UNDERSTANDING THE EXPERIENCE OF EARLY PREGNANCY ENDINGS AS A WORKPLACE ISSUE

Research Report 2024

Investigating how employees navigate experiences of early pregnancy endings (including miscarriage, abortions, terminations, molar and ectopic pregnancies)

Authors: Ilaria Boncori (University of Essex); Jo Brewis (The Open University); Julie Davies (UCL); Hamid Foroughi (University of Essex); Aimee Middlemiss (University of Plymouth); Killian Mullan (Aston University); Victoria Newton (The Open University); and Katy Schnitzler (The Open University)

The Open University
University of Essex
UNIVERSITY OF PLYMOUTH
Aston University BIRMINGHAM UK

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1. Executive summary

Pregnancy is a protected characteristic under the UK's Equality Act (2010). Yet in most workplaces, there is no entitlement to pregnancy-specific leave for employees who experience early pregnancy endings (including miscarriages, abortions, terminations, molar and ectopic pregnancies) before 24 weeks' gestation. Although early pregnancy endings are common, a lack of awareness, personalised[1] support, compassion, policies and/or guidance, and training can result in workers suffering physically, psychologically, emotionally, and financially, often in silence.

This report explores how employees navigate their experiences of early pregnancy endings and how organisations, especially line managers and HR professionals, might provide better and more personalised support. Drawing on data from qualitative interviews conducted in 2020-21 and a survey in 2022 (including quantitative and qualitative findings) as well as reflections from our knowledge exchange events, it highlights four key challenges:

i. A lack of awareness of the relevant issues, sociocultural bias, and silencing in a context of limited legislative protection.
ii. Concerns about the career-limiting impacts of disclosure of early pregnancy endings to line managers or HR professionals, a reluctance to ask for support and disquiet about confidentiality.
iii. Variable reactions to disclosure and in the workplace support provided.
iv. Questions about leave entitlements and types of leave taken, given that experiences of early pregnancy endings vary.

Based on our analysis, we propose ten best practice principles to support individuals in the workplace who experience early pregnancy endings more effectively, as follows:

1. We call for greater awareness and inclusion through disseminating information and providing formal training and resources in organisations.
2. We make the case for holistic support for employees' physical, emotional, and mental health and well-being with practical help based on carefully listening to individuals' needs.
3. Well-designed and evidence-based policies and/or guidance and procedures need to be implemented and monitored. These should allow for signposting, referrals, workload reviews and flexible working arrangements for those directly experiencing early pregnancy endings and for their partners.
4. Support for employees affected by early pregnancy endings needs to be personalised in recognition that a one-size-fits-all approach for such experiences is inappropriate.
5. Workplace policy must be complemented by formal training for line managers and HR professionals to compensate for the lack of national policy, legislation and statutory leave entitlements.
6. Policies and procedures must clearly address issues of disclosure and confidentiality to ensure that employee privacy is rigorously upheld.
7. Organisations must avoid stigmatising language and making assumptions about employees' preferences for using particular terms to describe early pregnancy endings.

[1] This term, and other terms such as individualised, are used in this report to refer to support which is tailored and adapted to an employee's situation, needs and preferences, as early pregnancy endings are unique experiences.

8. The application of formal policies can help with consistent, equitable, and fair treatment across all types of early pregnancy endings.
9. Formal and informal support in this space must be inclusive of all types of early pregnancy endings, and all those affected by them.
10. Finally, we note the human, legal, and economic imperatives to support individuals who are experiencing early pregnancy endings in the workplace and the implications for their productivity and performance.

"Although I had a termination, I lied to my employer and said I had a miscarriage, because I didn't think anyone would understand or be sympathetic."

2. Introduction

Many aspects of health and well-being have become increasingly researched in terms of their effects on organisations and the lives of people in these workplaces. In particular, aspects of what is often called 'women's reproductive health' (e.g. menstruation, endometriosis, menopause, (in)fertility, pregnancy and so on) are being addressed by management and organisation studies researchers, as well as by charities and other third sector organisations, and in research commissioned to inform government policy. This report addresses the issue of the end of a pregnancy before 24 weeks' gestation (i.e. an early pregnancy ending). However, the circumstances and gestational timeframe of the pregnancy ending, and whether it was spontaneous or chosen (for example through abortion/termination[2]) are not sufficient indicators of the experience and its impact on people's personal and professional lives. Early pregnancy endings are experienced very differently by different people and these experiences are nuanced, complex, and changing. They are not experienced consistently across different pregnancy endings, or across multiple endings for the same person. Moreover, the experience may only affect the person who has been pregnant or also have an impact on other people, such as partners and co-workers.

We use the term 'early pregnancy endings' to encompass all types of pregnancy ending which occur before the 24-week threshold, including miscarriages and recurrent miscarriages, ectopic and molar pregnancies[3], and abortion/termination. These endings are commonly also identified as 'first trimester' or 'early miscarriage/abortion/termination' (up to 12 weeks' gestation), and 'second trimester' or 'late miscarriage/abortion/termination' (between 12 and up to 24 weeks' gestation) pregnancies.

Recent policy in England has tended to focus on miscarriage and frames early pregnancy endings as pregnancy losses[4]. For example, in 2022, the Department for Health and Social Care published the *Women's Health Strategy for England*, highlighting the importance of an inclusive workplace and recommending that 'employers introduce or improve their workplace provisions and policies to better support women in different situations. This include[s] […] supporting women and partners undergoing fertility treatment or who have experienced a pregnancy loss' (page 36). The importance of addressing specific needs around early pregnancy endings was likewise highlighted in the independent *Pregnancy Loss Review* for England, commissioned by the Secretary of State for Health and Social Care. This recommended that 'All organisations should update their HR policies and practices to adequately support staff who experience pre-24-week baby loss' (Clark-Coates and Collinge, 2023: 14).[5]

Early pregnancy endings can also be understood as a fertility issue. In a survey by LinkedIn and Censuswide, 1,000 HR professionals recognised the positive impact of workplace fertility support

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[2] We use the term 'abortion/termination' throughout as our survey used the latter term to encompass termination for medical reasons (TFMR) and termination of pregnancy for foetal anomaly (TOPFA). TFMR encompasses TOPFA and also terminations where complications threaten the pregnant person's life. However, where a pregnancy is ended electively, without foetal anomaly or other medical reasons, the standard term is abortion. The only exceptions to this construction are in direct or indirect quotations.

[3] Ectopic pregnancies form outside the womb, often in the fallopian tubes. Molar pregnancies involve serious foetal anomaly. Neither is sustainable. They may end in miscarriage or require surgical intervention to end the pregnancy.

[4] For a critique of this framing see Fuller and Kuberska (2022).

[5] Of course with the recent change of government following the July 2024 general election, at the time of writing it is unclear to what extent the new government will seek to implement these recommendations.

on employees. Two thirds of respondents argued that it should be a statutory right, and 91% stated that further knowledge and support on the topic would help them in understanding and supporting employees' fertility issues (Churchill, 2019). The Chartered Institute of Personnel Development (CIPD) has published research reports on workplace support for employees who have experienced baby loss and/or miscarriage and complex fertility journeys (Miller and Suff, 2022, 2023), which are also linked to early pregnancy endings. Such engagement demonstrates recognition of early pregnancy endings as a key workplace issue.

To date, however, there has been very little consideration of abortion/termination as a workplace issue, despite the physical processes of miscarriage and abortion/termination being very similar. This is an omission which adds to the stigmatising of people who may choose to end a pregnancy for whatever reason, and is also problematic in its assumptions regarding miscarriage, notably that this always evokes significant grief for all those who experience it.

Our research report extends the extant work by:

- focusing particularly and inclusively on early pregnancy endings (up to 24 weeks' gestation), including abortion/terminations, miscarriages, ectopic pregnancies and molar pregnancies, because these experiences often go unreported and do not benefit from legal entitlement to leave from work;
- emphasising that not all pregnant people are cis women;
- providing insights into early pregnancy ending experiences at work from both qualitative and quantitative data;
- explicitly recognising that early pregnancy endings can result in psychological, emotional, social and professional impact alongside physical recovery needs;
- emphasising that it is important for workplaces to formally support non-pregnant partners who also experience pregnancy endings; and
- highlighting that all pregnancy endings should be accounted for in a non-stigmatising and non-judgmental way - framings of pregnancy endings only in terms of a 'loss' or 'bereavement' leads to the stigmatisation of people undergoing abortion/termination as well as those who do not experience miscarriages, ectopic or molar pregnancies as losses.

So far, clinical and statutory definitions of pregnancy endings are typically based on timing (when the pregnancy ending occurs) and on whether the pregnancy ending is chosen or happens spontaneously. These parameters vary across nations and countries (see Middlemiss et al., 2024), and correspond to different levels of support at the national, institutional and organisational levels.

Evidence on pregnancy endings – even though these often go unreported in the first trimester – show just how common these experiences are for women/pregnant people. Global annual estimations of pregnancy endings include 2 million events defined as stillbirth[6] (Hug et al., 2021), 23 million defined as miscarriages (The Lancet, 2021) and 73 million defined as abortions/terminations (Bearak et al., 2020). Miscarriages are not formally recorded; thus any figures are based on approximations. Nonetheless, there are an estimated 250,000 miscarriages each year in the UK, and ectopic pregnancies are thought to affect one in 80-90 pregnancies (Clark-Coates and Collinge, 2023). In 2021, 214,256 abortions took place in England and Wales, the highest figure since the Abortion Act came into effect in 1968 (Office of Health Improvement and Disparities, 2023).

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[6] Stillbirth refers to the death of a baby after the so-called viability threshold - in other words, when the foetus is assumed to be able to live outside of the uterus. This is a highly problematic concept, not least because viability thresholds vary from country to country.

