8 (0.9)
Disclosed loss	Yes	777 (85.1)
	No	136 (14.9)
Disclosed to[a]:	Direct manager / supervisor	707 (91.0)
	Colleagues / other staff	539 (69.4)
	HR manager / team	162 (20.8)
	Workplace doctor / nurse	44 (5.7)
	Trade Union representative	16 (2.1)
	Other management staff	5 (0.6)
	Other	4 (0.5)
	Clients / customers	3 (0.4)
Reactions received[a]:	They were emotionally supportive and understanding	555 (71.4)
	They were helpful	332 (42.7)
	They shared their own pregnancy loss stories	259 (33.3)
	They didn't know how to support me	106 (13.6)
	They weren't well informed about pregnancy losses	69 (8.9)
	They were surprised	67 (8.6)
	They didn't offer me any support	64 (8.2)
	They referred me to a helpline or to someone else	43 (5.5)
	They didn't say anything	39 (5.0)
	They didn't keep this information confidential	39 (5.0)
	They were embarrassed	24 (3.1)
	They criticised me	16 (2.1)
	They were distressed or upset	15 (1.9)

[a] Question asked if ticked 'yes' to disclosure of loss (N = 777). Participants could choose multiple reaction options or type a response.

Reasons for disclosing their pregnancy loss at work

The 777 participants (85.1%) that stated that they told someone in their workplace about their pregnancy loss were asked why they did so in an open-ended response question; 749 provided a response. Two themes were generated from this data which illustrate the main reasons why people disclosed their loss:

(1) Needed leave, to explain absence from work, or they know about the pregnancy
(2) For support and to increase awareness and understanding.

Theme 1: Needed leave, to explain absence from work, or they knew about the pregnancy

This theme describes reasons for disclosing pregnancy loss which could be described as outside of the individual person's control. Threaded through responses was the feeling that they had to disclose their loss to their employer (manager or HR representative) and/or colleagues, to validate the reasons for needing time off (or to secure a certain type of leave, usually 'sick leave'), and to gain more understanding from their employer. For some, this was particularly the case as they were relatively new in the role or company/workplace.

Participants primarily described how they felt they had to disclose their loss or explain their absence because they needed leave to recover, physically and/or emotionally, with some mentioning how they had been hospitalised or needed time off to undergo examinations or treatments (e.g. medical or surgical management) or because of complications experienced.

> I was booked to go into hospital to have an ERPC [Evacuation of Retained Products of Conception] so I had to book the time off. HR where informed and were exceptionally cold about my loss and just looked for proof of loss to confirm I could be paid sick pay. My line manager was horrified by this. (P109, First Trimester Miscarriage)

> I told my manager as I was grieving and needed to take time off work, I hadn't processed the situation well, was still on probation and was afraid if I didn't give a reason my career would be affected. (P680, First Trimester Miscarriage)

> I had to take annual leave to support my wife, there was an option to talk to my boss to see if he could grant special leave, however HR informed me it would not be guaranteed. I chose to take annual leave rather than get into any sort of discussions. (P888, First Trimester Miscarriage, Partner/Father)

> I knew I would be absent for a few days so I explained that I was having another miscarriage. It is hard to take time off in teaching without a good excuse. You quickly become labelled as lazy or a chancer for taking time off. Your absence as a teacher is an imposition on the school. (P364, First Trimester Miscarriage)
>
> So that they had complete understanding of why I was going to be on sick leave. So I would get some understanding from work. I only told one work colleague and my manager. Nobody else. This was to protect myself from gossip, ridiculous comments, suggestions and judgement. (P630, Second Trimester Termination of Pregnancy)
>
> I told them as you are interviewed over any work absences so I wanted to be honest so they would be empathetic if my work was affected (P812, First Trimester Miscarriage)
>
> It was an extremely busy time of the year and I felt guilty for taking time off, I had 2 weeks signed off and only took 1 week as I felt under pressure to return. (P827, First Trimester Miscarriage).

Some mentioned how they started to lose their pregnancy, or had perceived symptoms of same, at work (or partners who were informed of the pregnancy loss while at work), and/or had to leave work suddenly and therefore had to share the news with a colleague or management.

> It happened when I was working. I needed to leave and had to explain and then arrange cover for my class. (P429, First Trimester Miscarriage)
>
> I began to bleed in work and knew that I needed urgent care. I called my manager into a meeting room and let her know that I was in my second trimester of pregnancy and feared that I was losing the baby. (P778, Second Trimester Miscarriage)
>
> They found out because I was at work when my wife rang me and they heard me crying as I spoken to my Wife. I hadn't intended to tell them. Two friends at work knew but not the others until that point. (P395, Second Trimester Miscarriage, Partner/Father).

Some further stated that they disclosed as they needed someone to cover their role or work while they were absent.

> As I needed somone to take over my duties and needed a few days of work to have a medical termination. (P179, Second Trimester Termination of Pregnancy)
>
> I needed to inform my principal discretely as I would need to have cover available for access to bathroom frequently to change feminine towels due to bleeding after surgical intervention. The surgery was completed after working hours on a Friday to remove the pregnancy so this did not need to be communicated, I only communicated for my workplace safety. I also needed to miss two days to recover after infection, this is covered under

> substitute allowed medical leave so I needed to inform so she could get cover for my class. (P70, Ectopic Pregnancy).

Many spoke about how their employers/colleagues had known about their pregnancy and thus needed to be informed that it had ended also. For some, they felt they had to disclose their pregnancy, for various reasons, including COVID-19 guidelines, health and safety procedures, and maternity leave notification periods, or that it was obvious that they were pregnant as they were 'showing'. Resultantly they then had to tell them when precautions and/or maternity leave were no longer needed, or they did not return with a live baby.

> I voluntarily told them about the pregnancy so that my goals, workload and time off could be arranged well in advance. When I lost the baby I had to let them know that those accommodations were no longer needed. (P249, First Trimester Miscarriage)

> I work in a dental practice so it was necessary for them to know so I wasn't near xrays. I couldn't go back to work after my loss for a few weeks so I had to tell my boss. (P34, Molar Pregnancy)

> I told a few colleagues that I was close to about the pregnancy and loss but also as I worked with clients who have behaviours of concern I had to tell my colleagues for safety too. (P72, First Trimester Miscarriage)

> Everyone knew I was pregnant. I was very obviously showing. (P456, Second Trimester Termination of Pregnancy)

> I had already told them about my wife being pregnant and then it was only the normal thing to yell [tell] them we had had the loss. And so they would not be asking about how my wife was with the pregnancy. That would have been more hurtful than telling them. (P608, First Trimester Miscarriage, Partner/Father).

Some also mentioned that they had told their employer/colleagues about their pregnancy as they had been undergoing fertility treatment, or they had a previous pregnancy loss.

> Colleagues because it impacted on the service and the organisation of appointments. I felt a lot of pressure at this time because I was doing IVF and needing time off work. Colleagues were becoming frustrated because I was missing work, wasn't being covered and clinics couldn't run to capacity. (P901, First Trimester Miscarriage).

> Had told my line manager about pregnancy early as had a few appointments and scans with early pregnancy unit due to pregnancy loss in the previous pregnancy. Told the staff I line manage when pregnancy loss was identified in a scan at 8 weeks as I was intended to take two weeks unexpected leave. (P904, First Trimester Miscarriage).

A few mentioned how their sick certificate noted pregnancy loss and/or was from a maternity hospital and thus disclosure was not a choice for them.

> I told my manager when I phoned in sick, he is a very nice man and a good boss and I felt he should know. I did not want to inform HR but my employer insists that a sick cert state what exactly is wrong with you. (P613, First Trimester Miscarriage)

> In order to take sick leave. My sick note was also on headed paper from the hospital so I felt I had to explain. (P69, First Trimester Miscarriage).

Theme 2: For support, and to increase awareness and understanding

This second theme encompasses factors which are more related to what the employees themselves wanted employers/colleagues to know or provide, most often related to support and increased awareness and understanding around pregnancy loss. The people that participants most often referred to in responses were colleagues that they worked closely alongside, whom they were friendly with and/or trusted, and whom they wanted to tell of the pregnancy loss. Wanting people to know so that they could provide support was a key issue.

> Felt comfortable telling them - friend and mentor. Had told them about the pregnancy because we worked closely together. (P4, First Trimester Miscarriage)

> Told some of my close work colleagues/friends for additional support (note that on previous losses I probably wasn't as open or didn't know what I needed best to help me). (P264, First Trimester Miscarriage)

> As I was hoping for understanding and support. I was devastated and struggling to function so I hoped telling them would lead to more understanding about what was going on. (P664, First Trimester Miscarriage)

> We are quite close. I wanted them to know. They were very kind and supportive. I didn't consider not telling them. (P121, Second Trimester Miscarriage).

> Because it was a painful and horrific experience and we were burying our little boy and invited some of our work colleagues to come to his burial and it gave us strength. (P335, Second Trimester Miscarriage).

Telling people so that it would make their return to work easier was also frequently mentioned; this could be telling people themselves, or asking a manager to do it on their behalf. This was seen to help in the context of people knowing what had happened, to explain why they might be acting a particular way (e.g. upset, not working to full capacity) or needing more flexible work

arrangements (e.g. reduced hours, work from home, or avoid certain tasks such as heavy lifting, travel or certain meetings/interactions).

> ...was in hospital and needed to take sick leave. Everyone knew at work I was pregnant (18 weeks). I felt I needed people to know I had lost the pregnancy before I returned. They also needed to know so they could support me. (P114, Molar Pregnancy)

> I felt I wanted people to know why I was absent before I went back so I asked my manager to discretely inform senior team members. My colleagues are all caring people. I felt they would ask in concern why I was off when I returned to work. I did not want to discuss it in the workplace and I did not want to feel I had to be evasive either. It was a good decision. (P294, First Trimester Miscarriage)

> So they could understand why I was not working at full capacity. For support. For help with tasks. (P365, First Trimester Miscarriage)

> I was very upset and very sore and could do no bending over. I had to tell them so it would let them know I may take breaks when upset. (P106, Ectopic Pregnancy)

> After the miscarriage I was emotionally traumatised and vulnerable. I needed time off work while I dealt with the loss and when I returned to work I was still upset and distracted. I needed to tell colleagues as the loss impacted me severely and I was not able, nor was I willing, to hide the reasons why I was so upset and needing time to return to full duties. (P136, Second Trimester Miscarriage)

> I was unusually upset over a very minor thing that happened in work and unexpectedly burst out crying ... I then felt I had to explain why I was so emotional and tearful. (P811, First Trimester Miscarriage)

> I told my principal as well as one or two colleagues who I was working closely with. The reason I had to tell the principal was for time off to support my wife and mind my son. The reason I told my colleagues was because I needed people to understand that things were tough at home, as I felt that my work ethic/energy was suffering. (P671, First Trimester Miscarriage, Partner/Father).

Telling people was also seen by some as a way of formally acknowledging their pregnancy and their pregnancy loss. It was considered an opportunity for increasing awareness of pregnancy loss and reducing the perceived silence, stigma and shame around it. For some telling people within their workplace who also had lived experience of pregnancy loss helped, as well as seeing themselves as a potential source of support for others who may be going through similar experiences.

> It helped me grieve. My colleagues also told me ourv[of] their miscarriages also. It gsve [gave] me hope in the future. (P29, Ectopic Pregnancy)

> I feel silence around pregnancy loss leads to further taboo. When it is spoken openly it often encourages others to speak out and create a culture of support. (P471, First Trimester Miscarriage)
>
> Because I wanted to acknowledge that I was pregnant and that even at 8 weeks this was my baby. (P637, Molar Pregnancy)
>
> I told people because it happened and I was very sad about it and I don't believe in hiding it. (P851, Second Trimester Miscarriage).

Despite the need for openness for some, a few people who had terminations (for any reason) noted that they did not reveal the true reason for their pregnancy loss, with their being even greater stigma around certain types of pregnancy loss.

> I told one colleague who was like a maternal figure to me. I did not reveal it was an abortion and instead claimed it was a miscarriage. This was during a conversation about my upcoming birthday and it was part of an explanation of why I didn't want it celebrated in the work place. (P681, First Trimester Termination of Pregnancy)
>
> I had disclosed my pregnancy to the other staff members when I was 13 weeks. The school had shut due to the start of the pandemic when we found out our baby boy had foetal anomalies. After the trauma of the termination I told another teacher with whom I am close. I told the other staff members I had a late miscarriage as they were enquiring after the baby. (P837, Second Trimester Termination of Pregnancy).

Reasons for not disclosing their pregnancy loss at work

As noted above (Table 4.7), 136 participants (14.9%) stated that they did not tell anyone in their workplace about their pregnancy loss. When asked their reasons as to why they did not disclose their loss, 131 participants provided a response, many of whom had a first trimester miscarriage. Four themes were generated from this data which illustrate the main reasons why people did not disclose their loss:

(1) Didn't want or feel able to discuss, often due to grief, shame or guilt, or the perceived validity of the pregnancy or loss
(2) Impact on how they were perceived as a worker and on career opportunities
(3) A private matter, not 'the subject of gossip'
(4) Lack of support(s) anticipated or available in the workplace.

Theme 1: Didn't want or feel able to discuss, often due to grief, shame or guilt, or the perceived validity of the pregnancy or loss

Participants – many of whom had first trimester miscarriages – spoke about how they felt unable to disclose or speak about their loss due to the uncontrollable grief and emotions that they experienced. They didn't want to expose themselves to situations in which they would be questioned or sympathised with, and did not want to cause upset or discomfort to other people (e.g. their co-workers, children in class, partner). Some spoke about just wanting to 'get on with it' as a coping mechanism, often where multiple losses were experienced.

> I felt so upset that I couldn't talk to my boss about it. I said nothing. I needed to deal with it myself first. (P411, First Trimester Miscarriage)
>
> felt I wasn't able. I was a wreck. It would have meant a lot of tears which isn't ideal with a classroom of children. (P738, First Trimester Miscarriage)
>
> I was struggling to cope myself with stigma and shame. Felt too personal/ too raw to disclose to outsiders. (P692, First Trimester Miscarriage)
>
> It was our third loss and I didn't feel the need for everyone in my workplace to know what we were going through. It's horrible to say, but both me and my wife just got on with it. (P780, First Trimester Miscarriage, Partner/Father)
>
> I guess I didn't really want people to be feeling sorry for me and sympathising with me. It felt easier to compartmentalise it. Actually going back to work (when I was able) helped me focus on something other than the loss. Having people bring it up in work would not have been helpful really. (P488, First Trimester Miscarriage).

Shame and fear of judgement permeated some accounts, with people stating that they did not disclose their loss as 'it was early' (or unplanned) and would not perhaps be perceived as 'valid' in its own right, or as a later loss would be.

> Grief and I felt stupid grieving after a 7 week pregnancy. (P74, First Trimester Miscarriage)
>
> Too personal, did not want anyone to know we were TTC [trying to conceive]. Did not want anyone to minimise or belittle my experience because it was so early (6 weeks). (P614, First Trimester Miscarriage)
>
> It was too early on. It felt like telling people at that stage or afterwards was looking for attention. (P553, First Trimester Miscarriage)
>
> Nobody knew we were expecting. We didn't want to tell anyone until after 3 months and also after the result of the harmony test. We decided to terminate the pregnancy on the basis of that result and told absolutely nobody about it. (P789, First Trimester Termination of Pregnancy).

Theme 2: Impact on how they were perceived as a worker and on career opportunities

Participants – again many of whom had first trimester miscarriage – spoke about how it could be risky to disclose their pregnancy loss at work, as it could impact on: how they were perceived in terms of their ability to undertake their job, career progression opportunities, and how they were treated in general. They did not want to be treated differently. Some mentioned how this was particularly a factor as they had recently changed jobs (within the same company, or had moved employer), returned from maternity leave, or had a recent loss or losses.

> I felt I would have been told I am making excuses for my work not being up to my usual standard. (P83, First Trimester Miscarriage)
>
> Because it was early on in the pregnancy and I wasn't long return from maternity leave, I expected judgement and fallout. (P459, First Trimester Miscarriage)
>
> I had commenced a new role following promotion and felt this would undermine my commencement. The role was new but it was in the same workplace I had been in for a number of years. (P98, First Trimester Miscarriage)
>
> Did not take time for the most recent as had taken time for previous and for ectopic surgery earlier in the year and just didn't want to make a fuss and wanted to get on with it as it kept happening and I can't keep taking time off each time it happens. (P40, First Trimester Miscarriage).

Related to this was how some participants did not disclose their loss – and for some, their pregnancy – as they did not want their employer to know that they were 'trying for a baby' and may be taking maternity leave in the near future. Accordingly, some felt awkward about disclosing the loss when they hadn't disclosed the pregnancy. Some just generally noted the awkwardness that they felt around this more generally and that it was a difficult topic to raise.

> I didn't want knowledge of my trying to conceive to impact my progressions and opportunities at work. While this was never an overt concern, I personally didn't feel like it was information I wanted my employer to know. (P77, First Trimester Miscarriage)
>
> Didn't see any point. Was not entitled to any leave for pregnancy loss. Was afraid it would mean people looking at me for future pregnancies and affect roles etc I was offered in my job if people knew I was trying to expand family. (P727, First Trimester Miscarriage)
>
> They didn't know I was pregnant in the first place. If I had told them I would have worried about their reactions, like what they might have said. (P571, Second Trimester Miscarriage)

> Hadn't told anyone about the pregnancy, so felt it wasn't right to share about the miscarriage. (P419, First Trimester Miscarriage).

It should be noted that a few people mentioned that they didn't feel the need to disclose as they didn't need support, or were working from home, or on leave from work or out of term time when the loss happened.

> As I was working from home and could do my work remotely from my bed therefore no one needed to know as I could work and attend appointments/ stay in bed. (P500, First Trimester Miscarriage)

> I am an academic and it was outside the teaching term so I didn't have to- I would have been working from home/ researching. I was very sore and physically I'll after surgery with a bleed and antibiotics required so I did not want to talk to anyone. (P398, Ectopic Pregnancy).

Theme 3: A private matter, not 'the subject of gossip'

Confidentiality within the workplace, or lack thereof, was a key concern. Some participants spoke about how 'it was none of their business' and that they did not want to be 'the subject of gossip', while others stated that it was a personal matter and they were private people. A few mentioned how they had previous experience – directly or indirectly – of knowledge of their loss becoming widely known within their workplace, against their wishes.

> My principal is not trustworthy and he would tell all staff why I was off if I'd have taken leave. I told the gynae ward to give a sick cert to say I'd been at the gynae ward with no other details. A fellow teacher experienced a pregnancy loss at the same time as me. She told him and asked that he not tell anyone. Everyone was told unbeknownst to her, poor girl. (P510, First Trimester Miscarriage)

> I saw the way a pregnancy loss became public knowledge for others within my workplace. I didn't want that. I was in shock that I was pregnant as I had been told previously it was virtually impossible to become pregnant, so I wanted to deal with all myself without an audience. (P728, First Trimester Miscarriage).

For some, they felt uncomfortable sharing their loss with a particular person within the workplace – their line manager, or the person deputising in their absence. For a few there were particular issues that they wished to keep private; for example, that they had IVF, that they or their family were going through a difficult time, or that they had terminated their pregnancy due to fetal anomalies.

> Concern about gossip, pity etc...Situation was very complex- cervical ectopic and didn't want to have to explain personal health matters. (P619, Ectopic Pregnancy)
>
> At this stage in my life & career, I do not trust most people at work. We have toxic people in our department, my managers are very immature & the environment is dysfunctional. I share as little personal information as possible. (P632, First Trimester Miscarriage)
>
> I work with a young all female staff. Currently 2 members of staff are pregnant. One member is a Special Needs Assistant who is 6 months pregnant and is full-time with me in the classroom. Just didn't want the staff to know. Will bear the grief in silence. (P789, First Trimester Miscarriage)
>
> Shame, guilt, needed to travel to UK, as anomalies were not fatal and I was over 12weeks gestation (P305, Second Trimester Termination of Pregnancy).

Some participants felt that it wasn't relevant – or appropriate – to their work, or workplace, or that they didn't need support, many of whom identified as the partner or father of the baby:

> I am quite a private person. Further, given how early the loss was I did not see it as something I should talk about. Finally, I wasn't impacted much by the loss and therefore didn't feel the 'need' to talk to anyone. (P790, First Trimester Miscarriage, Partner/Father)
>
> Didn't feel it was appropriate/relevant. (P31, First Trimester Miscarriage)
>
> It didn't affect the work and I had no trauma or need to confide in anyone other than my wife. (P623, First Trimester Miscarriage, Partner/Father).

Theme 4: Lack of support(s) anticipated or available in the workplace

Participants spoke about how they did not think that people in their workplace would demonstrate understanding or support were they to disclose their loss, so they did not. For others, they did not perceive that any supports (such as dedicated leave) were available so there was no point in disclosing.

> I don't feel there's any support or understanding. I've also gone through IVF and feel there is no support and understanding. I need to attend appointments but use my own leave and haven't felt there is anyone I could share this information with who would understand. (P816, First Trimester Miscarriage)
>
> I felt they would not understand the scale of it, would not see it as a major issue. (P663, First Trimester Miscarriage, Partner/Father)
>
> I was so upset but my work involved supporting others, and management in general was unsupportive of my excessive work load so I didn't think my

> disclosure of miscarriage would make any difference. (P899, Second Trimester Miscarriage).

For some, this went further. They perceived that judgement and questioning would ensue were they to disclose their loss, and so they did not do so.

> Wanted to grieve in privacy, space to conceive again without pressure or questions. (P463, First Trimester Miscarriage)
>
> Fear of judgement. I'm a midwife and even though I and many of my colleagues are strongly pro choice, I still feared I would be judged. (P783, First Trimester Termination of Pregnancy).

A few participants mentioned that they did not disclose their loss as they had to keep working, due to a lack of other staff to replace them and/or the demands of their job.

> It was my third loss in a row. I was deflated, sad and unwell but needed to put on a front at work to keep the pharmacy open. (P754, First Trimester Miscarriage)
>
> I worked in a hospital and it was April/May 2020. The miscarriage started after midnight while I was midway through a 16 hour shift. I was working alone so I couldn't just leave. I had to carry on working and was just glad that all the PPE hid my tears. (P874, First Trimester Miscarriage).

Some cited that they did not disclose their pregnancy loss because they worked in a male-dominated industry or workplace and did not feel comfortable discussing it. The opposite was also observed however, with some participants stating that they did not disclose as they felt awkward working in a place where the majority were female, with some pregnant and/or trying to conceive.

> I worked with two men in a startup. It would have made me seem unreliable. (P362, First Trimester Miscarriage)
>
> We have a primarily female team, most of which are beyond child-bearing age. They regularly "joke" and comment about how one of the younger team members taking maternity leave would be bad for the team and for the individual (career-wise) so I didn't feel comfortable sharing my loss. (P839, First Trimester Miscarriage).

4.3.5 Pregnancy loss experiences at work: Leave

Most (77%) of the participants took some time off work following their pregnancy loss (Table 4.8). This most commonly took the form of paid sick leave (78%) and ranged from less than one week to more than six months. Just under a third of participants took between two weeks and one month off work. Over half of those

who took leave were required to provide medical certification in order to take this leave.

Table 4.8 Leave and characteristics of leave taken by participants (N = 705/913; 77%)

		n (%)
Type taken[a]	Annual leave	79 (11.8)
	Bereavement leave	9 (1.3)
	Compassionate leave	24 (3.6)
	Force majeure leave	5 (0.7)
	Maternity / paternity leave	4 (0.6)
	Miscarriage / pregnancy loss leave	7 (1.0)
	Parental leave	6 (0.9)
	Paid sick leave	521 (77.5)
	Unpaid leave	100 (14.9)
	Other	14 (2.1)
Length of leave[b]	Less than 1 week	90 (9.9)
	1 – 2 weeks	151 (16.5)
	2 – 4 weeks	261 (28.6)
	1 – 2 months	117 (12.8)
	3 – 6 months	52 (5.7)
	More than 6 months	9 (1.0)
Certification Required	Yes	445 (48.7)
	No	314 (34.4)
	Unsure	26 (2.8)
	N/A	128 (14.0)

[a] Participants could choose multiple responses or type a response

[b] 25 participants took an unspecified / unclear amount of leave

The length of leave taken by participants was statistically associated with the type of pregnancy loss experienced ($p<0.01$) (Table 4.9). A higher proportion of individuals who experienced a first trimester loss (miscarriage or termination) did not take leave (24%), or took less than one week (28%), whereas a significantly higher proportion of those who had a second trimester loss (miscarriage or termination) or other pregnancy loss (ectopic, molar, or other) took 3-4 weeks of

leave (26% and 25%, respectively). The percentage of individuals taking more than one month of leave was highest in the group who experienced a second trimester pregnancy loss (40%).

As seen in Table 4.9, the majority of individuals who did not disclose their pregnancy loss in workplace did not take any leave (58%), whereas a statistically significant higher percentage of those who disclosed their loss took longer lengths of leave (23%: 1-2 weeks, 22%: 3-4 weeks and 17%: > 1 month, p< 0.01).

Another aspect associated with length of leave taken after pregnancy loss was the type of pregnancy loss management strategy required (Table 4.9). Unsurprisingly, a significantly higher percentage of individuals who experienced expectant management of their pregnancy loss did not take leave (32% vs 15% for medical management and 15% for surgical management) or took less than one week of leave (31% vs 16% for medical management and 21% for surgical management). The reverse was also somewhat observed with higher proportions of individuals who required medical or surgical management of their pregnancy loss taking three to four weeks, or more than one month, of leave.

Table 4.9 Length of leave taken by disclosure of loss, type of pregnancy loss, management of the loss and number of losses

	Did not take leave n (%)	**Less than 1 week n (%)**	**1-2 weeks n (%)**	**3-4 weeks n (%)**	**More than 1 month n (%)**	***Total n (%)***
Disclosure of loss*						
No	79 (58.1)	34 (25.0)	12 (8.8)	4 (2.9)	7 (5.1)	*136 (100)*
Yes	120 (15.4)	181 (23.3)	181 (23.3)	167 (21.5)	128 (16.5)	*777 (100)*
Total	*199 (21.8)*	*215 (23.5)*	*193 (21.1)*	*171 (18.7)*	*135 (14.8)*	*913 (100)*
Type of loss*						
First trimester loss	168 (24.3)	193 (28.0)	160 (23.2)	114 (16.5)	55 (8.0%)	*690 (100)*
Second trimester loss	19 (12.9)	12 (8.2)	20 (13.6)	38 (25.9)	58 (39.5)	*147 (100)*
Other	12 (15.8)	10 (13.2)	13 (17.1)	19 (25.0)	22 (28.9)	*76 (100)*
Total	*199 (21.8)*	*215 (23.5)*	*193 (21.1)*	*171 (18.7)*	*135 (14.7)*	*913 (100)*
Pregnancy loss management*						
Expectant	114 (32.1)	109 (30.7)	64 (18.0)	37 (10.4)	31 (8.7)	*355 (100)*
Medical	36 (15.3)	38 (16.2)	45 (19.1)	68 (28.9)	48 (20.4)	*235 (100)*
Surgical	46 (14.8)	65 (21.0)	81 (26.1)	63 (20.3)	55 (17.7)	*310 (100)*
Total	*196 (21.8)*	*212 (23.6)*	*190 (21.1)*	*168 (18.7)*	*134 (14.8)*	*900 (100)*

	Did not take leave n (%)	Less than 1 week n (%)	1-2 weeks n (%)	3-4 weeks n (%)	More than 1 month n (%)	*Total n (%)*
Number of losses**						
1 pregnancy loss	90 (21.5)	96 (23.0)	88 (21.1)	85 (20.3)	59 (14.1)	*418 (100)*
2 pregnancy losses	54 (22.2)	65 (26.7)	50 (20.6)	42 (17.3)	32 (13.2)	*243 (100)*
3 or more pregnancy losses	52 (21.7)	51 (21.3)	53 (22.1)	41 (17.1)	43 (17.9)	*240 (100)*
Total	*196 (21.8)*	*212 (23.5)*	*191 (21.2)*	*168 (18.6)*	*134 (14.9)*	*901 (100)*

*p < 0.01, ** p > 0.05; [a] Other includes Molar or Ectopic pregnancy

There was no significant difference in the length of leave taken based on participants' work sector (public / private) or size of organisation. Similarly, there was no difference in length of leave or percentage of individuals taking leave, according to professional activity group or professional position (management position or not).

