Gender, Work & Organization

WILEY

ORIGINAL ARTICLE OPEN ACCESS

Fertility and the Workplace: The Role of the Firm, Society and Government in Supporting Reproductive Healthcare

Lived Experiences of Pregnancy Loss at Work: Realizing Meaningful Supports

Marita Hennessy[1,2] | Tamara Escañuela Sánchez[1,3] | Sara Leitao[1] | Ruadh Kelly-Harrington[1] | Maeve O'Sullivan[4] | Caroline Dalton-O'Connor[5] | Mary Donnelly[6] | Claire Murray[6] | Daniel Nuzum[1] | Keelin O'Donoghue[1,2]

[1]Pregnancy Loss Research Group, Department of Obstetrics and Gynaecology, University College Cork, Cork, Ireland | [2]INFANT Research Centre, University College Cork, Cork, Ireland | [3]National Perinatal Epidemiology Centre, University College Cork, Cork, Ireland | [4]J.E. Cairnes School of Business and Economics, University of Galway, Galway, Ireland | [5]Catherine McAuley School of Nursing and Midwifery, University College Cork, Cork, Ireland | [6]School of Law, University College Cork, Cork, Ireland

Correspondence: Marita Hennessy (maritahennessy@ucc.ie)

Received: 3 October 2025 | **Revised:** 1 April 2026 | **Accepted:** 8 April 2026

Keywords: abortion | employment | leave | miscarriage | reproductive health | stigma | work

ABSTRACT

There is increased focus on pregnancy loss at work over recent years, with many countries introducing or exploring the introduction of statutory leave for pregnancies that end pre-"viability." Individual organizations are also introducing their own pregnancy loss policies. However, academic focus on early pregnancy loss at work has lagged behind political discourse and organizational developments. Through analysis of qualitative data from a mixed-methods survey (n = 913) and interviews (n = 13) conducted in Ireland, we explore workers' lived experiences of early pregnancy loss to better understand what supports are needed and contextual factors that can aid the introduction and sustainment of effective interventions. Firstly, we examine the ways in which stigma and hierarchies of loss can shape experiences and available supports. Secondly, we illustrate the value and meaning of legislation and policy as it relates to early pregnancy loss at work. Finally, we discuss practical implications for legislation and policy development and implementation. Workers who experience early pregnancy loss report varied experiences and needs regarding supports within and across workplaces. Attending to factors at individual, organizational, and societal levels is crucial to realize meaningful supports. Importantly, making visible and addressing the inequities surrounding early pregnancy loss experiences in the workplace can be a catalyst for societal change and help to reduce the stigma surrounding early pregnancy loss.

1 | Introduction

Early pregnancy loss—the loss or ending of a pregnancy before it reaches "viability"—defined as under 24 weeks of pregnancy in the Republic of Ireland (herein referred to as Ireland) at the time of our study—affects a significant number of people, estimated at around one in four or five pregnancies (Kelly-Harrington et al. 2025). Such losses are not officially recorded however and are "relatively invisible to the state, the public, and employers" (Middlemiss et al. 2024, 77). The term "viability" is not unproblematic (Romanis 2020); however, we use it (in quotation marks) to be as specific as possible about our focus, whilst also acknowledging that variations of this threshold apply worldwide (Kelly-Harrington et al. 2025).

Pregnancy loss is a workplace issue. It can happen at work and people can continue working while experiencing physical and/or emotional impacts. Pregnancy loss can affect work-related

Marita Hennessy and Tamara Escañuela Sánchez contributed equally to this paper.

outcomes including productivity, and work can positively and/or negatively impact workers' experiences of pregnancy loss and well-being at this time (Gilbert et al. 2023; Keep et al. 2023). It is an experience that often conflicts with workplace norms of the disembodied "ideal worker" (Porschitz and Siler 2017; Acker 1990). Women of reproductive age—whether they are pregnant, have children, or do not wish or are unable to have children—are stigmatized in the workplace, with their reliability and productivity questioned (Trump-Steele et al. 2016). Pregnancy loss is an embodied experience which takes place in private and public spaces, blurring the artificial boundaries between both (Porschitz and Siler 2017; Boncori and Smith 2019). Individual struggles to maintain boundaries between personal and professional lives are not without consequence (Porschitz and Siler 2017). These worlds intersect; work influences personal outcomes and vice versa (Gilbert et al. 2023).

Over recent years, there has been increased focus on pregnancy loss at work. Much media attention has focused on countries such as New Zealand that have adopted statutory leave for early pregnancy loss, or those that are considering it, as well as individual companies that have introduced leave (Kelly-Harrington, Hennessy, et al. 2024). Indeed, it could be argued that academic focus on early pregnancy loss at work has lagged behind political discourse and organizational developments. That said, policy responses and workplace supports remain disjointed (Middlemiss et al. 2024).

In this paper, we examine workers' lived experiences of early pregnancy loss to better understand what supports are needed and contextual factors that can aid the introduction and sustainment of interventions such as statutory leave and organizational policies, procedures, and supports (amongst others), thus extending the nascent human resource management and organizational studies research in this area. We begin by exploring the research landscape regarding pregnancy loss at work and then outline our study methodology, before illustrating and discussing our analysis.

We use the term "pregnancy loss" to describe the physical loss or ending of a pregnancy irrespective of type; in using this term, we do not wish to imply that everyone experiences loss, grief or bereavement. We include abortion in this terminology as attending to how interconnected pregnancy loss experiences are—while appreciating how these may be felt and experienced differently (Boncori et al. 2024; Mullin 2015)—will help to destigmatize all pregnancy endings that do not result in a live birth (Browne 2018; Malory 2022). We use the term "early pregnancy loss" to describe pregnancies that end pre-"viability."

1.1 | The Research Landscape

Organization studies is increasingly attending to reproductive health issues in the workplace, including menstruation (e.g., Sayers and Jones 2015; Sang et al. 2021), fertility (e.g., Wilkinson and Rouse 2023; Griffiths 2021; Mumford et al. 2023), and related issues such as endometriosis (Hvala and Hammarberg 2025), pregnancy (e.g., Percival Carter 2024; Gatrell 2011; Gatrell et al. 2024; Hutson 2025; Maxwell et al. 2019), and menopause (e.g., Steffan 2021; Quental et al. 2023; Steffan and Loretto 2025; Whiley et al. 2023). Less attention has been paid to pregnancy loss (Porschitz and Siler 2017). This research has for the most part focused on later losses, that is, perinatal death (Meunier et al. 2021). There is, however, an emerging body of literature regarding earlier pregnancy losses—pregnancies that end pre-"viability" (Kelly-Harrington et al. 2025), also termed "early pregnancy endings" (Middlemiss et al. 2024). These studies tend to have small sample sizes, though two studies have been conducted, involving 607 (Keep et al. 2023) and 226 (Boncori et al. 2024) participants, respectively.

Some studies have examined workplace experiences of early pregnancy loss broadly (Boncori et al. 2024; Donaghy et al. 2026; Hazen 2003), whereas others have focused on all forms of pregnancy loss, extending to any gestation (Gilbert et al. 2023; Rose and Oxlad 2023; Obst et al. 2022; Meunier et al. 2026). Miscarriage has tended to be the focus (Porschitz and Siler 2017; Bevels Dunn 2023; Boncori and Smith 2019; Keep et al. 2023) with few studies on abortion (Bloomer et al. 2024; Boncori et al. 2024; Kelly-Harrington, Hennessy, et al. 2024; Middlemiss et al. 2024).