However, and regardless of the high frequency of early pregnancy endings, their impact on the workforce in terms of physical, emotional and cognitive well-being has thus far remained a significantly undeveloped area of study in management and organisation studies (see Boncori and Smith, 2019). These endings also have limited visibility in terms of national and international policy development, and limited inclusion in HR policies and training. In the UK, early pregnancy endings are related to legislation and the workplace, particularly in terms of leave and pay entitlements. Before 24 weeks' gestation women[7] are not entitled to any pregnancy-specific leave in most circumstances. Full maternity leave rights come into force after the 24-week period for any pregnancy ending, whether spontaneous or induced (Middlemiss et al., 2024).

This research report aims to assist organisations in delivering evidence-based workplace policies and other appropriate support to employees who have experienced any form of early pregnancy ending. It provides ten best practice principles based on qualitative and quantitative data collected by researchers in the fields of management and organisation studies, sociology, and health and well-being[8]. We approach this study from an intersectional and gender-inclusive perspective, valuing and respecting all experiences reported to us.

> ***"There are people who choose not to return to work because they... just can't face it. They can't face the stress that they feel because people aren't sympathetic or they don't understand."***

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[7] Note that the relevant legislation assumes that only cis women can be pregnant.

[8] For questions and clarifications on the survey please email EPE-project@open.ac.uk; for queries about the qualitative study, or for further support in terms of policy review and advice, training and consultancy please email Professor Boncori (iboncori@essex.ac.uk).

3. Background to the research

This research report is based on findings from two studies conducted between 2020 and 2022. The qualitative study (Understanding the Individual and Organisational Experiences of Miscarriage and Stillbirth in the Workplace, hereafter shortened to UMS), conducted by Ilaria Boncori and Hamid Foroughi, is based on in-depth qualitative interviews conducted with 38 people who had experienced early pregnancy endings (mostly miscarriages) while in employment in Higher Education in the UK. 31 participants identified as female, six as male, and one as non-binary. Interviews were also conducted with five practitioners working in professions supporting employees and advising organisations about the experience of pregnancy endings[9]. All five identified as women, and worked in third sector organisations, counselling, and/or occupational therapy. The data collection generated 589 hours of recordings and 670 pages of interview transcriptions (320,613 words).

The survey-based study (Early Pregnancy Endings and the Workplace, hereafter shortened to EPE) was conducted by Jo Brewis, Ilaria Boncori, Julie Davies, Aimee Middlemiss, Killian Mullan and Victoria Newton. It collected data from respondents in the four UK nations who had experienced early pregnancy endings at any time whilst in employment in this context. To simplify the survey format, participants were asked specifically about their most recent early pregnancy ending. However, there was space for a free text comment towards the end where respondents could index other endings they had experienced, as well as any other comments they wished to make. The survey was carried out online during the first six months of 2022, and resulted in a final sample of 226 people.

In this study, the majority of respondents (163) had experienced miscarriage; therefore our data on abortions/terminations (39) and molar (4) and ectopic pregnancies (13) are more statistically limited[10]. 207 respondents identified as women, one respondent stated that they 'prefer not to say', and 18 provided no information about their gender. 184 respondents identified as white, six as Asian, five as black and eleven as mixed heritage. Four respondents preferred not to say. In terms of sexual orientation, 180 identified as heterosexual, one as lesbian, 20 as bisexual, two as pansexual, one as demisexual and four preferred not to say.

In this report, we intersperse our quantitative findings with quotes from our UMS and EPE research participants. Participants in both studies provided full informed consent in order to participate in the research, and all data are fully anonymised. The survey was reviewed by, and received a favourable opinion from, The Open University Human Research Ethics Committee (reference number HREC/4201/Brewis). All quantitative survey data have been rounded to one decimal place. The qualitative study received approval from the University of Essex Humanities Ethics Sub Committee (reference number ETH1920-1228). We also draw on reflections offered by participants in our knowledge exchange events where we presented our key findings from this report and asked for questions and comments. Several of thee people had lived experience of early pregnancy endings.

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[9] In quotes from the qualitative study female participants are anonymised as 'UMS F', male participants as 'UMS M', and the non-binary participant as 'UMS NB'. Practitioners are anonymised as 'UMS P'.

[10] Note that a further eight respondents selected 'Other' to answer this question. Two had experienced TFMR. One had experienced 'neonatal death at 22 weeks' and another had experienced a stillbirth. In clinical terms these would be understood as miscarriages. Two others had missed miscarriages, where they experienced no symptoms. Another respondent stated they had experienced a 'Miscarriage presumed ectopic but non-visualised'. In this case, the pregnant person has had a positive pregnancy test, but the ultrasound could not detect the embryo or foetus. The final respondent had experienced 'Loss of 'twin 2' at approximately 10 weeks but didn't find out until the 12-week scan'.

4. Findings: early pregnancy endings in a workplace context

Tackling workforce health and well-being in an inclusive manner must be a priority for all organisations, helping employees flourish in an enabling and supporting environment. However, our studies have highlighted many instances where staff experiencing an early pregnancy ending could have been much better supported, especially in terms of visibility and awareness, disclosure, asking for support and the availability of different forms of leave, notably pregnancy-related and therefore statutorily protected sick leave. We deal with each of these issues in the sub-sections that follow.

a. Visibility and awareness

Visibility and awareness in workplaces around early pregnancy endings tend to be limited, contributing to the wider silencing and stigma around these experiences. The vast majority of our UMS interviewees reported not being aware of any workplace information, support, or material prior to their early pregnancy endings. For example:

> 'Why isn't that common knowledge that this is something so frequent? In the subsequent days I started researching this and realising that, yeah, it's like super common. And most people you talk to, they will tell you that this has happened to them.' (UMS M2)

Where resources were available, they suggested these were often limited to physical recovery, took gendered approaches (i.e. assumed the pregnant person was a cis woman and/or excluded any support for partners), often underestimated experiences in terms of impact and duration and were not specific to early pregnancy endings. All of this was deemed by participants to be informed by sociocultural bias, and fueled by a wider silence around these experiences.

Equally, 77.3% of EPE survey respondents reported the lack of dedicated workplace information, policies and processes about pre-24-week pregnancy endings. There were also comments about information needing to be legible, appropriate and easy to access:

> 'When you're going through this, the last thing you want to do is search your organisation's website for guidance. Maybe make info[rmation]/training embedded into the training programme for managers etc.' (EPE respondent)

Also, any specific needs and entitlements around early pregnancy endings, where they exist in workplaces at all, are often hidden behind broader policies around fertility and health and well-being, with a lack of nuance around these experiences especially. This is important because, as we have established above, there is very little legislative protection around this form of pregnancy ending with respect to leave from work, for example:

> 'I had a 'late miscarriage' at 21 weeks. Managers should be trained in how to support bereaved staff – 'everything happens for a reason' is not an appropriate response to a member of staff on their first day back at work after they birthed their dead baby.' (EPE respondent)

Particular sensitivity should be exercised in terms of leave entitlements, type of leave used, return to work adjustments and flexible work arrangements. We return to the specific issue of leave later, but the importance of individualised forms of support of whatever kind emerged very strongly in both data sets. For example:

> 'There are people who choose not to return to work because they, they just can't face it. They can't face the stress that they feel because people aren't sympathetic or they don't understand. They worry about how much time off they should have, even if they

> have a sick note. Because, well especially perhaps if they get messages from their manager saying 'you, you know, you've been off for a week now, don't you think, don't you think you should come back because other people are having to pick up your workload?'.' (UMS F1 – their emphasis)

Organisations can improve the visibility of early pregnancy endings in various ways, including implementing formal policy/guidance and/or providing relevant resources and training. Such initiatives must be inclusive, acknowledging that early pregnancy endings do not solely affect cis women in set ways. Information can be provided to employees through policy, and also through workplace intranet pages, e.g. on well-being hubs. Particularly, information on accessing relevant support should be available through policy/guidance, including external sources of support such as charities, and internal sources, such as counselling. Another issue which emerged from our knowledge exchange events is the importance of workplaces not assuming that staff who are affected by EPEs will receive all the psychological and physical support they need from healthcare personnel – this was reported to often not be the case. As such, organisations need to provide support of their own, at the very least to plug the gaps in healthcare support.

b. Disclosure and confidentiality

Disclosure rates were high for early pregnancy endings, as around three quarters of our survey respondents had told someone at their workplace about their most recent pregnancy ending (72.5%). However, disclosure of abortions/terminations at work was lower (55%). Most survey respondents told either their line manager (37.2%) or a colleague (43.2%), whereas only 7.7% disclosed to HR staff[11]. This further underlines the need for all staff groups to be educated about early pregnancy endings and appropriate workplace responses. One of the attendees at our knowledge exchange events specifically mentioned the importance of mental health champions or advocates receiving such training, as these may well be the first port of call for staff who have experiences an EPE.

UMS interviewees who chose to disclose reported doing so mostly to line managers and HR staff, to agree time off from work or negotiate flexibility upon return. Underpinning many of these accounts across both studies was a belief that different line managers would react differently to disclosure. For example:

> 'The line manager - mine was amazing. Supportive, helpful and I could trust him. I had a different line manager 12 months prior. If I'd told her, I don't think I'd have got that much support or guaranteed confidence. Miscarriage is a very personal thing, so you need to be able to feel you can confide and cry without judgement/gossip.' (EPE respondent)

Again, this bolsters our argument around needing to ensure that organisational responses are consistent whilst also sensitive to the needs of the individual disclosing. Line managers should be supported to give equitable and impartial support regardless of the EPE experienced. HR guidance should be clear and inclusive, especially so that managers' personal views about abortion/termination do not affect the support an employee is given.

[11] Note that respondents could tick as many options as applied to answer this question.

Figure 1 shows how many survey respondents identified the following reasons for disclosing early pregnancy endings: 1) physical symptoms; 2) emotional symptoms; 3) needing time off or other HR reasons; 4) needing help or support at work; and 5) wanting people to be aware[12].