4.3.6 Pregnancy loss experiences at work: Returning to work

Those who returned to work immediately after their pregnancy loss did so for a variety of reasons such as workload pressures (40%), an expectation to return (29%), or because they did not want to tell anybody in their workplace about their loss (46%) (Table 4.10). A third of participants did not want leave or felt able to return immediately. Sixteen participants (1.8%) did not return to work for the same employer following their pregnancy loss.

Table 4.10 Returning to work, no leave taken (N = 196/913; 21.5%)

		n (%)
Reasons for return[a]	I didn't want to tell anyone at work about my loss	84 (46.2)
	Work load pressures	73 (40.1)
	Expectation to return	53 (29.1)
	I felt able to return immediately	35 (19.2)
	Financial necessities / pressures	23 (12.6)
	I didn't have any leave that I could take	23 (12.6)
	I did not want leave	20 (11.0)
	Fear of missing promotion / career progression	18 (9.9)
Other arrangements	Engaged in flexible work	91 (10.1)
	Did not return to the same employer	16 (1.8)
	Returned to a different role	6 (0.7)

[a] Participants could choose multiple reasons or type a response. Typed responses were then re-categorised.

The majority of participants (85%) found it difficult to return to work (Table 4.11). Just under half of women experienced physical effects of pregnancy loss whilst at work. Most participants (69%) were not offered a referral to a support organisation from their workplace, of which 46% would have liked a referral (Table 8).

Table 4.11 Experiences of returning to work (N=913)

	Response	n (%)
Difficult to return	Yes	776 (85.0)
	No	137 (15.1)
Physical effects at work[a]	Yes	414 (48.1)
	No	419 (48.7)
	I don't know / I can't remember	27 (3.0)
Offered referral to a support organisation	Yes	81 (8.9)
	No	633 (69.3)
	I did not want a referral	91 (10.0)
	N/A	108 (11.8)
Would have liked referral[b]	Yes	289 (45.6)
	No	126 (21.5)
	I don't know	218 (34.4)

[a] This question was only asked to those who ticked "I carried the pregnancy" (N = 860)

[b] This question was only asked to those who ticked "No" when asked if they were offered referral (N = 633)

Most difficult thing about returning to work after pregnancy loss

Of the 776 participants who stated they found it difficult to return to work after pregnancy loss, 754 provided further detail on what they considered the most difficult thing about it. Three main themes were generated from these responses:

(1) The emotional, psychosocial, and physical impacts of the pregnancy loss
(2) Returning to work life, having the ability to carry out tasks or manage the workload, and dealing with specific roles or duties
(3) Social interactions in the workplace, dealing with other pregnancies, births, or children, the impact of not disclosing your loss or the conversations and responses from other people when you did disclose your loss.

Theme 1: The emotional, psychosocial, and physical impacts of the pregnancy loss

Participants described feelings such as sadness, anxiety, distress, guilt, and devastation following their loss. People were emotional and afraid of getting upset at work or crying in front of colleagues or clients. The grief of losing a pregnancy or a baby was discussed often, as well as the sense of loss about the future they had planned. Some participants were traumatised by their experiences of pregnancy loss. Returning to the workplace was especially difficult for some participants as they lost the pregnancy at work.

> Trying not to get upset during the working day (P159, Second Trimester Miscarriage)
>
> I felt overcome with grief and was trying to make sense of what happened. (P334, Second Trimester Miscarriage)
>
> Readjusting my life plan, had been looking ahead towards maternity leave, mapping out my future. Going back to work meant accepting that path is gone. (P283, First Trimester Miscarriage).

Participants often described the physical effects of the loss to be the hardest part of the experience. Pain, bleeding, and fatigue/exhaustion were common impacts of the pregnancy loss and made it difficult to work. Some participants experienced complications or faced multiple hospital appointments or re-admissions to manage their loss.

> I was still bleeding and I had a few gushing experiences where I leaked through my clothes onto my seat. (P43, First Trimester Miscarriage)
>
> Being physically and emotionally drained and being expected to return to full duties immediately without any acknowledgement of pregnancy loss. Being told "Oh well these things happen" and then being forced to continue working gruelling on call shifts. (P241, Second Trimester Miscarriage)
>
> Physically tired. Emotionally not well. Having to put on a smile for 28 pupils and try to be a good teacher while grieving. I went back too soon and ended up taking a month off, two months later. (P505, First Trimester Termination of Pregnancy)
>
> I felt extreme physical pain- labour pain- and could feel my pregnancy passing while trying to be mentally present to 5 year old children. It was the hardest thing I've ever had to do in my life. (P512, First Trimester Miscarriage)
>
> I lost my baby over a 3 week period at 22 weeks followed by medical management, labour, epidural and surgery for retained placenta. Delivering

> that baby was the most difficult delivery of all of my children (P115, Second Trimester Miscarriage)
>
> The pain. I was injured whilst being treated (sprained inguinal ligament) so walking etc was quite painful. (P107, Ectopic Pregnancy).

An aspect of returning to work that some participants found particularly difficult was the feeling that life was moving on from their loss or from their baby. A return to 'normal', either in their own life or in the world around them was a hard thing to accept.

> I just felt that I was closing the door on the miscarriage and my baby and that life was moving on and it would be forgotten. (P113, First Trimester Miscarriage)
>
> That life goes on for everyone else when your whole world has crumbled. (P164, Second Trimester Termination of Pregnancy).

Sometimes these experiences were exacerbated for those who had experienced multiple pregnancy losses. Recurrent loss also had an impact on whether they could take enough time off work.

> This had been my 4th miscarriage and felt I couldn't take as much time off as I would've liked as I already had time off for previous miscarriages. (P743, First Trimester Miscarriage).

Theme 2: Returning to work life, having the ability to carry out tasks or manage the workload, and dealing with specific roles or duties

While dealing with the impacts of pregnancy loss discussed above, some participants felt that they returned to work too soon. This made it difficult to cope with the emotional or physical toll the loss took on them, as they went back to their working life. Reasons for the premature return varied from a lack of leave, financial pressures, not knowing what to do, personal pressure or insistence from work.

> I returned far too soon because at the time I didn't know what to do or who / where to turn too. (P137, Molar Pregnancy)
>
> i felt i would be putting pressurre on my team if i did not return immediately as no cover is provided except for that given by colleagues. (P272, First Trimester Miscarriage)
>
> Manager was annoyed I had to leave on a half day and would not speak to me the next day. I was not fit to be in that day either but manager was such a bully. (P616, First Trimester Miscarriage).

Some participants felt this return to work forced them to leave their home or family sooner than they were ready. Male participants in particular expressed a need to still be with their partner at this time.

> My wife at home on her own. (P465, First Trimester Miscarriage, Partner/Father)
>
> Leaving my living baby (P122, First Trimester Miscarriage)
>
> Getting my mind into work mode. I was worrying a lot about my wife. It was a very tight time for her especially. (P214, First Trimester Miscarriage, Partner or Father).

Once back in the workplace, it was very common for participants to face cognitive difficulties in carrying out their tasks. Participants described struggling to concentrate or focus. This could be due to the emotional or physical effects they were still experiencing, hormone changes as a result of the pregnancy, or being distracted by thoughts of their loss.

> I couldn't concentrate on work. (P95, Ectopic Pregnancy)
>
> I was distracted and upset. It was difficult to focus on work. (P372, First Trimester Miscarriage).

Furthermore, some participants found it difficult to motivate themselves or care about their work, when what they had experienced seemed so much more important. It was a challenge to get back into work mode.

> It was hard to care about anything when my baby had died. Everything felt a bit pointless. (P422, First Trimester Miscarriage)
>
> But it was very hard to just get straight back into work like life. (P21, Second Trimester Miscarriage)
>
> I think possibly the biggest thing though was realizing that work didn't matter to me at all anymore; one of my biggest motivations for working in the difficult role was the prospect of providing well for the child I wouldn't have. I struggled to find meaning in work and motivate myself to do well. (P209, Second Trimester Miscarriage).

Some participants described the difficulty and stress of their workload as being hard to return to after their loss. If tasks were not reallocated during their absence, this meant a return to a greater workload than normal.

> I found the pressure and workload of ED [Emergency Department] too much. (P164, Second Trimester Termination of Pregnancy)

> My work load wasn't covered so I had 2 weeks of work to catch up on. (P901, First Trimester Miscarriage).

Additionally, many participants faced into a full-on schedule of normal duties as soon as they returned to work, with no flexibility or eased return available. Participants felt the strain of this at a time when they may have still been coping with the impacts of their loss.

> Having to jump straight back to full time work. No time to adjust or no consideration for work load. (P697, First Trimester Miscarriage)
>
> Exhaustion but no reduction in workload. (P375, First Trimester Miscarriage)
>
> I was excepted to be back at work full time immediately afterwards by HR. HR even expected me to return to a week of nights post sick leave. (P233, Ectopic Pregnancy).

Certain roles, duties, or tasks were particularly hard to return to. Jobs which required physical labour such as driving or heavy lifting were difficult to manage when the physical effects of pregnancy loss were ongoing. Other roles were emotionally demanding, and especially draining to perform while coping with their own grief or emotions. Some jobs involved working with babies, children, while others entailed working with women who were pregnant or also experiencing pregnancy losses.

> The expectation of heavy lifting once I returned to work. (P369, First Trimester Termination of Pregnancy)
>
> my job is to offer emotional support to the people we work with. I found that very difficult to do when I was going through such an emotional time. (P267, Molar Pregnancy)
>
> I work in a baby room in a creche it was very emotionally hard going into work to look after other people babies when I'd just lost mine. (P358, Second Trimester Termination of Pregnancy).

Theme 3: Social interactions, disclosure and facing other pregnancies in the workplace

Facing people or socialising with colleagues was often described as a difficult experience following a loss. Feeling emotionally fragile or exhausted made routine interactions with colleagues, customers, or clients difficult in the aftermath of the pregnancy loss.

> Facing people again (P396, First Trimester Miscarriage)

> Trying to engage in small talk with people and chatting about trivial things. (P444, First Trimester Miscarriage)
>
> I was anxious and nervous about returning to work and meeting all my colleagues (P514, Second Trimester Termination of Pregnancy).

It was particularly difficult for many participants to be around pregnant women, those who just gave birth, or celebrations in the workplace of pregnancy and children. Pregnancy announcements, conversations, and baby showers were hard to face or engage in after losing a pregnancy.

> There were 2 girls in the office pregnant which was hard to see and a lot of pregnancy chat. (P129, First Trimester Miscarriage)
>
> Watching another colleague who was due her baby at the same time continue on with her pregnancy. (P256, Second Trimester Miscarriage).

Many participants did not share their pregnancy loss with their colleagues or their workplace. The social norm of concealing a pregnancy until 12 weeks may have contributed to these decisions. Certain workplaces did not create an environment in which participants felt they could share their loss. Other participants chose to keep their loss to themselves as they didn't want others to know, or because it was too difficult to talk about. Many participants who did not disclose their loss felt the need to 'act normal', and sometimes make up a lie to tell colleagues why they had been absent. The pressure to act normal or professional was a difficult experience while feeling emotionally or mentally low. Furthermore, nondisclosure sometimes meant that leave or support could not be availed of.

> The grief was difficult to deal with [whilst] shilst no colleagues were aware of the situation. (P184, First Trimester Miscarriage)
>
> Returning to a v busy workload which didn't take account of what I'd been through - this would have been different if I had had felt comfortable telling my manager. (P213, First Trimester Miscarriage)
>
> Pretending I was ok. (P189, First Trimester Miscarriage)
>
> Having to act professional and deal with members of the public on a daily basis was quite hard when I was struggling mentally and emotionally. (P549, First Trimester Miscarriage)
>
> Not wanting to explain things – not wanting to be on calls – wasn't sure who had been told what – supervisor mentioned after that they just said I was off (P205, Second Trimester Miscarriage, Partner or Father).

However, the experience of sharing a loss and telling colleagues or management about their experiences was the hardest aspect for other participants. Sharing bad

news sometimes brought up a lot of emotions, both for the participants who experienced the loss, and for their colleagues hearing about it. In some cases, participants were forced to share this information, in order to access leave or because their workplace put pressure on them. Some participants explained how individuals in their workplace shared this information with others, without their knowledge or permission.

> As a few people knew I was pregnant it was difficult going back and having to tell them that I had lost my baby. (P271, First Trimester Miscarriage)
>
> My information was shared outside of my organisation. This made me feel extremely uneasy about my privacy and who knew my information. I found this experience distressing on top of an already distressing time. (P452, First Trimester Miscarriage).

An aspect of social interactions participants found particularly challenging was the questions they would be asked, or the discussions that would ensue about their pregnancy loss. Sometimes, it was the fear of being asked these questions when facing a return to work that participants struggled with.

> I was afraid that parents & students would ask me questions about the baby. (P837, Second Trimester Termination of Pregnancy)
>
> Having to see everyone and have that awkward conversation with people when they are asking are you ok, I appreciated it some days but sometimes it felt like I had to have that convo to like 5 or 6 people a day which is draining. (P21, Second Trimester Miscarriage).

The responses that some participants faced in the workplace were the hardest thing about their experience. As pregnancy loss is an under-studied and poorly misunderstood experience, as well as a topic subject to stigma and taboo, many colleagues did not know how to respond to disclosures of loss. Participants sometimes faced avoidance, dismissal of their experiences, or judgement from their colleagues. Furthermore, certain members of management treated their staff so poorly that their behaviour was described by participants as the hardest thing about their experience. One participant was fired from her job and some others changed role or company after their loss.

> People were so awkward. The same people that had congratulated me just avoided me and ignored it completely which really hurt. (P195, Second Trimester Miscarriage)
>
> Having to face people being pitiful and awkward towards me, people not knowing what to say, poor comments of sure at least you know you can

> conceive, judgement and people talking about me. (P390, First Trimester Miscarriage)
>
> Lack of understanding. Loosing [Losing] put [out] on career opportunities because I was seen to want children now they didn't want me anymore. (P418, First Trimester Miscarriage)
>
> I was actually let go due to my work being "not up to scratch". After I was given my termination letter I explained the reason for me spending more time in the bathroom than normal. My explanation made no difference. (P83, First Trimester Miscarriage).

These negative responses are part of the wider issue in workplaces and broader society of the lack of acknowledgement, understanding, and recognition of pregnancy losses. Participants felt that their colleagues or management did not understand the impact that their pregnancy loss had on their emotions or their body and felt a lack of acknowledgement of the gravity of their loss.

> I think it's a loss that's not recognised societally. (P48, First Trimester Miscarriage)
>
> Not one person acknowledged my loss when I returned. I feel that my manager should have taken the lead in this situation but she didn't. (P449, Second Trimester Miscarriage)
>
> Honestly the worst thing is that noone cares. If it was a "living person" then you are granted more sympathy and empathy. People react better and with more understanding. I was told "ah sure not like you knew it" by my male line manager. And was looked at like I had 10 heads when i requested annual leave. It was granted, but it was stressed how much they "needed" me back to work asap. I ended up hospitalised from blood loss, and when my husband contacted my workplace, it was a major inconvenience to them. No question of how I was or how I was coping. (P577, FTM).

What made returning to work easier

All participants–regardless of whether they had taken leave or not–were asked what, if anything, made their return to work easier or made them feel better supported. Of those who responded to this question (n = 832), a sizeable proportion (about one in five) answered that nothing helped, and some described particular difficulties they faced or ways they felt let down by their workplace. Some participants also cited supports outside of the workplace as making the experience easier, for example, private counselling, friends and family, personal coping strategies and resilience.

From the data pertaining to workplace factors which made participants' return to work easier, we generated three main themes:

(1) Time off work, and choice in when to return
(2) Work as a distraction and practical supports
(3) Interpersonal factors and relationships in the workplace
(4) Nothing helped.

Theme 1: Time off work, and choice in when to return

Participants highly valued time away from work for the chance to deal with the physical and emotional impacts of their pregnancy loss, and time to process their grief before returning to their workplaces and duties. Some participants also mentioned that they had holidays or annual leave coming up and felt able to get through some time at work knowing there was a break ahead.

> I had a number of weeks off due to the surgery so I had time to process the loss. (P898, Ectopic Pregnancy)
>
> The time off helped me get back on my feet (emotionally) and I felt more prepared to go back after those 8 working days off. (P111, First Trimester Miscarriage)
>
> Knowing that the summer holidays were not too far away and I could get away with my family to grieve and start to try and heal together. (P256, Second Trimester Miscarriage).

Participants particularly valued being given choice and flexibility in when to return. This occurred when paid leave was readily available or when workplaces communicated that there was no pressure to come back until participants were ready.

> Boss was supportive of the time off so I knew I wasn't going to be criticised for being off and that was appreciated. He normalised that time off was totally appropriate in the circumstances. (P48, First Trimester Miscarriage)
>
> HR called me when I was ready to say there was no rush for me to come back and to more time then I thought I needed to rest and process. (P33, First Trimester Miscarriage).

Theme 2: Work as a distraction and practical supports

Many participants described their return to work as a distraction from the grief of their loss and a way to take their mind off the experience. Normal routines and busy work environments sometimes allowed their focus to shift from their loss to the task at hand. Going to work provided an opportunity to get out of their house and out of their thoughts for a while, which was welcomed by some. Some work

roles, such as teaching or nursing, offered particular distraction to some participants.

> I wanted to return to working after a couple of weeks as sitting around doing nothing wasn't helpful to my mental health. (P226, Second Trimester Termination of Pregnancy)
>
> Felt the routine helped take my mind off things and meeting colleagues so I'd less time to dwell. (P104, First Trimester Miscarriage)
>
> I work with children they have a way of making u forget for a while. (P183, Second Trimester Miscarriage).

While some participants found returning to a busy workplace and normal routine beneficial, others felt that a phased return was the most helpful option.

> I was allowed to return on a reduced working week initially and gradually increase my hours. I worked this out with my manager and she was v accommodating. I probably wouldn't have gone back so soon if this wasn't an option. Phasing back was a really good way back. (P114, Molar Pregnancy).
>
> Working a shorter week for 1st 4 weeks has helped me. The exhaustion is horrendous in the evenings. It's hard holding space for your grief all day keeping it under wraps and trying to function as a normal person at work. You need the cushion of a shorter working week. You're energy stores are so low (P630, Second Trimester Termination of Pregnancy)
>
> Line manager supported returning on reduced days for first month by using an annual leave day per week. (P904, First Trimester Miscarriage)
>
> Being able to initially return part time (P132, First Trimester Miscarriage).

Some participants were supported by returning to a reduced workload. In some cases a manager or supervisor would delegate or reduce tasks; for others, colleagues or managers took on extra work to ease the burden on the person who had experienced the loss.

> My colleague actually did some of my work for me whilst I was away so I didn't just take leave to come back to a mountain of work. That was an unbelievable support that I will never forget and will be for always grateful for. (P152, First Trimester Miscarriage).

Where certain roles or tasks were particularly challenging following their loss, some participants were allowed to temporarily change their tasks. Others moved to a new role and found the change helpful.

> on my return I carried out treatments that would need minimal talk to clients. (P875, Second Trimester Miscarriage)

> Also occupational health signed me off night duty for a while. I lost the baby after a night shift & I found them too hard after. (P865, First Trimester Miscarriage)
>
> Also direct boss was supportive of my request to stay away from maternity services. (P40, First Trimester Miscarriage).

Many participants described practical supports afforded to them by management. In addition to phased return and reduced workload, this included flexibility in tasks and hours, extra time to complete tasks, or an understanding that they may not be returning to their usual productivity immediately.

> She gave me additional time to complete my school reports. (P37, Second Trimester Miscarriage)
>
> My manager advised me to take it easy and advised she expected a lower rate of productivity for a while on return to work. (P103, First Trimester Miscarriage)
>
> Bring [Being] allowed space to take time to build up to resuming my usual workload. (P664, First Trimester Miscarriage).

Having the option to work from home was described as helpful by some participants. Working from home afforded greater flexibility in hours and task management. It also meant that they didn't have to leave the house, which was particularly valued while physical effects of the pregnancy loss were ongoing. Furthermore, working from home meant that they could avoid social interactions with colleagues if they wished.

> I mainly worked from home after, which made things easier for me to a certain extent. It meant I didn't have to put on a brave face in public and pretend nothing happened. (P774, First Trimester Miscarriage)
>
> As I was working from the comfort of my own home it made it easier as I didn't have to leave the house (P858, First Trimester Miscarriage)
>
> Working from home as I could do the minimum hours required and then go back to bed. (P614, First Trimester Miscarriage).

Theme 3: Interpersonal factors and relationships in the workplace

Participants expressed different desires relating to disclosing their pregnancy loss in the workplace. Some participants felt that privacy and returning to normal was most important for them. Others felt that having their colleagues and management know about their loss, or talking about their experience, made their return to work easier.

Participants particularly valued when management or HR respected their decision not to disclose their loss and deal with the matter confidentially. Some participants did not disclose their loss to anybody in the workplace and felt that this allowed them to return without any extra attention on them.

> I was glad most people didn't know as I could not have faced their sympathies without crying and getting emotional. (P497, First Trimester Miscarriage)
>
> It was easier to continue as normal when I had not told people. (P350, First Trimester Miscarriage)
>
> My colleagues knew I had been hospitalised but didn't pry. (619, Ectopic Pregnancy).

For others, returning to a workplace where people knew what they had gone through was helpful. This meant that colleagues could avoid asking potentially insensitive or hurtful questions and understand the reason behind altered behaviour or reduced productivity. Some participants specifically mentioned that it was helpful to them when a colleague or manager had told others in the workplace on their behalf. This meant that they didn't have to have these conversations themselves, and colleagues had this information prior to their return. Some participants chose to share their loss with a small number of colleagues.

> It helped knowing that my manager knew my reason for being out along with a few trusted colleagues. There were no well meaning questions in meetings asking how I was or why I was absent. (P23, First Trimester Miscarriage)
>
> I had messaged people in work and told them to spread the word so I didnt have to talk about it. (P174, First Trimester Miscarriage)
>
> Also, communicating to the team on my behalf was very helpful, I wanted everyone to know well before I returned to work so they could internalise it. (P226, Second Trimester Termination of Pregnancy).

Some participants found their return to work was made easier by having the opportunity to talk about their loss in their workplace. These conversations allowed further processing of their grief, and a chance for their colleagues to acknowledge and sympathise with their loss. An aspect of these conversations which some participants found particularly helpful was when others shared stories of their own losses. This helped to normalise the experience and show participants that they weren't on their own.

> I was very open about my experience which was my choice and it made it easier for me in my opinion. (P528, First Trimester Miscarriage)
>
> The willingness of colleagues to share their experience with me was invaluable. I felt understood, listened to and that my loss and suffering were understood / appreciated / vindicated. (P136, Second Trimester Miscarriage)
>
> knowing others had been through it really helped, I didn't feel so alone. (P12, First Trimester Miscarriage).

Many participants described the support and kindness they experienced from their workplace. This came from their friends on staff; immediate colleagues; or the wider workplace. Emotional support and kindness took the form of checking in, expressing sympathy, spending extra time with them, or visiting outside of work.

> The kindness of my colleagues really helped, and how they checked on me and helped me. (P21, Second Trimester Miscarriage)
>
> Colleagues who knew supported me and made sure to be with me on breaks and lunches. (P579, First Trimester Miscarriage)
>
> My immediate colleagues on the management team were so very kind. They could not make the work or pressure ease up but they cared so much. One colleague phoned me every day, whether she was working or not. (P325, First Trimester Miscarriage)
>
> Most of the girls I worked with were so caring and always done what they could to make me smile and then on what would have been my little girls due date they got me a bunch of flowers ans [and] it meant the world to me. (P291, Second Trimester Miscarriage).

An aspect of this support which made a big difference to some participants was the sense that their workplace understood and properly acknowledged their loss. Participants felt supported when colleagues or management recognised their experience and their needs, as pregnancy loss is often dismissed or viewed as solely a physical experience,

> The school community minded me. I got texts and phone calls and it made me feel remembered and they my baby was real and he was important to people in my life. (P335, Second Trimester Miscarriage)
>
> My colleagues were conscious not to include me in any emails regarding baby arrival announcements. (P339, Second Trimester Miscarriage)
>
> Compassion from HR. Not having to explain myself about the format of the cert after losing my baby. Acknowledgment of the bereavement as its acknowledged in other situations. (P611, First Trimester Miscarriage).

A small number of participants described how their colleagues or management prioritised their wellbeing over productivity or paperwork.

> They both reached out to let me know I didn't need to provide any documents or letters. That I should only focus on recovery and that I only had to come back when I was ready. Even when I did come back my manager checked on me the first couple of weeks and told me to take it easy. (P38, First Trimester Miscarriage)
>
> My emotional wellbeing was top of mind for my manager and she would check in with me regularly so it was easy to be transparent with where I'm at. (P58, Second Trimester Termination of Pregnancy).

Theme 4: Nothing helped

Many participants responded that nothing made their return to work easier or feel supported. Some participants simply stated "Nothing" while others emphasised how hard their experience was, or described a specific problem they faced when returning to work. Some participants spoke about how they had to rely on themselves and their personal resources to get through it. Some participants mentioned that they had to return to work, due to pressure from management or financial strain. A desire for leave was expressed again.

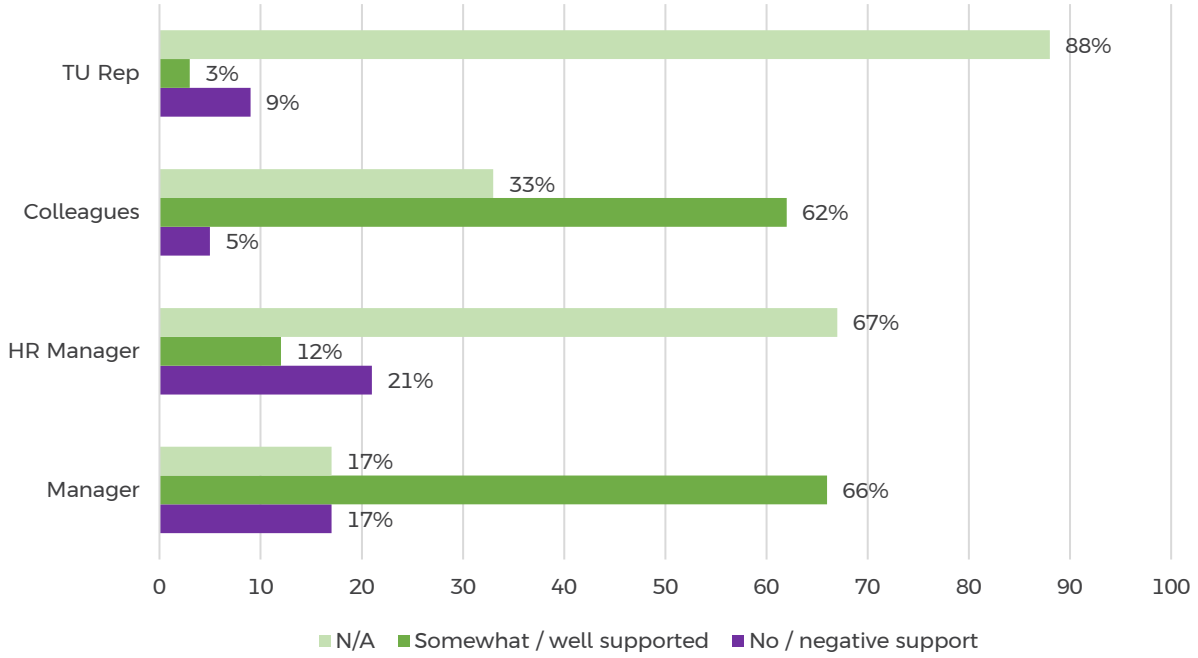
> Nothing (P85, Ectopic Pregnancy)
>
> Nothing. Horrific experience. (P47, First Trimester Miscarriage)
>
> Nothing in work made it easier, there were no supports. HR people see your medical cert with miscarriage on it and there aren't any policies in place as far as I know to try and support staff. It's just treated the same as someone returning after a sinus infection! (P158, First Trimester Miscarriage)
>
> Nothing. I have nothing positive to say about how my boss or colleagues handled my miscarriage. (P229, First Trimester Miscarriage).

4.3.7 Pregnancy loss experiences at work: Supports

As noted in Section 4.3.4, some participants reported that the people they disclosed their pregnancy loss to in their workplace did not know how to support them (14%) and 8% of people were not offered any support from their workplace following disclosure of their loss (Table 4.7).

In the survey, participants were also asked how well they felt they were supported, if at all, by various types of people within their organisation: their manager, HR manager, colleagues, trade union representative. They reported that

they felt supported most commonly by their manager (66%), and immediate colleagues (62%) (Figure 4.3).