The extant literature tends to mostly capture the experiences of women (Kelly-Harrington et al. 2025), with some studies focusing specifically on particular types of workers such as teachers and academics (Porschitz and Siler 2017; Bevels Dunn 2023; Boncori and Smith 2019). Explorations of the experiences of fathers/partners (Obst et al. 2022; Meunier et al. 2026) and LGBTQ+ people (Rose and Oxlad 2023) have received limited attention.

Common themes regarding people's experiences of early pregnancy loss in the workplace are evident within the growing literature. These include silence and stigma (Bloomer et al. 2024; Bevels Dunn 2023; Boncori and Smith 2019; Gilbert et al. 2023); lack of leave and/or returning to work before being ready to do so (Donaghy et al. 2026; Gilbert et al. 2023; Obst et al. 2022); (non-)disclosure (Boncori et al. 2024; Gilbert et al. 2023; Keep et al. 2023; Rose and Oxlad 2023); disruption to relationships at work (Boncori et al. 2024); the need for flexibility (e.g., working from home, reduced hours, less work travel, extra breaks, and reduced work load); and role adjustments (Donaghy et al. 2026; Gilbert et al. 2023; Rose and Oxlad 2023; Obst et al. 2022) as well as sign-posting to supports including counseling (Obst et al. 2022). The lack of recognition of, and supports (including leave) for, partners is also an issue (Gilbert et al. 2023; Obst et al. 2022; Rose and Oxlad 2023; Meunier et al. 2026). Thus, although we are beginning to better understand people's experiences within the workplace, further work is needed to inform the development and implementation of meaningful workplace supports.

1.2 | The Present Study

The aim of this study is to explore the lived experiences of early pregnancy loss (pre-"viability") in the workplace. Specifically,

we examine workers' experiences of all forms of pregnancy loss under 24 weeks and highlight how to create the supportive structures needed. Our work addresses gaps within the literature in several ways as it includes all forms of pregnancy loss pre-"viability," involves the perspectives of partners as well as people who carried the pregnancy that ended, it is a large study incorporating the views of 913 people and it shifts the lens from documenting people's experiences within the workplace, to what supports are needed and how they can be implemented.

We extend what is known, not only by interpreting people's experiences but by unpacking the underlying tensions so that meaningful and equitable supports can be realized in policy and practice.

Our research context is Ireland where, at the time of writing, there is no specific statutory leave for people who experience pregnancy loss pre-"viability." In cases of stillbirth, defined as a baby born at $\geq$ 23 weeks or weighing $\geq$ 400 g with no signs of life (Civil Registration (Electronic Registration) Act 2024), full statutory maternity and paternity leave provisions apply (Department of Social Protection 2025a, 2025b). A bill proposing statutory reproductive health-related leave, providing for 20 days leave for people who experience miscarriage, is being considered (Houses of the Oireachtas 2021), alongside another more recently introduced bill which would provide for 5 days of pregnancy loss related leave for a person whose pregnancy does not result in a live birth or stillbirth (Houses of the Oireachtas 2025). These are both private members bills and, without government support, neither is likely to progress. Even if both did, they are unlikely to result in separate pieces of legislation. Some companies (only 9 of the 20 companies that responded, out of the 179 companies that were contacted) have specific pregnancy loss policies in their workplace which incorporate leave; this can be paid leave, range from 3 to 20 days, be termed compassionate, bereavement, miscarriage or pregnancy loss leave, and include partners and people who have an abortion (Kelly-Harrington, Hennessy, et al. 2024). Workers have a statutory right to sick leave (subject to certain conditions) which, at the time our data was generated, was 3 days paid sick leave per year (5 days since January 2024) as a legal minimum (Sick Leave Act 2022). However, employment contracts in individual workplaces may offer a greater amount or higher pay (Citizens Information 2025). People may avail of sick leave when they experience pregnancy loss if they have sufficient sick leave entitlements available to them, are certified by a doctor as unable to work, and meet other eligibility conditions.

2 | Methods

The PLACES—Pregnancy Loss in Workplaces: Informing Policymakers on Support Mechanisms—project was commissioned by the Irish Government to inform decision-making regarding the introduction of statutory leave for early pregnancy loss and other supports needed. We adopted a mixed-methods approach to address our research questions, enabling us to gain insights into participants' experiences and views drawing on both quantitative and qualitative data from a survey study, and qualitative data from a subsequent interview study. In this article, we focus on qualitative data from the survey and interview studies. Our analysis aligns with constructionism, acknowledging that knowledge is socially, culturally, and historically located (Burr and Dick 2025). We draw on critical feminist research principles (Lafrance and Wigginton 2019), attending to reflexivity, language/discourses, intersectionality, and the overall project aims to mobilize research for social change, namely to create more compassionate work environments.

2.1 | Researcher Characteristics and Reflexivity

Members of the research team span a variety of disciplines, including law (MD and CM), human resource management (MOS), medicine (obstetrics; KOD), nursing (CDOC), occupational health (SL), psychology (RKH and TES), public health/health promotion (MH and SL), and spirituality (DN). KOD is a clinician, leading pregnancy loss clinical services, and actively involved in the care of people who experience all forms of pregnancy loss. All team members have research experience in earlier and/or later pregnancy loss, including abortion, women's health issues, and/or bereavement. During project and study-specific meetings, and associated research activities, team members discussed their positionality, engaged in reflexivity and maintained related records.

2.2 | Data Generation Methods

2.2.1 | Survey

We designed a survey, hosted on Qualtrics (Qualtrics, Provo, UT), drawing on prior surveys, particularly in relation to pregnancy loss experiences in the workplace (Brewis et al. 2023; Keep et al. 2023; Obst et al. 2022; Russell et al. 2011). The survey—available on OSF (Kelly-Harrington et al. 2026)—contained 48 questions, divided into 6 sections: demographics (n = 5); workplace information (n = 14); your pregnancy loss experience (n = 7); your experience of pregnancy loss in your workplace (n = 23); future supports (n = 7); and tell us a bit more about yourself (n = 3). Open-ended questions (the focus of our current analysis) explored reasons for (non)disclosure of loss at work, what made returning to work easier or harder, and what type of supports were needed in Ireland, including the potential provision of statutory leave. The latter explored ideal duration and whether limits should be placed on the number of times such leave could be taken.

2.2.2 | Qualitative Interviews

A topic guide was developed and used to frame discussions (see Supporting Information S1: Supplementary File 1). We focused on specific aspects of workplace experiences which we felt required further detailed exploration following preliminary analysis of survey responses. Specifically, we were interested in what determined the length of time that people took off from work, and their views on proposed leave for early pregnancy loss, including what it should be called, how long it should be,

eligibility criteria, and what might influence its implementation in practice. The topic guide was reviewed by an expert by experience within the Pregnancy Loss Research Group. All interviews were conducted by RKH (the first led by MH) via Microsoft Teams, or phone, and recorded.

2.3 | Sampling and Recruitment

Women and men aged over 18 years, who had experienced any form of pregnancy loss under 24 weeks within the preceding 5 years whilst working and living in Ireland, were eligible to take part in the survey. Workers included those engaged in employment or paid work on a full/part-time or casual basis; based within the public/private sector; and employed/self-employed. We limited experiences of pregnancy loss to within 5 years to capture relatively recent experiences, whilst acknowledging that experiences can vary within and across time and are shaped by socio-cultural contexts.