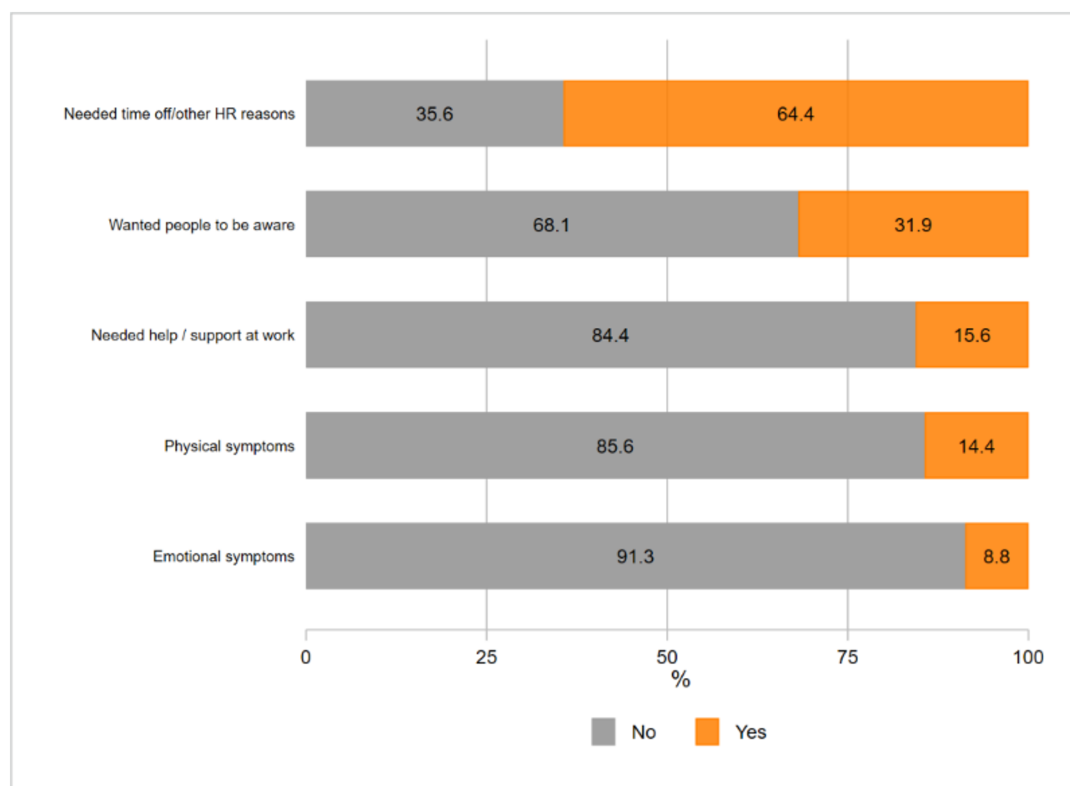

Figure 1: Reasons why survey respondents disclosed early pregnancy endings at work

While physical and emotional symptoms were less prominent as reasons for disclosing an early pregnancy ending at work, these were most likely to underpin the need to take time off from work, as we discuss in a later subsection. We saw limited disclosure where employees had more flexible work arrangements, or more agency in deciding their work patterns and mode of work.

Disclosure rates were similar across organisation types, regardless of employees' education level, employment status, whether they were on full-time or part-time contracts, or whether their work required standing for long periods. There were also no strong patterns between those disclosed to and factors linked to the pregnancy ending (type, trimester, when it occurred).

Survey respondents who had experienced abortions/terminations explained in qualitative commentary that their disclosures were due to the need to take time off. For example:

> 'I told my line manager before it happened, and asked them to tell my colleagues while I was signed off work so they didn't wonder and to prevent rumours.'

[12] Again respondents could select more than one answer to the relevant question.

'To authorise time off for the termination and to ensure I could deal with pregnancy symptoms eg. morning sickness without judgement or extra stress.'

'I had to because I needed the time off work for the abortion. Also I discovered I was pregnant on the day of [another] planned surgery, which had to be cancelled.'

Our survey data also indicated that disclosure of an early pregnancy ending can be very distressing, especially when a number of colleagues were aware of the pregnancy:

'I had a silent[/missed[13]] miscarriage so, I continued to experience all the ongoing symptoms of my pregnancy with no knowledge that my baby had passed. I found it really distressing that it was so sudden and out of the blue. Everyone knew I was pregnant so it was a whole process to go through in terms of telling people.'

Other survey data point to those who didn't disclose having low expectations around what work could offer other than time off or lacking any sense of entitlement to support. Some respondents simply felt unable to disclose because of the emotional toll their early pregnancy ending took on them:

'The most recent termination plunged me into a kind of depression. I went through the motions but life was hard and heavy. No one at work knew. I carried on. It took around four years to feel ok again. Had I told work or been offered support there, rather than having a strong divide between personal life and work life, it could have made a difference for me. There are not enough places to talk about termination and be unconditionally supported.'

'I found out I was bleeding during a workshop with all the senior staff. I didn't feel able to tell anyone or do anything, so I went back in and carried on until the workshop ended. I work in a lovely place, with great people - I just find it really sad that even in a really positive work environment I felt so alone and isolated.'

Equally, the 75% of EPE respondents who disclosed their early pregnancy ending at work but did not ask for **support** provided a range of reasons: being unaware of the options for support at work; wanting to appear in control; and feeling embarrassed. A quarter stated they were too upset to ask for support, while around one in five stated that they were worried about the repercussions for their job. 11.8% stated that they were worried about issues relating to confidentiality. Just under 9% stated that they did not need support, 5% stated it was not appropriate, and 15% stated that they knew that they would not receive any support[14]. Figure 2 provides the relevant data.

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[13] A silent or missed miscarriage occurs when there is no foetal heartbeat but the pregnancy is ongoing. These EPEs are frequently asymptomatic.

[14] This survey question also allowed respondents to choose as many answers as were relevant.

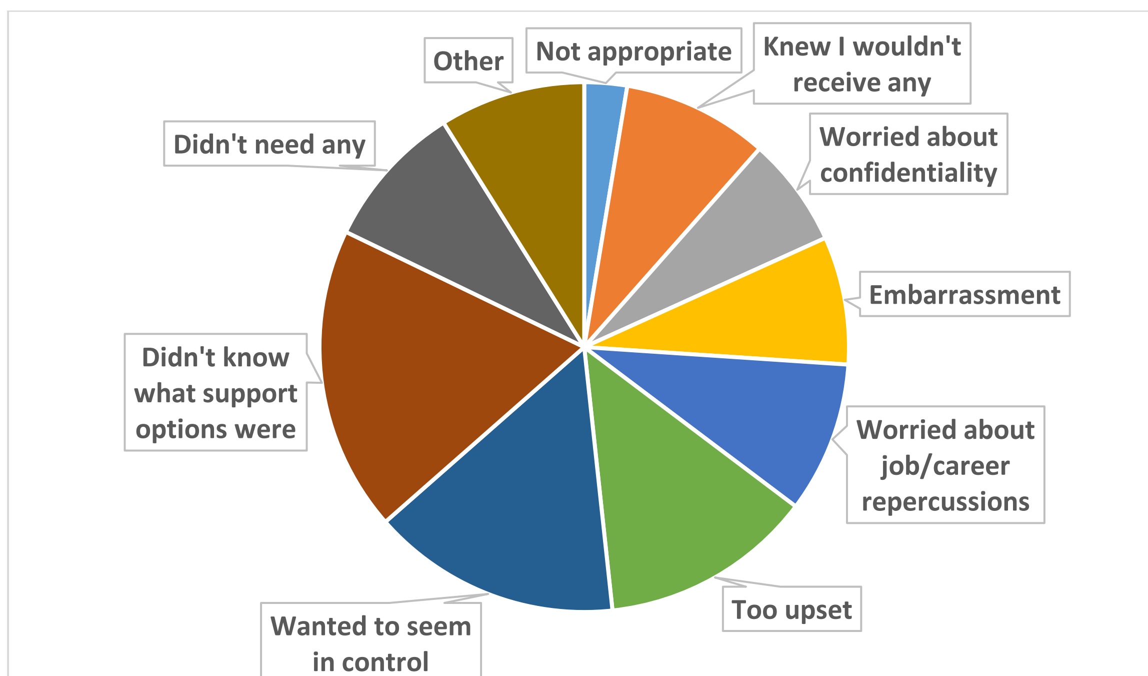

Figure 2: Distribution of reasons why survey respondents did not ask for support at work

It is of particular concern that a scant 8.9% of these respondents reported that they didn't ask for support because they didn't feel they needed it.

These reasons were echoed in the stories shared by our UMS interviewees, who highlighted the importance of the line manager, and of co-workers and HR staff to a lesser extent, as gatekeepers for the provision of various types of support in the workplace:

> 'The fact that you don't seek support doesn't necessarily mean that you couldn't use support, or wouldn't benefit from support. But also people don't seek support if they don't need support. People don't seek support if they've already got it, from people around them. People don't need support if it's not a big deal for them.' (UMS F1)

EPE survey respondents working part-time were more likely to report that they did not need any support (43%) than those working full-time (15%). 22% of the latter group, on the other hand, did not ask for support due to potential repercussions at work with only a single respondent who was working part-time reporting this reason.