TU: Trade Union; HR: Human Resources

Figure 4.3 Extent to which participants felt supported by various people within their workplace

A high percentage of individuals who disclosed the pregnancy loss at work felt supported by colleagues. However, it is interesting to note that a much higher percentage of those who disclosed the loss did not feel supported by management / supervisors (19% did not feel supported by supervisors whereas 7% did not feel supported by colleagues) (Table 4.12).

There was no significant difference in the length of leave taken based on professional sector (whether public or private) or dimension of the organisation (Large or Small / Medium Organisation (Table 4.12). Similarly, there was no statistically significant difference in the length of leave or percentage of individuals taking leave, according to professional activity group, professional position (managerial or not) or level of income of participants ($p>0.05$, data not shown).

The percentage of individuals reporting feeling supported (by management or colleagues) at work did not vary significantly by professional activity group. Generally, the vast majority felt supported across all professional groups with a

higher proportion reporting support from colleagues. It is interesting to note that, of all professional activity groups, those working in Health and Social Care reported the lowest percentage of support from management (77%) and colleagues (89%) (data not included in table).

Table 4.12 Support from manager or supervisor and colleagues

	Support from manager or supervisor			**Support from colleagues**		
	No support n (%)	Supported n (%)	*Total n (%)*	No support n (%)	Supported n (%)	*Total n (%)*
Disclosure of Loss*						
No	19 (61.3)	12 (38.7)	*31 (100)*	9 (40.9)	13 (59.1)	*22 (100)*
Yes	136 (18.8)	589 (81.2)	*725 (100)*	41 (6.9)	550 (93.1)	*591 (100)*
Total	*155 (20.5)*	*601 (79.5)*	*756 (100)*	*50 (8.2)*	*563 (91.8)*	*613 (100)*
Type of Loss[a]						
First trimester	112 (20.2)	443 (79.8)	*555 (100)*	45 (10.3)	390 (89.7)	*435 (100)*
Second trimester	31 (23.7)	100 (76.3)	*131 (100)*	4 (3.2)	120 (96.8)	*124 (100)*
Other	12 (17.1)	58 (82.9)	*70 (100)*	1 (1.9)	53 (98.1)	*54 (100)*
Total	*155 (20.5)*	*601 (79.5)*	*756 (100)*	*50 (8.2)*	*563 (91.8)*	*613 (100)*
Type of Management**						
Expectant	66 (24.3)	206 (75.7)	272 (100)	26 (12.4)	184 (87.6)	*210 (100)*
Medical	27 (13.6)	172 (86.4)	199 (100)	7 (4.1)	162 (95.9)	*169 (100)*
Surgical	61 (22.3)	213 (77.7)	274 (100)	17 (7.6)	207 (92.4)	*224 (100)*
Total	*154 (20.7)*	*591 (79.3)*	*745 (100)*	*50 (8.3)*	*553 (91.7)*	*603 (100)*
Size of Business[a]						
Small / medium business	61 (20.6)	235 (79.4)	*296 (100)*	15 (5.9)	240 (94.1)	*225 (100)*
Larger business	92 (20.5)	357 (79.5)	*449 (100)*	32 (9.2)	317 (90.8)	*349 (100)*
Size unknown	2 (18.2)	9 (81.8)	11 (100)	3 (33.3)	6 (66.7)	*9 (100)*
Total	*155 (20.5)*	*601 (79.5)*	*756 (100)*	*50 (8.2)*	*563 (91.8)*	*613 (100)*

* $p < 0.01$, ** $p < 0.05$, [a] $p > 0.05$ for manager/supervisor, $p < 0.01$ for colleagues.

4.3.8 Views on proposed leave for pregnancy loss <24 weeks gestation

Nearly all (95%) of participants stated that they would take specific pregnancy-loss related leave if it was available (Table 4.12). This decreases to 87% and 85% if disclosure and certification were necessary, respectively.

Table 4.13 views on proposed pregnancy loss leave

		n (%)
Would you take (paid) pregnancy loss leave (N = 913)	Yes	870 (95.3)
	No	4 (0.4)
	Unsure	39 (4.3)
Would you take this leave: If disclosure necessary (N = 913)	Yes	795 (87.1)
	No	24 (2.6)
	Unsure	94 (10.3)
Would you take this leave: If certification necessary (N = 913)	Yes	774 (84.8)
	No	31 (3.4)
	Unsure	108 (11.8)
Length of leave[a] (N = 712)	Less than one week	9 (1.3)
	One to two weeks	95 (13.3)
	Two to four weeks	288 (40.4)
	One to two months	243 (34.1)
	Two to six months	70 (9.8)
	Six months or more	7 (1.0)
Limit on taking leave (N = 897)	Yes	12 (1.31)
	Maybe / Unsure	28 (3.07)
	No	857 (93.9)

[a] Participants typed responses, some of which couldn't be categorised as above

Participants' views on proposed statutory leave for pregnancy loss: length and implementation issues

We asked participants how long proposed statutory leave from work for people experiencing pregnancy loss under 24 weeks gestation should be (specifying days/weeks/months); we also asked them to tell us the reason for their answer. 897 participants provided a response to this question.

As noted in Table 4.13, participants most frequently responded that this leave should be two to four weeks (40%) or one to two months (34%).

Almost a third of participants (n = 295) did not provide a rationale for the length that they provided. Of those who did, one overall theme captures the essence of their responses: "Pregnancy loss is so individual, so it isn't a one policy fits all". Many who responded to this question stated that different people will experience pregnancy loss differently and therefore it was difficult to suggest an ideal length of leave that would suit everyone – instead, a flexible approach was needed.

Participants spoke about the need for leave in order to physically and/or emotionally 'recover' from their pregnancy loss, acknowledging that, for some, recovery would take longer than leave would cover, however long it were to be.

> A least two weeks. You are still bleeding wearing maternity pads but no baby. You are grieving the loss of baby and all the hopes and dreams that went with finding out you were pregnant. (P3, Second Trimester Miscarriage)
>
> 2 months or more. My reason is I was in no fit state to go back to work when I did. It took me weeks if not months to feel some what normal. (P34, Molar Pregnancy)
>
> I'm not an expert, but as much as the person needs, maybe up to a ceiling of a few weeks. A loss isn't just something that needs physical recover, I found the mental piece the hardest part. (P62, First Trimester Miscarriage)
>
> It's a difficult question. I think at 22 weeks I needed to recover from the trauma the birth and the grief. I needed full maternity leave. I've had earlier losses and didn't take any leave, but hard to know where to draw the line. I'd suggest 12 weeks or more. (P115, Second Trimester Miscarriage)
>
> 2 weeks, the physical pain after a d&c requires rest so it is not possible to return to a job standing all day. And then the emotional side where you may need to talk to someone before returning to work to cope better. (P396, First Trimester Miscarriage).

People tended to report the amount of leave they themselves took and whether this worked for them or whether they would have liked longer or not. Some noted that it should be decided by the person what they need, with a few noting that this could be done in consultation with a health professional (GP, hospital doctor, psychologist).

> Depends on the situation, and the needs of each person. Should be individualised. (P49, Ectopic Pregnancy)

> Miscarriage is different for everyone. Individuals react to trauma differently. (P339, Second Trimester Miscarriage)
>
> 3 months. Obviously depends on individual cases and reasons etc. I can only speak to mine. (P871, Second Trimester Termination of Pregnancy)
>
> I was lucky that my GP certified my sick leave so in a way I already had this. I'm conscious that it has taken from my sick leave though (I've had 3 miscarriages since Aug 2019). Every miscarriage is different. I took one week the first time and that was ok. Given the circumstances and need for more medical input more recently I needed longer. It varies with each miscarriage for lots of reasons. (P884, First Trimester Miscarriage)
>
> This should be recommended by a professional on a case by case basis. Each person deals with loss differently and I don't feel there should be a one size fits all. Minimum 2 weeks would be my suggestion though. (P92, Second Trimester Miscarriage).

For some participants, getting back to work was seen as a distraction and an important part of the recovery process. Others, however, felt that getting back to work too early impeded their recovery, and negatively impacted on their functioning and performance at work.

> 2-3 weeks, depends on type of management to allow physical healing and sufficient time to try recover mentally but I felt I needed the distraction too so was good tk [to] get back to routine. (P16, First Trimester Miscarriage)
>
> 4-6 weeks. I took 4 weeks off work. The first two weeks were incredibly emotional and I only spoke to close friends and family. The third week I began doing a few more normal things and opened up my support network. After 4 weeks I was craving some sort of normality and don't know what I would have done if I had been off work for longer especially since my partner had returned to work. My job is mainly desk based and I have a lot of flexibility in my day to day work which helped. (P159, Second Trimester Miscarriage)
>
> 12 weeks-this is how long it took me to recover and to be functioning in a way that allowed me to do my job properly. I feel returning to work too early set me back. (P524, First Trimester Miscarriage).

Throughout their responses, participants highlighted various issues that they felt needed to be taken into consideration when determining the length of leave required. For many, how the pregnancy loss was managed or the circumstances of the loss were important. This included the time from finding out they were losing their pregnancy and when they lost their pregnancy, and included issues around how the pregnancy loss was managed (expectant, medical and/or surgical management), waiting for test results/procedures, and any associated

complications. For some this involved weeks and was very difficult to concentrate on work and/or go into work between appointments or healthcare encounters.

> 2-3 weeks. I knew my pregnancy wasn't viable however I didn't miscarry naturally for another full week. There is no way I was able to work in the time between finding out and miscarrying. Then after the miscarriage, I needed at least a week off to get over the physical effects. (P12, First Trimester Miscarriage)
>
> As long as needed, everyone has different pregnancy loss. I had to attend the maternity unit very frequently for bloods and scans as it was ectopic. I needed admission and eventually needed methotrexate, all over the course of approx 3 weeks. That was very different to my first loss, where it was just like a heavy period and I returned to work within a few days. (P124, Ectopic Pregnancy)
>
> The physical management of a miscarriage can take a long time. I had a molar pregnancy, I had to have weekly blood tests for two months after it and surgery. This takes its toll. People don't realised that miscarriages can be very slow, they're not the sudden gush of blood that you see on tv. After the molar pregnancy, I was exhausted. (P389, First Trimester Miscarriage)
>
> 2 to 4 weeks. I had a surgical management, but a spontaneous miscarriage can take weeks to complete, I can't imagine having to flush that down a toilet in the office, that's just unimaginable and should be taken into consideration. (P406, First Trimester Miscarriage)
>
> 3 months. It took me from mid January to the end of March for the miscarriage to fully complete. It was horrendous. Trips to hospital to be told hormone levels were dropping as my baby faded away. I felt utter despair and had to keep on going to work before and after each appointment. (P551, First Trimester Miscarriage)
>
> Up to 2 weeks initially (with the option to extend if needed). The hospital told me to wait 2 weeks for the miscarriage to complete and then test to ensure nothing remained. I had high anxiety until two weeks passed. Previously with an ectopic pregnancy, my expectant management took 6 weeks - it took 2 weeks to diagnose, so the possibility of extending is crucial. (P839, First Trimester Miscarriage).

Another issue highlighted by some participants was that people who experienced the loss of a pregnancy at a later gestation might need more leave, with some suggesting a graded approach to the length of leave that could be needed/taken. For some this came from direct experience, and for others this was an observation as they themselves had an earlier loss and could not imagine what it would be like to lose a baby further along in pregnancy. Some noted however that pregnancy loss was difficult, regardless of the gestation. A few participants also noted that more leave could be required if a person had recurrent losses, if they

had experienced fertility issues, if it was their first pregnancy or if they did not have any living children.

> 12 weeks minimum. I had to use all of my paid sick leave, I had no other choice but to return to work when my 12 weeks full pay was up, I would have had to go on 1/2 pay, so I had to return to work. Having had a second trimester miscarriage was very traumatic and to think that I was expected to just return to work after delivering my son and burying my son I was just expected to carry on as normal and go back to work, no leave was offered to me, I decided it was time I needed and I would have taken more if it was offered. I was supposed to work from home because I was pregnant and over 35 and it was the middle of covid, working from home was never offered to mr when my son died. (P807, Second Trimester Miscarriage)
>
> I think this depends on how far along the pregnancy is. I took 2 weeks off after losing a child at 8 weeks. I can't imagine 2 weeks being half enough if I had been closer to 24 weeks. (P286, First Trimester Miscarriage)
>
> Varying dependent on gestation and management of the pregnancy loss. For example- surgical management of a first trimester loss may be shorter than a loss closer to 24 weeks. (P31, First Trimester Miscarriage)
>
> 4months per year minimum but not necessarily taken at once depending on circumstances. When you have loss under 24 weeks you don't get your mat leave however the closer you are to 24weeks the more movements you felt and the more your body demanded of you. delivery is still a massive physical trauma on your body and mentally a mess with you that your child was so close to being recognised as a person by the state and the benefits that come with that. Often loss like that is investigate and it takes time to get answers and you shouldn't be expected to return to work with that hanging over you. (P57, First Trimester Miscarriage)
>
> For my early pregnancy loss I think 2 week would be sufficient, but it's all relative. I think 2 weeks for every 6 weeks pregnant maybe. (P106, Ectopic Pregnancy)
>
> I think leave should be separated into 3 stages just like the trimesters. 3rd trimester- you get 24 weeks, 2nd trimester should get 12 weeks and then there should be an option in trimester 1 to have 2-6 weeks leave. (P470, Second Trimester Miscarriage)
>
> Minimum 2 weeks. A pregnancy loss before 12 weeks is still a pregnancy loss. This doesn't make it any easier to deal with. Especially if is a couples first pregnancy. (P906, First Trimester Miscarriage)
>
> I felt 2 weeks was enough for me, the hormones were back to normal. I had other children and felt blessed to have them and a busy job I needed to get back to. My sense of loss of small but I think if it was my first or one or many failed pregnancies my answer might be different. (P890, First Trimester Termination of Pregnancy).

The need for partners to have access to leave was mentioned by some participants, to deal with their own grief and to be there to provide emotional and

practical support to their partner. The majority stated a length of leave that was less than that required for the person who physically experienced the loss. Some further noted that men often felt that they couldn't ask for and/or take this leave.

> Something needs to be offered for men too. We had a number of pregnancy losses and this loss hit him hard. He needed time off work and ended up taking sick leave but felt guilty about it. (P114, Molar Pregnancy)
>
> 1 week (for father) - gives time to orginise funeral / grieve / help mother Grieve. (P205, Second Trimester Miscarriage, Partner/Father)
>
> Up to 3 months for the mother and up to 1 month for the father. (P595, First Trimester Miscarriage)
>
> For a father of a pregnancy loss an allowance of 70 hours should be allocated to provide for additional family drop offs, half day work place to support at home care, for both practical, emotional and physical assistance. These hours can then be taken to support the homelike not workplace. (P721, Second Trimester Miscarriage)
>
> 1-2 weeks to be there for the initial stages to support my partner and take the pressure off in caring for our other child. (P748, First Trimester Miscarriage, Father/Partner).

The need for dedicated leave was evident across responses. Some noted how they had to return to work as they could not afford to take more time off, e.g. due to limited available sick leave, or how the type of leave available to them did not match with what they needed (e.g. sick leave rather than bereavement, or maternity leave). Some also spoke about the need for leave to be supplemented with other supports in the workplace, including flexible working arrangements – for example, working from home, and reduced hours on returning to work.

> While respecting the confidential rights of the employee I believe normalising miscarriage leave creates a supportive environment for women and it should be certified and notified to a designated person in the organisation (HR, line manager, other) so that employers can understand the extent to which this is a workplace issue and to ensure they are constantly working to provide supports to workers. (P136, Second Trimester Miscarriage)
>
> A lot of emmen [women] can't afford time off work as they don't get paid sick leave, this forces them to have to go back to work straight away. (P201, First Trimester Miscarriage)
>
> It would help to give time to heal without worrying about money or using sick leave and I know friends who have had to take annual leave or unpaid sick leave which made the whole experience even more stressful. (P252, First Trimester Miscarriage)

> In my opinion I feel I needed a lot more time to grieve than I was able to. I wasn't granted any official time to grieve I had to take sick leave. This isn't right. I feel a minimum of 3 months leave would have helped my mental and physical well being somewhat. (P256, Second Trimester Miscarriage)
>
> 1 week- this gives time for the body to heal while also some time for the mind to prepare to return to work. (P313, First Trimester Miscarriage)
>
> At least 10 days. It was 5 days from my scan to when I physically lost my baby, then I was bleeding. Emotional distress aside, the physical process is not quick or something you can get on with. However, this may be different for those who can work from home. I am in a face to face frontline role working with vulnerable adults. (P283, First Trimester Miscarriage)
>
> I had 3 pregnancy losses in last 3 years all at different stages from 8 wks to 14 wks. Each was different and def think not takin enough time off after made my healing harder mentally. Def need least 3/4 wks and option of reduced hours for first two wks after return to work. (P644, Second Trimester Miscarriage).

Additional points raised by some participants regarding the implementation of a pregnancy loss leave policy included the option to have a certain amount of days/time for this leave, with the option for additional time off (paid/unpaid) to be taken by the employee on a needs basis.

> Allowance for up to 4 weeks but if one wishes to take less or more unpaid, then allow that. (P70, Ectopic Pregnancy)
>
> Possibly up to 2 weeks, or maybe a fixed period of at least 1 week with extra time available at request. (P149, First Trimester Miscarriage)
>
> There should be an option to take 3 months with an option to extend if needed. My late losses meant I was physically still recovering for weeks, as well as organising things like my baby's funeral and cremation. I was in shock for several weeks but I still had to return to work. (P747, Second Trimester Miscarriage).

A few also highlighted that the option to take leave in blocks or at different time points would be useful, rather than having to take it all at once.

> On my first pregnancy loss I needed 3 weeks leave at the time. But this loss hit me very hard 6/7 months later and I needed 3 months off at this point (which I took as sick leave) due to depression and anxiety directly related to the pregnancy loss. (P212, First Trimester Miscarriage)
>
> 15 days in the month so you can take a block of leave and have some days leave to take randomly when you return so that you can attend appointments or do two shorter weeks returning as it is so tiring emotionally. (P410, First Trimester Miscarriage)

> It would have been great to take some time the week that we found out we were losing the pregnancy but also to have taken some time when my wife was having the D&C which wasn't until a few weeks later so some flexibility would be necessary. Possibly a leave similar to paternity leave where you have a certain length of time to take the leave within. (P889, First Trimester Miscarriage, Partner/Father).

Should there be a limit placed on the number of times you can avail of leave for pregnancy loss under 24 weeks?

We asked participants if they thought that there should there be a limit placed on the number of times that a person could avail of the proposed leave for pregnancy loss under 24 weeks, and to tell us the reason for their answer. This was an open question; accordingly, participants provided a textual response. Data were analysed in two ways – quantitatively (responses were recoded as yes, maybe, no, no response) and qualitatively. We report both below.

Nearly all (94%) of participants responded (n = 897) that there should be no limit on the amount of times a woman or her partner can avail of this leave; 1% said yes, a further 3% said maybe, and the remainder did not provide a response (Table 4.13). It is worth noting that this question elicited quite strong reactions from participants, with some using strong adjectives to indicate their 'no' responses, and even aversion to this question being posed at all. For example:

> I think this is a shocking question. I have suffered one loss. I can't imagine it becomes a more accepted situation to the person experiencing the loss as the number increases. (P449, Second Trimester Miscarriage)
>
> To even question this is absolutely horrendous and very ignorant. More research on this topic is obviously needed. (P577, First Trimester Miscarriage)
>
> Absolutely not!!!! I had 4 losses, the trauma got worse each time, imagine running out of leave! Horrific. (P725, First Trimester Miscarriage).

Three themes were generated from the responses to this question:

(1) A loss is a loss, with emotional and physical impacts, which may be greater (or not) the more losses that are experienced, and should be recognised as such
(2) Pregnancy loss is out of your control and you shouldn't be penalised for it
(3) Implementation issues.

Theme 1: A loss is a loss, with emotional and physical impacts, which may be greater (or not) the more losses that are experienced, and should be recognised as such

Participants emphatically described how the number of times that one could take leave for pregnancy losses under 24 weeks gestation should not be limited because it would signal a diminishment of the loss experienced, and the associated emotional and/or physical impacts. Descriptors such as suffering, draining, devastation, heartbreak, grief, and trauma were frequently used by participants to describe experiences of pregnancy loss. Many used the phrase "a loss is a loss", or a variation of same to describe their views around this and how one pregnancy loss could not be deemed more significant or important than another. They felt that not imposing a limit validated the experience and its impacts, and was a fair approach.

> No. A loss is a loss. It doesn't matter if it's a woman's first loss or her fifth. (P347, First Trimester Termination of Pregnancy)
>
> No. Women can suffer more than one miscarriage. It shouldn't be considered "easier" after one and all losses should get the leave. (P12, First Trimester Miscarriage)
>
> Good Jesus, is it not bad enough to be subjected to the physical pain, humiliation and devastation of loss and its terrible impact on the body - without needing to apologise or demur when it happens multiple times. I worked so hard my whole life, worked myself down to the bloody bone, could the system and society not just saw [say], "we got you this time when you need help and support." (P325, First Trimester Miscarriage)
>
> There should be no limits, We've had two, both have been traumatic. the first one was outside the hospital, the second was in the hospital, we had waited years to get this far, and it took time to recover from it. (P484, First Trimester Miscarriage, Partner/Father)
>
> No. Pregnancy loss is something that deeply affects an individual and by introducing a limit it's giving the impression that one pregnancy loss is more significant than another. (P783, First Trimester Termination of Pregnancy)
>
> No. How can someone decide if one loss deserves more time than another loss? (P786, Molar Pregnancy)
>
> Absolutely not!!! I've had 4 miscarriages 2019-2020 and each excruciatingly difficult, the last being more severe (miscarriage bleeding with undiagnosed ectopi [ectopic] rupturing a week later needed emergency surgery to fix it and also remove the tube) How can you say one miscarriage would be more deserving of time off than others? No way!!!! (P752, Ectopic Pregnancy).

While some further stated that people may need longer periods of leave the more losses that are experienced, others felt that each loss warranted the same amount of time. Such views came from people who either had experienced recurrent pregnancy loss themselves, or people who had experienced one pregnancy loss but perceived that losing further pregnancy losses could be even more difficult for a person/couple.

> Absolutely not. The more loss you experience the more leave should be available. Those navigating fertility issues have to learn and research this area independently. It's a full time job in itself. (P416, First Trimester Miscarriage)
>
> No. I experienced 4 losses and each loss is as difficult as the previous one. (P796, First Trimester Miscarriage)
>
> No, having suffered from recurrent miscarriage, if anything you need more leave with subsequent miscarriages. They get physically and emotionally more gruelling each time. (P801, First Trimester Miscarriage)
>
> No limit. Losing a child in pregnancy is traumatic and very very sad and to think there are people out there that go through it multiple times is even sadder and probably have no sick leave after multiple losses and have to just go back to work with no time off. (P807, Second Trimester Miscarriage).

Participants also spoke about how people can have different experiences of each pregnancy lost and different needs, including the need for leave. They mentioned that while dedicated leave should be available to all for a specified length, it should be up to the individual as to whether they felt they needed to (or could in a number of cases) take this leave, and for what duration.

> No! In fact the more often it happens the longer a person should get for it. It doesn't get any easier. There is no limit on the number of miscarriages a person can have. Miscarriages differ from each other even for the same person, there is no telling how your body will react. There is no obligation to take all of the leave on offer and I expect not everyone would take the leave. (P364, First Trimester Miscarriage)
>
> No - bereavement affects people differently. There should be flexibility allowing the individual decide when to return. My first pregnancy loss was an early loss I.e. <12 weeks and it didn’t effect me too much...I just put it down to bad luck and really just wanted to get back to normal asap. I realize lots of people feel very differently at a time like that but my first loss had much less impact on me than other losses. (P114, Molar Pregnancy)
>
> No, because pregnancy loss happens. If people don't want to avail of it, that is their choice but at least have it available. (P178, Second Trimester Miscarriage)

> No. Miscarriages are a devastating thing to go through and I feel that if somebody has experienced it themselves they would understand why there shouldn't be a limit on the amount of times you can take that leave. I think women and couples can be judicious in deciding how much time they need themselves. Some times people may need to take the full leave allocated but if they suffered a subsequent miscarriage they may deal with that differently. It is such a sensitive topic so I don't think couples would take advantage of it. (P374, Ectopic Pregnancy)

> No way. I would be apprehensive to take the leave as I wouldn't want everyone to know and while my manager is discreet the person over my clock isn't. That is why I would have reservations about taking the leave but it should be available and for multiple miscarriages. (P802, First Trimester Miscarriage).

A few participants argued that there was no limit on the number of times that one could take maternity leave so why should there be for pregnancy loss – perceiving it to be discriminatory, with others noting the lack of limits placed on bereavement leave.

> No because some people are unfortunate to have multiple losses. A maternity leave is 26 weeks and cover is made for that so five losses over years isn't even a quarter of one maternity leave. It's discriminatory and it undermines the loss. (P516, First Trimester Miscarriage)

> Absolutely not. There is no limit placed on bereavement leave... Pregnancy loss is bereavement no matter at what point of pregnancy... I pray I do not experience this heaty break again but if I do I would not like to think there would be a limit on the amount of times of could apply for leave if I required it. (P567, First Trimester Miscarriage).

Theme 2: Pregnancy loss is out of your control and you shouldn't be penalised for it

The second dominant pattern within participants' responses to the question of whether leave should be limited or not, centred around the fact that pregnancy loss happens, whether a person wants a pregnancy or not; it is outside of a person's control and that it was not a woman's 'fault'. Many spoke about the nature of trying to build a family, and how pregnancy loss can happen while trying to do so. Participants felt that people who experience pregnancy loss should not be 'penalised' or 'punished' for it, by limiting the number of times that they could take leave from work for it.

> I don't think so. Nobody wants this to happen and if you are unfortunate enough to have multiple miscarriages you shouldn't be penalised for that misfortune. The approach should be one of compassion and understanding. (P4, First Trimester Miscarriage)

> No there should be no limit. It is out of the control of a woman if she is to miscarry and she deserve space and time to recoup as it is a physical and emotional hardship. (P797, Ectopic Pregnancy)

> I have suffered pregnancy loss 4 times before I had my 1st live child last year. This was through no fault of my own and to place a limit would be like telling someone your first three pregnancies were validated but anymore after that doesn't count. (P513, Second Trimester Miscarriage)

> I think placing a limit on it is profoundly disturbing. No one is going to go get a termination or have a miscarriage so they can get time off work! This would just strengthen stigma--especially for people having miscarriages of wanted pregnancies--if someone is trying to conceive and struggling with fertility and they have say 5 miscarriages, how horrible would they feel if there was an "appropriate number" or limit on lifetime miscarriages and they don't get leave for there most recent one? (P707, First Trimester Termination of Pregnancy).

Theme 3: Implementation issues

There was some discussion around perceived 'abuse' of this type of leave. The vast majority of people who mentioned it stated that it was not the type of leave that would be abused. Many felt that it was not the type of leave that anyone really wanted to take, in terms of what it signified. People stated that if certification was required, that would validate the need for (or in some cases 'prove' the need for) leave.

> No, I don't believe any woman either miscarrying or terminating a pregnancy would do so lightly and the system wouldn't be abused (P226, Second Trimester Termination of Pregnancy)

> No. It's not the type of leave that can be faked or manipulated if it is required to be certified and it would be unfair to limit it- how many miscarriages would be allowable- who would decide that number?? (P213, First Trimester Miscarriage)

> No limit. I don't think any woman wants to go through a miscarriage. I have had 5 consecutive miscarriages and the pain emotionally/physically gets harder each time. Statistically it is less common to have consecutive miscarriages so only a small number of women would be availing of multiple miscarriage leave. (P470, Second Trimester Miscarriage)

> people may abuse the system if there are no limits but very difficult to put a limit in place; certification by a doctor of the loss may be a more robust and fairer way of protecting the system. (P867, First Trimester Miscarriage)

> No! Once there is medical evidence there is no reason to restrict this leave. Each pregnancy loss has the potential to be as traumatic and painful as the others, I don't suppose one "gets used to it" if multiple occur. Additionally, this question is loaded with the implication that people might get pregant to abort or miscarry just for the sake of some time off, or

> fake it to exploit the leave. This just isn't a plausible consequence. (P681, First Trimester Termination of Pregnancy)
>
> No some people struggle with fertility issues and failed IVF implantations. It would be very obvious if someone was exploiting the system as you can only have so many losses in a year naturally so there should be no limit (P707, First Trimester Miscarriage, Partner/Father).