We recruited participants in various ways. Recruitment posters were designed and adapted to target specific populations (e.g., men and self-employed workers). We shared study information on social media platforms (Twitter, LinkedIn, and Instagram) through our professional and/or personal accounts.

Various organizations, including trade unions, advocacy groups, and support groups, shared through their networks. We also displayed posters across hospital and university sites.

We based our decision on when to stop sampling when we had sufficient data to address our research questions (Braun et al. 2021; Malterud et al. 2016). As the study progressed, we purposively recruited under-represented groups within the sample, for example those who had an abortion, partners, self-employed, diverse ethnicities and sexualities, and precarious workers. Survey recruitment took place between March 6 and April 25, 2023.

People who completed the survey and consented to follow-up were eligible to take part in individual interviews. We advised participants that we would conduct a limited number of interviews and that not all who expressed an interest would be contacted. We used purposive sampling to select potential interviewees, aiming for diversity in ages, pregnancy loss experiences, workplaces, and ethnicities. Again, we ceased sampling when we had sufficient "information power" within the data to address our research questions (Malterud et al. 2016). Interviews took place between June 8 and September 6, 2023.

2.4 | Ethical Considerations

We received ethical approval from 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 provided informed consent prior to participation. Details of pregnancy loss support organizations and research team contact information were provided, as part of broader distress protocols for participants and researchers used across our work and detailed elsewhere (Hennessy et al. 2022).

2.5 | Data Analysis

We downloaded open-ended survey responses from Qualtrics and removed incomplete or ineligible responses and pseudo-anonymized identifying information before importing the data into NVivo 14 (Lumivero 2023) for analysis. Interview transcripts were checked for accuracy against recordings, pseudo-anonymized, and imported into NVivo. We analyzed data inductively using reflexive thematic analysis (Braun and Clarke 2021); see Supporting Information S1: Supplementary File 2. The analytical process was iterative; we moved back and forth between the data and existing research to interrogate the data and develop new understandings and perspectives. RKH, MH, SL, TES, and KOD had frequent discussions about the data, preliminary codes, and categories and reflected on their positionality, assumptions, and interpretations. Themes were reviewed and discussed by the PLACES project team (all authors), and experts by experience within the Pregnancy Loss Research Group. In the following section, we contextualize our analysis in relation to existing literature across varied disciplines on pregnancy loss, and at times, broader reproductive health issues, in the workplace and beyond.

3 | Analysis and Discussion

3.1 | Overview

We conducted an online survey and follow-up qualitative interviews to explore the lived experiences of early pregnancy loss in the workplace and to determine how to best support workers in this regard. We included data from 913 survey participants in our analysis: 1434 people consented to participate, of these, 233 were excluded as they did not meet the eligibility criteria and 288 did not complete the survey. Most participants had carried the pregnancy that ended under 24 weeks (95%), were aged 34–44 years (69%), had completed a university degree or higher award (88%), identified as heterosexual (98%), and were White Irish (96%). Almost two-thirds (65%) had one or more living child(ren).

Over two-fifths (42%) had experienced more than one pregnancy loss ever (see Table 1). Most worked full-time, permanent (89%), in the public sector (67%), in a large (250+ employees; 59%) or small ($<$ 50 employees; 26%) company, and within education (29%) and human health and social work (28%) sectors.

Participants responded to questions based on their most recent experience of pregnancy loss, the majority of which were first trimester miscarriages (FTM, 75%); the remainder included second trimester miscarriage (STM, 13%), ectopic pregnancy (EP, 5%), termination of pregnancy $\geq$ 12 weeks (ST,ToP, 3%), molar pregnancy (MP, 2%), and termination of pregnancy $<$ 12 weeks (FT,ToP, 2%).

We completed interviews with 13 people, their most recent loss being a/an: first trimester miscarriage (n = 6), first trimester

TABLE 1 | Types of pregnancy loss experienced.

Type of pregnancy loss	*N*	No. of losses	No. /% of participants	
			N	%
First trimester miscarriage	910	1	444	48.6
		2+	343	37.6
Second trimester miscarriage	909	1	123	13.5
		2+	26	2.8
Ectopic pregnancy	910	1+	83	9.1
Molar pregnancy	910	1+	38	4.2
Termination of pregnancy (< 12 weeks)	912	1+	40	4.4
Termination of pregnancy (≥ 12 weeks)	912	1	34	3.7
Stillbirth	912	1	22	2.3
Neonatal death	913	1+	9	1.0
Infant death	913	1	3	0.3
Embryo/IVF transfer failures	913	1	4	0.4

termination of pregnancy ($n = 1$), ectopic pregnancy ($n = 3$), second trimester miscarriage ($n = 2$), and second trimester termination of pregnancy ($n = 1$). The majority had one pregnancy loss ($n = 10$), were aged over 35 ($n = 8$), employed full-time ($n = 9$), female ($n = 11$), and identified as White Irish ($n = 11$). Six had living children. Participants worked in the public ($n = 7$) or private ($n = 6$) sector.

In the following sections we explore workplace experiences of early pregnancy loss within the context of three main themes generated during our analysis (Table 2). First, we examine how stigma and hierarchies of loss shape experiences and supports. Secondly, we illustrate the meaning of legislation and policy as it relates to early pregnancy loss. Finally, we discuss practical implications for legislation and policy development and implementation.

We use pseudo-anonymized verbatim illustrative quotes throughout the text (with additional quotes provided in Table 2), noting the participant ID and type of pregnancy loss most recently experienced. We use abbreviations for brevity, not to minimize meaning or experiences. We note "Partner/Father" (P/F) where applicable. Similarly, quotations marked with "Int" designate that they originate from interviews.

3.2 | Theme 1. Stigma, Hierarchies of Loss, and Realities at Work

Stigma surrounding pregnancy loss, within and across different forms of losses, pervaded participants' accounts. This is perhaps unsurprising given the stigma, shame, and blame surrounding pregnancy loss (Gilbert et al. 2023), which extends to stigmatized bodies, such as pregnant bodies, more generally within society and the workplace. Participants directly or indirectly spoke to how early pregnancy loss is perceived at societal level, and resultantly at organizational, interpersonal and individual levels, and how this affected their experiences, including decision-making regarding disclosure of their loss and/or accessing supports such as time off work. This tied in with hierarchies and questioning of the realities of pregnancy loss, as well as "felt stigma"—the sense of shame and fear of discrimination—and in some cases, "enacted stigma" (i.e., discrimination) (Scambler 2009). It could also be argued that the lack of supports for early pregnancy loss, or invisibility thereof, can reinforce stigma.

3.2.1 | Hierarchies of Loss

Constructions of hierarchies of loss (Middlemiss and Kilshaw 2023) were evident across narratives. These related to the timing of pregnancy loss (i.e., pregnancies that end within the first 12 weeks vs. those that end later), types of pregnancy loss (particularly regarding termination of pregnancy), and the situating of partners regarding supports at work. Through participants' responses, it was evident how some losses can be perceived as more legitimate than others, for example later versus earlier losses—as also observed in other studies (Gilbert et al. 2023; Boncori et al. 2024; Obst et al. 2022), and therefore more "worthy" of acknowledgment or support.