Our UMS data also contained commentary around the different ways people react to early pregnancy endings, underlining that these are very diverse in terms of the support needed at work. For example:

> 'For some people work is impossible. They cannot concentrate. They cannot focus. It seems meaningless. For some people, work is an absolute saviour. Because it provides a framework. It provides a focus that isn't on loss and sadness. And I suspect that for many people it's something in between. And they get through. And there will be times when they absolutely don't get through.' (UMS F1)

c. Reactions to disclosure and support provided at work

Reactions to workplace disclosure varied. In our survey data, many who had disclosed described the reaction as helpful or supportive (45.9%), although a substantial proportion reported that those to whom they disclosed were not well informed about the issue (9%) and/or did not provide any support (17.7%). 9% reported that their disclosure elicited surprise, while 6.4% reported that their disclosure caused feelings of embarrassment or distress for those to whom they disclosed. This speaks to the fact that there is a need for better guidance, support, and awareness training in organisations around the range of EPEs. The first interaction in the workplace when someone has disclosed an EPE is especially important as it can deeply shape relations and affect well-being going forward. As one of our UMS respondents suggested,

> 'I think what's really important is that you find out how they are, let them speak first, you don't go with any preconceived ideas of how they may be feeling, because each person's obviously individual and very different. So, giving them time to speak, asking them how they would like to be supported, and what were their expectations of support. [...] It's really important that we, as an employer, support them and signpost them into the right places for support. So, I think that's what's really essential.' (P1)

Even though 'only' 4.1% of EPE respondents indexed facing criticism, ridicule or having their disclosure communicated without their permission to others, UMS interviewees told us that these were often the reasons behind lack of disclosure, or reluctance in communicating their experiences to managers due to stigma, and fear about negative consequences for their career progression and job security. For example:

> 'I hadn't told anyone I was trying, because I think that's a danger at work - like if you tell anyone, and then people think you're not going to be around, you're not basically going to be given any responsibility or anything that's promotion[-related].' (UMS F12)

Respondents also reported feeling isolated, and provided examples whereby the news of their early pregnancy ending had created tensions in or disruptions to relationships at work, as people did not know how to behave around them, or sensitivities around office celebrations, such as baby showers for other colleagues and insensitive language/responses. Many complained about lack of confidentiality, negative judgements or inappropriate support, like this EPE respondent:

> 'I was made to go to Occupational Health because I wanted to be able to continue working from home and I didn't realise just how much they would break confidentiality, telling my manager (who doesn't like me and I've felt previously was trying to get rid of me) all about my reproductive problems. Absolutely awful.'

Other EPE respondents told us that it was very important for others at work to:

> 'Stay open minded for those who choose to end their pregnancy and not just those who miscarry etc. [T]here tend[s] to be sympathetic support for uncontrolled circumstances but not for the other, I didn't feel comfortable to say anything [about my abortion/termination] in [...] case I was judged'.
>
> 'Ensur[e] we are not made to feel guilty or embarrassed for having to take time off, when often the choices being made (in the case of a termination) are gruelling enough.'

Similarly:

> 'Where a staff member has disclosed their choice to have a termination, they should be allowed sick leave and/or flexible/home working where possible to allow them to manage the symptoms. I would have been able to work as I did not feel too bad, however the risk of extremely heavy bleeding meant I did not want to be away from home so had to take sick leave, when I could have worked at home if it was allowed. Line managers etc[.] need to be aware that it is not over in a day and staff may experience symptoms for days and weeks afterwards.'

In some cases, these reactions meant our respondents were reluctant to disclose any subsequent pregnancy endings:

> 'If your first experience of having a miscarriage [was] that your manager was very supportive, then you might feel much more inclined to tell them, or maybe a work colleague, than if they were just not supportive, completely didn't get it and just said, 'Well, you know, you, erm, there's a piece of work that needs doing. I hope you can do it from home, even if you need to take time off'.' (UMS F1)

> 'Have experienced two early losses at work, [with] the first I experienced the total absence of HR knowledge/policy/understanding. The second I didn't bother to tell anyone. Both went on for several weeks, affecting performance at work.' (EPE respondent)

However, some people found comfort in sharing their experience with colleagues who had been open about their own experiences of pregnancy endings, mostly on a one-to-one basis.

Although a high proportion of survey respondents disclosed their early pregnancy ending to someone at work, only one quarter specifically asked for **support.** Just over half of these people asked for time off, with 29% asking for some flexibility or other adjustments to their work. Managers were more likely to ask for time off, and non-managers for flexible working or other adjustments. However, there was no strong association between levels of job autonomy (for example, ability to control the tasks undertaken, how they were done and in what order) and asking for support.

Other survey respondents noted the lack of workplace understanding, support and resources they had received upon disclosure. Only 44.1% of respondents who had an abortion/termination reported that the person they disclosed to was helpful and supportive, compared with 61.8% of those who miscarried. This indicates a worrying lack of consistency across different types of pregnancy endings, which could lead to heightened feelings of stigma and shame. Moreover, 27.7% of those who miscarried said they had received no response at all, and an even more concerning 44.1% of those who had had an abortion/termination. The qualitative data from the survey also suggest that all too frequently:

- People who disclose are expected to handle the experience alone, with resources that are available outside of work.
- People who disclose might hear 'all the right noises' but their managers keep up the work pressure anyway.
- When people take time off, this is with the expectation that they 'handle' their EPE and then return to work without any further issues.
- The onus is on the individual to state what they want/need for physical and emotional processing, e.g. to avoid triggering events.

Thankfully, others reported that those to whom they disclosed a miscarriage: offered empathy; said they were sorry for the loss that had been experienced; shared a similar experience; told them to take as much time off as they needed; and/or signposted them to relevant networks and resources.

Our UMS data highlighted the importance of a supportive line manager in particular:

> ‘My Head [of department] – I was at four miscarriages already – he had scheduled very light teaching for me for the middle term. And then I had two miscarriages in succession. And he didn't increase my teaching load. He said that, you know, ‘This was bad enough as it was’ and, in fact, he gave me an option to opt out completely from the teaching. […] I did opt out because I felt completely, completely exhausted. And also, it wasn't a normal pregnancy, a normal miscarriage, because I did an egg donation and so that involved a lot of hormone injections and very significant stress’ (UMS F4).

There were therefore marked differences in whether support had been offered as well as in perceptions of the helpfulness of the support received. Moreover, only 54.5% of EPE respondents who requested flexible work patterns or other adjustments to work were given what they asked for in comparison to 87% who asked for time off.

There were also some concerning comments in the qualitative data from the survey, with respondents feeling forced to disclose because they: needed to take sick leave; were in physical pain and/or very upset; were unable to perform their roles adequately; and/or needed to attend medical appointments related to their early pregnancy ending. Another example is one survey respondent reporting specific negative repercussions related to the leave she needed to take due to hospitalisation:

> ‘My manager used it against me and called me lazy for taking time off, despite the fact I had to stay in hospital’.

Our findings therefore suggest that better support mechanisms need to be established in workplaces around early pregnancy endings. Clear information and processes must be available and communicated to employees and their line managers, with flexible reporting lines. For example, our EPE respondents commented as follows:

> ‘There is still a lot of stigma about early miscarriages, molar pregnancies and etc. A[n] institution or company-wide approach would help women feel more able to accept help or ask for help. It would clearly show that the government, institution or company take it seriously and recognise the trauma experienced even if your Line Manager is less empathetic.’

> ‘Shame and guilt were a huge part of my experience and although people at work were very kind, I felt like I couldn't hide my situation from people very easily, both before and after the termination. I was trying to carry on like normal, but nothing felt normal. I always wondered who else knew about it, like I had a terrible secret. Being able to trust confidentiality is so important, but I felt sure it had been broken. I may have benefitted from support from someone outside of the immediate team, like an HR or Occupational Health rep[resentative] who was impartial and didn't know my colleagues. I would encourage any managers/supervisors to try and provide a source of independent support if possible.’

As this last quotation also makes clear, confidentiality must be protected to ensure safe work cultures and signposting of internal and external sources of information and support must be done regularly. We provide examples in section 7 of this report. In the event of an early pregnancy ending being disclosed, organisations must have a consistent and coherent approach across teams to ensure duty of care for all employees and avoid discrimination or any reliance solely on individual line managers, their understanding and experience. Organisational support must be premised on inclusivity to avoid stigma and the fear of repercussions for career and job safety. Equally, staff need to be supported in personalised ways, with sensitive communication, to provide temporary or more long-term adjustments to foster their health and well-being. Equally, where disclosure takes place but no specific support is requested – for example because remaining at work and carrying out one’s usual tasks is helpful for the individual concerned - this must also be respected.

As one of our interviewees noted:

> ‘We should be led by not only overall policies and processes, but about listening and recognising that different people may have different needs. If you say ‘everybody who's had a miscarriage should have three weeks’ time off’, that's really unhelpful. Because for some people, getting back to work quickly is absolutely what they need. And for others, they may need six months. And it doesn't help to compare one with the other.’ (UMS F1)

“People say the most ridiculous things, or hurtful things. It’s ‘Oh well, never mind. There would have been something wrong with it.’ ‘I'm sure it will be fine next time.’ ‘At least it was early.’ ‘At least you've already got kids’. You know, all the things that people say with the best of intentions, mostly.”

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d. Leave entitlements

Leave for early pregnancy endings was a key theme in our findings. Figure 3 shows that nearly 31.4% of survey respondents who took time off did so in order to physically recover from their early pregnancy ending, although only just over 22.2% did so to receive medical care. In addition, nearly a third who took leave reported that they did so to recover emotionally[15].