In addition, a few mentioned that recurrent pregnancy loss was uncommon and therefore smaller numbers of people would be availing of this leave on multiple occasions than some might imagine. A few also referred to the natural limit on the number of pregnancy losses that a person could experience in a year, and during their reproductive years.

A minority – mainly those who said that a limit should be placed on this type of leave – highlighted issues surrounding the implementation of this type of leave. Some noted that the number of times it could be taken should be limited out of 'fairness' to employers and/or co-workers who may find it difficult to cover the costs of this leave and/or replacement staff. Limits suggested included by miscarriage, by year, by gestation of the pregnancy at the time of loss, and those imposed for sick leave. Others suggested having Government co-finance leave or having provision for unpaid leave where necessary.

> Yes, I think there has to be a fairness to businesses also. Some people have many losses, employers especially small business would struggle with this. (P207, First Trimester Miscarriage)
>
> No that would be horrendous and like saying one loss is not as valid as another. I can understand the worry about paying for all this leave but women and their mental and physical health need to be prioritised. Ireland has an awful history of not caring for women's health, especially in pregnancy and it is time this changed. (P531, First Trimester Miscarriage)
>
> That is a hard one. I suppose by right yes because every loss is a loss but then you have to understand that in the teaching profession it is difficult to get subs etc. (P724, Second Trimester Miscarriage)
>
> No...Maybe it should be partially funded by the government as I'm aware how expensive it would be for businesses. Maybe the generic sick leave and allow businesses to top up the wage. (P818, First Trimester Miscarriage)
>
> I think it does need to be limited to a certain degree, perhaps in a similar way to the sick leave legislation. Without a limit, women of childbearing age will be further discriminated against when employers are recruiting and promoting staff. (P417, First Trimester Miscarriage).

4.3.9 Other workplace-based supports needed for pregnancy loss <24 weeks gestation

Participants were asked to describe workplace supports which could or should be introduced for pregnancy losses before 24 weeks in the Republic of Ireland. This question was answered by 736 people.

Many participants responded that they did not know what workplaces could have done to help them, or that there was nothing which would have helped. A few participants felt that workplaces were not where they felt supports should come from as they did not want to share their loss with their workplace, or they were more comfortable accessing support elsewhere (e.g. health services, personal social system). Some participants spoke of the importance of society in general becoming more aware of pregnancy loss and open to discuss these experiences - "I think that as a soceity [society] we need to talk about pregnancy loss more openly to allow more supports to become available" (P146, First Trimester Miscarriage). A cohort of participants were well supported by their workplaces.

Specific to workplace supports which could be introduced, we identified the following themes:

(1) Dedicated, sufficient, paid, and accessible leave for pregnancy loss to manage the physical, psychological and grief effects
(2) Workplace policies and training to create supportive, compassionate workplaces; alongside access to professional supports
(3) Organisational supports that could facilitate an easier return to work
(4) Professional or peer support to cope with the pregnancy loss or the return to work.

Theme 1: Dedicated, sufficient, paid, and accessible leave for pregnancy loss to manage the physical, psychological and grief effects.

Participants expressed a strong desire or need for time off work following their loss. This leave would allow them to manage the physical and emotional impacts of their pregnancy loss. Leave would also be an acknowledgement of what they had experienced as something significant in their lives and deserving of support. Some participants noted the need for partners to also have a leave entitlement.

For leave to be effective, participants felt that it was important that it was paid. Many participants spoke of returning to work earlier than they were ready due to a lack of paid leave and financial pressures.

> Paid time off as I felt pressured to returning due to unpaid sick leave. (P396, First Trimester Miscarriage)
>
> I don't know what would apply here for me other than being paid my normal wage, the bills still needed paying etc. (P277, First Trimester Miscarriage).

A common experience among participants was needing to take leave that was deducted from their future leave entitlements – e.g. sick leave, annual leave. This was particularly problematic for participants who experienced recurrent pregnancy loss or infertility. Many participants returned to work too soon as they ran out of sick leave or other entitlements. Therefore, for leave to be just it would need to be separate to existing limited sick or annual leave.

> Miscarriage leave so I didn't have to use all my sick leave for my 4 Miscarriages. (P240, First Trimester Miscarriage)
>
> Miscarriage leave. I had previously used up sick leave on surgeries(gynae related), ivf related leave etc so all my paid sick leave was gone. It made me go back before I felt ready. (P494, First Trimester Miscarriage)
>
> I wish I didn't have to use my sick leave. I'm currently off work with pregnancy related sickness and a high risk pregnancy but have exhausted my sick leave because of the time I took off after my mid trimester loss last year. I am down to half pay. (P37, Second Trimester Miscarriage).

In certain roles, it was important to participants that their work was covered by a substitute/locum so that they could take adequate time away from work.

> Locum availability so I could have taken a day or 2 off. (P54, First Trimester Miscarriage)
>
> Also there is a sub shortage for teachers so knowing my class were being split and doing worksheets etc instead of being taught made me return before I was ready. (P494, First Trimester Miscarriage)
>
> Perhaps clarity that you work would be covered by someone else. Some jobs are harder than others to get cover for. If you are working in a shop where you serve customers when the shop is open, then someone else covers your job when you're not there. But other roles, e.g., research/lecturing are not so easy to replace. So even though you might get a few days off, the work does build up as it may not be being done while you're off. (P30, First Trimester Miscarriage).

Furthermore, participants spoke of the importance of being supported by their workplace in taking this leave. A lack of judgement about time off work, or pressure to return sooner, would facilitate participants in taking the leave they need. Some participants expressed the need for this leave to be a statutory entitlement, so that it would be accessible to everyone and seen as a sufficient reason to take leave.

> Understanding from my boss that I might need some time off for medical appointments and to process what had happened. (P4, First Trimester Miscarriage)

> I feel the whole experience would have been more bearable without pressure from my boss about substitute cover. I should not have had to worry about who would cover my class when I had a sick cert and being made to feel guilty about taking time off. I emailed in lots of work as well as leaving plans and work organised in my class. At the end of the day it is the principal's job to get staff (especially a principal who is in an office all day). (P497, First Trimester Miscarriage)

> Some statutory entitlement or even entitlement written into contract or employee handbook if not statutory allowing a certain amount of leave following pregnancy loss (this could be tiered depending on gestation which in itself could be problematic but there has to be some structure to it). I felt that I was far sicker/weaker after delivery of my child lost at 17 weeks than after delivery of three full term babies (and that includes on C section)..:yet I felt I was constantly having to justify the time I took, having to justify this time didn't leave me the time and head space to heal mentally and emotionally and puts you under pressure, I feel anyway (P263, Second Trimester Miscarriage).

For some participants, it was important that leave be called something other than sick leave. This is in recognition that they are not experiencing an illness, they are experiencing a loss. Names discussed by participants included "bereavement", "pregnancy loss", "miscarriage", "maternity", "parental", "special", "mental health", "pregnancy related sickness", "compassionate", or "pregnancy support" leave. Furthermore, a dedicated leave would contribute to greater understanding and validation of the need to take leave following a pregnancy loss. Many participants stated that they would feel more comfortable or entitled to take leave if a specific and protected leave was statutory. Additionally, the availability of specific and statutory leave would ease the burden of figuring out or negotiating leave entitlements at a stressful and painful time.

> I didn't like that it was recorded as sick leave. It's something very different. (P110, First Trimester Miscarriage)

> I would have liked bereavement leave - it's very strange to have had a service for your child yet your child is not recognised. (P18, Second Trimester Miscarriage)
>
> Pregnancy loss leave would be so nice to have, if it was a specific type of leave available it would ease some of the anxiety about having to take time off. (P406, First Trimester Miscarriage)
>
> I would have liked a more formal type of leave for pregnancy loss, where I wouldn't have had to think about what to do when I was feeling so vulnerable. (P137, Molar Pregnancy).

Theme 2: Workplace policies and training to create supportive, compassionate workplaces; alongside access to professional supports.

Many participants expressed the need for workplaces to become environments in which people could be supported following a loss. This would include developing and implementing a policy on pregnancy loss; training and educating management and staff on the effects of pregnancy loss and the need for support; treating employees with decency and empathy; and respecting individuals' needs, including privacy and confidentiality when desired.

Simple practices such as asking a person how they would like to manage their return to work was highlighted. Some participants experienced a lack of basic decency or compassion from their workplaces. Many people just listed being treated with "empathy", "sympathy", and "kind words" as key support.

> I think the simple question of being asked how I would like to be supported on my return would have been appreciated. (P92, Second Trimester Miscarriage)
>
> The HR not even having the decency to say sorry for your loss really bothered me. So even if they could include that in responses would be beneficial. A colleague of mine also had a miscarriage (1st trimester) and they didn't say it to her either so clearly it is commonplace. (P21, Second Trimester Miscarriage).

A workplace culture of openness, "An atmosphere of encouragement to talk about loss" (P11, FTM) would further contribute to the creation of a supportive place of work. However, while some participants viewed sharing and talking about their loss as an important element of dealing with their experience, many others expressed a strong desire for privacy and confidentiality at this time. In addition to the feeling of potential negative impact on career or work

opportunities (as outlined in previous sections), some individuals simply wanted to keep their experience to themselves.

> I think it's important to note that I did not want half my company knowing I was trying for a baby. It would have made me feel 'more visible' when I wanted to be discrete. So anything in the workplace would have to be incredibly discrete. The ability to take time off without it needing 2nd level manager, or HR approval would have been important. I would have wanted to take miscarriage leave without needing excessive paperwork - I would have been fine with providing a nonspecific GP note. I would not want the leave saved in our Time/Payroll system as Miscarriage leave for HR, payroll, any senior manager, or future direct line manager to see. To be very candid, I think women deserve privacy around their pregnancy (failed or successful) and the thoughts of involving corporate bureaucracy during my time of grief makes me uneasy. I support miscarriage leave, the problem is the organisations that would be implementing it are flawed. Women are not supported, they are not adequately represented in management and I think a woman's career would suffer if her leadership knew she was trying to get pregnant. (P407, First Trimester Miscarriage).

In order to create supportive environments, many participants discussed the need for clear policies and training to staff. Standardised policies would ensure that all employees had access to supports that were clearly laid out and didn't involve negotiation or self-advocacy. Information about these policies should be easily accessible, and referred to any time an employee experiences a pregnancy loss. Furthermore, as pregnancy loss is still not understood across society, training to management and staff may be necessary to effectively implement these policies and support employees.

> Maybe just a standardised approach for dealing with grief in the workplace. My experience was quite variable. (P8, First Trimester Miscarriage)

> Hr support / clear leave policies and an employee handbook. (P302, First Trimester Miscarriage)

> A policy explaining what I needed to do in this situation e.g. The miscarriage began at the weekend and I went to work on the Monday and had to set up a meeting with my manager to discuss the situation. (P103, First Trimester Miscarriage)

> I believe if employers had formal miscarriage policies, miscarriage leave, signposting protocols for support etc, designated contact people etc, it would help raise the understanding of miscarriage in the workplace, and perhaps educate people about the stupid things NOT to say to a woman who has suffered this pain. (P136, Second Trimester Miscarriage).

Theme 3: Organisational supports that could facilitate an easier return to work

Participants presented some ideas for organisational supports which could enable an easier return to work. Sometimes these ideas were as a result of positive experiences they had, or supports they would have liked to have. Overall, supports which gradually allow an employee to return to the full timetable and workload of their role were described as helpful. This including additional breaks, changing roles or tasks, flexible hours or a phased return, or temporarily working from home.

> More breaks or staggered return to work. On my first pregnancy loss I didn't realise how weak I would feel physically and when I returned to work I had to leave later that day before work was over as I felt so weak. It would have been better if I could have taken more breaks or returned for shorter days to begin with. (P212, First Trimester Miscarriage)
>
> change of hours so not doing shift work and having that exhausted feeling while going through trauma. (P390, First Trimester Miscarriage)
>
> Option to handover some work to other colleagues if workload is too demanding upon initial return to work. (P340, First Trimester Miscarriage)
>
> Light duties/non confrontational role to ease back in. (P390, First Trimester Miscarriage)
>
> Ability to work from home to be closer to my partner. (P593, First Trimester Miscarriage)
>
> I feel that I was fortunate to be able to work from home during this period, the medication made me immune compromised, and I was weakened by blood loss. If I had not been working from home I would probably have needed to take longer sick leave and lose income. I think workers who are recovering from a miscarriage or any medical situation should have the opportunity to work from home in 'normal' circumstances. It would have been difficult to answer questions, even well intentioned ones in the immediate aftermath. (P619, Ectopic Pregnancy).

Theme 4: Professional or peer support to cope with the pregnancy loss or the return to work

Finally, many participants felt that they could benefit from working with a professional, such as a psychologist or occupational health practitioner; or access peer support or pregnancy loss support groups. It was not always clear from participants' responses where they thought this professional help should come from, however, many specifically stated that these services should come from or via their workplace. Some participants discussed how their workplaces did have a

counselling service or Employee Assistance Programme, however, they were unable to access or not informed of this support at the time of their loss.

> I am not sure if this is something that would get off the ground but maybe even a support group created within the workplace for people who have lost babies. Even a support buddy system eg. If i offered myself as a support to anyone and hr have my name on file and gives the person recently bereaved the option to be put in touch with someone who they could talk to about it all, someone who can relate to what they going through. Maybe offer grief support/training to people who offer their services. (P636, First Trimester Miscarriage)
>
> Possibly a chat with a medical professional to see if I was emotionally ready to look after patients with possible miscarriage. (P473, First Trimester Miscarriage)
>
> Probably a counsellor or therapist that was subsidised by my employer. The HSE free counselling [HSE National Counselling Service] is a long wait and only offers 6 free sessions of 45 minutes each which isn't great. (P462, First Trimester Miscarriage)
>
> My organisation does have counselling available free of charge - however it was difficult to access the information and it wasn't offered. (P336, Ectopic Pregnancy).

4.4 Summary

Across the Republic of Ireland, 913 workers participated in our mixed-methods survey. Most participants were female, heterosexual, white Irish, and had a university degree or more. The majority of participants were in permanent full-time employment, and the most common sectors for participants to work in were education and healthcare. First-trimester miscarriage was the most common type of pregnancy loss.

The majority of participants shared their pregnancy loss with somebody in work – most commonly their manager or colleagues. The main reasons for sharing were needing to explain or access leave; seeking emotional support; or to normalise the topic. Some participants did not share their loss with anybody in work, because they did not want to speak about an emotional or private event at work, or for fear of insensitive comments or career implications.

Most participants took some time off work following their pregnancy loss – most commonly paid sick leave. This ranged from less than one week to more than six months, though most often between two to four weeks. Those who experienced a second-trimester loss were the most likely to take more than one month of leave.

Returning to work was rated as difficult by most participants. Experiencing physical symptoms, feeling sad or grieving at work, and dealing with conversations or questions were some of the most difficult things about going back. Workplaces sometimes made the return easier by offering practical supports and accommodations or providing practical support. Some participants found the return to routine and distraction beneficial. Many participants spoke about how their time off work was what they needed to recover from their loss.

The vast majority of participants would take paid pregnancy loss leave if introduced to the Republic of Ireland. Nearly all of those would still take this leave if it meant disclosing their pregnancy loss to their workplace or needing to provide certification. Most participants felt that between two weeks and two months would be an appropriate length of leave – but for some this would vary depending on gestation of the pregnancy, management of the loss, or personal factors. Almost all participants felt that there should be no limit imposed on how many times a person could take this leave.

Participants discussed what could be introduced to workplaces or legislation to support women and partners after a pregnancy loss. Participants expressed a strong desire for time off work – statutory, paid, specific leave, which would enable every worker to take adequate time away from work without worrying about finances or career implications / repercussions in their workplace. Furthermore, workplace policies and procedures which detail leave entitlements or practical accommodations could allow for an easier return to work. Training of management or HR personnel on pregnancy loss and its impacts would also be helpful.

Chapter 5. Phase 2: Interview study

Key messages

- 13 people participated in this interview study
- Most interviewed participants disclosed their pregnancy loss to someone in their workplace
- In some cases, to access leave, participants were required to inform their workplace within a very short period after the loss and/or, were required to submit certification soon after their loss. These conversations or processes were described as extremely difficult at an already highly emotional and distressing time
- Most participants took some leave from work following pregnancy loss (from a few days to a few months). Some participants–regardless of whether they took leave or not–felt pressured to return to work, or had to return due to financial strain
- The time taken off work was affected by type of loss, clinical management of the loss, and personal factors
- There is a need for statutory leave that is available to all workers and which does not affect sick leave entitlements. Participants also considered:
    - This is especially important for those who do not have access to sufficient paid sick leave, or those in precarious employment
    - This leave should be equally available to those who have experienced a termination of pregnancy
    - Some leave for partners would be welcome, to allow them to process the loss, and support their partner
- Statutory leave for pregnancy loss could have a specific name such as pregnancy loss leave, or be included in other broader leave entitlement such as compassionate leave, to protect privacy
- Workplace supports such as a phased return, alternative working arrangements, or flexible hours could facilitate an easier return to work and requests of such should be accommodated
- Participants expressed a desire for professional counselling, through Employee Assistance Programmes, or through referral and signposting
- There is a need for pregnancy loss to be discussed in the workplace, to reduce the stigma and isolation associated with these experiences. Introducing a statutory leave may facilitate and promote these discussions.

5.1 Background

From the survey data we learned about the workplace experiences of over 900 individuals following their pregnancy loss under 24 weeks gestation. This data provided insight into the reasons people chose to share their pregnancy loss with their workplace or not; the length of leave people took from work; and the amount of people who would avail of paid pregnancy loss leave, if introduced to the Republic of Ireland. Following this, we wanted to learn more about how and when these disclosures took place; the reasons participants returned to work, and what future supports could be introduced. In particular, we sought to find out what type of leave participants thought would be appropriate, whether leave was necessary for partners or those experiencing termination of pregnancy; and what workplace supports could facilitate their return to work.

5.2 Methods

We conducted semi-structured interviews with people who had experienced pregnancy loss under 24 weeks gestation.

5.2.1 Setting and participants

We recruited interview participants from the sample of individuals who had completed the survey, i.e. people who were employed and who had experienced a pregnancy loss under 24 weeks gestation in the Republic of Ireland within the five-year period preceding survey completion. At the end of the survey, participants were asked if they would like to be contacted for an interview study, and if so, to leave their name and contact details. Participants were advised that we would be conducting a small number of interviews and that not everybody who expressed interest would be contacted.

A purposive sampling strategy was used to select interview participants from the group who completed the survey and who agreed to further contact. Participants with a diverse range of ages, pregnancy loss experiences, workplaces, and ethnicities were contacted and invited to participate. Participants were given an initial invitation and two follow-up chances to consent to an interview study. If no response was received, another survey participant with similar demographics was contacted and invited to participate instead.

We ceased sampling when we had sufficient data across the sample to address our research questions (Malterud et al., 2016). Initially, as outlined in the Tender for

this research, we had estimated that we may have needed to conduct 30-35 interviews before we reached this point. However, given the unanticipated large response to the survey (over 900 participants, compared with the 100 envisaged) and the richness of the data generated, we were able to focus our interview questions on key areas where further understanding was needed and conduct fewer interviews as a result.

5.2.2 Data collection

Interviews took place between 8th June and 6th September 2023 via Microsoft Teams or via phone in accordance with the wishes of the participant. The first interview was led by MH, with RKH leading the second interview; all subsequent interviews were conducted by RKH. Interviews were recorded using Microsoft Teams or a digital Dictaphone.

A clear protocol was developed and used to inform and guide participants on the online interview process, basic technical information on the platform and security measures. Participants were asked to provide a phone number so that the interview could be completed by phone in the event of a poor or dropped internet connection. Participants provided informed, electronic consent in advance of the interview; ongoing verbal consent was also sought.

A topic guide was used to frame the discussion (see Box 5.1). It was developed based on previous research (Keep et al., 2021; Meaney et al., 2017; Meunier et al., 2021; Obst et al., 2022) and further refined based on responses to the survey study to gather further insights into participants' views and experiences. In particular we were interested in what determined the length of time that people took off work and their views on proposed leave for pregnancy loss under 24 weeks gestation, including what it should be called, how long it should be, who should be eligible to take this leave (with a particular focus on partners and types of pregnancy loss) and what might influence its implementation in practice. The topic guide was reviewed by members of the research team and a member of the PLRG who had lived experience of pregnancy loss. The topic guide was also continually reviewed and adapted as interviews progressed to allow exploration of any new insights that arose.

Box 5-1 Topic guide

Background/Contextual information

- Can you tell me more about your work? Probe: What is the size of your team, how long have you been in that job, what is the male/female divide?
- Do you want to tell me a bit about your family? [Tailored according to survey responses]

Experience of pregnancy loss in the workplace

- Did you tell anyone at work about it? Had you told anyone at work that you were pregnant?
- How did they react when you told them?
- Did you take any time off work? Probe: What determined how much time you took off?
- Were there any supports in your workplace?

Experience/Recommendations

- What kind of supports would you have liked to see in your workplace?
- If Government were to introduce leave around pregnancy loss, what do you think this should cover and why? Probe: Type of leave, length of leave, type of losses, gestation, certification, etc. How do you think it should be implemented in practice? What might help or hinder its implementation?

5.2.3 Ethical considerations

Ethical approval for the study was granted by the Clinical Research Ethics Committee of the Cork Teaching Hospitals [Reference number: ECM 4 (h) 13/12/2022 & ECM 5 (5) 21/02/2023].

Participants were contacted via email or phone call and subsequently sent an email with an invitation to participate in the interview which included a participant information leaflet and consent form. This information leaflet described the purpose of the study, what was involved in participation, and assurance that their data would be confidential and anonymous. Participants were asked to reply with a consent statement if they wished to participate. Interviews were arranged at a time and with a platform/software of the participant's preference.

At the interview, following introductions participants were reminded about the purpose of the study, that participation was voluntary, that they were free to withdraw from/stop the interview, at any time and without giving a reason, and that they were free to withdraw their data from the study up to the point of pseudonymisation. Participants were then invited to ask questions regarding the study or interview procedure and requested to verbally reaffirm their consent.

A distress protocol for both the research team and participants was in place for the study. Participants were informed that they could request signposts to supports from the interviewer, either at the time of the interview or after. If agreeable to the participant, the interviewer contacted them within 24 hours of the interview to check on their wellbeing and reiterate this offer of support signposting.

5.2.4 Data analysis

Interview audio files were securely transferred and transcribed verbatim by an external professional transcriptionist or by the interviewer. Transcripts were checked and pseudo-anonymised by the interviewer. Anonymised transcripts were imported to NVivo 12 for analysis (QSR International Pty Ltd., 2018).

Similar to the analysis of qualitative survey data, interview data were analysed using reflexive thematic analysis (Braun & Clarke, 2022). Thematic analysis allows for the systematic identification, organisation, and presentation of insight into patterns of meaning, or themes, across a dataset. This involved data familiarisation; generation of initial codes; generation of themes; review of potential themes; definition of themes; and production of a report. RKH, MH and SL read and re-read the transcripts and met regularly to discuss the analysis. Themes were generated through a rigorous process of refining codes, generating initial themes, and refining themes by checking candidate themes against the coded data and the entire dataset.

Results are presented thematically, with original quotes from participants to support each theme. To contextualise these quotes, participants IDs are presented alongside the type of loss they experienced. Quotes from partners or fathers are also identified. Quotes are written verbatim. Where partial quotes are presented, text which has been removed is represented with an ellipsis (...). In cases where the meaning of words is unclear or acronyms are unlikely to be understood by the general population, an explanation is provided in square brackets. Potentially

identifying information has been pseudo-anonymised and presented in square brackets. Expletives have been censored in this report. Where questions posed by the researcher are included in quotes, these are presented in italics.

5.3 Results

5.3.1 Participant characteristics

A total of 27 women and two men were invited to participate between the 22nd of May and the 12th of July 2023. Recruitment ceased once there was sufficient data depth and richness to address the research questions (Malterud et al., 2016). Interviews took place between 8th June and 8th September 2023, and lasted between 40 minutes and two hours.

We interviewed 13 participants about their workplace experiences and views on potential supports, including diversity across age ranges, type of loss experienced and employment contexts (Table 5.1). We interviewed 11 women, and two men whose wives had experienced pregnancy loss. Most participants we interviewed had experienced first trimester miscarriages – two participants had experienced multiple consecutive first trimester losses.

Table 5.1 Interview participant characteristics

Demographic	n
Most recent type of loss (at the time of survey completion)	
1st trimester miscarriage	6
1st trimester termination of pregnancy	1
Ectopic pregnancy	3
2nd trimester miscarriage	2
2nd trimester termination of pregnancy	1
Pregnancy history	
1 loss	10
Recurrent loss	3
Children	
No living children	7
Living children	6
Pregnant at time of interview	
Yes	3
Age	
18 – 24	2
25 – 34	3
35 – 44	7
45 +	1
Sector	
Public sector	7
Private sector	6
Job Type	
Full-time employee	9
Self-employed	2
Precarious employment	1
Manager	1
Sex	
Female	11
Male	2
Ethnicity	
White Irish	11
Other	2

5.3.2 Theme 1: Disclosure of pregnancy loss at work

Participants were asked to talk about their experience of disclosing (or not) their pregnancy loss at work. They provided details such as who they told, when they told them, and what their reasons for disclosing were. They also spoke about the experience of having these conversations, and the reactions from their workplace.

Most participants informed somebody in their workplace as soon as they experienced the loss or found out that their pregnancy was going to end. This was particularly true for women and did not vary according to length of pregnancy.

> So I had to very awkwardly go into my manager on the Monday afternoon in a lot of pain and bleeding already now for nearly two weeks saying that I was like this is a really uncomfortable situation but I need to go to the hospital. And he was panicking like what's going on, what's wrong, and I had to say my doctor said that they think I'm having a miscarriage but if the pain gets any worse I have to go to the hospital. And it was really uncomfortable because that was the first time telling them I was even pregnant and I had to tell them that I was losing it. (P106, Ectopic Pregnancy)

> So I actually had to ring from the emergency room … I was supposed to be on duty on Wednesday, so I had to ring them straight away and let them know be like I'm not going to be there. (P657, Ectopic Pregnancy).

Participants were motivated to share their loss for different reasons. Some participants had already disclosed their pregnancy to their workplace, either because they were further along into their pregnancy, or because they required adjustments from their workplace. Disclosure was also discussed as part of the process of accessing leave. Existing positive relationships in the workplace facilitated the disclosure of pregnancy loss.

> We would tell our management nearly straight away when we know we're pregnant. There's kind of a policy in school that once you're pregnant you actually don't do yard duty… there's kind of a safety risk… And then I suppose at about 10 weeks I kind of started to tell the rest of the staff that I was pregnant. So by the time we found out the pregnancy wasn't viable everybody knew I was pregnant. (P886, Second Trimester Miscarriage)

> I told the parents of the children… my scan was the next morning so he knew the next day because I couldn't collect his children from playschool. So I couldn't hide it. I just told him straight out what hospital I was going to (P107, Ectopic Pregnancy)

> I told my supervisor that I needed her to cover a class because I was having an abortion (P704, First Trimester Termination of Pregnancy)

> So then I had to call my boss again and say yeah so I'm actually getting surgery now so I won't be in for the next few days. (P106, Ectopic Pregnancy)
>
> That evening then I had to text [my principal] and be like I'm out, I'm not gonna be back. (P886, Second Trimester Miscarriage)
>
> I felt comfortable telling her. I kind of wanted to tell her … I don't think I said it straight away because I was still feeling a bit upset. I didn't want to be getting upset when I was talking to my boss obviously. (P660, First Trimester Miscarriage, Partner/Father).

This conversation was often described as very difficult and painful, mostly because participants were already upset and processing the loss or because this was a highly sensitive topic and extremely difficult for participants to talk about at the time. For some participants this was increased as their workplace had not known about their pregnancy previously.

> And because I hadn't told anyone I was pregnant to just phone up and to just say I've had a miscarriage you know is a bit startling for them but also I felt physically sick you know having to do that. I was completely and utterly in shock. I wanted to… I was you know crying into my pillow. I couldn't leave the bedroom you know for the first 24 hours. And to have to break that sort of I don't know wallowing or whatever that I was in to actually have to put my sensible hat on and actually phone my manager to say this has happened to me just felt cruel. (P861, First Trimester Miscarriage).

Some participants went into more detail about how their managers or colleagues responded when they disclosed their loss. Mostly responses were generally supportive and sympathetic. This was more often the case when participants already had good relationships in their workplace.

> he was very supportive, very sympathetic to the loss. Yeah he was really good. (P249, First Trimester Miscarriage)
>
> Oh very supportive. They were. They were very supportive and were 100% just concerned about me. (P173, First Trimester Miscarriage).