Participants spoke about the social dismissiveness surrounding early pregnancy loss. Some felt that earlier losses are less recognized socially than second trimester loss or stillbirth and often perceived as less *"genuine and deserving of statutory leave"* (P861-FTM-Int). Some participants felt a lack of entitlement to leave as their loss occurred very early in their pregnancy; for some this was magnified when their losses were recurrent and/or they had a history of infertility as they had requested time off on multiple occasions. Participants also noted that people who had losses later in their pregnancies might need more leave (based on their own experience, or observation if they had an earlier loss and imagined what later loss might mean) and that a graded approach to leave may be needed. Others felt that pregnancy loss was a difficult experience, regardless of gestation, with some noting that more leave may be required in

TABLE 2 | Overview of themes and sub-themes.

Theme	Sub-themes	Additional illustrative quotes
1. Stigma, hierarchies of loss and realities at work	Hierarchies of loss	• "I was distraught; even though I was six and a half weeks pregnant, I still kind of felt, "oh God, you know, I can't really be off for this" (P456-ST, ToP-Int)
		• "Because my loss was due to TMFR I was afraid I'd be judged. I felt it is better to share so people are aware and have an option to support, however I didn't have a good appreciation to how much I should/shouldn't share. Also the loss was 18 weeks and therefore still considered as miscarriage rather than stillbirth/baby loss (oh the terminology!!) big part of me didn't feel I deserved sympathy and any special treatment" (P58-ST,ToP)
		• "I don't see any differentiation like in the leave or the kind of compassion you give someone based on y'know how the pregnancy ended, em I don't think I don't think it's a whole pile easier just because you choose it like, for whatever reason" (P660-FTM-P/F-Int)
		• "There's no space for him [my partner] to grieve, no time for him to process any of it because he just saw the pain I was in, and the grief I was in, and he just kept going to keep me going" (P861-FTM-Int)
	Disclosure: support versus the threat of discrimination	• "After the miscarriage I was emotionally traumatized 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-STM)
		• "Nobody knew why I was off. I told my boss I had to get "lady" tests done. I can't trust my boss to keep confidential medical info private" (P510-FTM)
		• "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. Was a distressing time and I

(Continues)

TABLE 2 | (Continued)

Theme	Sub-themes	Additional illustrative quotes
		found it very difficult to speak to anyone about it" (P727-FTM)
		• "The impact and the feeling of guilt and shame and worry about work was overwhelming when really all of my concentration should have been on grieving and processing and it wasn't. Most of my concentration was on oh my God I'm off work sick, they're all gonna think this of me" (P861-FTM-Int)
		• "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-FTM)
	"The realness problem": Proof of loss	• "The cloud of judgment for being off sick... It's all about feeling the need to, you know, prove or verify my reasons for being off work, and the fact that I was in hospital, I felt vindicated, you know, by taking the leave and that's why I took probably a month off" (P861-FTM-Int)
2. Meaningful and purposeful legislation and policy	The need for leave	• "I couldn't afford to live on €112 a week because my rent would barely be covered. My rent is 400 a month. And I wasn't living with my partner yet. Financially I had to go back to work 2 days after I came out of hospital because I was already after having been in hospital 8 days. So I was under huge pressure" (P173-FTM-Int)
		• "It felt easier to compartmentalize it. Actually, going back to work (when I was able) helped me focus on something other than the loss" (P488-FTM)
		• "It kept my mind busy and acted as a distraction. It gave me purpose and I felt that at least at work I could do something right but with my pregnancies I was failing and failing my poor babies" (P754-FTM)
		• "It wasn't necessarily about getting back to normal. It was more I just couldn't be at home, so I just wanted to get out and have something to occupy my time and my brain a little bit that wasn't the loss" (P173-FTM-Int)
	Instrumental effects of leave: Time and space for emotional, psychosocial and physical "recovery"	• "I've had friends having to go to work in agony, still cramping and bleeding after having early miscarriages because

(Continues)

TABLE 2 | (Continued)

Theme	Sub-themes	Additional illustrative quotes
		they had no annual leave left and no paid sick leave. These women had used all their leave having IVF and then had none when they had a miscarriage. It's horrendous, and inhumane" (P789-ST,ToP)
		• "Following my pregnancy loss it was hard to concentrate, my confidence was rocked and I suffered from anxiety which made performing my role very difficulty. I would often have panic attack before meetings and felt overwhelmed and would be left to deal with clients on my own which was additional stress which I found very difficult to deal with and effected me on a daily basis" (P240-FTM)
		• "For me, both times, it was a slow process which stretched between 8 and 12 weeks due to the nature of the miscarriages (missed miscarriages, early on so scans didn't show much, medical management only partially worked each time, steady bleeding for months - both physically and mentally exhausting)" (P67-FTM)
		• "I felt extreme physical pain- labor 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-FTM)
	Symbolic effects of leave: Statutory leave facilitates recognition and social change	• "On a bigger scale, introducing this type of leave will have the impact on society that is needed. Current miscarriage is an unspoken about, alone experience. Normalizing it in the workplace will plan a large part in normalizing it in society" (P319-STM)
		• "I suppose with kind of two hats as in an employer giving sick leave you know if it becomes mandatory for us to have to pay full pay we couldn't afford it" (P841-FTM-Int)
		• "In my job you don't get paid if you're not there. There's no sick leave. 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-EP-Int)

(Continues)

TABLE 2 | (Continued)

Theme	Sub-themes	Additional illustrative quotes
		• "If you make it at the discretion of the individual employers most people that work in the private sector, specially those that work in lower income jobs and probably more physically demanding jobs will never be able to avail from it" (P695-FTM)
		• "I can understand the worry about paying for all this leave but women and their mental and physical health need to be prioritized. Ireland has an awful history of not caring for women's health, especially in pregnancy and it is time this changed" (P531-FTM)
	Framing pregnancy loss leave	• "My baby was born at 20 weeks. He was perfect and I was grieving not sick" (P443-STM)
		• "Bereavement or compassionate yeah. I don't think I'd like to tell people I was out on stillborn leave. It's very personal you know. Some people wouldn't want to be giving... Now some people would, but I'm not sure I would" (P456-ST, ToP-Int)
		• "I would not want my workplace knowing what leave I was on, so if it could be called Sick Leave, but confidentially noted as Early Pregnancy Loss Leave on some back system, so nobody in my building knew about it, that would be the only way I would take it" (P604-FTM)
3. Practical implications for policy and legislation development and implementation	Practical and individualized organizational supports	• "The secretary that we had before Christmas kind of she was talking to me about it and she was like I'm not sure what we're putting you down for leave wise so I'm gonna put you down as pregnancy related sick leave and if nothing happens we'll just leave it that way" (P886-STM-Int)
		• "I didn't take any time and continued work as normal. Thankfully I was working from home at the time or I think I would have had to take time as wouldnt have been able to face the office" (P40-FTM)
		• "Pregnancy loss is so common yet it can be such a varied experience from person to person. Everyone's needs will be different but there should be basic universal response guidelines for

(Continues)

TABLE 2 | (Continued)