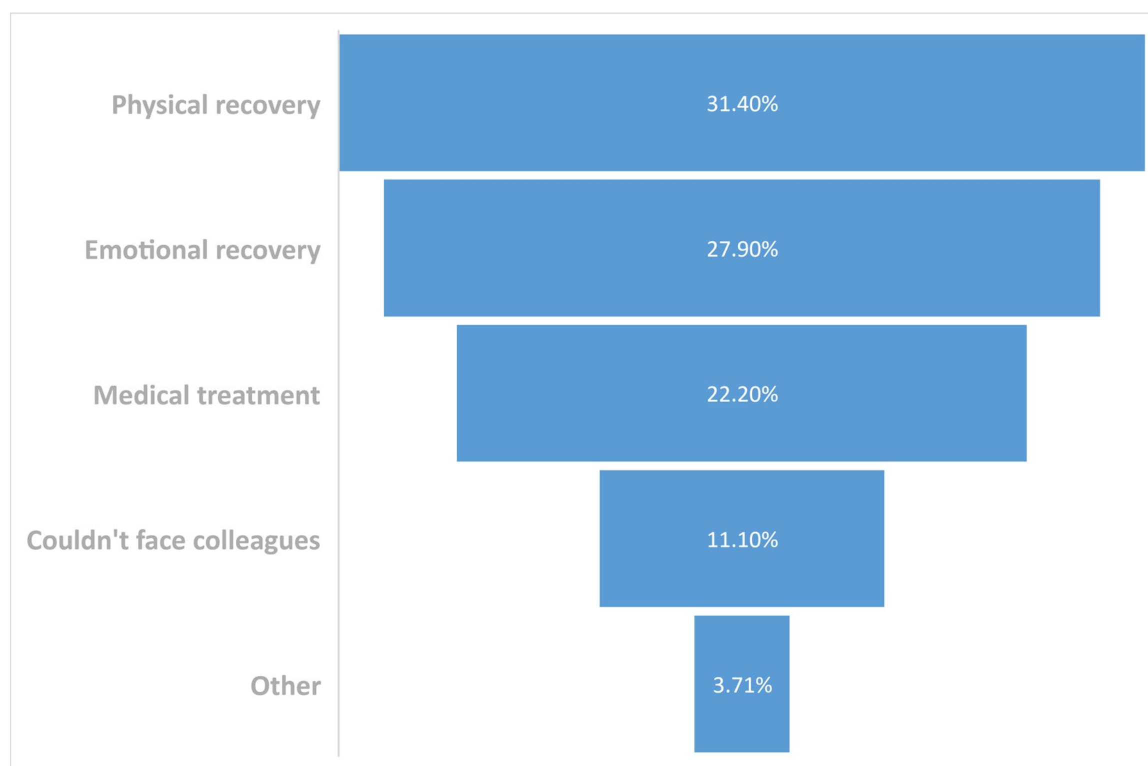

Figure 3: Survey respondents' main reasons for taking time off

In terms of type of pregnancy endings, a higher proportion of women who miscarried reported taking leave to recover emotionally compared with those who chose an abortion/termination (71% versus 45%).

Some of our male partner interviewees also noted that, while they had received practical support in terms of work adjustment, they would have appreciated other types of support:

> 'For me I think the [practical] support was always going to be there, but it's the mental and emotional support from colleagues that counts' (UMS, M3).

[15] Again, respondents could select as many reasons as they saw fit to answer the relevant survey question.

Figure 4 shows the distribution of the distinct types of leave from paid work our survey respondents took following their early pregnancy ending. In most cases, there was no dedicated leave and women were required to take self-certified sick leave, doctor-certified sick leave and compassionate leave. Importantly, around 8% of women used annual leave and around 6% used unpaid leave. These figures are relatively small but suggest that many of our respondents used a generic form of leave that was not specific to early pregnancy endings, whilst only two (just under 1%) reported taking dedicated EPE leave. Those who miscarried were also more likely to take doctor-certified sick leave compared to those who had an abortion/termination.

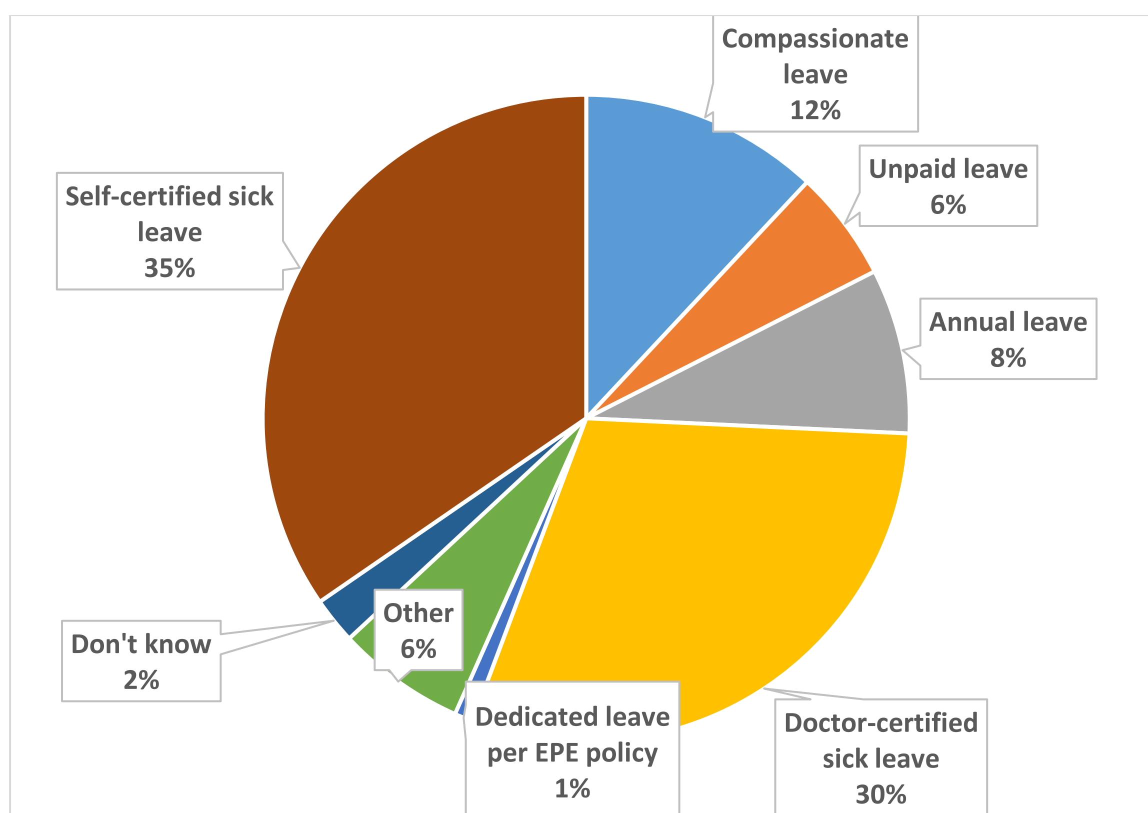

Figure 4: Distribution of types of leave taken by survey respondents

Almost half of the 172 respondents who had time off took 1-5 days off; around a third took 6-15 days off; and just under a quarter took 16 or more days off. Doctor-certified sick leave tended to be longer, with 45.6% of respondents accessing this form of leave taking 16 or more days, and only 7.4% taking 1-5 days. Taking self-certified sick leave, on the other hand, tended to mean shorter periods of leave, with almost two thirds of these respondents taking 1-5 days leave (63.5%). Of course self-certification in many UK organisations is only permissible for a short duration anyway.

Those who had miscarried were more likely to take more time off than those who had an abortion/termination, which may reflect the persistent sociocultural stigma around this kind of pregnancy ending. As such, around three quarters who had had an abortion/termination and did take leave took just 1-5 days off, compared with 45% of those who miscarried. Perhaps unsurprisingly, among respondents who took time off, those who did not disclose their pregnancy at work were more likely to take a short amount of leave (5 days or fewer) than those who disclosed (79% versus 40%). This suggests that disclosure was necessary to access longer periods of leave and echoes the point we make above about self-certification. This is important because not everyone, as we have already seen, felt willing or able to disclose that they had experienced an early pregnancy ending at work.

Moreover, a higher proportion of managers or supervisors took self-certified sick leave (52%) than respondents without these responsibilities (37%), suggesting that those in more subordinate positions, and with less autonomy, may feel disadvantaged in this regard. Other concerning findings were that 1. just 1.3% took the full leave allocation (or whatever type) to which they were entitled; and 2. low numbers thought specific kinds of leave were very appropriate for their situation: 45.5% for compassionate leave; 32.7% for doctor-certified sick leave; and 12.2% for self-certified leave.

Around one in five survey respondents did not take any time off. 20.2% of this group didn't want to disclose their EPE so were unable to avail themselves of leave. 11.4% were concerned that they might be judged or stigmatised for taking time off; and the same percentage saw work as a good distraction. 10% didn't know leave might be available to them[16]. These data echo narratives shared by some of our UMS participants who deemed their pregnancy ending to be something personal that they did not wish to disclose formally in the workplace or who were concerned about being judged or stigmatised.

For example:

> 'If people are getting rid or looking to reduce the numbers of staff or, furlough or not furlough, then your sickness record might make a difference, and the thought that you might be interested in having a baby and therefore be taking time out'. (UMS F1)

Equally, on the subject of work as a potential distraction, an EPE respondent commented that line managers should:

> 'Treat [the person who has had the EPE] as you would someone who is grieving (… if the individual terminated/planned to end the pregnancy, respect that they may need time to process the event). Offer time off to save staff having to ask. Keep offering if they refuse **but don't pressure them if they [feel] they need the distraction.** Follow up in the month following. They might need time off a few weeks after the fact. Grief isn't linear.' (our emphasis)

Many UMS interviewees also commented on the limitations imposed by the type of leave, the number of days off which were permissible, and going through the request process at a time that for many was challenging. It is important to add that the majority of miscarriages, ectopic pregnancies, molar pregnancies, and abortions/terminations before 12 weeks' gestation that require clinical intervention are treated by taking medicines, either at home or under the care of general practitioners or gynecology and maternity services. After 12 weeks, most pregnancy endings require the foetus to be born and/or a surgical procedure, which often require more significant recovery time.

However, support in the workplace should not be limited to physical recovery, as employers must help staff manage the potential impacts on their mental health and well-being. Our survey data certainly support this, with the second most significant reason for taking time off after an early pregnancy ending being to recover emotionally, after physical recovery and before being able to access medical care. The qualitative survey findings also indicate that, for some respondents, the important thing was to be able to take a sufficient period of time off to process what had happened as opposed to just stopping work, because the latter simply increased their anxiety. Indeed, a small number were forced to take time off which they found uncomfortable when they wanted to be busy.

[16] Again for this question respondents could select as many reasons as they wished to explain why they did not take any leave due to their early pregnancy ending.

That said, and as one UMS respondent commented:

> 'It's also really important for us to recognise the individuality of these experiences. Miscarriage isn't always a devastating loss'. (UMS F1)

Most of our cis male UMS interviewees reported not needing to take time off after their experience of pregnancy ending, or having to only take the occasional day to accompany their partner to medical appointments. This may have been due to the nature of their jobs and the flexibility therein. However, workplace support to non-pregnant partners was reported across both studies to be insufficient and inconsistent.