However, some participants were faced with a lack of sympathy, or outright hostility. Violations of privacy also sometimes occurred. These reactions sometimes affected how participants felt about returning to work. One participant's husband left his job of ten years following his experience of the pregnancy loss.

> Well the first time I didn't no [disclose loss to anyone at work]. I didn't at all … But a really horrendous thing was that … I told my friend because I knew

> she'd be covering for me for the week … I said [colleague's name] don't tell anybody please. The principal will be the only person that knows. … he had told the secretary … and then she had subsequently gone down to the whole of the staffroom and told everybody. And that's the one thing I'm really upset to this day about that. (P395, First Trimester Miscarriage, Partner/Father)

> He never ever would acknowledge it … Yeah, I thought it was really disrespectful to be honest, that he never once acknowledged it … I don't think it's good enough … I'm like he just didn't have the decency … All he had to do is bring me in and say, you know, like I'm really sorry, or just acknowledge it, to be honest. (P657, Ectopic Pregnancy)

> She would have been the one I liaised with and she was horrific like asking me when I'd be back to work. She was just a really nasty person. I've since finished up with them. I couldn't keep going with them. (P107, Ectopic Pregnancy)

> And [my husband] was under so much pressure at work and they knew that I was having a miscarriage but it did not matter. They were putting pressure on him to come in on Saturdays and Sundays on the weekends while I was at home … He's worked for this company for ten years and at Christmas he got no Christmas bonus … And when he went back in January he just handed in his notice. (P886, Second Trimester Miscarriage).

5.3.3 Theme 2: Experiences of taking leave

Participants spoke about their time off work, if any, including the length they took. They also spoke about the factors which influenced time taken off work, and their reasons for return to work. For this particular theme, we note how long participants took off from work alongside their quotes, with ID numbers and type of loss.

Most participants took some time off work, ranging from one day to several months. There was a variety of considerations influencing the time taken, including how far along they were in the pregnancy, physical symptoms and type of clinical management of the loss, the emotional impact of the loss, and recurrent losses.

> I needed time off physically and mentally at the time. (P173, First Trimester Miscarriage, 2 weeks)

> So it was what they call a missed miscarriage where you don't actually miscarry but the fetus isn't viable … Obviously I was out of work then for the next 5 or 6 weeks … and again because school is difficult you have to be firing on all cylinders to come in here. (P886, Second Trimester Miscarriage, 5-6 weeks)

> We were further on in the journey than we had been before … and she told me and I just shouted no no no … I was upset and then I had to leave … Because [my wife] was coming back from it … She was coming back home and I didn't want her. I just had to be here because I was worried that something could happen on the road and everything. (P395, First Trimester Miscarriage, Partner/Father, <1 week)

> I was 20 weeks … I had to go back in then and be induced … Because of the infection and everything I was high risk for getting Covid … so I took 6 weeks fully off and then I took another 6 weeks where I only worked part-time. (P175, Second Trimester Miscarriage, 6 weeks)

> I think on my third one … I said to her 'I can't work today because', and I blurted it out you know 'I've just lost a third baby you know' … And I was like 'it doesn't matter, at this stage it doesn't f*%$ing matter, I'm gonna be back in work on Monday' (P861, First Trimester Miscarriage, 1 day).

Participants returned to work for different reasons. Some felt ready to return, while others faced pressure from their employers or workplaces.

> Well my wife went straight back to work … But yeah that ruled it out then for me. I just felt there was no need then. (P660, First Trimester Miscarriage, Partner/Father, No Time Off)

> When I woke up to teach Wednesday morning I was just quite ill. And it was at the point where I had to teach at 9 … no-one's gonna be awake to kind of approve you not teaching the class or students may have already started coming in. (P704, First Trimester Termination of Pregnancy, 1 day)

> Like in hindsight, it was way too soon to go back to work … I just felt like they're going to just think now that I'm on the doss basically. (P657, Ectopic Pregnancy, 2 weeks).

> they emotionally blackmailed me… she was like I can't look after her and all this so I just got sucked in … I felt like I had to kind of honour the work that I was put down for … She kept trying to pressure me into hours … I don't know how I let them treat me like such sh*# but I think it was just because I had no fight left in me. (P107, Ectopic Pregnancy, 1-2 weeks)

Many participants spoke of the lack of leave entitlement, whereby financial concerns forced their return.

> I had the surgery on the Wednesday and in the phone call my boss said ah don't worry you don't have to come in for the rest of the week, I'll see you on Monday … I got three days off to have the surgery and to recover and come back in. … because in my job you don't get paid if you're not there. … So like if I didn't go in on Monday I didn't get paid you know which would have sucked. (P106, Ectopic Pregnancy, 3 days)

> You're self-employed so if you need leave it's up to you to report to social welfare for sick pay … But I wasn't entitled to sick pay because I didn't have enough stamps. (P107, Ectopic Pregnancy, 1-2 weeks).

A number of participants spoke of the need to return to work as a distraction or a coping mechanism. Some commented on the difficulty in delaying the return further and so decided to get the return 'over with'.

> When I physically felt fine … y'know, I like work, I suppose I like the routine, it takes your mind off it… (P841, First Trimester Miscarriage, 2 days)

> When I felt like I needed to go back and be busy that was probably the main thing. The other side of it I suppose honestly was financial because it was unpaid leave from work. (P173, First Trimester Miscarriage, 2 weeks)

> I was conscious of getting back to school before Christmas because I didn't want the return to school hanging over me over the Christmas holidays, I just wanted to be done with it. So I came back for two and a half days before Christmas. (P886, Second Trimester Miscarriage, 5-6 weeks).

5.3.4 Theme 3: Need for pregnancy loss leave

Aside from the leave they took, participants spoke about the need for statutory leave to be introduced for pregnancy loss. They covered issues relating to accessing leave, fairness and other leave entitlements; and the need for leave to be statutory, in order to be available to everyone. We explicitly asked participants for their views around leave for partners, leave for termination of pregnancy, and what leave for pregnancy loss should be titled.

Some participants highlighted the discrepancy between current entitlements in the Republic of Ireland: full maternity leave if you lose a pregnancy after 24 weeks, i.e. experience a stillbirth, and the lack of any entitlements for pregnancy losses before this time.

> But that you're entitled to your maternity leave if you deliver a stillborn baby … Yeah like that's just disgusting. I just feel it stipulates something it's so precise that I don't feel you can be that precise … I mean maybe not a six month maternity leave but Jesus like should there not be some sort of statutory time even that is definitely given to somebody that they don't have to beg. Like I went back to work after my pregnancy losses before I was ready each time. You know I didn't wanna go back to work. I wanted to spend time grieving. (P861, First Trimester Miscarriage)

> Because if I had been 24 weeks I would have gotten maternity leave but because I was 23 and a half weeks I wasn't eligible for it so I was running out of sick leave. I had full pay for a while and then I was on half pay … I tried to get you know force majeure or some kind of special leave or bereavement but I got nothing. I applied for it afterwards or tried to get and they said that I wasn't eligible. (P456, Second Trimester Miscarriage)

> I suppose depending on how far along the pregnancy has gone … Like if it's very early then maybe a lesser amount of time … Like I know after 24 weeks

> [you have maternity leave], I think it should be maybe like sequentially brought back … at this amount of weeks you get this amount of time. (P657, Ectopic Pregnancy).

Need for leave to be statutory

Many participants identified that it should be mandatory for employers to offer this leave to employees. Otherwise, certain workplaces would allow the 'bare minimum' and those in precarious or low-paid employment would be further disadvantaged. The vulnerable position of self-employed individuals in situations of pregnancy loss was also highlighted, with no specific financial supports available in these cases.

> For me it was fine but it wasn't for my husband … They were putting pressure on him to come in on Saturdays and Sundays … That company [he] was working for they did not care. He probably could have done with the leave … It would absolutely have had to have been a statutory right. Yeah I think he'd have had to go in and be like I'm entitled to this, best of luck. (P886, Second Trimester Miscarriage)

> If there was just some sort of standardised this is the leave that I need to take instead of having to predict my supervisor's emotional responses or their own work styles. (P704, First Trimester Termination of Pregnancy)

> I think it should be a statutory requirement. That way it's taken out of the hands of everybody. This is just the law on this. This is what has to happen, so it's not a case of you're dependent on the flexibility or you know the willingness of your employer, you know who may or may not give it to you. (P657, Ectopic Pregnancy)

> The way it worked is everything was as minimal as possible so the least amount of annual leave, the least amount of any sort of leave you were given. It was all bare minimum. (P106, Ectopic Pregnancy)

> Like for self-employed people it's quite rough. There's nothing really. It would have to be more a government scheme. … Like log into mygov.ie and just do it. Like the covid payment how easy was that. (P107, Ectopic Pregnancy).

However, one participant who worked in a self-employed capacity in a small business expressed concerns over financing of this leave.

> You know, if it becomes mandatory for us to have to pay full pay for all, we couldn't afford it … Do you know while if it's a case of when they can claim the state, I mean when the Covid was 350, they can claim things like that, it's fine … It's just for a lot of people, the difference between what the state will pay versus what their actually salary is so huge. (P841, First Trimester Miscarriage).

Challenges to accessing leave

Much of the discussions were also around the challenges accessing leave. Some participants had difficulty accessing medical certification, and others were deeply upset by having to arrange certification and paperwork at such a distressing time.

> So much of what happened I had to follow normal procedure and I feel there should be other procedures … And I had to go and visit my GP, pay my GP again and get a letter from the GP confirming all these dates over a two year period were related to pregnancies … Having to go and do that was actually just, it felt traumatic." "And I think if we could take some of the responsibility from the person that they have to ring their boss and go through detail of what's just happened. (P861, First Trimester Miscarriage)

> It would have been nice to kind of have whether it was contacting HR or someone else and just having it submitted (P704, First Trimester Termination of Pregnancy)

> They don't give you one … I didn't get anything … So I had no certification that I was in hospital. (P106, Ectopic Pregnancy)

> It was the day of the anomaly scan. … So I just texted my manager and said I won't be in. So then she asked me for a cert. *Interviewer: Immediately?* Pretty much yeah … And then I sent in the cert but the cert was kind of I think it had said a few months on it or something like that but she only works with dates so she asked me to go back and get another cert that had dates on it. But I actually ignored that message. I just said I've enough to be doing without worrying about that so I didn't. (P456, Second Trimester Miscarriage).

Leave for partners

We also spoke with participants about the possibility of a pregnancy loss related leave for partners. Generally participants felt that partners should also be entitled to leave, in order to support the woman who is physically losing the pregnancy, to look after other children, and to process their own emotional responses to the pregnancy loss. However, most participants felt that partners would not need the same amount of time off work.

> So 100% there has to be and should be some provision in public policy for partners … I think even two weeks leave would seem like a decent gesture to help support the women … After the second day when he was saying to me love I have to go into work and I'm upstairs on the bed absolutely you know balling like the world had ended and he had to leave the house and go to work. You know it's just cruel … But also my partner he didn't process any of those … There's no space for him to grieve, no time for him to process any of it. (P861, First Trimester Miscarriage)

> I think he would have felt better if there was a way he could have just taken those days off … we just needed help with the physical bit of it that

> you know he probably would have just wanted a day or two (P704, First Trimester Termination of Pregnancy)
>
> He didn't take the day after I had the D&C off work so I was at home on my own with the two kids … I was so cross with him … But he was getting caught from both ends where he was coming under pressure with work, he was under pressure at home … What we really needed was him to take the week off and the week after the D&C off … (P886, Second Trimester Miscarriage)
>
> Yeah it would seem to me yeah probably a different kind of timeline should apply for the woman (P660, First Trimester Miscarriage, Partner/Father)
>
> he did take a couple of days off but I suppose I pushed him back to work in one sense. But he did take a couple of days off initially and then later on when I was sick and I was in hospital he was able to take a little bit of time off there … I think having that leave there as an option would be important to recognizing actually that you have a right to space and to grieve too. … This sounds terrible but in a way I do think that the person who has experienced the actual physical loss could need longer. I do feel that. (P173, First Trimester Miscarriage)
>
> Having a partner by your side during this is really helpful. Because I was in quite a bit of pain and my husband you know he kind of was upset about the loss as well. It wasn't physically happening to him but you know we were kind of planning for this new life and this future… … So he was kind of you know upset and grieving a bit about it but nowhere near to the level that I was, so if he doesn't get leave it's fine. *laughs* (P249, First Trimester Miscarriage)
>
> … he'd be very different in the way that he'd want to work. You know he'd want to keep going… I think it would be nice if they could be at home with you maybe for a few weeks. (P456, Second Trimester Miscarriage).

Termination of pregnancy

We spoke with participants about termination of pregnancy and whether leave should be provided in these cases. One participant experienced a first-trimester termination of pregnancy; another participant experienced a termination of pregnancy for medical reasons at 23 and a half weeks; and all others experienced spontaneous pregnancy loss and shared their personal views on termination of pregnancy. Overall, participants spoke of the need to support women through these experiences, noting the physical effects of termination of pregnancy, the distress and grief of termination for medical reasons, and the need for understanding and compassion to be offered at a time that might be difficult for a variety of reasons. Some participants spoke of the stigma and judgement surrounding termination of pregnancy in the Republic of Ireland, and the need to counteract this with acceptance and support.

I just needed days to physically recover. (P704, First Trimester Termination of Pregnancy)

I can't imagine that anybody who is having an abortion is in that position because they want to be there… absolutely 100% if they need time they need time, I wouldn't begrudge it to anybody … I think I'd nearly feel sorrier for someone that found themselves in a position of having an unwanted or an unviable pregnancy (…) Whereas God if you find yourself with an unwanted pregnancy or a pregnancy that's inviable I think you'd need more time than four weeks. (P886, Second Trimester Miscarriage)

I feel they should get it too because it's different but no-one knows their reasons. .. But even the reason shouldn't matter. No-one goes out and gets pregnant and terminates it for the craic. It's not an easy choice. Yeah, it's medical. Your body has been through a trauma. I feel like your body needs time to heal from that trauma. It doesn't matter what reasoning was behind the trauma, who decided on the trauma, your body feels it all the same regardless. So I feel like the laws should be there regardless. (P107, Ectopic Pregnancy)

Yeah I think they should be entitled to the same leave as well. Abortions aren't always something that a person chooses and even if it is something that they choose they're still dealing with the physical effects of the loss. There's still material being passed or blood being passed. There's all of that that still happens you know. They're still cramping. There's still pain. It's not an easy you decided and all of a sudden it's gone kind of a thing. So I think some support for that is still necessary. (P249, First Trimester Miscarriage)

Absolutely. I suppose… I can't see any reason why I wouldn't, it's a procedure like anything else … So I don't see any reason why not, no. (P841, First Trimester Miscarriage)

So I really do think it's important that abortion is included in this also just because that goes a long way towards restoring the place of abortion is just a natural pregnancy outcome. Like there will be pregnancy loss unplanned. There might be abortion. It is a normal part of the reproductive life cycle and I think if it wasn't included I could kind of understand the logistical argument why some governments do that but putting it in actually helps further normalise and destigmatize abortion. (P704, First Trimester Termination of Pregnancy).

How leave related to pregnancy loss should be titled

We explicitly asked participants what they thought about how leave related to pregnancy loss should be titled, if introduced. Many participants expressed that is it challenging to decide or suggest a specific name and some were reluctant to do so. Most of the participants described themselves as people who were open to sharing and talking about their pregnancy losses and therefore would be amenable to a name specifically associated to this issue such as "pregnancy loss leave", or "miscarriage leave". However, they recognised that not everybody may

be willing or able to share, and in some workplaces it would be unsafe or potentially detrimental to do so. Therefore, privacy was frequently cited as a concern related to the adequate choice of name for a leave related to such a sensitive issue. Hence, the benefit of a non-pregnancy related or pregnancy-loss specific name, such as, compassionate leave or women's health leave were recognised.

> I mean my instinct is to say pregnancy related but at the same time if you were to include you know people who have to go through terminations you know they may not want it known or they may not want it on their record or whatever. I don't know. So it's a tough one actually. And again I'm sure there are women you know who go through miscarriage and don't want anyone to know … maybe something that catches everything might be the best like women's health leave or you know something specific to women that might then also cover any future inclusions of the likes of menopause or period or whatever. (P861, First Trimester Miscarriage)

> I think it's important that miscarriage leave would include abortions but maybe not calling it miscarriage and abortion leave, something more like pregnancy loss. (P704, First Trimester Termination of Pregnancy).

Additionally, participants highlighted that it was important that this leave is not called sick leave, that it does not count towards sick leave allowance, and that it reflects the difficulty and significance of pregnancy loss.

> Me personally, I'd call it that … miscarriage leave and it's not ever seen … or that it never goes down as sick leave. You know you still have your sick leave entitlements basically from the end of it. (P395, First Trimester Miscarriage, Partner/Father).

5.3.5 Theme 4: Workplace supports

We spoke with participants about any workplace supports they received, and if they were helpful. We also asked if there were ways in which their workplace could or should have supported them. Their responses primarily related to flexible and reasonable allowances.

Some participants were afforded extra supports while others discussed supports they wished they had been afforded. This could look like flexibility in hours, working from home, reduced workload, or alternative work arrangements where employees could avoid the more emotionally challenging or triggering aspects of their role (for example working with children or pregnant women, physically demanding tasks, among other circumstances). These supports, by necessity, look

different for each workplace and each role, so would need to be considered in the context of each workplace.

> Even just half days. I would have taken the pay cut you know for a half day for a week or two. Even just do the evenings and just be able to sleep a bit more and get a bit more rest and stuff like that. (P106, Ectopic Pregnancy)

> He kind of let me have a bit of a slower few weeks to you know get myself back into it... So he asked me to re-prioritise, look at my worklist and just say yeah as long as you can get these few things sorted like take as much time as you need, these are the important things we really need to achieve here. So that was really helpful. (P249, First Trimester Miscarriage)

> The benefits of working from home ... if I needed 15 minutes or half an hour to myself I had that space and I was in my own space for it as well. ... And I was still dealing with the physical effects of it ... I needed time for bathroom breaks and changes and stuff like that so it was very helpful to kind of be working from home at that point. (P249, First Trimester Miscarriage)

> I had kind of requested to come back at reduced hours I suppose I was working with young children so it was hard in that sense. And also it was quite a stressful job so I just didn't know if I'd actually be able to dedicate myself fully to it at that time mentally ... I came back on a part-time capacity. (P173, First Trimester Miscarriage)

> So I took a full 6 weeks off and then I had 6 weeks of basically I could just take whatever file I wanted and worked away on it and he spoke to the clients for me ... I didn't have to take any calls. And I made the decision then when I was ready then to take calls. (P175, Second Trimester Miscarriage)

> so a lot of my work at that time was with kids and I asked could I go back either kind of just seeing adults or just doing kind of admin of which we have plenty of admin ... because there was another girl who'd been out sick and had come back only doing admin so she kind of said to me when I came back well we don't want you just sitting around doing nothing. So when I asked could I just see adults or could I just do admin that was the response I got. (P456, Second Trimester Termination of Pregnancy).

Regarding other supports, participants discussed the need for emotional or psychological support. Some participants expressed a need or desire for counselling, either through their workplace Employee Assistance Programme (EAP) or through referral.

> I would have liked to have seen maybe some contact numbers for helplines or someone to talk to about it. It wouldn't be much. (P106, Ectopic Pregnancy)

> Even just the case of I suppose having support there, having some form of counselling or therapy that they could have actually referred me to ... And

> yeah I think I didn't actually go and really seek any counselling or help for a while and again that was kind of based on finances really. So if it had been something that was linked to work even like that if it was some form of an EAP program that you even had you know three or four sometimes there's six sessions that are covered it definitely would have helped. (P173, First Trimester Miscarriage)

> There was no kind of mention of any counselling or anything … I had a a couple of sessions with the bereavement nurse in the [maternity hospital 2] and I was seeing a very good counsellor in the sexual health clinic in town actually … But yeah there was nothing from work. … I mean every time I open my work emails from the [health care organisation] they're all about you know employee wellbeing and this and that and it would kind of make you laugh a little bit you know. When it actually comes down to it there isn't actually the support when you need it you know. (P456, Second Trimester Miscarriage).

While a few participants were able to access counselling through the EAP, others spoke about accessing their own support privately. The importance of having counselling available for this issue specifically (beyond the assigned sessions included in the general EAP) was also mentioned.

> We have an employee assistance program which gives you six counselling sessions. And earlier on in 2018 I had used up my six counselling sessions … within a few weeks I had lost that baby. And straight away I rang him again. And I rang him about three times and I left voicemails but he never called me back and I know it was because I had exceeded my six feckin counselling sessions … So I think on the basis of somebody presenting to work or their boss that they've had this situation should 100% no matter what be offered you know assistance from the counselling, the occupational health service immediately regardless of whether you've had your six sessions before or whatever. So I think it should be an immediate thing. (P861, First Trimester Miscarriage)

> So we would have doctors here in [my workplace] … She was brilliant … I went to see her afterwards. Just, you know, just to get her to check the wounds or whatever … And sure like just I suppose in general like asking me how I was, offered me support, gave me her own number … and then we would have … access to counsellors or social work or whatever. (P657, Ectopic Pregnancy)

> I was going to a guy. [My therapist] was brilliant … [He] was an ex-principal who became a therapist and I was going to see [him]. (P395, First Trimester Miscarriage)

> I was offered emotional support if I needed and counselling if I needed it. (P249, First Trimester Miscarriage).

5.3.6 Theme 5: Public policy and awareness

Across the interviews, participants often returned to a point which many of them felt was the most important next step for supporting those through pregnancy loss – talking about it.

Participants described miscarriage or pregnancy loss as a taboo subject, particularly in the context of a 'Catholic Ireland' which has not recognised or respected women's health. They discussed how this taboo contributes to women and their partners staying silent about their pregnancy loss, not knowing where to look for support, or facing unhelpful reactions in their personal lives, healthcare settings, and the workplace. Many participants felt that by the Government introducing statutory leave provisions and supports, it would be a national recognition of pregnancy loss experiences, and this would serve to facilitate and encourage conversations about pregnancy loss at all levels of society.

> I think public awareness around pregnancy loss is not where it should be. And I think that can only come about as a result of government policy or government awareness raising … Changing public awareness and out of that will then come you know a softening in attitudes. (P861, First Trimester Miscarriage)

> I think like that if they put in some kind of like statutory like leave it would acknowledge that it happens and it would also acknowledge that there's a grieving process as part of it … in the kind of vacuum of it not been spoken about. (P660, First Trimester Miscarriage, Partner/Father)

> I suppose women in general in Ireland have always been second class citizens. You can see that with nearly everything … We've got the Catholic church with regards fertility and contraception and everything how long that took to come in. (P841, First Trimester Miscarriage)

> I do think it's the last taboo. It really is the last. We're dealing with a lot of stuff as a country. Like you know we've had the referendums and all those on gay rights and gay marriage and abortion and all this stuff and rightly so and I just think this one is the last. This needs to be talked about I think. That's why I'm here now. It just does need to be discussed. It's a horrible topic but it needs to be. (P395, First Trimester Miscarriage, Partner/Father).

5.4 Summary

We interviewed eleven women and two men who experienced pregnancy loss in the past five years. Participants experienced a variety of losses, including first- and second-trimester miscarriages, ectopic pregnancies, first- and second- trimester termination of pregnancy, and multiple consecutive miscarriages. Almost all participants shared their loss with somebody in their workplace, usually to access

or explain leave. Most participants received supportive or empathetic responses, but some faced negative reactions or a lack of accommodation. Almost all participants took some time off work following their pregnancy loss. Those who experienced second-trimester losses took significantly more time than earlier losses.

Almost all participants supported the idea of statutory leave for pregnancy loss. Participants emphasised that this leave would need to be paid and not affect sick leave entitlements. All participants who discussed termination of pregnancy felt that this should be included in statutory leave. Leave for partners was also seen as necessary, but not to the same extent or for the same length as women.

Many participants spoke of the need for pregnancy loss to be discussed in workplaces and Irish society, to raise awareness and reduce the stigma and taboo around the topic. Acknowledgement and recognition from the Government was seen as crucial to open up this conversation.

Chapter 6. Key findings and discussion

6.1 Background

In June 2022, the Department of Children, Equality, Disability, Integration and Youth (DCEDIY) commissioned the authors of this report to examine the workplace experiences of people whose pregnancy had ended prior to 24 weeks gestation. The rationale for this focus on earlier pregnancy loss was that people who experience pregnancy loss from 24 weeks gestation are entitled to full maternity and paternity leave. The overall aim of the PLACES (Pregnancy Loss in Workplaces) Project was to examine workplace experiences of pregnancy loss and determine what formal or informal support mechanisms could be introduced in the workplace to better support people who experience pregnancy loss under 24 weeks gestation.

This aim was met through a series of studies:

- **PHASE 1:** Scoping study
    - Literature review and comparative analysis of international models with expert/key informant input (Chapter 3)
- **PHASE 2:** Qualitative/quantitative research studies
    - Survey and in-depth interviews to capture the workplace experiences of workers who have experienced pregnancy loss (Chapters 4-5).

In this chapter, we integrate the findings from Phases 1 and 2 of the Project to produce recommendations for formal or informal support mechanisms that could be introduced in the workplace. In the following section (6.2), we outline and integrate key findings from the Project. Key issues and associated recommendations then follow in Section 6.3.

6.2 Key findings

6.2.1 Literature

Though literature discussing workplace experiences of pregnancy loss before viability is sparse, recent studies in the area have found common themes – across countries, types of pregnancy loss, and demographics. Women and partners need time off work following pregnancy loss; this leave should not detract from other leave entitlements. Work is difficult to return to following pregnancy loss, and

workplaces can implement supports in order to make this return easier. Supports can include flexible working, access to counselling, and emotional support from management or colleagues. Despite the prevalence of early pregnancy loss, it continues to be a stigmatised and silenced topic.

6.2.2 Phase 1: Scoping study – Legislation review

Just 10 of 80 jurisdictions assessed in this review provide statutory leave from work in the case of pregnancy loss before viability. This leave varies significantly in terms of length, eligibility, and conditions of leave.

New Zealand and Australia both recently introduced compassionate / bereavement leave of less than one week for women and their partners experiencing pregnancy loss. This leave entitlement does not apply to those who have had a termination of pregnancy. This provision of leave gives recognition to miscarriage as a loss and allows some days away from work to process the experience, and is inclusive of partners, but the length may be an insufficient rest period to physically recover, and exclusion of termination of pregnancy serves to reinforce stigma and suggests that people who decide to terminate their pregnancies are undeserving of the same compassion.

South Korea and Taiwan set out different lengths of leave depending on gestational age at which the pregnancy ends. Those with later term losses have access to longer leave periods which may reflect the stronger physical and emotional impacts of a later pregnancy loss. This may not adequately support those with earlier losses which have significant physical or emotional impacts. Panama, Puerto Rico, and Portugal provide leave whose length is determined by the doctor attending to the miscarriage. This places a large amount of responsibility and power in the hands of medical staff, and may not account for the emotional impacts of a pregnancy loss. Partners are excluded from this leave – this may be due to the focus on the physicality of miscarriage. Iceland and Macao only allow employees to take leave if the pregnancy ends after 18 weeks and three months, respectively. Québec provides leave of three weeks to those who experiences any type of loss at all gestational ages. However, this leave is unpaid. A lack of payment may mean that some employees are unable to avail of this leave due to financial reasons. This leave is also not available to partners.

Other jurisdictions such as Northern Ireland, Catalunya, Nova Scotia, and Alberta are considering legislative changes to introduce leave specifically for pregnancy

loss. Some low- and middle-income countries such as India and China have had leave provisions for early pregnancy loss for decades.

6.2.3 Phase 1: Scoping study – Company policies

Of the 179 companies in the Republic of Ireland that were contacted, 20 companies shared whether they have a pregnancy loss before 24 weeks policy, of which 9 did. All nine companies provide paid leave to employees who experience a miscarriage, between 3 and 20 days (average of 9 days; one company has no specific limit; one company varies length of leave according to gestation). Most companies provide leave to partners and include termination of pregnancy in this leave entitlement. Other supports within these companies include flexible working arrangements and access to free professional counselling.

6.2.4 Phase 2: Primary research – Survey study

Nine hundred and thirteen individuals were included in our survey analysis. Many women experienced physical effects of their pregnancy loss, including pain, bleeding, infection from surgery, or postpartum symptoms. Most women and men/partners went through a period of sadness or grief over the loss of the pregnancy and loss of the future they had planned.