Theme	Sub-themes	Additional illustrative quotes
		employers/mangers and staff themselves with the available supports along with the option of paid leave if required by the person" (P597-FTM)
		• "I think there is a fundamental lack of training, awareness and understanding of pregnancy loss. If you haven't experienced it you don't understand it, will likely have never have discussed it with anyone. My MD was sympathetic, he had experienced it himself. My female Director is not a female advocate, she didn't support a paid mat leave scheme, she wasn't sympathetic during my previous 2 losses, she is not helpful to female staff members when children are sick etc" (P182-FTM)
		• "It would have been good if I had supper from occupational health or counseling service. It was only months later when I moved to a different role in the organization that an occupational health nurse called me and said she was reviewing my paperwork and that I had been through a lot and now with starting a new role if I would like to be linked in with anyone. It was really nice that she called me but was a bit late" (P91-EP)
	Supportive management styles	• "She responded in a way that was very kind and human and she's been like that ever since so you know it was easier" (P861-FTM-Int)
		• "Nobody in the office knew, just my manager. While she was supportive when I told her about the miscarriage I felt like it was "business as usual" when I went back to work. Nothing was mentioned about it, it felt like my baby didn't matter" (P201-FTM)
		• "One day she texted me and she was like what are your HCG levels, will you be back to work for next Monday. And just horrible things" (P107-EP-Int)
		• "I am very grateful for my manager's support and their openness in me being able to share my story, which helped the transition back to work. Everyone was extremely supportive and reinforcing of the fact that I need rest, deserve sympathy, etc. being able to openly talk about my loss with those few that got to know my journey. My emotional wellbeing was

(Continues)

TABLE 2 | (Continued)

Theme	Sub-themes	Additional illustrative quotes
		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. Flexibility offered on the back of it in terms of working time was extremely empowering" (P58, ST,ToP)
		• "I think there should be mandatory HR training for line managers on handling such situations. My own experience was fine, my boss said very little other than sorry, but I know of others who had to deal with a lot of comments like "Well at least you got pregnant" (P785-FTM)
	Compassionate systems and procedures	• "Dedicated leave that you can apply for via HR but you don't need to inform everyone in your department. Making the leave as easy to apply for as possible, without having to deal with multiple people and forms" (P143-FTM)
		• "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 work-place would have to be incredibly discrete. The ability to take time off without it needing second 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 organizations 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-FTM)

(Continues)

TABLE 2 | (Continued)

Theme	Sub-themes	Additional illustrative quotes
		• "What if you don't have a good relationship with your boss... I could pick a couple of guys in the department who I would hate to have to ring up and tell them because they're quite, I don't know, chauvinist is too strong a word, but they'd be boy's boys. You know they wouldn't be the type to be even talking about women's issues, never mind comfortable with me ringing and saying I've had a loss you know. So you know maybe there's some mechanism where you can contact somebody in HR, I don't know if you feel that you can't" (P861-FTM-Int)

Note: Illustrative quotes provided within the text also.

particular contexts, for example recurrent miscarriage, fertility issues, no living children, or a first pregnancy.

Regarding abortion, most participants felt that there should be no differentiation in terms of entitlements to leave compared to other types of pregnancy loss. Some further acknowledged that there are many reasons why a person might decide to end their pregnancy; it still should be considered a pregnancy loss with associated physical and/or emotional impacts. That said, participants' narratives highlighted that given abortion stigma, it could be perceived, in general, that the need for leave was less necessary or legitimate for people who have an abortion, who may be viewed as *"third class citizens"* and *"what they have to go through"* (P861-FTM-Int) not appreciated. Shame and stigma were also evidenced in the accounts of some who had terminations for medical reasons. While they disclosed their loss, they often concealed the exact form, stating that it was a "miscarriage" or "loss" though were not explicit about their reasons for doing so. Potential reasons for concealment noted elsewhere include feelings of guilt, fear of judgment, and wanting to protect others' feelings (France et al. 2013; Bloomer et al. 2024). Abortion stigma and the silencing of pro-choice views through systems of discipline and surveillance reproduced in workplaces has been noted (Bloomer et al. 2024) and must be attended to in discussions regarding support entitlements, including statutory leave (Middlemiss et al. 2024; Kelly-Harrington, Hennessy, et al. 2024).

The lack of recognition and acknowledgment of the experiences and support needs of partners—at societal, organizational, interpersonal, and individual levels—was discussed by participants. They spoke about how partners require leave to attend to their own needs or grief (but often do not recognize or acknowledge this themselves), and to provide practical and emotional support for their partner, but they can find it difficult to ask for or take leave in this situation, as observed in other studies (Boncori et al. 2024; Gilbert et al. 2023). Most participants strongly felt that partners needed leave, with some stating that they may not require as much as the person who carried the pregnancy. Thus, who is included in—or excluded from—workplace supports matters and has the potential to mitigate or reinforce stigma.

3.2.2 | Disclosure: Support Versus the Threat of Discrimination

Varied levels of disclosure and responses from line managers were reported, as also noted by Boncori et al. (2024). Most participants told some(one) at work about their loss, for various reasons, including: to access leave or other supports (Donaghy et al. 2026; Boncori et al. 2024; Gilbert et al. 2023); to explain their absence, any deviations from their usual performance, or visible physical or emotional impacts; or because details of their pregnancy were known, due to health and safety requirements, mandatory maternity leave notification periods, or its visibility.

Decisions to disclose were in response to, or to shape, workplace culture, as noted in other studies (Boncori et al. 2024; Donaghy et al. 2026; Keep et al. 2023). We observed "pockets of resistance" (Whiley et al. 2023, 897) within narratives whereby some were vocal about their loss as a means of advocacy—to dismantle stigma and signal their availability for peer support. Many described how hearing about co-workers' or managers' own pregnancy losses normalized the experience and helped them feel less alone (Gilbert et al. 2023; Keep et al. 2023), with most unaware of others who had experienced pregnancy loss until they shared themselves (Steimel 2021). Supportive workplace cultures, including good relationships with managers and supportive colleagues, facilitate disclosure (Keep et al. 2023). Although many participants in our studies did disclose, it was often only to one person or a few people, usually a line manager and/or colleagues with whom they worked closely or considered friends. Many did not want the wider workplace to know. That said, some did, telling people directly themselves or via their line manager or another colleague. The latter was perceived to make returning to work easier as they did not have to tell people themselves and could potentially avoid insensitive comments or awkward conversations (Steimel 2021; Obst et al. 2022). Many

experienced negative social interactions at work, however, including minimization of their loss (Boncori et al. 2024; Gilbert et al. 2023; Hazen 2003; Donaghy et al. 2026). Thus, although disclosure could facilitate access to supports, it could be emotionally challenging (Donaghy et al. 2026; Boncori et al. 2024; Keep et al. 2023; Rose and Oxlad 2023). A strong feature across responses was the degree of "choice" participants felt around disclosure; having agency in disclosing, or to whom they disclosed, was important. Whereas some made an active decision, others felt forced to share. For example, to access leave or explain absence, or where the pregnancy loss happened at work (Steimel 2021), or it *"became public knowledge"* (P728-FTM) if working in a hospital where the loss or associated appointments occurred, or in a HR department where related documentation is processed, or through the grapevine (Steimel 2021). Involuntary disclosure could also occur through certification requirements, for example if certificates mentioned pregnancy loss, or had identifiers such as a maternity hospital logo.

Some participants did not disclose their loss at work, where secrecy is an "integral part" of the pregnancy loss experience (Porschitz and Siler 2017, 565) and indeed pregnancy more generally (Gatrell 2011). For some, silence or non-disclosure was a way of maintaining some emotional control or respite, as well as protecting their privacy (Porschitz and Siler 2017; Hazen 2003; Keep et al. 2023; Rose and Oxlad 2023) and avoiding exposure to inappropriate comments (Rose and Oxlad 2023). Some participants—particularly those who had earlier or recurring losses, or unplanned pregnancies—did not feel their loss warranted a discussion at work, often related to the perceived (in)validity of the loss, or belief that it was *"a private matter"* (P393-FTM). Although silence about a pregnancy, or its ending (in loss), may offer a veil of protection, it is often not a "choice" (Porschitz and Siler 2017, 565).