For example:

> 'My husband really struggled too, but felt even less able to take time off or speak to his workplace. He dealt with his own grief while also supporting me. The attention from our family and medical professionals was all on me, and he shouldered a lot of horrible experiences without any recognition or support. Partners matter too in these circumstances'. (EPE respondent)

"I hadn't told anyone I was trying, because I think that's a danger at work - like if you tell anyone, and then people think you're not going to be around, you're not basically going to be given any responsibility or anything that's promotion[-related]."

5. Findings: The diverse experiences of our respondents

Here we focus in more depth on the experiences of early pregnancy endings for the people who live through them. We begin by emphasising just how individual EPEs are to each person and then discuss how these endings are often minimised insensitively by others at work.

a. Pregnancy endings are unique

The most important findings across our quantitative and qualitative studies are that early pregnancy endings are very personal experiences, and employees require a flexible and individualised approach to be best supported in these circumstances. However, of our survey participants, just 28.9% suggested that the person to whom they disclosed was emotionally supportive and understanding; whereas only 17% reported that this person provided any assistance[17].

Almost two thirds of survey respondents reported experiencing a physical effect of the pregnancy ending whilst at work (63.3%), with bleeding, cramping and pain/internal pressure being the most frequently reported. Figure 5 outlines these data in more detail[18].

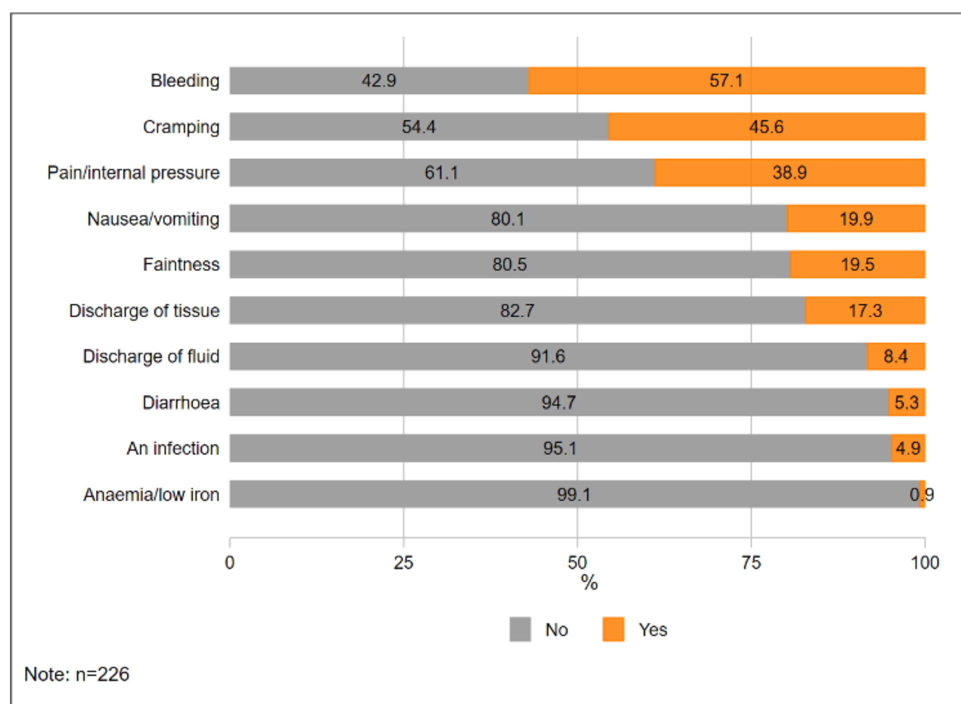

Figure 5: Distribution of physical effects at work: all pregnancy endings

Breaking these data down into types of EPE, for those experiencing miscarriages the most commonly reported physical effects at work were bleeding, cramping, pain/internal pressure and faintness. For those experiencing abortions/terminations, the most common physical symptoms at work were cramping, bleeding and nausea/vomiting. Across all four types of early pregnancy ending, respondents suggested they had experienced more than one physical symptom. In our qualitative

[17] Again, this question allowed respondents to choose as many answers as applied to their situation.

[18] This was also a question asking respondents to select as many answers as were relevant.

survey data, respondents reported physical symptoms lasting several weeks, and in some cases both physical and emotional effects for months or years, while organisations only considered pregnancy endings as a short-term event (for example, with the pre-set availability of a fixed number of days for leave).

In some cases, our EPE survey participants had had a miscarriage while at work. One commented as follows:

> 'I've had two miscarriages whilst at work. I needed surgery for one. I didn't take time off for either as it was a new job and I didn't feel I could talk to my boss about it. I felt alone and dreadfully sad. My husband was very supportive but it is not just the emotional part, it is also physically happening to your body and sometimes can take weeks. It would be good if there was more obvious support available for people going through any form of baby loss. It impacts men and women in different ways.'

Participants in both studies also shared the prolonged challenges of pregnancies with anomalies or which ended because of missed miscarriages. Here they had to wait for a natural miscarriage (which can take weeks), or opt for a TOPFA.

For example:

> 'We decided to proceed with the pregnancy and had hospital appointments every two weeks until she sadly passed at 23 weeks. This is the pregnancy that really fell through the gaps in terms of workplace support. Once the pregnancy ended then there was clear policy and support in place, but when we were in the no man's land of testing, scanning and waiting there was nothing. And it was incredibly difficult to deliver anything at work when wondering if every kick was going to be the last one. Once it was confirmed that she had died, I was induced and gave birth the following day.' (EPE respondent)

> 'We had a couple of really good scans before that, and then we went for the anomaly scan[19] like 19 weeks and a couple of days. And everything seemed to be fine until the end when she said, 'I can't really properly measure a part of your daughter's brain, so I'm going to send you for a second opinion to a hospital'. […] It measured way too small so it was like three weeks behind. And she also thought that the shape was off. So, then, we were like thrown into this rollercoaster of decisions that we immediately had to make. So that started a whole like three-week thing, where we had to go to the hospital multiple times a week for additional scans. We did an MRI as well. […] So we decided that we wanted to terminate the pregnancy. I was like almost 23 weeks pregnant at that point and there's like a, there's a 24-week cut off. […] then I had to go to the hospital and they induced the labour with medicine. […] So we went to the hospital when I went to labour and yeah. It was a very long labour. It was not nice.' (UMS F15)

Missed miscarriages may require medical or surgical intervention across prolonged periods of time:

> 'I had to have a D and C[20] done. I opted for that because I was just like, 'let's just get this done. I don't want to hang around'. By then, I was like 12 weeks and nothing had happened, [so I thought] 'this could go on for ages'. And I was teaching and I was like, 'I

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[19] In the UK, this ultrasound scan is usually done between weeks 18 and 21 of a pregnancy. It checks the physical development of the foetus and can also identify certain rare conditions including cleft palate and Edwards' syndrome.

[20] Dilatation and curettage, surgery which removes the foetal body from the uterus after an incomplete miscarriage.

> don't want to be in the middle of a classroom and suddenly have to deal with this stuff and have it on my mind for weeks'. So I was like, 'let's just get this done, sorted'.' (UMS F12)

After 13 completed weeks of pregnancy women are most likely to have to undergo spontaneous or induced labour and birth rather than surgical removal of the foetal body, including in TOPFA (Middlemiss, 2022). But the extended duration of some pregnancy endings before 24 weeks is not appreciated by employers and this can impact on employees who may have widely varied physical experiences.

Our data also highlight how pregnancy endings can affect both work and personal life, and are often connected to fertility journeys bringing together sociocultural contexts, family dynamics, and different approaches to grief and bereavement. Although the vast majority of our participants had experienced early pregnancy endings within the last five years, some had had experiences up to 23 years previously. As the personal circumstances, physical recovery and emotional responses to pregnancy endings are so very individual, the **impact and intensity over time** of these experiences also varied greatly, and were not simply correlated to the most recent EPE.

In some cases, for both women and men, the pregnancy ending was felt as a loss – not only of their baby, but of their parent identity and the plans they had made for their family. A survey respondent who told us that she had had three different types of EPE also described how it felt to have a TOPFA:

> 'I had my termination because I knew I would not be able to cope - I was afraid of the effect on my existing daughter (and our relationship), but I also manage PTSD symptoms following the suicide of my brother and I simply knew that I would not be able to cope with caring for a disabled child. The effect of suicide loss of my sense of self as a parent has been huge and I knew I would be unable to deal with the anxiety. Ending a very much wanted pregnancy was almost as traumatic as learning my brother had killed himself, not least because I was taking a sibling away from my daughter, making her sibling-less too. The meaningfulness of that [to] me cannot be underestimated. I have been unable to speak publicly about this type of loss, as it has greatly damaged my sense of self.'

But this was not the case for all:

> 'You get through grief in the way that you get through it. And for some people, it takes less time than others. For some people it takes more time than others. We shouldn't have expectations. […] I'm going through it backwards and forwards. But I'm also living with other people's expectations of how I'm supposed to grieve'. (UMS F1)

Our interviewees also commented on the more nuanced aspects of their pregnancy endings, and the emotional or psychological impact they had experienced. For some (the women themselves and/or their partners), their first EPE had been deeply traumatic (emotionally and psychologically, although in some cases also physically), while others felt worse about the last in a series of pregnancy endings, or for EPEs involving twins.