Returning to work was a stressful / upsetting experience for many participants. Many participants returned to work before they were ready due to a lack of leave or cover, pressure from their workplace, or feeling the need to get back to avoid a buildup of work or burdening colleagues.

Most participants shared their loss with somebody in their workplace. However, some people kept their loss to themselves, to protect their privacy or to avoid negative and/or hurtful reactions, or adverse career implications.

Participants expressed a strong need and desire for paid, protected time off work which would not affect other leave entitlements. Participants also discussed the need for workplaces to receive training and increase knowledge and awareness about pregnancy loss, so that they would know how to better support employees who have these experiences.

6.2.5 Phase 2: Primary research – Interview study

Thirteen participants from our survey study subsequently participated in our interview study.

Most participants disclosed their pregnancy loss to someone in their workplace, and received reactions from helpful and supportive to unsympathetic, awkward, or malicious. All participants who sought time off work were granted some leave, almost always sick leave. Some participants faced an untimely return to work due to a financial strain, expectation to return, or fear of implications for their career.

Most participants were in agreement that there is a need for statutory leave for pregnancy loss before 24 weeks. A number discussed the importance of a legal entitlement to this leave to make it accessible to all. Participants strongly supported the inclusion of termination of pregnancy in this leave. They also felt that partners should be entitled to some leave, in order to manage their own sense of loss, and to support their partner, especially physically. Participants emphasised the need for awareness and recognition of pregnancy loss, the importance of destigmatising the topic, and the value of statutory support in encouraging these conversations.

6.2.6 Integration of findings across studies

Integrated findings from above studies (Sections 6.2.1-6.2.5) are presented in Table 6.1 and summarised here. Returning to work following a pregnancy loss at any stage poses emotional, social, and physical challenges. Many participants faced insensitive comments or questions, or unhelpful reactions to their pregnancy loss. Feared or actual discrimination relating to pregnancy and pregnancy loss was frequently discussed.

Across the literature and our primary research, leave from work was necessary in most cases. In the majority of countries and workplaces included in our studies there is no separate or protected leave entitlement for pregnancy loss. Ten high-income countries, and nine companies in the Republic of Ireland who responded to our request for information, provide specific leave – this varies from 2 to 90 days; and differs on need for certification; eligibility of partners; inclusion of termination of pregnancy; and factors influencing length of leave. Participants in studies faced challenges in taking adequate leave, including financial concerns, lack of leave entitlement, and pressure to return to work. Sick leave was the most common form of leave taken following pregnancy loss, though this was not what participants generally felt is appropriate or supportive. Upon return to work, allowances such as working from home, flexible hours, and altered working arrangements were appreciated by participants, alongside emotional support from management and/or colleagues.

Pregnancy loss is still a taboo topic and individuals experiencing loss face stigma, judgement, and a lack of understanding. Workplaces are not equipped to support those who experience loss, nor is wider society. Policymakers and management within workplaces need to promote awareness and understanding, and create policies to support those experiencing pregnancy loss before 24 weeks gestation.

Table 6.1 Integrated findings across studies

Key Finding	Literature (Chapter 1)	Legislation (Chapter 3)	Company Policies (Chapter 3)	Survey (Chapter 4)	Interview (Chapter 5)
Difficulties in returning to work	Productivity was often affected • Diminished ability to concentrate • Distracted by emotions and thinking about their loss • Losing motivation / caring about work anymore Dealing with physical symptoms • Bleeding • Cramps Managing relationships in the workplace • Facing judgement, a lack of understanding • Insensitive comments or questions			The emotional, psychosocial, and physical impacts of the pregnancy loss: • Sadness, grief, sense of loss • Bleeding, pain, fatigue, recovery from surgery • Ability to concentrate on the work, caring about their job • Returning to normal life or work life • Socialising with colleagues; facing other pregnant women; discussing their loss • Managing their workload, especially in stressful jobs or working with children / pregnant women	Some participants were still experiencing physical symptoms when they returned to work, sometimes with physical job demands A small number of participants faced unaccommodating or unkind managers when they returned to work who didn't respect their need for time off or their request for altered duties Certain roles, such as working with children, were especially difficult to return to. Four participants and one participant's husband left their role shortly after their pregnancy loss experience
Taking leave	Some participants took no leave following their pregnancy loss, especially men, or those who experienced earlier losses	10 / 81 high-income countries / regions provide pregnancy loss leave	9 / 20 companies that participated had a specific pregnancy loss policy including paid leave	77% of participants took some time off work following their pregnancy loss: • 78% took paid sick leave	Some of our participants took no leave or just a few days. The reasons for this varied from not needing leave to not

Key Finding	Literature (Chapter 1)	Legislation (Chapter 3)	Company Policies (Chapter 3)	Survey (Chapter 4)	Interview (Chapter 5)
	Across the world, participants faced issues with a lack of entitlement to sufficient / paid / appropriate leave	• Compassionate or bereavement leave (3) • Maternity / paternity leave (4) • Miscarriage / pregnancy loss leave (2) • 2/3 days in Australia and New Zealand • 3 weeks in Québec and 2 months in Iceland • 5-60 days in South Korea; 5-30 days in Taiwan, depending on gestation • Determined by medical practitioner in Portugal, Panama, Puerto Rico, Macao • Some provisions for partners and termination of pregnancy • Certification generally required	• Majority provide as compassionate or bereavement leave (7); Miscarriage leave (2) • Average of 9 days of leave for women across companies, range 3 – 20 days • 1 company varies by gestation: 5 days for 1-3 months of pregnancy; 20 days for 4+ months of pregnancy • Certification generally not required • Generally provide leave for partners and termination of pregnancy	• 15% took unpaid leave • 12% took annual leave • 27% took up to 2 weeks leave • 29% took between 2 weeks and 1 month • 20% took 1 month or more • The percentage of participants taking more than one month leave was highest for those who experienced a second trimester pregnancy loss • Nearly half of participants were required to provide certification	having any leave that they could take Participants who experienced ectopic pregnancy or first trimester termination of pregnancy described needing leave to deal with physical symptoms primarily Participants who experienced second-trimester losses took over a month's leave from work and were supported in doing so Some participants felt that they were penalised by their workplace for taking time off
Workplace supports	Practical supports: • Working from home • Modified duties or work arrangements		In addition to their leave policies, some companies also provided:	Participants found it helpful when supports such as phased return; reduced workload; altered schedule/duties;	Access to counselling services through the workplace were varied – some participants were unable to avail of

Key Finding	Literature (Chapter 1)	Legislation (Chapter 3)	Company Policies (Chapter 3)	Survey (Chapter 4)	Interview (Chapter 5)
	• Flexibility Emotional supports: • Recognition and acknowledgement of the loss • Kindness and talking about it • Sharing stories about personal pregnancy losses		• Employee Assistance Programmes with counselling • Flexibility on return • Guidebook for pregnancy loss supports • Buddy system • Direct leader support	working from home; or flexible deadlines were offered. Many participants described how kindness and emotional support from colleagues made their return to work easier	services or were not offered referral, while some participants could have accessed counselling through their workplace or trade union Flexible working arrangements were not commonly provided; few mentioned that they were accommodated in a phased return to work Most participants were treated with kindness by their colleagues on their return
Awareness and stigma	Across the literature, the stigma, silence, and lack of knowledge surrounding pregnancy loss is discussed. Many authors and participants noted how the lack of awareness and acknowledgement negatively impacted on pregnancy loss experiences			Many participants who chose not to disclose their pregnancy loss to anyone in their workplace discussed the stigma and shame still surrounding pregnancy loss, especially earlier losses or termination of pregnancy. The need for greater awareness around this issue was frequently mentioned	Some participants spoke at length about the lack of awareness, recognition, and acknowledgement of pregnancy loss, particularly in Ireland Participants felt strongly that more needs to be done at a governmental or societal level to increase awareness and decrease stigma and taboo around pregnancy loss

6.3 Discussion

In this section, we discuss the integrated findings presented above, and present key recommendations from the Project. These recommendations encompass three areas:

- Legal aspects of pre-viability pregnancy loss (Section 6.3.1)
- Workplace environments and pregnancy loss before viability (Section 6.3.2)
- Public awareness of pregnancy loss (Section 6.3.3).

6.3.1 Legal aspects of pre-viability pregnancy loss

The law is important in responses to pre-viability pregnancy loss for two reasons – first, because legal rights provide certainty and protection, and secondly because the fact that a legal right exists has an important educative and expressive function as it shows that the State takes these rights seriously. This can impact on behaviour outside of the legal framework.

Statutory leave

In the Republic of Ireland at present, the only statutory leave entitlement for an employee who experiences pregnancy loss before 24 weeks gestation is sick leave. By European standards, statutory sick leave entitlements in the Republic of Ireland are limited. Under the Sick Leave Act 2022, an employee who is incapable of working due to illness or injury is entitled to three days paid sick leave in a year (Section 3.1). This entitlement will increase incrementally to a total of 10 days by 2026. The leave is paid for by the employer at 70% of the employee's normal pay, up to a maximum of €110 per day. This entitlement will not apply to self-employed people.

In order to access the leave, the employee must have been working for 13 weeks and must provide his or her employer with a medical certificate. Many employees will have more generous sick leave entitlements as part of their contracts of employment. The extent of the leave and the requirement for the leave will depend on the contract of employment. As the review of company policies (see Section 3.2) shows, some employees may also have a contractual right to bereavement or compassionate leave including in respect of pregnancy loss before 24 weeks.

A key message emerging from the survey is that current statutory leave entitlements are not seen as satisfactory. While this is true at all stages of pregnancy loss, it is seen as a more significant problem where the pregnancy is

more advanced. There were a number of factors contributing to this view, including the fact that with a second trimester loss more people will know about the pregnancy and there could perhaps be a birth and a funeral. There was a feeling that the current legal framework was unfair because it imposed an arbitrary cut-off of 24 weeks, after which the loss is identified as a stillbirth and full maternity leave entitlement arises.

Participants in the study favoured the introduction of statutory paid leave in cases of pregnancy loss and emphasised that statutory leave was important because it took the matter out of employers' control and paid leave was important because it ensured accessibility. Participants identified that this would be especially important for more vulnerable and low-paid workers. A striking majority (95%) of participants stated that if leave had been available to them, they would have taken it, although that percentage decreases slightly if disclosure of pregnancy/pregnancy loss or certification was a pre-requisite to taking leave.

The review of statutory leave for pre-viability pregnancy loss in other jurisdictions found that there is no standard approach to leave entitlements nor is there a standard definition of viability. In broad terms, we can see two statutory approaches (although sometimes both are mixed). The first is a sick leave model, generally paid for by the employer, where the duration of the leave is linked to the physical impact of the pregnancy loss and where the leave is generally certified by medical professionals who exercise clinical judgement in determining the duration of leave. Some jurisdictions e.g. South Korea and Taiwan link the duration of leave to the stage of gestation of the pregnancy with later term pregnancy losses entitled to longer leave. This leave is generally available for pregnancy loss for all reasons, including termination. Because of the nature of this leave, which is primarily aimed at addressing the physical aspects of the pregnancy loss, it is generally not available to partners.

The second model is a compassionate/bereavement leave model. This is typically available in jurisdictions which already had some form of statutory compassionate/bereavement leave in place, with leave for pre-viability pregnancy loss simply being added as another basis for leave within an existing framework. Again this form of leave was generally paid for by the employer. Bereavement/compassionate leave is intended to acknowledge the grief associated with pregnancy loss and is usually available to a broader range of affected parties e.g. the partner of the person who has experienced the pregnancy loss. This leave is generally quite limited in duration - in Australia, it is for two days paid leave and in New Zealand it is for three days paid leave. Medical certification

is less important under this model. In the countries examined which adopted this approach the leave generally did not apply to pregnancy losses which are as a result of termination of pregnancy. One of the features of this model of leave is that it can play a symbolic or expressive role, indicating an acknowledgement by the State of the impact of pregnancy loss on those affected. However, the introduction of statutory bereavement leave for pregnancy loss in the Republic of Ireland in the absence of other forms of leave, e.g. statutory bereavement leave in respect of the death of a child or spouse, could be contentious.

Neither model discussed above exactly matches what participants in this project indicated that they needed, although the sick leave model seems to align better with the responses to the survey. In general, participants were of the view that having the option to take a longer period of leave was important to recognise the physical impact of the loss and because the circumstances within which the loss occurs vary considerably. Relevant factors mentioned which impact on duration of the leave included whether it was a second trimester loss; whether the person had experienced multiple losses; and whether leave was needed for the management of the pregnancy loss, for example if surgery was required. Participants were generally accepting that this leave should be certified, although as noted above this may discourage some people from availing of such leave. Some participants in the study chose not take leave so that they did not have to disclose, as this was seen as a very personal and private situation.

Having said this, there was also support for aspects of the bereavement/compassionate leave model. A significant number of participants indicated support for including partners within the scope of pregnancy loss leave and some participants also emphasised their need for privacy which could be better achieved through a bereavement/compassionate model when the reason for the leave might not have to be made public.

Recommendation 1

A statutory right to paid leave should be introduced for pre-viability pregnancy loss, regardless of the gestational stage or the reason for the loss. This should be subject to medical certification. This would play two roles: first it would allow for a period of recovery, and second it would show societal recognition of the impact of pre-viability pregnancy loss.

Recommendation 2

Any leave introduced should be of sufficient duration to meet the needs of those affected, which are presented in this report.

In the other jurisdictions examined, the model of pregnancy loss leave introduced was influenced by the existing statutory leave frameworks, all of which are more generous than in the Republic of Ireland. The duration and scope of any leave in the Republic of Ireland would have to be considered in the context of existing statutory paid leave provision. Current statutory paid sick leave is three days (to be increased to 10 days by 2026), while the statutory entitlement to leave following a stillbirth after 24 weeks of pregnancy is 26 weeks maternity leave. Payment of maternity benefit is subject to having the requisite PRSI contributions, and there is no statutory entitlement to receive payment from the employer while on maternity leave, although employers can choose to pay employees while on maternity leave. The needs of people experiencing pre-viability pregnancy loss will vary and any statutory provisions introduced will need to have regard to this.

Recommendation 3

A statutory right to paid leave for pregnancy loss should also be introduced for partners. According to international literature and the findings of primary research detailed in this report, this leave is needed in order to process their own loss and to support their partner (including the care of any children).

Protections against discrimination

Participants in the study identified fear of discrimination – either of being sidelined at work or having fewer opportunities for career progression – as a factor that prevented them from disclosing their pregnancy or the loss of their pregnancy in the workplace. At present in the Republic of Ireland the Employment Equality Acts prohibit someone being treated less favourably on the basis of pregnancy under the gender ground (section 6 Employment Equality Act 1998, as amended), and this includes conditions of employment and promotion, and also less favourable treatment while on maternity leave or on return from maternity leave. In addition, the Unfair Dismissals Act 1977, as amended, prohibits someone being dismissed for reasons relating to their pregnancy (section 6(2)(f)) (including giving birth, breastfeeding or attending antenatal classes) or for availing of statutory leave provisions including: maternity leave, adoptive leave, paternity

leave, carer's leave, parent's leave, parental leave or force majeure leave (Unfair Dismissals Act 1977, 2016). A recent decision of the Workplace Relations Commission (WRC) illustrates how the existing statutory framework in relation to unfair dismissals for reasons relating to pregnancy continues to apply in circumstances where the complainant has experienced pregnancy loss. In *Siudak v Slane Trading Company Limited* [2023] ADJ-00038952 the complainant was dismissed from her role (Workplace Relations Commission, 2023). She had disclosed her pregnancy to her employer and sought alternative working arrangements due to concerns relating to Covid. This accommodation was provided. The complainant subsequently experienced a miscarriage and returned to work. Shortly after she was dismissed. The adjudicating officer rejected the respondent's argument that the dismissal was related to underperformance in the role and found instead that the dismissal was related in some way to the complainant's gender and pregnancy and therefore it was a discriminatory and unfair dismissal. While the law in relation to unfair dismissals is clear, some participants in the study described how they were denied pregnancy-related sick leave when they experienced a pregnancy loss on the basis that they were no longer pregnant and therefore not entitled to that particular form of leave. For the avoidance of any doubt, therefore, any specific statutory leave related to pregnancy loss introduced should specify that it would be covered by equality law and less favourable treatment on the basis of taking such leave would be prohibited on the gender ground as a pregnancy related issue. In addition pregnancy loss leave, if introduced, would need to be added to the list of family/care related leaves which are covered by the Unfair Dismissals Act.

Recommendation 4

If, in accordance with the recommendation above, statutory paid pregnancy loss leave is introduced, it should be added to the list of family/care related leaves which are covered by the Unfair Dismissals Act. The statutory wording introducing any such leave should also make clear that such leave is covered by equality law and less favourable treatment on the basis of taking such leave is prohibited under the gender ground as a pregnancy-related issue.

If statutory paid pregnancy loss leave is not introduced, then guidance should be issued to employers to clarify that any less favourable treatment of an individual for taking existing leave entitlements following pregnancy loss is covered by the provisions of employment equality legislation and would amount to discrimination on the gender ground as a pregnancy-related issue

6.3.2 Workplace environments and pregnancy loss before viability

Workplace environments can both positively and negatively impact individuals who have experienced pregnancy loss before viability. Positive working environments can support individuals experiencing pregnancy loss as they transition back into the workplace. Participants in this study have described situations where their news of pregnancy loss was received with a lack of compassion, empathy, absence of support and even disregard for their experience or need for recovery, at times with pressure to remain at or return to work. To ensure workplace environments are responsive to individuals experiencing pregnancy loss, the impact of toxic workplace environments and discriminative practices must be understood, and consistent appropriate policies and practices put in place to develop positive work-based cultures and climates. The findings of this study, that workplaces have the capacity to support individuals during pregnancy loss, have been reflected in the work of Gabriel et al (2022) and Gilbert et al. (2023) who have identified that organisations which encourage supportive supervisors and co-workers can positively impact on maximising perinatal and antenatal maternal care. Appropriate education and training must be provided within workplaces and policies developed which recognise the importance of supportive environments and mitigating the impact of stigma around pregnancy loss. The importance of responsive workplace environments where practical and psychological supports are readily available to individuals' experiencing pregnancy loss before viability must be recognised and embedded within workplace cultures and environments.

Promoting positive workplace cultures and environments

The impact of workplace cultures and environments on individuals experiencing pregnancy loss before viability was identified from both a positive and negative perspective in this report. Strong and positive workplace cultures, which encouraged openness and good communication in relation to pregnancy loss, fostered supportive workplace environments. Such workplace environments ensured that employees could choose to disclose as little or as much as they wanted, in terms of their experience of pregnancy loss. Workplace environments where individual employees felt empowered to talk about and share their experiences, promoted open disclosure, reduced stigma and fostered positive “peer to peer” support along with formal support services such as formal policies on leave eligibility, and the availability of employee counselling services. This importance of fostering good communication and promoting the sharing of experiences has been shown to counter the “silence” around pregnancy loss within organisations, and these “silences" have been shown to have a negative

impact not only on the individual themselves, but also their co-workers (Hazen, 2006). The importance of empathetic and compassionate responses from HR personnel, such as commiserating with individuals on their loss, was seen as significant in supporting individuals to access work-based supports, both in this study and in literature (Steimel, 2021).

Many individuals in this study indicated that their experience of pregnancy loss was an intensely private experience which they might only wish to discuss with a small number of individuals, and supportive work environments had structures in place to ensure staff members were aware of this prior to the individual involved returning to the workplace (Steimel, 2021). In other instances, individuals wanted to talk about their loss, and valued the social support provided by colleagues and friends at work. Participants indicated that fostering environments where pregnancy loss could be openly discussed could help dissipate the societal taboo around this topic. Returning to work was identified as an important coping mechanism in this study, and in the available literature (Gilbert et al., 2023; Meunier et al., 2021). This was especially the case when the workplaces involved were able to support these employees, cognisant of the physical, psychological and emotional impact of pregnancy loss on the individual involved.

The issue of toxic work environments was raised by study participants and significantly negatively impacted the wellbeing of these employees. A lack of basic empathy, such as not commiserating with the employee involved, caused significant distress. Requests for supporting documentation such as medical certs caused difficulties, particularly if the employee involved did not want to reveal they had experienced a pregnancy loss. This was particularly true in environments where the privacy of individuals was not respected and individuals did not want to become the subject of gossip. This study has further found that in some work environments, individuals did not disclose their pregnancy loss as they pre-empted that supports would not be available to them, or feared their disclosure might impact their career advancement and promotion prospects.

Recommendation 5

Given the individuality of each person's experience of pregnancy loss, patient and public involvement in the development of policies and practices which promote positive workplace cultures and environments is recommended.

Workplace policies and supports for pregnancy loss

One of the Project's key findings relates to HR and line managers' lack of information and education on pregnancy loss. People managers need to be empowered to provide thoughtful support for colleagues affected by pregnancy loss. A recent survey by the Chartered Institute of Professional Development in the UK found that just one in four employers (26%) provided line manager training to support employees experiencing pregnancy loss (Miller & Suff, 2022). Providing empathetic support and using sensitive language to address the issue of pregnancy loss and its associated impacts is equally important. Apart from the positive impact on mental well-being, the business case for support provision is evident, leading to better job performance, intention to stay and a more positive employer brand image (Bevan, 2010; Jain et al., 2018; Litchfield et al., 2016).

Findings from this report, in line with previous studies, show that there is still plenty that organisations and employers can do to support and facilitate staff who experience pregnancy loss (Meunier et al., 2021; Miller & Suff, 2022; Porschitz & Siler, 2017). Studies show that lack of support can lead to longer recovery periods, prolonged leave, lower productivity, poorer work engagement and even issues with staff retention as individuals might ultimately leave their job as a result of this (Gilbert et al., 2023; Tommy's, 2022). Hence the provision of a support structure and environment in the workplace is of crucial importance to employees but also offers benefits to employers.

An organisational framework regarding pregnancy loss is essential. Such a framework should encompass clear policies and practices, promoting a supportive environment, adequate training for staff and management (as outlined above), organisational measures, adequate support structures, referral systems and further support initiatives or programmes available.

Workplace pregnancy loss policy

Establishing clear policies and practices that clearly outline the organisation's position and support towards pregnancy loss-related issues is a fundamental element which should set the ethos for all employees and management. This should be clearly disseminated among all staff, promoting open communications contributing to destigmatising this topic which is often a taboo in the work environment.

Policies should facilitate leave and clearly signpost how to best support employees and how to address situations of pregnancy loss among staff. Following on from a survey of employees and senior HR professionals (Miller & Suff, 2022), the Chartered Institute of Personnel and Development created guidance for managers and people professionals in developing or implementing policies for pregnancy or baby loss (CIPD, 2022d, 2022c), accompanied by case studies (CIPD, 2022b, 2022a). This guide and practical advice available from the Miscarriage Association (UK) website (Miscarriage Association, n.d.) are some of the useful tools to assist in the implementation of the above initiatives outlined and which can make a significant contribution in adequately addressing pregnancy loss in the workplace. Additionally, the inclusion of staff with lived experience of pregnancy loss and involvement of all relevant stakeholders throughout the development and implementation of such initiatives and policies is vital for their success (Azeez et al., 2019; Grawitch et al., 2006).

In recent research conducted by the UK's Co-operative Group (CIPD, 2022a), employees strongly believed that leave for pregnancy loss did not fall under the 'sickness' or general 'bereavement' category but rather as a standalone policy. Developing a bespoke pregnancy loss policy ensures appropriate support to those affected but must be accompanied by a managers' guide to assist with initiating conversations, offering practical advice and specific accommodations. As previously stated, the support needed varies substantially so a pregnancy loss policy needs to be sufficiently flexible to accommodate the needs of individuals in a supportive environment. In terms of peer support, having supportive colleagues who are trained to provide a 'listening ear' in a non-judgemental manner may also foster open communication and reduce pregnancy loss stigma.

Workplace training on pregnancy loss

As part of the policies and promotion of a supportive environment, it is important that management and their leadership clearly understand the complexities of grief related to pregnancy loss and the need for (physical and emotional) recovery. Tailored training on these issues so managers and leaders are adequately informed about pregnancy loss, its impacts and how to best support colleagues, is essential. It is also vital that awareness is raised around the need for confidentiality and privacy when an individual experiences pregnancy loss, how to communicate with someone who is experiencing pregnancy loss and, importantly, whether to communicate with other colleagues about such events and, if so, how this should be done. As highlighted by Gilbert et al (2023),

managers should recognise the important role they have as an intermediary between employees and organisations, the leave available and further supports it offers.

Wider training for staff and awareness-raising initiatives are also essential to clearly inform and promote open communication among colleagues within the organisation, ensuring a more inclusive and less stigmatising environment.

Further workplace supports for pregnancy loss

Literature has clearly shown (as also highlighted in this report) that organisational measures are crucial to ensure individuals can have a healthy and as positive a transition back to work as possible (Keep et al., 2021; Porschitz & Siler, 2017). Supports such as a phased or gradual return to work (with reduced hours or adjusted tasks or responsibilities), adjusted workload programmes, facilitating flexible hours or remote work are some of the many ways which have shown to be invaluable for a smoother return to work following pregnancy loss (Keep et al., 2021; Miller & Suff, 2022; Porschitz & Siler, 2017).

Further practical supports are also essential. Offering access to Occupational Health to individuals impacted by pregnancy loss, while promoting referral to external specialised organisations on this issue, or facilitating access to Employee Assistance Programmes (EAP) tailored for this, are among the many practical measures employers can put in place (Gilbert et al., 2023; Miller & Suff, 2022; Miscarriage Association, n.d.; Walker, 2021). Access to specialised counselling can be of particular importance, especially within the EAPs as the limited number of counselling sessions available through these programmes can be used for different issues, leaving employees without access to further counselling essential to deal with pregnancy loss. Ensuring that counselling sessions specifically to address pregnancy loss are available regardless of what other type of counselling individuals have accessed previously as part of their EAP could be an important way of providing much needed support to staff.

Studies have also shown that specific initiatives such as employee support groups for pregnancy loss or “buddy systems” (where colleagues engage with one another to support and share their experience) can also have a significant positive effect on employees (Gilbert et al., 2023; Miller & Suff, 2022; Walker, 2021).

Recommendation 6

The implementation of leave entitlements should be carefully considered by workplaces. Procedures on notification, submitting certification, and requesting leave should be developed with sensitivity to the needs of individuals experiencing pregnancy loss. This includes considering the need for privacy and compassion, as well as allowing reasonable time to notify the employer.

Recommendation 7

Additional supports and accommodations should be made available to workers experiencing pregnancy loss. An organisational framework including policies and practices regarding how to support employees experiencing pregnancy loss, clearly outlining the organisational ethos/positioning regarding this issue and highlighting the different measures and supports available to staff, should be a priority in organisations.

For this purpose, clear guidance should be provided, by relevant Government Departments, to organisations on how to develop and implement such frameworks, encouraging each employer to apply and adjust these to their workplace contexts in the most suitable way.

Further to Recommendation 5, involvement of individuals with lived experience of pregnancy loss and relevant stakeholders (e.g. external organisations and individuals/groups specialised in this issue) is essential for an adequate development of policies and practices in this field, as well as their successful implementation.

Recommendation 8

Information about leave and support entitlements for pre viability pregnancy loss needs to be clear, publicly available and accessible, to ensure that individuals can easily inform themselves about these and avail of such supports when needed.

6.3.3 Public awareness of pregnancy loss

Key findings across studies conducted within this project highlight issues frequently cited across the broader pregnancy loss literature, namely the lack of awareness and acknowledgement of pregnancy loss in terms of its incidence, and the associated physical and emotional impacts.

Many participants did not share their pregnancy loss with their colleagues or their workplace. The social norm of concealing a pregnancy until 12 weeks may have contributed to these decisions. Awkwardness and difficulty around speaking about pregnancy loss in general was mentioned. Our survey data shows that the responses that some participants faced in the workplace were the hardest thing about their experience. Many reported that colleagues/management did not know how to respond to disclosures of loss, resulting in participants sometimes feeling ignored/avoided, judged or that their experience/loss was dismissed. Cultural, societal and religious influences on reproductive rights have influenced how pregnancy loss is perceived and experienced in the Republic of Ireland (Nuzum & O'Donoghue, 2022), as noted by some participants across the survey and interview studies. Analysis of our primary research within the PLACES Project highlighted that secrecy and stigma attached to pregnancy loss remains, in general, and even more so regarding earlier losses and termination of pregnancy, and pregnancy loss following infertility and related treatments; also observed in a recent Irish survey (Hennessy & O'Donoghue, 2023). This can prevent people sharing their loss or seeking support, particularly in the workplace. Many participants anticipated negative reactions or repercussions relating to disclosure of their loss, ranging from insensitive comments or questions to discrimination at work in the form of dismissal or limited career progression opportunities. Stigma is a key barrier to improving outcomes and care experiences (Hanschmidt et al., 2016; Sorhaindo & Lavelanet, 2022).