The impacts can be heightened for some forms; for example, people who had an abortion/termination for medical reasons often generated "acceptable narratives" to explain work absences rather than reveal the true reason (Bloomer et al. 2024, 2561). Some felt that it was not worth disclosing their pregnancy loss, because of a perceived lack of access to, or benefit of, organizational supports (Boncori et al. 2024). We also observed limited disclosure where workers had more flexibility or agency in their work arrangements (Boncori et al. 2024) which could facilitate returning to work without accessing leave (Donaghy et al. 2026). Some participants, however, expressed regret that they did not tell anybody at work about their loss as it prevented them from receiving needed supports. Silence can increase feelings of isolation and grief (Boncori and Smith 2019; Porschitz and Siler 2017).

Many participants—women and partners—engaged in emotional labor at work, *"trying to put on a brave face and a mask and pretend nothing was going on when I was broken on the inside"* (P92-FTM) as they had not disclosed their loss or felt that people would not understand why they were sad or anxious (Bevels Dunn 2023; Donaghy et al. 2026; Gilbert et al. 2023; Rose and Oxlad 2023; Bloomer et al. 2024) or to protect others from emotional impacts (Bevels Dunn 2023; Donaghy et al. 2026; France et al. 2013; Steimel 2021). This is an extension of "the silent shift" associated with pregnancy at work, whereby people do not disclose their pregnancies, requiring constant self-management of appearance and behaviors (Hutson 2025).

Concerns around how disclosure of pregnancy loss or taking leave would impact on their employment and professional identity permeated narratives. For example, one participant described how they were *"made to feel like a liar and that I should have been over it sooner"* (P485-FTM) by their manager after they took 6 weeks off following their miscarriage. Participants were apprehensive about how they would be perceived at work, not wanting to be treated differently or their abilities questioned—on a professional or personal level—and potential impacts on career progression or overall job security, also noted in other studies (Donaghy et al. 2026; Gilbert et al. 2023; Keep et al. 2023; Boncori et al. 2024; Meunier et al. 2026). For some, these issues were particularly salient as they had recently changed jobs, returned from maternity leave or had a previous pregnancy loss(es), or were in precarious employment or more patriarchal organizations (Keep et al. 2023).

Many did not want their employer to know that they were trying for family and/or that they would potentially be on maternity leave in the future. This also affected partners; one woman described how her partner was *"seen as a time waster... and... not committed"* because of taking leave when they had their second miscarriage (P861-FTM-Int). Some can resign from their jobs or change roles because of negative experiences in the workplace surrounding their pregnancy loss (Boncori et al. 2024; Donaghy et al. 2026; Meunier et al. 2026) and indeed a few in our study did. Despite equality legislation, discrimination—including concerns regarding the negative impacts of pregnancy and maternity leave on promotion and progression—is an ever-present risk for people who become pregnant (Hutson 2025; Maxwell et al. 2019; Gatrell et al. 2024). Our analysis indicates that this also relevant to pregnancy loss.

While some female participants cited concerns about disclosure to or support received from male managers or within a male-dominated workplace, others reported negative experiences with female managers or colleagues and/or better support from males. Our analysis suggests that workplace culture and individual relationships may be a more significant factor in how supported someone feels at work. This contrasts with gendered perceptions of managers' treatment of female workers regarding menopause for example, with an understanding male manager and unsupportive female manager often perceived as "the exception rather than the rule" (Daly et al. 2024, 170).

3.2.3 | "The Realness Problem": Proof of Loss

Participants commonly experienced feelings of guilt and shame for requesting or taking time off work, likely responses to societal and internalized stigma surrounding pregnancy loss. This guilt was sometimes alleviated if physical symptoms were experienced—tangible or visible "proof" (P109-FTM) that leave was required. In contrast, women who did not experience strong

physical symptoms, or when their physical symptoms resolved, felt that their need for leave was less legitimate or visible. For some, medical reassurance that time off work was necessary provided validation and relief, highlighting the ingrained stigma and lack of value afforded to women's own embodied knowledge.

The issue of medical reassurance extends to discussions about the need for leave and duration of same. Many participants stated—while noting that it was a very personal experience and that the length of leave needed should be individualized—that it could be legitimized by making medical certification a requirement. Some further noted that the length of leave needed could be determined by, or in consultation with, a health professional. For some, providing certification was anticipated or part of routine procedures for taking leave (e.g., sick leave). Certification for some others, however, exuded negativity, with a range of feelings described when they were asked to provide it: "*embarrassed and insulted*," "*uncomfortable*," "*upset*," "*sad*," "*heartbroken*," "*numb*," "*stressed*," "*annoyed*," "*angry*," "*extremely traumatizing*," "*violated*," "*not trusted*," and "*like I was lying!*." Practicalities and legitimacy of securing a medical certificate for earlier or biochemical losses were also highlighted, for example, and the "*issues that may arise for very early loss in 'proving' the loss*" (P272-FTM), amplifying "the realness problem" of pregnancy loss (Layne 2003, 104).

Matters concerning certification and "proving" the loss also arose in relation to minimizing *"any abuse of the system"* (P251-FTM) when asked if limits should be placed on leave. Whereas some explicitly mentioned that pregnancy loss leave was not the type of leave that would be abused as *"no one wants to experience pregnancy loss..."* (P757-FTM), a few did suggest that: *"certification by a doctor of the loss may be a more robust and fairer way of protecting the system"* (P867-FTM), including employers. Similar concerns have been noted elsewhere in relation to menstrual leave (Wong et al. 2025). Many participants stated that pregnancy loss is outside of an individual's control and that they should not be penalized or punished for this experience. This was juxtaposed with the feeling of self-blame and shame for many regarding the loss of their pregnancy.

3.3 | Theme 2. Meaningful and Purposeful Legislation and Policy

Dedicated, paid leave for pregnancy loss was a priority for participants in terms of their own experiences and what they perceived was needed to better support workers who experience early pregnancy loss. This is a key theme across studies (Boncori et al. 2024; Keep et al. 2023). Whereas perspectives varied in our study on how long such leave should be, with 2–4 weeks commonly suggested, some stated that perhaps there should be a set amount with the option to take additional time off (paid or unpaid) as needed. Participants discussed how the introduction of statutory leave for early pregnancy loss would have multiple effects. These included enabling people to have time and space to deal with the physical and/or emotional impacts of their loss, as well as the symbolic value of implementing legislative or policy measures.

3.3.1 | The Need for Leave

The absence of legislation or formal organizational pregnancy loss leave policies often left participants navigating complex emotional experiences without organizational support. For some, returning to work without taking leave was not a "choice": they needed the time to grieve but lacked sufficient leave entitlements (Rose and Oxlad 2023; Van Tuyl 2024) or financial means (Obst et al. 2022). While some could afford to take unpaid leave, others could not (Meunier et al. 2026), reinforcing inequity. Some limited the amount of leave they took by design or circumstance; for example, by drawing on different forms of leave (e.g., sick leave and annual leave (Gilbert et al. 2023; Keep et al. 2023)), if pregnancy loss coincided with pre-arranged annual leave or holiday periods, or by arranging clinical appointments or management (e.g., medication regimens) outside of working hours. The latter has also been observed regarding first trimester abortion management (Conlon et al. 2025). As we observed, however, some workers may have less flexibility regarding when or if they can take leave, including teachers, as also noted by Bevels Dunn (2023).