Particular difficulties were faced by people who had been trying to conceive for some time, either naturally or via assisted reproductive methodologies, and in the case of multiple EPEs. This often involved emotional distress, challenges to mental health and diminished well-being. An example from an UMS interviewee follows:

> 'People who are also struggling with fertility issues are also possibly discriminated against in in many ways. If they are taking time off for fertility treatment, and **then** if they have fertility treatment, **and** they conceive, and **then** they lose the baby, so even more so in terms of the difficulties and in terms of the emotional distress that that can cause and their anxieties about the future'. (P1 – their emphasis)

While non-pregnant partners did not require physical recovery, their needs and emotional well-being were often neglected in their workplaces, as well as the time they may have needed to attend medical appointments or offer other support to their partner and family members. For example, one of our UMS respondents said that:

> 'I was trying so hard to hold it all together, and to carry on earning a living and to look after my daughter, which become a hugely important focus for me. That she wouldn't get damaged by all of this. You know, that it seemed that I had to kind of hold on to this, keep this all to myself. I, yeah, I suppose, at the same time, I didn't believe they could help me.' (M3)

Respondents had also sometimes had very different experiences across their early pregnancy endings and needed different types of support (or none at all). For example, an EPE participant told us that:

> 'I ticked miscarriage [in the survey] because that was my most recent [EPE] - but I also had two ectopic pregnancies. I think my experiences were different with my first miscarriage, the ones after (because then it becomes a horrible pattern), ectopic pregnancies (because they are life threatening) and then miscarriages after IVF (because there is so much at stake).'

"Line managers need to be aware that it is not over in a day and staff may experience symptoms for days and weeks afterwards."

b. Minimisation and the hierarchy of loss

Many of our participants reported experiencing 'disenfranchised grief' whereby their experiences had been minimised, invalidated or belittled (Doka, 1989, 2002) and/or a 'hierarchy of loss' when the impact and importance of their early pregnancy ending were diminished – especially in the first trimester – in comparison to endings happening later in pregnancy (Lovell, 1983; Robson and Walter, 2013; Middlemiss and Kilshaw, 2023). Lovell also suggests that the hierarchy varies by type of pregnancy ending, from neonatal death[21] at the top, through stillbirth, infertility, late miscarriage and early miscarriage at the bottom, as in Figure 6 below. Note that it completely overlooks abortion/termination.

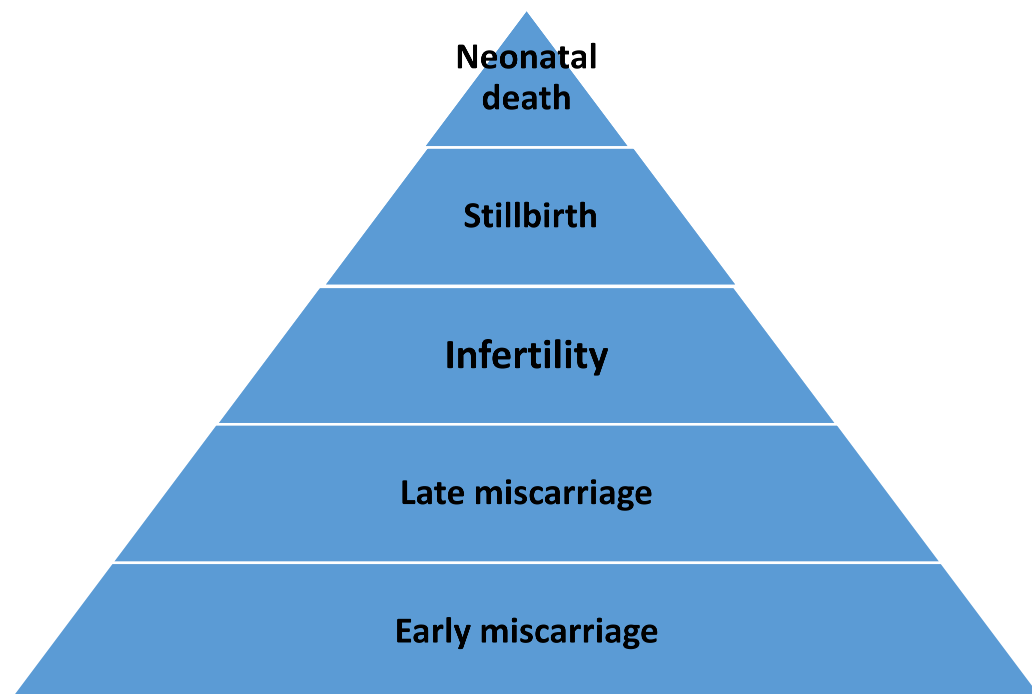

Figure 6: Lovell's (1983) hierarchy of loss

In exemplifying this hierarchy, EPE respondents commented as follows:

> 'Early miscarriage at 5 weeks' gestation in 2016. My miscarriage changed me as a person. It changed my outlook on my life and my career and contributed to my marriage breakdown. It is undermined and minimised but I found it to be the most devastating event I've been through.'

> 'Although I had a termination, I lied to my employer and said I had a miscarriage, because I didn't think anyone would understand or be sympathetic.'

This minimisation of EPEs was experienced in conversations with healthcare practitioners, friends, family members, and line managers and HR staff in the workplace. As we suggested earlier, while employers may assume that individuals experiencing early pregnancy endings receive adequate support from healthcare professionals, such experiences can be minimising, insensitive and even traumatic. They may also leave the person affected without adequate information regarding the

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[21] Neonatal death refers to the death of a baby within 28 days of birth.

physical effects of their EPE. And these experiences can in turn affect workplace experiences, notably fear of disclosure.

Equally, dismissive responses could contribute to a negative and unwelcoming workplace environment upon return, and were also linked to **language**. Our data suggest very explicitly that it is vitally important to take the lead from people as to:

- how they want to refer to their pregnancies and their own status (e.g. as bereaved parents, as people who were expecting, as individuals experiencing pregnancy etc., all of which may be used by those who had abortions/terminations just as much as those who had miscarriages or ectopic or molar pregnancies);
- whether 'baby', 'foetus' or 'embryo' or a first name is used etc.;
- and the language used for the pregnancy ending (e.g. whether it is lived as a loss, or not).

Not knowing what to say and how to support others through the experience of pregnancy endings, even well-meaning family, friends, healthcare professionals and colleagues often used language that lacked sensitivity and affected our respondents' well-being. This again underlines the need for dedicated training and resources on early pregnancy endings in workplaces for all staff, notably advice on how to respond to disclosures:

> 'People say the most ridiculous things, or hurtful things. It's 'Oh well, never mind. There would have been something wrong with it. I'm sure it will be fine next time. At least it was early. At least you've already got kids'. You know, all the things that people say with the best of intentions, mostly.' (UMS F1)

This respondent also commented that, in some cases, women decide to change their job or industry, reduce their workload or move to another organisation after an EPE:

> 'People might think about maybe changing their work, career, either because they think it will reduce stress and possibly reduce the risk of miscarriage, or because they cannot cope with whatever is going on with them at work, on top of what they're going through. Or they're feeling unsupported, or positively discriminated against.'

Another told us that:

> 'If I conceive again, I know I'll be a nervous wreck possibly throughout the whole pregnancy, so my productivity will dip again. I have considered quitting, moving careers and even got to the final stages of a new role but didn't move due to their maternity policy and my desperation to conceive again. I feel trapped and in limbo until I either conceive again or we stop trying. It's incredibly isolating. There is apparently an employee assistance program[me] at work but HR is remote and makes it difficult to access [their support].' (EPE respondent)

And a third reported that, after her EPE, she is:

> 'Definitely demotivated and more isolated at work. I don't feel I have the job security to disclose that I'm hoping to get pregnant and I feel pressure to be pregnant again soon due to [my] fixed term contract and poor maternity pay provision (both organisational and governmental). I work in the baby/pregnancy loss sector so constantly face triggers.' (EPE respondent)

As this comment suggests, lack of support in terms of emotional and mental well-being, of flexibility and of an enabling and inclusive work culture also meant reduced focus and productivity and other consequences. Another EPE respondent told us that:

> 'I had a bitter taste in my mouth about how my line manager dealt with the situation, especially as I had two miscarriages in my time working there. Afterwards, I developed

> endometriosis, with very similar symptoms to miscarriage and it was difficult for me to manage my normal duties. There was no flexibility for me and after many absences due to pain, bleeding, sickness, appointments and procedures, I left my job. My line manager told me this was the right thing to do because eventually they would call into question my capability to [fulfil] the duties of the job. I left my career and well-paid job after 10 years being in the organisation with nothing. I took another job, with the same hours, but much less pay and less holidays.'

Yet in other cases, an initially negative impact on work turned into a positive outcome:

> 'TFMR induced a horrendous amount of guilt, shame and decreased self-confidence in me that ultimately filtered into my work at first - I doubted myself a lot as I developed my research - however, as work has progressed it has proved to be a way to cope. I feel calm through my work as it provides purpose, focus, motivation'. (EPE respondent)

Equally, and as we suggested earlier, 11.4% of EPE respondents told us they didn't take time off from work after their experience because it provided a welcome distraction. To illustrate this, one suggested that:

> 'I didn't tell anyone in work but I found the distraction of work helpful. It put perspective on my life and work. I became more confident and assertive.'

As such, work can be an important source of meaning and reassurance for people undergoing early pregnancy endings.

Finally, we turn to our recommendations.

"I got no support from work (although they knew) at that time or no allowances made that I was having a difficult time. I was told I needed to be signed off sick or to perform at 100%, there was no middle ground."

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6. What would make workplaces better?

In this section of the report, we consider factors that respondents indicated would improve their workplaces in connection with supporting people who experience an early pregnancy ending. We then provide a list of ten best practice principles for organisations accordingly.

a. Establishing conducive environments

Most respondents in our survey reported that their work could be improved in some respect in connection with early pregnancy endings, with just 14.2% reporting that there was nothing that applied in this respect. Table 1 shows the complete list of options given in the survey question and the proportion who selected them[22]. Around one third stated that being entitled to paid time off would have helped and 28% reported that having more time off would have helped. Combined, 106 respondents (46.9%) selected either of these options with 37 (16.4%) selecting both.

Table 1: What could have improved the respondents' experiences of pregnancy endings at work?

	%
Time off	
Being entitled to paid time off	35
Being able to take more time off than I was able to take	28
Changes to work	
Being able to change my work pattern	20
Being able to change the type of work I did	11
Being able to work from home or another location	26
Having better information about my employment rights	33
Acknowledgement /awareness	
Acknowledgement of my situation	19
More awareness of and knowledge about the topic from my line manager/supervisor	25
Having colleagues who understood my situation	15
A more compassionate organisational culture	40
Support	
Receiving follow-up support for some time after the pregnancy ending, not just immediately afterwards	32
Being able to share my situation with others	12
Confidential helpline or counselling provided at work	26
Support group	10

[22] Again respondents could select more than one answer to this question.