Though pregnancy loss affects one in four pregnancies, it does not tend to feature in broader pregnancy discourses (Browne, 2023). It is notable that some participants told somebody in their workplace (most often their manager or immediate colleagues) about their pregnancy loss to remove stigma, normalise the topic and create more supportive and understanding work environments. In the Republic of Ireland, similar to other countries, public awareness and understanding is limited around all types of pregnancy loss, including miscarriage (McCarthy et al., 2020; San Lazaro Campillo et al., 2020; San Lazaro Campillo, Meaney, Sheehan, et al., 2018), ectopic pregnancy (Spillane et al., 2018) and molar

pregnancy (Joyce, Coulter, et al., 2022). The National Perinatal Epidemiology Centre has repeatedly called for increased public education and awareness of stillbirth/perinatal death in its annual reports (O'Farrell et al., 2019, 2021; San Lazaro Campillo et al., 2022); similar calls to action are needed for earlier pregnancy losses. It is also evident that the physical processes and impacts of pregnancy loss and associated management strategies, in particular, need to be brought out of the shadows. This includes the length of time it takes to manage a pregnancy loss, complete medical care, and physically recover. Across other studies people report not knowing what to expect and feeling unprepared for the physicality and realities of pregnancy loss (Hennessy et al., 2023; Meaney et al., 2017). Data from our survey and interview studies would suggest that employers and workplaces may also underestimate the physical aspects of pregnancy loss and its management. Within workplaces, it would seem that individuals, and particularly managers, are often uninformed about pregnancy loss and ill-equipped to support employees during these experiences. This highlights the need for further training and support around pregnancy loss and how to support employees/colleagues who experience pregnancy loss. There is also a role for healthcare settings to provide greater information and sign-posting to supports to people who experience pregnancy loss about impacts on work. Though not the focus of the PLACES Project, many participants spoke about poor care experiences within healthcare settings; findings which have been demonstrated in other studies nationally (Flannery et al., 2023; Health Information and Quality Authority, 2023; Hennessy et al., 2023).

As noted within the literature in Chapter 3, pregnancy loss can also have a significant impact on men/partners, who often sideline their own grief, instead focusing on supporting their partner (Harty et al., 2022; Meaney et al., 2017; Obst et al., 2021). There is a need to also recognise and enhance knowledge and awareness of the impacts of pregnancy loss on men/partners, and to provide necessary supports, including within workplaces.

Many participants in our interview study felt that the introduction of statutory leave for pregnancy loss under 24 weeks gestation, and associated supports, would signal recognition of pregnancy loss experiences and impacts, and contribute to addressing the silence and stigma surrounding pregnancy loss, with ripple effects. They also perceived that this would facilitate conversations about pregnancy loss within and across all levels of society. In addition to the need for legislation, some participants spoke of the importance of society in general

becoming more aware of pregnancy loss and open to discuss these experiences. There is a clear need for enhanced discussion, awareness and understanding around pregnancy loss in workplaces and wider society, to reduce stigma, shame and confusion and enhance supports.

As noted by the Lancet–O'Neill Institute Commission on Global Health and Law, well-designed laws have the power to address social determinants of health, including employment and working conditions (Gostin et al., 2019). Within the context of this project, to inform supports for pregnancy loss under 24 weeks in the workplace, it is important that any legislative supports do not further marginalise or stigmatise people who experience pregnancy loss. This is particularly important in discussions around how the leave is framed (e.g. sick leave, compassionate/bereavement leave), as well as what types of pregnancy loss are deemed eligible, or not (e.g. termination of pregnancy, pregnancies below a certain gestation), and whether leave includes partners or not (Middlemiss et al., n.d.). This also ties in with discussions within the literature around 'hierarchies of loss' and how some people's reactions to loss are deemed more legitimate than others (Middlemiss & Kilshaw, 2023). To destigmatise pregnancy loss, a more inclusive model of pregnancy is needed, one which encompasses all types of pregnancies, including pregnancy endings (Browne, 2023). Appreciating how connected pregnancy loss experiences are will help to normalise and de-stigmatise all forms of pregnancy loss (Malory, 2022; Moscrop, 2013). It is important to note that while participants generally felt that greater awareness and discussion of pregnancy loss was needed within society, they expressed different desires relating to disclosing their pregnancy loss in the workplace. Some wanted privacy, while others valued having their colleagues/management know about their loss, or talking about their experience, and the associated practical and emotional supports provided. While more and better discourses around pregnancy loss are needed, individual's needs and preferences should be respected.

Political leadership is needed to drive changes in public awareness and perceptions surrounding pregnancy loss. This requires various actions, such as the inclusion of education around pregnancy loss as part of overall sexual and reproductive health education within schools, antenatal curricula and through other channels/settings (e.g. media/social media, websites (Health Service Executive, 2023b)), and in national policies and action plans, including – but not limited to – the Women's Health Action Plan (Department of Health, 2022), the

National Maternity Strategy (Department of Health, 2016), and the Health Service Executive National Service Plan (Health Service Executive, 2023a).

Notwithstanding the above discussion surrounding the often silenced discourses relating to pregnancy loss, the large response rate to the PLACES survey (over 900 participants) and the richness of the responses received – is testament to both the need for better supports for pregnancy loss within the context of work and workplaces, but also the ability of people to communicate around their experiences. The challenge is now to translate what we have learned into meaningful action.

Recommendation 9

Political leadership is needed to drive changes in public awareness and perceptions surrounding pregnancy loss – in general, and specifically relating to workplaces and how to support workers in this regard. This requires various actions, such as the inclusion of education around pregnancy loss as part of overall sexual and reproductive health education within schools, antenatal curricula, and through other channels/settings, and in national policies and action plans (across all Government Departments, including Health; Children, Equality, Disability, Integration and Youth; Education; Enterprise, Trade and Employment; Justice; Social Protection).

6.4 Summary

Across findings from the literature and the primary research conducted for this report, a need for statutory leave from work following pregnancy loss was identified. Furthermore, workplaces need to create and implement policies which support employees' return to work. The Irish government should play a role in raising awareness and providing education / training to increase understanding of the prevalence, impact, and support needs of women and partners experiencing pregnancy loss before 24 weeks gestation.

Chapter 7. Recommendations

The following recommendations are put forward to the Department of Children, Equality, Disability, Integration and Youth, based on the findings of the PLACES (Pregnancy Loss in Workplaces) Project:

Recommendation 1

A statutory right to paid leave should be introduced for pre-viability pregnancy loss, regardless of the gestational stage or the reason for the loss. This should be subject to medical certification. This would play two roles: first it would allow for a period of recovery, and second it would show societal recognition of the impact of pre-viability pregnancy loss.

Recommendation 2

Any leave introduced should be of sufficient duration to meet the needs of those affected, which are presented in this report.

In the other jurisdictions examined, the model of pregnancy loss leave introduced was influenced by the existing statutory leave frameworks, all of which are more generous than in the Republic of Ireland. The duration and scope of any leave in the Republic of Ireland would have to be considered in the context of existing statutory paid leave provision. Current statutory paid sick leave is three days (to be increased to 10 days by 2026), while the statutory entitlement to leave following a stillbirth after 24 weeks of pregnancy is 26 weeks maternity leave. Payment of maternity benefit is subject to having the requisite PRSI contributions, and there is no statutory entitlement to receive payment from the employer while on maternity leave, although employers can choose to pay employees while on maternity leave. The needs of people experiencing pre-viability pregnancy loss will vary and any statutory provisions introduced will need to have regard to this.

Recommendation 3

A statutory right to paid leave for pregnancy loss should also be introduced for partners. According to international literature and the findings of primary research detailed in this report, this leave is needed in order to process their own loss and to support their partner (including the care of any children).

Recommendation 4

If, in accordance with the recommendation above, statutory paid pregnancy loss leave is introduced, it should be added to the list of family/care related leaves which are covered by the Unfair Dismissals Act. The statutory wording introducing any such leave should also make clear that such leave is covered by equality law and less favourable treatment on the basis of taking such leave is prohibited under the gender ground as a pregnancy-related issue.

If statutory paid pregnancy loss leave is not introduced, then guidance should be issued to employers to clarify that any less favourable treatment of an individual for taking existing leave entitlements following pregnancy loss is covered by the provisions of employment equality legislation and would amount to discrimination on the gender ground as a pregnancy-related issue.

Recommendation 5

Given the individuality of each person's experience of pregnancy loss, patient and public involvement in the development of policies and practices which promote positive workplace cultures and environments is recommended.

Recommendation 6

The implementation of leave entitlements should be carefully considered by workplaces. Procedures on notification, submitting certification, and requesting leave should be developed with sensitivity to the needs of individuals experiencing pregnancy loss. This includes considering the need for privacy and compassion, as well as allowing reasonable time to notify the employer.

Recommendation 7

Additional supports and accommodations should be made available to workers experiencing pregnancy loss. An organisational framework including policies and practices regarding how to support employees experiencing pregnancy loss, clearly outlining the organisational ethos/positioning regarding this issue and highlighting the different measures and supports available to staff, should be a priority in organisations.

For this purpose, clear guidance should be provided, by relevant Government Departments, to organisations on how to develop and implement such frameworks, encouraging each employer to apply and adjust these to their workplace contexts in the most suitable way.

Further to Recommendation 5, involvement of individuals with lived experience of pregnancy loss and relevant stakeholders (e.g. external organisations and individuals/groups specialised in this issue) is essential for an adequate development of policies and practices in this field, as well as their successful implementation.

Recommendation 8

Information about leave and support entitlements for pre viability pregnancy loss needs to be clear, publicly available and accessible, to ensure that individuals can easily inform themselves about these and avail of such supports when needed.

Recommendation 9

Political leadership is needed to drive changes in public awareness and perceptions surrounding pregnancy loss – in general, and specifically relating to workplaces and how to support workers in this regard. This requires various actions, such as the inclusion of education around pregnancy loss as part of overall sexual and reproductive health education within schools, antenatal curricula, and through other channels/settings, and in national policies and action plans (across all Government Departments, including Health; Children, Equality, Disability, Integration and Youth; Education; Enterprise, Trade and Employment Justice; Social Protection).

References

77/2022: Lög um sorgarleyfi., 77 (2022). https://www.althingi.is/altext/stjt/2022.077.html

Act of Gender Equality in Employment, (2022). https://law.moj.gov.tw/ENG/LawClass/LawAll.aspx?pcode=N0030014

Addati, L., Cassirer, N., & Gilchrist, K. (2014). *Maternity and paternity at work – Law and practice across the world*. https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_242615.pdf

Ahmad, I., & de Leon, L. P. (2021). *Decent Work Check 2021*. https://wageindicator.org/documents/decentworkcheck/latinamerica/colombia-english.pdf

Alberta government alters bereavement leave legislation amid abortion debate. (2022, May 11). *Victoria News*. https://www.vicnews.com/news/alberta-government-alters-bereavement-leave-legislation-amid-abortion-debate-100181

ASTI. (2021). *Pregnancy Related Sick Leave*. Association of Secondary Teachers in Ireland. https://www.asti.ie/news-campaigns/latest-news/pregnancy-related-sick-leave-asti-receives-clarifications/

Azeez, R. O., Fapohunda, T. M., & Jayeoba, F. I. (2019). Unpacking Healthy Workplace Practices Effects on Intrinsic Motivation of ICT Professionals: A SEM Approach. *Trends Economics and Management*, *13*(33), Article 33. https://doi.org/10.13164/trends.2019.33.19

Bearak, J., Popinchalk, A., Ganatra, B., Moller, A.-B., Tunçalp, Ö., Beavin, C., Kwok, L., & Alkema, L. (2020). Unintended pregnancy and abortion by income, region, and the legal status of abortion: Estimates from a comprehensive model for 1990-2019. *The Lancet. Global Health*, *8*(9), e1152–e1161. https://doi.org/10.1016/S2214-109X(20)30315-6

Bellhouse, C., Temple-Smith, M. J., & Bilardi, J. E. (2018). "It's just one of those things people don't seem to talk about…" women's experiences of social support following miscarriage: A qualitative study. *BMC Women's Health*, *18*(1), 176. https://doi.org/10.1186/s12905-018-0672-3

Bevan, S. (2010). *The Business Case for Employee Health and Wellbeing: A report prepared for Investors in People*. The Work Foundation. http://investorsinpeople.ph/wp-content/uploads/2013/08/The-Business-Case-for-Employee-Health-and-Wellbeing-Feb-2010.pdf

Bill 17 Labour Statutes Amendnent Act, 2022, (2022). https://docs.assembly.ab.ca/LADDAR_files/docs/bills/bill/legislature_30/session_3/20220222_bill-017.pdf

Bill 203—Labour Standards Code (amended), 203 (2022). https://nslegislature.ca/legc/bills/64th_1st/1st_read/b203.html

Black, K. I., de Vries, B. S., Moses, F., Pelosi, M., Cong, A., & Ludlow, J. (2017). The impact of introducing medical management on conservative and surgical management for early pregnancy miscarriage. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, *57*(1), 93–98. https://doi.org/10.1111/ajo.12573

Boncori, I., & Smith, C. (2019). I lost my baby today: Embodied writing and learning in organizations. *Management Learning*, *50*(1), 74–86. https://doi.org/10.1177/1350507618784555

Boyd, S., Feeney, S., Harte, K., Hayes, S., McCarthy, C., & Hayes-Ryan, D. (2022). National Clinical Practice Guideline: Investigation and managemnt of complications of early termination of pregnancy. *National Women and Infants Health Programme and The Institute of Obstetricians and Gynaecologists*.

Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide* (1st ed.). SAGE.

Braun, V., Clarke, V., Boulton, E., Davey, L., & McEvoy, C. (2021). The online survey as a qualitative research tool. *International Journal of Social Research Methodology*, *24*(6), 641–654. https://doi.org/10.1080/13645579.2020.1805550

Brewis, J., Newton, V., Davies, J., Middlemiss, A., Mullan, K., & Boncori, I. (2023). *Early pregnancy endings and the workplace*. The Open University. https://business-school.open.ac.uk/research/projects/early-pregnancy-endings-workplace

Broen, A. N., Moum, T., Bødtker, A. S., & Ekeberg, Ø. (2005). The course of mental health after miscarriage and induced abortion: A longitudinal, five-year follow-up study. *BMC Medicine*, *3*(1), 18. https://doi.org/10.1186/1741-7015-3-18

Browne, V. (2023). *Pregnancy without birth: A feminist philosophy of miscarriage*. Bloomsbury Academic.

Capmas, P., Bouyer, J., & Fernandez, H. (2014). Treatment of ectopic pregnancies in 2014: New answers to some old questions. *Fertility and Sterility*, *101*(3), 615–620. https://doi.org/10.1016/j.fertnstert.2014.01.029

Central Statistics Office. (2022a). *CSO Standard Classifications*. CSO. https://www.cso.ie/en/methods/classifications/csostandardclassifications/

Central Statistics Office. (2022b, November 24). *Labour Force Survey Quarter 3 2022*. CSO. https://www.cso.ie/en/releasesandpublications/ep/p-lfs/labourforcesurveyquarter32022/employment/

CIPD. (2022a). *CIPD | Case study: The Co-operative Group*. CIPD. https://www.cipd.org/uk/knowledge/case-studies/case-study-co-op/

CIPD. (2022b). *CIPD | Case study: Vodafone UK*. CIPD. https://www.cipd.org/uk/knowledge/case-studies/vodafone-uk/

CIPD. (2022c). *CIPD | People manager guide: Supporting employees through pregnancy loss*. CIPD. https://www.cipd.org/uk/knowledge/guides/manager-guide-pregnancy-loss/

CIPD. (2022d). *CIPD | Workplace support for employees experiencing pregnancy or baby loss: Guidance for people professionals*. CIPD. https://www.cipd.org/uk/knowledge/guides/supporting-employees-guidance-pregnancy-baby-loss/

Citizens Information. (2023a). *Other types of leave from work* (Ireland). Citizensinformation.ie. https://www.citizensinformation.ie/en/employment/employment-rights-and-conditions/leave-and-holidays/types-of-leave-from-work/

Citizens Information. (2023b). *Sick leave and sick pay* (Ireland). Citizensinformation.ie. https://www.citizensinformation.ie/en/employment/employment-rights-and-conditions/leave-and-holidays/sick-leave-and-sick-pay/

Código Del Trabajo. https://www.mitradel.gob.pa/trabajadores/codigo-detrabajo/

Código do Trabalho. https://guiadoinvestidor.dre.pt/PDF.aspx?Idioma=1&DecretoLeiId=38

Creinin, M. D., Huang, X., Westhoff, C., Barnhart, K., Gilles, J. M., & Zhang, J. (2006). Factors Related to Successful Misoprostol Treatment for Early Pregnancy Failure. *Obstetrics and Gynecology*, *107*(4), 901–907. https://doi.org/10.1097/01.AOG.0000206737.68709.3e

dandalopartners. (2021). *Pink Elephants' 'Leave for Loss' Campaign: Estimating the cost of providing Bereavement Leave to couples who experience miscarriage.* Pink Elephants.

Darmody, J. (2021, December 8). Pinterest adds new parental benefits for employees globally. *Silicon Republic*. https://www.siliconrepublic.com/careers/pinterest-parental-benefits-parental-leave

De Montigny, F., Verdon, C., Meunier, S., Zeghiche, S., Lalande, D., & Williams-Plouffe, M.-C. (2018). *Supporting Families After A Perinatal Death*. Centre for Studies and Research on Family Intervention.

Department for the Economy. (2022, September 27). *Miscarriage Leave and Pay | Department for the Economy*. Economy. https://www.economy-ni.gov.uk/consultations/miscarriage-leave-and-pay

Department of Health. (2016). *Creating a Better Future Together: National Maternity Strategy 2016-2026*. Government Publications. http://health.gov.ie/blog/press-release/varadkar-launches-irelands-first-national-maternity-strategy/

Department of Health. (2022). *Women's Health Action Plan 2022 – 2023*. Department of Health. https://www.gov.ie/en/publication/232af-womens-health-action-plan-2022-2023/

Department of Health. (2023, June 22). *Fourth Annual Report on Notifications in accordance with the Health (Regulation of Termination of Pregnancy) Act 2018*. https://www.gov.ie/en/press-release/9851a-fourth-annual-report-on-notifications-in-accordance-with-the-health-regulation-of-termination-of-pregnancy-act-2018/

Department of Social Protection. (2023a, January 6). *Maternity Benefit*. https://www.gov.ie/en/service/apply-for-maternity-benefit/

Department of Social Protection. (2023b, January 19). *Register a Stillbirth*. https://www.gov.ie/en/service/e6c3d6-registering-a-stillbirth/

Department of Social Protection. (2023c, May 12). *Paternity Benefit*. https://www.gov.ie/en/service/apply-for-paternity-benefit/

Devall, A., Chu, J., Beeson, L., Hardy, P., Cheed, V., Sun, Y., Roberts, T., Ogwulu, C. O., Williams, E., Jones, L., Papadopoulos, J. F., Bender-Atik, R., Brewin, J., Hinshaw, K., Choudhary, M., Ahmed, A., Naftalin, J., Nunes, N., Oliver, A., … Coomarasamy, A. (2021). Mifepristone and misoprostol versus placebo and misoprostol for resolution of miscarriage in women diagnosed with missed miscarriage: The MifeMiso RCT. *Health Technology Assessment*. https://doi.org/10.3310/hta25680

Diageo, (2022). *Diageo introduces pregnancy loss guidelines and enhanced bereavement support for employees. Diageo*. https://www.diageo.com/en/news-and-media/stories/2022/diageo-introduces-pregnancy-loss-guidelines-and-enhanced-bereavement-support-for-employees

Doka, K. (2008). Disenfranchised Grief in Historical and Cultural perspective. In *Handbook of Bereavement Research and Practice.* (p. 658). American Psychological Association.

Dumitrascu, M. C., Iliescu, M., Petca, Sandru, F., Mehedintu, C., Farcasanu, P. D., Maru, N., Chibelean, C., & Petca, A. (2019). *The Chemical Pregnancy*. *8*(12).

El Govern de la Generalitat incorpora un permís per dol gestacional en l'àmbit laboral. (2022). Administració i Funció Pública. http://administraciopublica.gencat.cat/ca/actualitat/221006_NOVES_MESURES_CONCILIACIO

Enforcement Decree of the Labor Standards Act, (2012).

English, A. (2021). *Ireland's 150 Best Employers: New challenges for employers as world of work turns on its axis*. Irish Independent. https://www.independent.ie/business/irelands-best-employers/irelands-150-best-employers-new-challenges-for-employers-as-world-of-work-turns-on-its-axis-40451439.html

Escañuela Sánchez, T., O´Donoghue, K., Byrne, M., Meaney, S., & Matvienko-Sikar, K. (2023). A systematic review of behaviour change techniques used in the context of stillbirth prevention. *Women and Birth*. https://doi.org/10.1016/j.wombi.2023.05.002

Eurostat. (2020). *EU Labour Force Survey*. https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Employment_statistics

Fair Work Act 2009, 28 (2009). https://www.legislation.gov.au/Details/C2023C00097

Fair Work Ombudsman. (n.d.). *Parental leave for stillbirth, premature birth or infant death—Fair Work Ombudsman*. Retrieved 17 August 2023, from https://www.fairwork.gov.au/leave/maternity-and-parental-leave/parental-leave-for-stillbirth-premature-birth-or-infant-death

Farren, J., Jalmbrant, M., Ameye, L., Joash, K., Mitchell-Jones, N., Tapp, S., Timmerman, D., & Bourne, T. (2016). Post-traumatic stress, anxiety and depression following miscarriage or ectopic pregnancy: A prospective cohort study. *BMJ Open*, *6*(11), e011864. https://doi.org/10.1136/bmjopen-2016-011864

Farren, J., Mitchell-Jones, N., Verbakel, J. Y., Timmerman, D., Jalmbrant, M., & Bourne, T. (2018). The psychological impact of early pregnancy loss. *Human Reproduction Update*, *24*(6), 731–749. https://doi.org/10.1093/humupd/dmy025

Flannery, C., Hennessy, M., Dennehy, R., Matvienko-Sikar, K., Lucey, C., Dhubhgain, J. U., & O'Donoghue, K. (2023). Factors that shape recurrent miscarriage care experiences: Findings from a national survey. *BMC Health Services Research*, *23*(1), 317. https://doi.org/10.1186/s12913-023-09347-1

Flannery, C., Hennessy, M., Dennehy, R., Matvienko-Skiar, K., Lucey, C., & O'Donoghue, K. (2022). The care experiences of women and men who have received recurrent miscarriage care in Ireland: A national survey. *J Epidemiol Community Health*, *76*(Suppl 1), A50–A50. https://doi.org/10.1136/jech-2022-SSMabstracts.102

Flenady, V., Wojcieszek, A. M., Middleton, P., Ellwood, D., Erwich, J. J., Coory, M., Khong, T. Y., Silver, R. M., Smith, G. C. S., Boyle, F. M., Lawn, J. E., Blencowe, H., Leisher, S. H., Gross, M. M., Horey, D., Farrales, L., Bloomfield, F., McCowan, L., Brown, S. J., … Reddy, U. (2016). Stillbirths: Recall to action in high-income countries. *The Lancet*, *387*(10019), 691–702. https://doi.org/10.1016/S0140-6736(15)01020-X

Frost, N. (2021). Paid leave after miscarriage: New Zealand passes pioneering legislation for affected couples. *The Irish Times*. https://www.irishtimes.com/life-and-style/health-family/paid-leave-after-miscarriage-new-zealand-passes-pioneering-legislation-for-affected-couples-1.4520174

Gabriel, A. S., Arena, D. F., Calderwood, C., Campbell, J. T., Chawla, N., Corwin, E. S., Ezerins, M. E., Jones, K. P., Klotz, A. C., Larson, J. D., Leigh, A., MacGowan, R. L., Moran, C. M., Nag, D., Rogers, K. M., Rosen, C. C., Sawyer, K. B., Shockley, K. M., Simon, L. S., & Zipay, K. P. (2022). Building Thriving Workforces from the Top Down: A Call and Research Agenda for Organizations to Proactively Support Employee Well-Being*. In M. Ronald Buckley, A. R. Wheeler, J. E. Baur, & J. R. B. Halbesleben (Eds.), *Research in Personnel and Human Resources Management* (Vol. 40, pp. 205–272). Emerald Publishing Limited. https://doi.org/10.1108/S0742-730120220000040007

Genetic Health Act, (2009). https://law.moj.gov.tw/ENG/LawClass/LawAll.aspx?pcode=L0070001

Ghosh, J., Papadopoulou, A., Devall, A. J., Jeffery, H. C., Beeson, L. E., Do, V., Price, M. J., Tobias, A., Tunçalp, Ö., Lavelanet, A., Gülmezoglu, A. M., Coomarasamy, A., & Gallos, I. D. (2021). Methods for managing miscarriage: A network meta-analysis. *Cochrane Database of Systematic Reviews*, *6*. https://doi.org/10.1002/14651858.CD012602.pub2

Gilbert, S. L., Dimoff, J. K., Brady, J. M., Macleod, R., & McPhee, T. (2023). Pregnancy loss: A qualitative exploration of an experience stigmatized in the workplace. *Journal of Vocational Behavior*, *142*, 103848. https://doi.org/10.1016/j.jvb.2023.103848

Gostin, L. O., Monahan, J. T., Kaldor, J., DeBartolo, M., Friedman, E. A., Gottschalk, K., Kim, S. C., Alwan, A., Binagwaho, A., Burci, G. L., Cabal, L., DeLand, K., Evans, T. G., Goosby, E., Hossain, S., Koh, H., Ooms, G., Periago, M. R., Uprimny, R., & Yamin, A. E. (2019). The legal determinants of health: Harnessing the power of law for global health and sustainable development. *The Lancet*, *393*(10183), 1857–1910. https://doi.org/10.1016/S0140-6736(19)30233-8

Government of Puerto Rico Human Resources Administration and Transformation Act, (2017).

Grawitch, M. J., Gottschalk, M., & Munz, D. C. (2006). The path to a healthy workplace: A critical review linking healthy workplace practices, employee well-being, and organizational improvements. *Consulting Psychology Journal: Practice and Research*, *58*(3), 129–147. https://doi.org/10.1037/1065-9293.58.3.129

Graziosi, G. C. M., Van Der Steeg, J. W., Reuwer, P. H. W., Drogtrop, A. P., Bruinse, H. W., & Mol, B. W. J. (2005). Economic evaluation of misoprostol in the treatment of early pregnancy failure compared to curettage after an expectant management. *Human Reproduction*, *20*(4), 1067–1071. https://doi.org/10.1093/humrep/deh709

Great Place to Work. (n.d.). *Great Place to Work® | Building and Recognising Great Cultures*. Retrieved 15 December 2022, from https://www.greatplacetowork.ie/home/

Great Place to Work. (2022). *Ireland's Best Workplaces 2022*. https://www.greatplacetowork.ie/great-workplaces/irelands-best-workplaces/irelands-best-workplaces-2022/

Gribble, K. D., Bewley, S., Bartick, M. C., Mathisen, R., Walker, S., Gamble, J., Bergman, N. J., Gupta, A., Hocking, J. J., & Dahlen, H. G. (2022). Effective Communication About Pregnancy, Birth, Lactation, Breastfeeding and Newborn Care: The Importance of Sexed Language. *Frontiers in Global Women's Health*, *3*. https://www.frontiersin.org/article/10.3389/fgwh.2022.818856

Hackney, K. J., Wu, C., & Nuner, J. E. (2020). Invisible grief: An examination of miscarriage in the workplace. In *Stress and quality of working life: Finding meaning in grief and suffering.* (rayyan-407279008; pp. 27–46). Information Age Publishing, Inc.