People returned, or felt pressure—from their employer or themselves, out of a sense of obligation to others, for example not wanting to let anyone else down or inconvenience others—to return to work before they were physically or emotionally ready. This can lead to presenteeism (Obst et al. 2022; Meunier et al. 2026), decreased productivity and burnout (Donaghy et al. 2026; Gilbert et al. 2023; Obst et al. 2022; Rose and Oxlad 2023). Some people, however, wanted to continue working or return to work soon after their loss (Van Tuyl 2024; Rose and Oxlad 2023; Obst et al. 2022; Meunier et al. 2026). The distraction or routine afforded by work, and supportive work environments (including social connections and access to other supports), were positively viewed (Porschitz and Siler 2017; Gilbert et al. 2023; Rose and Oxlad 2023; Obst et al. 2022; Meunier et al. 2026). Some, however, later realized that they needed to take time off as this strategy was counter-productive for them (Rose and Oxlad 2023). For some, continuing to work can be part of their identity, shaped through internalized norms of minimizing grief, being a resilient person or "not wallowing" (Rose and Oxlad 2023, 277). It may also be the case that people focus on work where they feel they have a purpose or a sense of control, when they experience liminality, a lack of control and loss in confidence in their own body regarding their reproductive capabilities (Dennehy et al. 2022). Pregnancy loss can erode a person's self-confidence and sense of competence (Hazen 2003).

3.3.2 | Instrumental Effects of Leave: Time and Space for Emotional, Psychosocial and Physical "Recovery"

Many found returning to work, and *"trying to get back to normality"* (P60-FTM), extremely difficult, on top of emotional and physical impacts related to the pregnancy loss. This impacted on both their work performance and overall "recovery." Trying to complete tasks, attend meetings, or interact with people was challenging. Participants described the wide range of

emotional impacts of pregnancy loss, which could vary between individuals, or within or across losses. These included sadness, grief, and loss—about their pregnancy, the future they had imagined for themselves and for their family; anxiety and in some cases post-traumatic stress disorder; shame in relation to their loss(es) or fertility issues, and how they were coping (or not); and associated loss in self-confidence or self-esteem. It was acknowledged that partners require leave to address their own needs, as well as to provide practical and/or emotional support to support their partner (Obst et al. 2022). Women often described the physical impacts experienced during and/or after their loss whilst trying to work. For many, this was the most difficult thing about the experience. Pain, bleeding and fatigue were commonly described and varied depending on how the loss was managed or treated, the type of loss, or complications experienced.

Participants felt that having designated leave could alleviate some of these impacts, whilst acknowledging that impacts could be felt far beyond the time that could be afforded by such leave. The majority found it difficult to suggest an ideal length of leave. They noted the individual nature of each experience of pregnancy loss and how it could be influenced by a range of factors, including how the pregnancy loss was managed, personal history (e.g., pregnancy loss or infertility), waiting times for test results or procedures, or complications experienced. As noted across other studies, leave is required for physical and/or emotional recovery as well as prolonged management or interactions with healthcare services (Boncori et al. 2024; Gilbert et al. 2023).

3.3.3 | Symbolic Effects of Leave: Statutory Leave Facilitates Recognition and Social Change

Evident in our analysis is the potential power of the expressive or "symbolic" function of law (Sunstein 1996) regarding statutory leave for early pregnancy loss and its social meaning, which would in turn reshape social norms. Participants felt that such leave would be a statement from Government acknowledging such losses, their impacts and the need for supports. It would facilitate a *"societal shift"* (P395-FTM-P/F-Int) in how people view and respond to early pregnancy loss as *"public policy affects public perception"* (P861-FTM-Int). Similarly, support structures, including workplace policies, are a starting point to normalizing pregnancy loss—including abortion (Bloomer et al. 2024)—as a workplace issue.

Participants emphasized that, by making leave for pregnancy loss pre-"viability" a statutory requirement, this would create more equitable structures, as access would not be reliant on the *"flexibility"* (P58-ST,ToP) or *"goodwill"* (P48-FTM) of individual managers, employers, or employment type. Provision of leave would not only legitimize the option of taking time off work due to pregnancy loss, but it would also ensure that people in more precarious job positions have the same basic rights and entitlements. Our review of statutory leave for early pregnancy loss drew similar conclusions (Kelly-Harrington, Murray, et al. 2024). Keep et al. (2023) have also noted how statutory leave (in their case, bereavement leave for miscarriage) validates and acknowledges the loss, as well as providing time for physical recovery and/or emotional processing and financial support. Many participants also discussed how leave for pregnancy loss should also be funded, ideally by the government, if not fully, at least partly, given that it may be challenging for some employers.

Participants also mentioned how having a policy or legislation around pregnancy loss entitlements would also provide guidance and set clear expectations for both employers and employees, to avoid any confusion and difficult situations. Organizational policies can be silent on pregnancy loss and there can be lack of information about leave options (Gilbert et al. 2023). Some participants acknowledged lack of a policy or guidance *"sucks for the person who lost it and it sucks for the HR person who has to figure this out"* (P106-EP-Int).

The historical neglect of women's issues in Ireland in general, leading to lower prioritization within legislation and a general lack of awareness and understanding of such issues, was mentioned by some as a key barrier to affecting legislative or policy change (Hennessy and O'Donoghue 2024).

3.3.4 | Framing Pregnancy Loss Leave

Many—not all—participants framed their pregnancy loss as a bereavement or loss and not an illness. They expressed the need for dedicated leave for pregnancy loss, which was not categorized as sick leave, either in terms of contributing to sick leave entitlements or in name. In general, there was lack of consensus about what leave for workers who experience early pregnancy loss should be called. Various preferences were put forward—bereavement or compassionate leave, pregnancy-related leave, miscarriage leave, and sick leave (separate from standard sick leave)—with some noting issues with the terminology and its implications, whereas others stated that they just wanted leave.

That said, some voiced concerns about having dedicated pregnancy loss leave and noted that if it were available, they might not avail of it—for reasons related to stigma, discrimination, and unwanted disclosure discussed in Theme 1. Legislation and policies can inadvertently (or otherwise) reinforce hierarchies of loss in various ways, for example, how leave is framed (e.g., bereavement leave or maternity leave), who is eligible to avail of such leave or not (e.g., partners or people who have an abortion), and the duration of leave given (e.g., can vary by gestation in some contries) (Kelly-Harrington, Murray, et al. 2024). As cautioned by Middlemiss et al. (2024), bereavement framing surrounding early pregnancy loss is an example of reproductive governance, which makes some strategies of intervention more possible than others.

3.4 | Theme 3. Practical Implications for Policy and Legislation Development and Implementation

Our analysis demonstrates that various factors need to be considered when designing policies or legislation around early

pregnancy loss. These include practical and individualized organizational supports, supportive management styles, and compassionate systems and procedures.

3.4.1 | Practical and Individualized Organizational Supports

In addition to paid leave, participants spoke about other practical supports that were or would be helpful, particularly when returning to work. These include phased returns; reduced workload; temporary/permanent role reassignment (e.g., from night shifts and public-facing work); flexibility in work tasks, hours, and location; more time to complete tasks; and understanding that their work performance or productivity might be affected for a time.