One survey respondent offered considerable detail as to how inadequate the support she received at work was:

> 'My miscarriage [w]as a missed miscarriage. I knew from an early scan my baby wasn't growing as fast as would be expected. I got no support from work (although they knew) at that time or no allowances made that I was having a difficult time. I was told I needed to be signed off sick or to perform at 100%[:] there was no middle ground. I would have appreciated being able to work for the distraction, but had acknowledgement that I might not be at my best. There was no compassion. This was a huge multinational company[.] one of the most famous brand names in the world who likes to boast of awards as an employer of choice for women. It's all lies. They couldn't care less about you, you're just a tiny cog in a very large machine'.

Another described a profound breach of confidentiality at work around a termination:

> 'This was my third miscarriage in 18 months. With the same employer. I have never told any of my managers with this employer about any of these horrendous experiences. This is probably because approx[imately] 10 years previously I'd had a termination and told my manager who decided to tell other work colleagues about my reason for my absence, who then promptly told me that they knew why I'd been off as soon as I returned to work. I consequently left this employment and complained about the manager I felt I had no other choice but to leave. It was [nobody's] business to know this about me. I was horrified that this highly personal, traumatic, painful and upsetting experience was being discussed without my consent.'

These findings highlight the importance not only of the availability of policies and practical processes in support of employees, but also of compassionate and enabling organisational cultures that focus on the individual needs of all employees. A UMS interviewee said that:

> 'I had five miscarriages while in employment. […] it was the most distressing and life changing experience for me. This was compounded by the lack of any humanity by colleagues and the appalling treatment I had. I hope no other woman ever has to go through this. […] My boss never asked me how I was, ever. The exposure to other people's pregnancies in the team, and the constant discussions, photos, baby showers etc. was the most harrowing and distressing experience I have ever had. I reckoned I was a statistic in a predominantly female workplace, and my suggestions for improved policies, processes and support [were] not just to help me, but to address a fundamental unfairness and inequality in the workplace. Unfortunately, nothing changed. I experienced miscarriages around 10 weeks each time.[…] People ask questions about 'do you have children?' and 'you better not leave it too late'. It's really hard and shouldn't be like this.' (UMS F7)

Importantly, two out of five survey respondents indicated that having 'a more compassionate organisational culture' would have made a positive difference to their experience at work. We therefore recommend that organisations follow the ten best practice principles below to strengthen workplace support for all staff members affected by pregnancy endings, regardless of gender or parental status. These overlap to some extent but are all important and significant.

b. Best practice principles for effective early pregnancy endings support in the workplace:

Awareness and inclusion: It is important that organisations raise awareness around pregnancy endings for employees, line managers and HR professionals. All forms of early pregnancy endings, miscarriages, ectopic and molar pregnancies and abortions/terminations (including TOPFAs and TFMRs), must be integrated into organisational processes to avoid the silencing of these experiences. The presence and dissemination of information will challenge stigma around them, signal an inclusive organisational culture and foster a supportive work environment. Organisations can raise awareness through various means, including formal training, whilst also providing resources on their intranet pages - e.g. on well-being hubs.

Holistic support: In designing policies and support mechanisms, organisations must consider not only employees' physical health, but also their emotional and mental health and other individual needs, placing their well-being at the centre of organisational culture and practical support mechanisms. For example, HR and line managers could organize occupational health support and counselling referrals if appropriate.

Policies and processes: Evidence-based workplace policies, and other appropriate support, should be designed, widely consulted on, regularly shared and updated and made visible for women and other pregnant people, and their partners, who experience early pregnancy endings. Practical adjustments and flexible working should be offered in addition to options in terms of leave entitlements. This can be implemented, for example, through:

- explicit signposting of the relevant policies and procedures;
- referrals to internal support mechanisms (e.g., counselling or occupational health therapists) and/or external organisations and charities (e.g., Tommy's; the Miscarriage Association; SANDS; Abortion Talk; BPAS);
- revised workload and work patterns upon return; and
- flexible modes and hours of work.

Organisations must have visible and accessible policies and procedures in place that are adopted consistently across teams to support employees during and after their pregnancy endings. This includes those who physically experience the pregnancy endings, and their partners.

Personalised support: Organisations must avoid a 'one size fits all' approach to early pregnancy endings. No assumptions around factors such as gestational time, whether the pregnancy ending was spontaneous or chosen or whether the person involved has other children should be made in terms of how they feel about the pregnancy ending. Organisations should be careful not to embed assumptions about how the person involved will respond to the pregnancy ending into policies and procedures.

Training: Given the frequency of early pregnancy endings and the impact they can have on employees, training for line managers and HR staff must be compulsory alongside existing training on pregnancy support and parental leave. Given the lack of national policy, legislation and statutory leave entitlement, this should actively counter marginalisation and discrimination. This is particularly likely in the case of abortion/termination. Additionally, training should be provided to staff to handle the relevant disclosures with sensitivity and discretion, ensuring a supportive and respectful environment.

Disclosure and confidentiality: These are two key aspects of the experience of early pregnancy endings affecting people in the workplace. Policies and procedures should address issues such as disclosure, expectation management, and confidentiality in the workplace. This includes ensuring that individuals feel safe and supported when disclosing sensitive information. Confidentiality must be strictly maintained to protect the privacy of those affected. Clear guidelines should be established to manage the flow of information, specifying who can access it and under what circumstances.

Language: The language used around issues of early pregnancy endings is important as it can deeply affect people going through these experiences. Organisations should take the lead from the employee as to:

- whether they want to discuss the issue at work;
- how they wish to talk about the experience (e.g. 'baby loss', 'pregnancy ending', 'termination', 'abortion' etc.);
- how they refer to themselves (e.g., 'bereaved parent'; 'I had a miscarriage', 'I had an abortion/termination', 'I lost a baby' etc.); and
- how they describe their pregnancy ending (e.g., using a first name; using the terms 'baby', 'embryo', 'foetus', 'child' etc.).

Organisations should avoid stigmatising language and managers should not make assumptions based on the pregnancy ending experienced, or let their personal views on abortion/termination inform their responses to employees.

Consistency: Organisations must provide consistent and fair treatment for all employees experiencing early pregnancy loss, across all levels of seniority and job types. Formal policies can assist with this.

Inclusivity: Organisations must ensure that support is available for all employees and across all types of pregnancy endings. Everyone and their choices must be respected, regardless of gender, sexual orientation, race, ethnicity, age, or religion. Our data suggest differential treatment for pregnancies that end at an early stage, but also that stigma is more present for abortions/terminations, thus reinforcing discrimination and a 'hierarchy of loss' that maintains or increases inequality in the workplace.

Productivity and performance: Existing research estimates that loss in productivity caused by an early miscarriage costs £471 million per annum in the UK alone, with potential longer-term effects on employees and their ability to carry out their work (Quenby et al., 2021). Our studies confirm that lack of support after early pregnancy endings can negatively affect people's physical, emotional and mental well-being, and impact on performance and retention. As such, it needs to be made clear to line managers and HR professionals in particular that, although social responsibility is a vital reason for careful attention to be paid to support for early pregnancy endings a work, there is also a clear economic case. The legal case is equally significant, because pregnancy is a protected characteristic under the UK's Equality Act (2010).

"The first interaction in the workplace when someone has disclosed an early pregnancy ending is especially important as it can deeply shape relations and affect well-being going forward."

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7. Useful UK resources

Abortion Rights. One of our project partners, this organisation aims to:

- Oppose any restrictions in women's current rights and access to abortion.
- Improve the current abortion law for women to make abortion available on the request of the woman.
- Improve women's access to, and experience of, abortion – ensure all women in Britain have equal access to safe, legal, and free abortion.

Abortion Talk also campaign against abortion/termination stigma. They run 'the UK's first and only free, confidential Talkline for anyone who needs a safe space to talk about their abortion experience … [and] workshops for abortion providers, community groups, and advocacy professionals, giving them time to explore the rewards of their work and the challenges of abortion-related stigma.'

Antenatal Results and Choices (ARC) 'offers impartial information and support to expectant parents facing decisions about antenatal tests and results' They 'do this throughout their journey – before, during and after tests, receiving unexpected or difficult news from tests and making decisions about what to do.'

The British Pregnancy Advisory Service (BPAS) are our other project partner. They provide abortions/terminations for the NHS but also a range of other services including pregnancy testing, miscarriage care and emergency contraception.

Mind provides 'advice and support to empower anyone experiencing a mental health problem' They also 'campaign to improve [mental health] services, raise awareness and promote understanding.'

The Miscarriage Association was founded with the following aims:

- 'offering support and information to anyone affected by the loss of a baby in pregnancy
- raising awareness of miscarriage and
- promoting good practice in medical care.'

MIST Workshops Ltd. provide organisation-wide training and policy guidance and implementation support related to early pregnancy endings. support related to early pregnancy endings.

The NHS provides information on miscarriage, abortion/termination, ectopic and molar pregnancy as follows:

- Miscarriage - NHS (www.nhs.uk)
- Abortion - NHS (www.nhs.uk)
- Ectopic pregnancy - NHS (www.nhs.uk)
- Molar pregnancy - NHS (www.nhs.uk)

PaNDAS (PnD awareness and support) provides a range of support for people who are affected by perinatal mental health challenges.

Petals – funded in 2011, this charity provides and promotes specialist counselling for parents across the UK following baby loss.

Sands 'exists to reduce the number of babies dying and to support anyone affected by the death of a baby, before, during or shortly after birth, whenever this happened and for as long as they need support.'

Tommy's researches 'the causes and prevention of pregnancy complications, miscarriage, stillbirth and premature birth', provides midwife-led advice to those experiencing these and works to raise awareness and share knowledge across the NHS.

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