Hanschmidt, F., Linde, K., Hilbert, A., Riedel-Heller, S. G., & Kersting, A. (2016). Abortion Stigma: A Systematic Review. *Perspectives on Sexual and Reproductive Health*, *48*(4), 169–177. https://doi.org/10.1363/48e8516

Harty, T., Trench, M., Keegan, O., O'Donoghue, K., & Nuzum, D. (2022). The experiences of men following recurrent miscarriage in an Irish tertiary hospital: A qualitative analysis. *Health Expectations*, *25*(3), 1048–1057. https://doi.org/10.1111/hex.13452

Hazen, M. A. (2006). Silences, perinatal loss, and polyphony: A post-modern perspective. *Journal of Organizational Change Management*, *19*(2), 237–249. https://doi.org/10.1108/09534810610648933

Health Information and Quality Authority. (2023). *National survey of maternity bereavement care in Ireland shows most parents were positive about the care they received, but some areas can be improved | HIQA*. https://www.hiqa.ie/hiqa-news-updates/national-survey-maternity-bereavement-care-ireland-shows-most-parents-were

Health (Regulation of Termination of Pregnancy) Act 2018, Pub. L. No. Number 31 of 2018 (2018). https://www.irishstatutebook.ie/eli/2018/act/31

Health Service Executive. (2023a). *National Service Plan 2023*. Health Service Executive. https://www.hse.ie/eng/services/publications/serviceplans/national-service-plan-2023.pdf

Health Service Executive. (2023b). *Women's health A to Z*. HSE.Ie. https://www2.hse.ie/conditions/womens-health-a-z/

Heazell, A. E. P., Siassakos, D., Blencowe, H., Burden, C., Bhutta, Z. A., Cacciatore, J., Dang, N., Das, J., Flenady, V., Gold, K. J., Mensah, O. K., Millum, J., Nuzum, D., O'Donoghue, K., Redshaw, M., Rizvi, A., Roberts, T., Toyin Saraki, H. E., Storey, C., … Lancet Ending Preventable Stillbirths investigator group. (2016). Stillbirths: Economic and psychosocial consequences. *Lancet (London, England)*, *387*(10018), 604–616. https://doi.org/10.1016/S0140-6736(15)00836-3

Hennessy, M., Dennehy, R., Meaney, S., Linehan, L., Devane, D., Rice, R., & O'Donoghue, K. (2021). Clinical practice guidelines for recurrent miscarriage in high-income countries: A systematic review. *Reproductive BioMedicine Online*, *42*(6), 1146–1171. https://doi.org/10.1016/j.rbmo.2021.02.014

Hennessy, M., Dennehy, R., Meaney, S., Matvienko-Sikar, K., O'Sullivan-Lago, R., & O'Donoghue, K. (2023). Stakeholder perspectives on recurrent miscarriage services and improvement priorities: Qualitative findings from a national evaluation. *American Journal of Obstetrics & Gynecology*, *228*(1), S161–S162. https://doi.org/10.1016/j.ajog.2022.11.311

Hennessy, M., & O'Donoghue, K. (2023). Barriers and facilitators to knowledge translation in the field of pregnancy loss: Findings from a qualitative survey with a range of knowledge users. *British Journal of Obstetrics and Gynaecology*, *130*(S1), 65. https://doi.org/10.1111/1471-0528.17419

Holidays (Bereavement Leave for Miscarriage) Amendment Act, (2021). https://www.legislation.govt.nz/act/public/2021/0010/latest/whole.html#LMS220706

Houses of the Oireachtas. (2021, March 16). *Organisation of Working Time (Reproductive Health Related Leave) Bill 2021 – No. 38 of 2021 – Houses of the Oireachtas* (Ireland) [Text]. https://www.oireachtas.ie/en/bills/bill/2021/38

Houses of the Oireachtas Joint Committee on Social Protection, Community & Rural Development and the Islands. (2023). *Report on pre – legislative scrutiny of the General Scheme of the Civil Registration (Electronic Registration) Bill 2023*. Houses of the Oireachtas. https://data.oireachtas.ie/ie/oireachtas/committee/dail/33/joint_committee_on_social_protection_community_and_rural_development_and_the_islands/reports/2023/2023-07-25_report-on-pre-legislative-scrutiny-of-the-civil-registration-electronic-registration-bill-2023_en.pdf

HSE. (n.d.). *Sick leave*. Staff Site. Retrieved 23 August 2023, from https://healthservice.hse.ie/staff/leave/sick-leave/

HSE. (2015). *HSE HR Circular 019/2015*.

Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland & Directorate of Clinical Strategy and Programmes, Health Service Executive. (2014). *Clinical Practice Guideline: The Diagnosis and Management of Ectopic Pregnancy*. Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland and Directorate of Clinical Strategy and Programmes, Health Service Executive. https://pregnancyandinfantloss.ie/wp-content/uploads/2019/03/CLINICAL-PRACTICE-GUIDELINE-ON-THE-DIAGNOSIS-AND-MANAGEMENT-OF-ECTOPIC-PREGNANCY.pdf

Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland & Directorate of Strategy and Clinical Programmes, Health Service Executive. (2012). *Clinical Practice Guideline: Management of Early Pregnancy Miscarriage. Version 1.0*. Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland and Directorate of Strategy and Clinical Programmes, Health Service Executive.

Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland & Directorate of Strategy and Clinical Programmes, Health Service Executive. (2014). *Clinical Practice Guideline: The Management of Second Trimester Miscarriage. Version 1.0*. Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland and Directorate of Strategy and Clinical Programmes, Health Service Executive. https://pregnancyandinfantloss.ie/clinical-practice-guideline-on-the-management-of-second-trimester-miscarriage/

Irish Independent. (2022). *Ireland's 150 Best Employers 2022: Full list*. Independent. https://www.independent.ie/business/irelands-best-employers/irelands-150-best-employers-2022-full-list-41671604.html

Irish Nurses and Midwives Association. (n.d.). *Sick Leave*. Retrieved 23 August 2023, from https://www.inmo.ie/Home/Index/58/11435

Irish Statute Book. (1994). *Stillbirths Registration Act*. Office of the Attorney General. https://www.irishstatutebook.ie/eli/1994/act/1/enacted/en/print#sec2

Jackson, P., Power-Walsh, S., Dennehy, R., & O'Donoghue, K. (2023). Fatal fetal anomaly: Experiences of women and their partners. *Prenatal Diagnosis*, *43*(4), 553–562. https://doi.org/10.1002/pd.6311

Jahoda, M. (1981). Work, employment, and unemployment: Values, theories, and approaches in social research. *American Psychologist*, *36*(2), 184–191. https://doi.org/10.1037/0003-066X.36.2.184

Jain, A., Leka, S., & Zwetsloot, G. I. J. M. (2018). The Economic, Business and Value Case for Health, Safety and Well-Being. In A. Jain, S. Leka, & G. I. J. M. Zwetsloot (Eds.), *Managing Health, Safety and Well-Being: Ethics, Responsibility and Sustainability* (pp. 67–98). Springer Netherlands. https://doi.org/10.1007/978-94-024-1261-1_3

Joyce, C. M., Coulter, J., Kenneally, C., McCarthy, T. V., & O'Donoghue, K. (2022). Experience of women on the Irish National Gestational Trophoblastic Disease Registry. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, *272*, 206–212. https://doi.org/10.1016/j.ejogrb.2022.03.039

Joyce, C. M., Fitzgerald, B., McCarthy, T. V., Coulter, J., & O'Donoghue, K. (2022). Advances in the diagnosis and early management of gestational trophoblastic disease. *BMJ Medicine*, *1*(1). https://doi.org/10.1136/bmjmed-2022-000321

Jurkovic, D., Overton, C., & Bender-Atik, R. (2013). Diagnosis and management of first trimester miscarriage. *BMJ*, *346*(jun19 2), f3676–f3676. https://doi.org/10.1136/bmj.f3676

Keep, M., Payne, S., & Carland, J. E. (2021). Experiences of Australian women on returning to work after miscarriage. *Community, Work & Family*, *26*(2), 258–267. https://doi.org/10.1080/13668803.2021.1993140

Kelly, K., Meaney, S., Leitao, S., & O'Donoghue, K. (2021). A review of stillbirth definitions: A rationale for change. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, *256*, 235–245. https://doi.org/10.1016/j.ejogrb.2020.11.015

Knight, M., Bunch, K., Shakespeare, J., Kotnis, R., Kenyon, S., & Kurinczuk, J. J. (2022). *Saving Lives, Improving Mothers' Care, Core report—Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20*. National Perinatal Epidemiology Unit, University of Oxford. https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2022/MBRRACE-UK_Maternal_MAIN_Report_2022_UPDATE.pdf

Kolte, A. M., Olsen, L. R., Mikkelsen, E. M., Christiansen, O. B., & Nielsen, H. S. (2015). Depression and emotional stress is highly prevalent among women with recurrent pregnancy loss. *Human Reproduction (Oxford, England)*, *30*(4), 777–782. https://doi.org/10.1093/humrep/dev014

Koslowski, A., Blum, S., Dobrotic, I., Kaufman, G., & Moss, P. (2022). *18th International Review of Leave Policies and Related Research 2021*.

Labor Standards Act, (2002). https://www.legisquebec.gouv.qc.ca/fr/document/lc/N-1.1?langCont=fr#ga:l_iv-gb:l_v_1-h1

Labour Insurance Regulations of the People's Republic of China, (1951). https://www.ilo.org/dyn/travail/docs/817/Labour%20Insurance%20Regulations%201951.pdf

Law No. 8/2020, Macao Special Administrative Region (2020), 7/2008. https://bo.io.gov.mo/bo/i/2020/21/lei08_cn.asp

Lawn, J. E., Blencowe, H., Waiswa, P., Amouzou, A., Mathers, C., Hogan, D., Flenady, V., Frøen, J. F., Qureshi, Z. U., Calderwood, C., Shiekh, S., Jassir, F. B., You, D., McClure, E. M., Mathai, M., Cousens, S., Flenady, V., Frøen, J. F., Kinney, M. V., … Draper, E. S. (2016). Stillbirths: Rates, risk factors, and acceleration towards 2030. *The Lancet*, *387*(10018), 587–603. https://doi.org/10.1016/S0140-6736(15)00837-5

Loi sur les Normes du Travail, (2020). https://www.legisquebec.gouv.qc.ca/fr/document/lc/N-1.1?langCont=fr#ga:l_iv-gb:l_v_1-h1

Linehan, L., Hennessy, M., Khalid, A., Whelan, J., & O'Donoghue, K. (2023). *National Clinical Practice Guideline: Recurrent Miscarriage*. National Women and Infants Health Programme and The Institute of Obstetricians and Gynaecologists. https://www.rcpi.ie/Faculties-Institutes/Institute-of-Obstetricians-and-Gynaecologists/National-Clinical-Guidelines-in-Obstetrics-and-Gynaecology

Litchfield, P., Cooper, C., Hancock, C., & Watt, P. (2016). Work and Wellbeing in the 21st Century. *International Journal of Environmental Research and Public Health*, *13*(11), Article 11. https://doi.org/10.3390/ijerph13111065

Lok, C., Frijstein, M., & van Trommel, N. (2021). Clinical presentation and diagnosis of Gestational Trophoblastic Disease. *Best Practice & Research Clinical Obstetrics & Gynaecology*, *74*, 42–52. https://doi.org/10.1016/j.bpobgyn.2020.12.001

Maker, C. (2010). The Miscarriage Experience: More Than Just a Trigger to Psychological Morbidity? *Psychology & Health*, *18*, 403–415. https://doi.org/10.1080/08870440310000693 43

Malory, B. (2022). The transition from abortion to miscarriage to describe early pregnancy loss in British medical journals: A prescribed or natural lexical change? *Medical Humanities*, *48*(4), 489–496. https://doi.org/10.1136/medhum-2021-012373

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample Size in Qualitative Interview Studies Guided by Information Power. *Qualitative Health Research*, *26*(13), 1753–1760. https://doi.org/10.1177/1049732315617444

Mao, S. (2020, January 24). Maternity Leave and Allowances in China. *China Law Help*. https://chinalawhelp.com/maternity-leave-and-allowances-in-china/

McCarthy, C. M., Meaney, S., Rice, R., Sheehan, J., & O'Donoghue, K. (2020). The general populations' understanding of first trimester miscarriage: A cross sectional survey. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, *254*, 200–205. https://doi.org/10.1016/j.ejogrb.2020.08.042

McPherson, E. (2016). Recurrence of stillbirth and second trimester pregnancy loss. *American Journal of Medical Genetics Part A*, *170*(5), 1174–1180. https://doi.org/10.1002/ajmg.a.37606

Meaney, S., Corcoran, P., Spillane, N., & O'Donoghue, K. (2017). Experience of miscarriage: An interpretative phenomenological analysis. *BMJ Open*, *7*(3), e011382. https://doi.org/10.1136/bmjopen-2016-011382

Mellen, R., & Pannett, R. (2021, March 31). New Zealand becomes one of the first countries to legalize paid leave for miscarriages. *Washington Post*. https://www.washingtonpost.com/world/2021/03/26/new-zealand-miscarriage-bereavement-law/

Meunier, S., de Montigny, F., Zeghiche, S., Lalande, D., Verdon, C., Da Costa, D., & Feeley, N. (2021). Workplace experience of parents coping with perinatal loss: A scoping review. *Work (Reading, Mass.)*, *69*(2), 411–421. https://doi.org/10.3233/WOR-213487

Middlemiss, A. L., Boncori, I., Brewis, J., Davies, J., & Newton, V. L. (n.d.). Employment leave for early pregnancy endings: A biopolitical reproductive governance analysis in England and Wales. *Gender, Work & Organization*, *n/a*(n/a). https://doi.org/10.1111/gwao.13055

Middlemiss, A. L., & Kilshaw, S. (2023). Further Hierarchies of Loss: Tracking Relationality in Pregnancy Loss Experiences. *OMEGA - Journal of Death and Dying*, 00302228231182273. https://doi.org/10.1177/00302228231182273

Miller, J., & Suff, R. (2022). *Workplace support for employees experiencing pregnancy or baby loss: Survey report*.

Ministry of Labour & Employment. (1961). *Maternity Benefit Act, 1961*. https://labour.gov.in/sites/default/files/TheMaternityBenefitAct1961.pdf

Miremberg, H., Oduola, O., Morrison, J., & O'Donoghue, K. (2023). Fetal anomaly diagnosis and termination of pregnancy in Ireland; evaluation following implementation of abortion services. *American Journal of Obstetrics & Gynecology*, *228*(1), S316. https://doi.org/10.1016/j.ajog.2022.11.556

Miscarriage Association. (n.d.). A miscarriage policy. *The Miscarriage Association*. Retrieved 13 September 2023, from https://www.miscarriageassociation.org.uk/miscarriage-and-the-workplace/human-resources-hr-information-and-support/a-miscarriage-policy/

Morris, A., Meaney, S., Spillane, N., & O'Donoghue, K. (2016). The postnatal morbidity associated with second-trimester miscarriage. *The Journal of Maternal-Fetal & Neonatal Medicine*, *29*(17), 2786–2790. https://doi.org/10.3109/14767058.2015.1103728

Moscrop, A. (2013). 'Miscarriage or abortion?' Understanding the medical language of pregnancy loss in Britain; a historical perspective. *Medical Humanities*, *39*(2), 98–104. https://doi.org/10.1136/medhum-2012-010284

Moseson, H., Zazanis, N., Goldberg, E., Fix, L., Durden, M., Stoeffler, A., Hastings, J., Cudlitz, L., Lesser-Lee, B., Letcher, L., Reyes, A., & Obedin-Maliver, J. (2020). The Imperative for Transgender and Gender Nonbinary Inclusion: Beyond Women's Health. *Obstetrics & Gynecology*, *135*(5), 1059–1068. https://doi.org/10.1097/AOG.0000000000003816

Musodza, W., Sheehan, A., Nicholls, D., & Dahlen, H. (2021). Experiences of Maternity Healthcare Professionals Returning to Work Following a Personal Perinatal Loss: A Scoping Review of the Literature. *OMEGA - Journal of Death and Dying*, 0030222821991312. https://doi.org/10.1177/0030222821991312

Mother and Child Health Act, § 14 (2015). https://elaw.klri.re.kr/eng_mobile/viewer.do?hseq=33648&type=part&key=38

National Care Experience Programme. (2023). *Early pregnancy loss: A scoping review of research in Ireland*. https://yourexperience.ie/wp-content/uploads/2021/10/Scoping-Review-of-Early-Pregnancy-Loss-in-Ireland_12102021-1.pdf

National Clinical Programme for Neonatology, National Perinatal Epidemiology Centre, & National Women and Infants Health Programme. (2021). *Determination of signs of life for births before 23+0 weeks gestation where active resuscitation is not considered appropriate*. Health Service Executive. https://www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/neonatology/determination-of-signs-of-life-for-births-before-23-plus-0-weeks-gestation.pdf

National Gestational Trophoblastic Disease Registry, Monitoring and Advisory Centre. (2020). *Gestational Trophoblastic Disease—Molar Pregnancy*. https://irelandsouthwid.cumh.hse.ie/gynaecology/gtd-centre/what-is-gtd/

National Women and Infants Health Programme. (2023). *Irish Maternity Indicator System: National Report 2021*. National Women and Infants Health Programme. https://www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/national-reports-on-womens-health/irish-maternity-indicator-system-national-report-20211.pdf

Neville, S. (2021, June 3). Lidl gives leave for pregnancy loss and miscarriage. *Irish Examiner*. https://www.irishexaminer.com/news/arid-40305554.html

New paid miscarriage leave for public sector workers. (2022, October 6). *Catalan News*. https://www.catalannews.com/politics/item/new-paid-miscarriage-leave-for-public-sector-workers

NICE. (2023). *Ectopic pregnancy and miscarriage: Diagnosis and initial management. NICE guideline [NG126]*. NICE. https://www.nice.org.uk/guidance/ng126

Nuzum, D., Meaney, & O'Donoghue, K. (2019). *Pregnancy Loss: A disturbing silence and theological wilderness*. *60*(2), 133–145.

Nuzum, D., & O'Donoghue, K. (2022). Pregnancy Loss: A silent loss and challenging birth. In *Birth and the Irish: A Miscellany*. Wordwell Books.

Obst, K. L., Due, C., Oxlad, M., & Middleton, P. (2020). Men's grief following pregnancy loss and neonatal loss: A systematic review and emerging theoretical model. *BMC Pregnancy and Childbirth*, *20*(1), 11. https://doi.org/10.1186/s12884-019-2677-9

Obst, K. L., Due, C., Oxlad, M., & Middleton, P. (2022). Australian men's experiences of leave provisions and workplace support following pregnancy loss or neonatal death. *Community, Work & Family*, *25*(4), 551–562. https://doi.org/10.1080/13668803.2020.1823319

Obst, K. L., Oxlad, M., Due, C., & Middleton, P. (2021). Factors contributing to men's grief following pregnancy loss and neonatal death: Further development of an emerging

model in an Australian sample. *BMC Pregnancy and Childbirth*, *21*(1), 29. https://doi.org/10.1186/s12884-020-03514-6

O'Callaghan, H. (2022, April 19). Support for employees who want to have children. *Irish Examiner*. https://www.irishexaminer.com/lifestyle/advice/arid-40853603.html

O'Farrell, I., Manning, E., Corcoran, P., Greene, R. A., & on behalf of the Perinatal Mortality Group. (2019). *Perinatal Mortality in Ireland Annual Report 2017*. National Perinatal Epidemiology Centre. https://cora.ucc.ie/server/api/core/bitstreams/4f15d5f3-64b2-4b28-84e3-4c9c28452262/content

O'Farrell, I., Manning, E., Corcoran, P., White, E., Greene, & on behalf of the Perinatal Mortality Group. (2021). *Perinatal Mortality in Ireland Biennial Report 2018/2019*. National Perinatal Epidemiology Centre. https://www.ucc.ie/en/media/research/nationalperinatalepidemiologycentre/annualreports/NPECPerinatalMortalityinIrelandannualreport2018_2019FINAL.pdf

Organisation of Working Time Act, (1997). https://www.irishstatutebook.ie/eli/1997/act/20/section/19/enacted/en/html

Parental Bereavement (Leave and Pay) Act (Northern Ireland) 2022, (2022). https://www.legislation.gov.uk/nia/2022/5/contents/enacted

Parental leave eligibility. (n.d.). Employment New Zealand. Retrieved 16 August 2023, from https://www.employment.govt.nz/leave-and-holidays/parental-leave/eligibility/

Paul, K., & Batinic, B. (2009). The need for work: Jahoda's latent functions of employment in a representative sample of the German population. *Journal of Organizational Behavior*, *31*, 45–64. https://doi.org/10.1002/job.622

Petrou, S., Trinder, J., Brocklehurst, P., & Smith, L. (2006). Economic evaluation of alternative management methods of first-trimester miscarriage based on results from the MIST trial. *BJOG: An International Journal of Obstetrics & Gynaecology*, *113*(8), 879–889. https://doi.org/10.1111/j.1471-0528.2006.00998.x

Porschitz, E. T., & Siler, E. A. (2017). Miscarriage in the Workplace: An Authoethnography. *Gender, Work & Organization*, *24*(6), 565–578. https://doi.org/10.1111/gwao.12181

Power, S., Meaney, S., & O'Donoghue, K. (2020). The incidence of fatal fetal anomalies associated with perinatal mortality in Ireland. *Prenatal Diagnosis*, *40*(5), 549–556. https://doi.org/10.1002/pd.5642

Pregnancy Loss Research Group. (2023). *PLACES | Pregnancy Loss in Workplaces: Informing policymakers on support mechanisms*. University College Cork. https://www.ucc.ie/en/pregnancyloss/researchprojects/places/

QSR International Pty Ltd. (2018). *NVivo* (Version 12) [Computer software]. QSR International Pty Ltd.

Quenby, S., Gallos, I. D., Dhillon-Smith, R. K., Podesek, M., Stephenson, M. D., Fisher, J., Brosens, J. J., Brewin, J., Ramhorst, R., Lucas, E. S., McCoy, R. C., Anderson, R., Daher, S., Regan, L., Al-Memar, M., Bourne, T., MacIntyre, D. A., Rai, R., Christiansen, O. B., … Coomarasamy, A. (2021). Miscarriage matters: The epidemiological, physical, psychological, and economic costs of early pregnancy loss. *The Lancet*, *397*(10285), 1658–1667. https://doi.org/10.1016/S0140-6736(21)00682-6

Republic Act No. 11210. (n.d.). Retrieved 15 December 2022, from https://lawphil.net/statutes/repacts/ra2019/ra_11210_2019.html

Rose, A., & Oxlad, M. (2022). LGBTQ+ peoples' experiences of workplace leave and support following pregnancy loss. *Community, Work & Family*, *0*(0), 1–17. https://doi.org/10.1080/13668803.2021.2020727

Russell, H., Watson, D., & Banks, J. (2011). *Pregnancy at Work: A National Survey*.

San Lazaro Campillo, I., Manning, E., Corcoran, P., Keane, J., O'Farrell, I., McKernan, J., White, E., Greene, R., & on behalf of the Perinatal Mortality National Clinical Audit Governance Committee. (2022). *Perinatal Mortality National Clinical Audit in Ireland. Annual Report 2020*. National Perinatal Epidemiology Centre.

San Lazaro Campillo, I., Meaney, S., O'Donoghue, K., & Corcoran, P. (2018). Ectopic pregnancy hospitalisations: A national population-based study of rates, management and outcomes. *European Journal of Obstetrics, Gynecology, and Reproductive Biology*, *231*, 174–179. https://doi.org/10.1016/j.ejogrb.2018.10.054

San Lazaro Campillo, I., Meaney, S., O'Donoghue, K., & Corcoran, P. (2019). Miscarriage hospitalisations: A national population-based study of incidence and outcomes, 2005-2016. *Reproductive Health*, *16*(1), 51. https://doi.org/10.1186/s12978-019-0720-y

San Lazaro Campillo, I., Meaney, S., Sheehan, J., Rice, R., & O'Donoghue, K. (2018). University students' awareness of causes and risk factors of miscarriage: A cross-sectional study. *BMC Women's Health*, *18*(1), 188. https://doi.org/10.1186/s12905-018-0682-1

San Lazaro Campillo, I., Meaney, S., Sheehan, J., Rice, R., & O'Donoghue, K. (2020). Reproductive Health Knowledge About Miscarriage: A Cross-Sectional Study of University Students. *Maternal and Child Health Journal*. https://doi.org/10.1007/s10995-020-03017-y

Seguranca Social. (2023). *Subsídio parental*. https://www.seg-social.pt/subsidio-parental

Sex Discrimination and Fair Work (Respect at Work) Amendment Act 2021, (2021). https://www.legislation.gov.au/Details/C2021A00104

Shields, R., Hawkes, A., & Quenby, S. (2020). Clinical approach to recurrent pregnancy loss. *Obstetrics, Gynaecology and Reproductive Medicine*, *30*(11), 331–336. https://doi.org/10.1016/j.ogrm.2020.09.005

Sick Leave Act, (2022). https://www.irishstatutebook.ie/eli/2022/act/24/enacted/en/html

Silverman, M. (2020). *Women's Return Work Experience Post-Miscarriage* (rayyan-407283892; Issue 28025728). Fielding Graduate University.

Sorhaindo, A. M., & Lavelanet, A. F. (2022). Why does abortion stigma matter? A scoping review and hybrid analysis of qualitative evidence illustrating the role of stigma in the quality of abortion care. *Social Science & Medicine (1982)*, *311*, 115271. https://doi.org/10.1016/j.socscimed.2022.115271

Spillane, N., Meaney, S., & O' Donoghue, K. (2018). Irish women's experience of Ectopic pregnancy. *Sexual & Reproductive Healthcare*, *16*, 154–159. https://doi.org/10.1016/j.srhc.2018.04.002

Steimel, S. (2021). Communication Privacy Management and Pregnancy Loss in Interpersonal Workplace Communication. *Women's Studies in Communication*, *44*(3), 397–418. https://doi.org/10.1080/07491409.2020.1843579

Tavoli, Z., Mohammadi, M., Tavoli, A., Moini, A., Effatpanah, M., Khedmat, L., & Montazeri, A. (2018). Quality of life and psychological distress in women with recurrent miscarriage: A comparative study. *Health and Quality of Life Outcomes*, *16*(1), 150. https://doi.org/10.1186/s12955-018-0982-z

Toffol, E., Koponen, P., & Partonen, T. (2013). Miscarriage and mental health: Results of two population-based studies. *Psychiatry Research*, *205*(1), 151–158. https://doi.org/10.1016/j.psychres.2012.08.029

Tommy's. (2022). *Pregnancy and Parenting at Work Survey Findings*. https://www.tommys.org/pregnancy-and-parenting-work-survey-findings

TRAVAIL legal databases. (2011). Nicaragua - Maternity Protection. https://www.ilo.org/dyn/travail/travmain.sectionReport1?p_lang=en&p_countries=NI&p_sc_id=2000&p_year=2011&p_structure=3

Unfair Dismissals Act 1977, (2016). https://www.lawreform.ie/_fileupload/RevisedActs/WithAnnotations/HTML/EN_ACT_1977_0010.html

van den Berg, M. M. J., Dancet, E. A. F., Erlikh, T., van der Veen, F., Goddijn, M., & Hajenius, P. J. (2018). Patient-centered early pregnancy care: A systematic review of quantitative and qualitative studies on the perspectives of women and their partners. *Human Reproduction Update*, *24*(1), 106–118. https://doi.org/10.1093/humupd/dmx030

Walker, E. (2021). *Supporting Employees Affected by Pregnancy Loss*. https://www.hrheadquarters.ie/health-and-well-being/supporting-employees-affected-by-pregnancy-loss/

Walsh, A.-M. (2023, February 15). Bank of Ireland staff to get paid leave for early miscarriage and if undergoing fertility treatment. *Independent.Ie*. https://www.independent.ie/irish-news/health/bank-of-ireland-staff-to-get-paid-leave-for-early-miscarriage-and-if-undergoing-fertility-treatment/42342963.html

Westin, M., Källén, K., Saltvedt, S., Almström, H., Grunewald, C., & Valentin, L. (2007). Miscarriage after a normal scan at 12–14 gestational weeks in women at low risk of carrying a fetus with chromosomal anomaly according to nuchal translucency screening. *Ultrasound in Obstetrics & Gynecology*, *30*(5), 728–736. https://doi.org/10.1002/uog.5138

Workplace Relations Commission. (2023, April 1). *ADJ-00038952 Adjudication Officer Decision: Marta Siudak v Slane Trading Company Limited*. Workplace Relations Commission. https://www.workplacerelations.ie/en/cases/2023/january/adj-00038952.html

World Bank. (2022). *High-Income Countries 2022*. https://worldpopulationreview.com/country-rankings/high-income-countries

World Health Organisation. (2021). *Abortion*. https://www.who.int/news-room/fact-sheets/detail/abortion

Pregnancy Loss Research Group: www.ucc.ie/pregnancy loss

Pregnancy and Infant Loss Ireland: www.pregnancyandinfantloss.ie

DCEDIY: https://www.gov.ie/en/organisation/department-of-children-equality-disability-integration-and-youth/

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