Flexibility to work from home was another highly valued form of support. It allowed participants to recover in their own space which made handling physical symptoms easier—or being *"able to just do what my body needed because I was at my house"* (P704-FT,ToP-Int) similar to *"if I had little mini accidents I could just change and not have to be fussed at work about it"* (P249-FTM-Int) or *"have a little cry in a corner"* (P249-FTM-Int), thus hiding their "leaky bodies" (Frost 2006; Remnant et al. 2023; Gatrell 2011) from others at work. The latter was sometimes a particular concern for workers such as teachers who lacked access to toilet facilities, a material problem noted elsewhere (Remnant et al. 2023). Participants could also manage their own time and breaks. Some participants expressed that such flexibility also meant that they needed less time off work; or, for some who worked from home in any event (e.g., during the COVID-19 pandemic), negated the need to take leave. It must be noted; however, that although some can work from home, there are many roles where people cannot. For example, some participants—namely teachers, health professionals and retail workers—noted that this was not an option in their case.

Narratives highlighted the importance of flexibility and tailoring supports to individual needs. It is evident that pregnancy loss-related leave needs to be flexible to accommodate individual's emotional and physical needs and should be optional. Some said they would take leave immediately after the loss, with some needing it for continuing appointments (e.g., in cases of molar pregnancy, medical management, and complications) or at varied timepoints (e.g., at time of diagnosis and later if they had to wait for surgery). Some mentioned that they would benefit from it before the actual loss, if expected (e.g., in cases of termination) or at future dates (e.g., around due dates and anniversaries of the loss).

Specific professions or roles may require even more considerations when designing pregnancy loss policies. For example, people who work in maternity/healthcare settings, education or retail and who may encounter pregnancies, babies or children more regularly (notwithstanding that, for some, working with children was perceived as a positive distraction). It also applies to jobs which require physical labor (e.g., driving or heavy lifting) or emotionally demanding roles. People spoke about pressure they felt to not take time off and/or to return to work before they were ready due to lack of available cover or difficulty getting replacements (e.g., for teachers, clinicians, or those on shiftwork) or the particular roles they held that required them to be at work, or to fulfill their duties—for example to students who are in examination classes (as also noted by Bevels Dunn (2023)) or those who are self-employed (Meunier et al. 2026). This could be compounded if people felt that their work would not be covered if they took time off and they then had to return to unwieldy workloads.

Participants also spoke about supports directly provided by the workplace that they found helpful. For example, having access to a doctor or counseling service through work was beneficial and mitigated personal financial costs. There was a clear differentiation between the type of formal supports that could be provided by large companies as opposed to small companies, with the latter struggling more to provide formal additional services or support payments for pregnancy loss-related leave. Some described how they were *"just lucky"* (P173-FTM-Int) in terms of their employer or manager how they, and their pregnancy loss, were treated, regardless of company size.

Participants also spoke about the value of support received through colleagues at work. This included emotional and psychosocial support, such as acknowledgment of their loss through conversations, sending cards, or flowers; remembering due dates and anniversaries; attending burials or ceremonies; and checking in as to how they were doing. It also included practical or instrumental support such as helping with their workload, covering work while they were away so they did not have to catch up when they returned from leave. Such acknowledgment—of the loss and experience—through words or gestures is important (Steimel 2021).

Some participants expressed confusion about leave entitlements and mentioned that it was hard for them to identify what support was available through their workplace. Participants expressed that it was important to have clear referral pathways in the workplace, and that managers and supervisors are aware of the policies and supports, with the need for training highlighted. Deficits in awareness and visibility of supports (policies, guidance, resources, training, etc) have been highlighted across other studies (Boncori et al. 2024; Gilbert et al. 2023). In our study, many spoke about how, in the absence of clear policies or guidance, or lack of appropriate leave forms, some managers or administrative staff accommodated leave requests outside of formal channels—in ways that could be described as forms of "quiet" resistance to structural barriers, putting the needs of employees ahead of bureaucracy or uncompassionate systems.

3.4.2 | Supportive Management Styles

Aside from particular roles, sometimes returning to work was made more difficult by how management, HR, or related structures/services (e.g., occupational health and medical assessment providers) responded to workers who had experienced pregnancy loss. Although many people reported generally good support from colleagues and managers, particular deficits in support from HR departments were observed (Keep

et al. 2023): "*HR not even having the decency to say sorry for your loss really bothered me*" (P21-STM). HR personnel were sometimes described as rude, invasive, or cold by participants during discussions regarding leave or certification.

Empathetic management styles were valued. Some participants anticipated that their manager would be supportive and compassionate, which facilitated the disclosure of pregnancy loss.

Managers who were respectful, flexible, and maintained confidentiality were highly regarded. Some participants also described how negative experience with managers made their recovery and experience more difficult. Some managers were not flexible to the individual's needs or pressurized individuals to return to work before they were ready. Some participants felt that they could not openly discuss their loss with their manager. In some cases, participants also felt like their loss was not acknowledged at all, and that their manager was avoiding the discussion. Some acknowledged that managers, and indeed colleagues, did not know how to handle such situations—handling them badly, or worse, ignoring them—and that training was needed. Lack of acknowledgment of pregnancy loss by co-workers (for any reason, including not knowing what to say) can leave people feeling dismissed, unsupported, and invalidated (Gilbert et al. 2023; Steimel 2021). Participants in our study also highlighted that feeling "*believed and supported*" (P202-FTM) by managers and colleagues was important.

Across the literature, differences are reported in whether support is offered and the helpfulness of support received at work/from managers (Boncori et al. 2024; Gilbert et al. 2023). Support is often informal rather than formal (Keep et al. 2023) and often the onus is on the individual to state what they want or need (Boncori et al. 2024). Positive workplace experiences following loss can renew workers' sense of appreciation for their workplaces, whereas poor experiences can result in workers' reduced engagement, or even transferring roles or organizations (Gilbert et al. 2023; Obst et al. 2022).

3.4.3 | Compassionate Systems and Procedures

Participants frequently mentioned how traumatizing it was to have to call their workplace to disclose the pregnancy loss and explain why they needed time off work: "*when you're going through something so awful you know the last thing you want to think about is how you're getting your cert into work*" (P456-ST, ToP-Int). Some noted how their employers required them to ring in directly, even if they were in hospital actively miscarrying or undergoing management/treatment; it would be *"frowned upon"* (P861-FTM-Int) if they did not. Having to *"go through it again and tell people again"* (P173-FTM-Int) was also difficult for many, with calls for more compassionate systems: *"some of those rules have to be bent when it comes to this"* (P861-FTM-Int).

Participants highlighted how procedures for accessing leave for pregnancy loss were not standardized. They expressed how complex it was in some cases to provide a GP's note (with associated financial and time burdens), and that internal procedures within were different and hard to navigate at such a vulnerable time. Some highlighted that while hospitals could provide medical certificates (though these were not always offered/provided), some types of leave (e.g., statutory sick leave), or company policies could only be secured with a medical certificate or signed form from a GP—the need for "proof" of pregnancy loss, discussed in Theme 1. The importance of having the option of not disclosing directly to line managers, or people with whom you did not feel particularly comfortable with, was also raised, with some preferring to discuss with HR.

4 | Conclusion

Our analysis of lived experiences makes visible the inequities produced through managing early pregnancy loss in the workplace. It reinforces understandings of the social construction of pregnancy loss where some pregnancy losses are considered more impactful or more meaningful than others, as well as more socially validated (Middlemiss et al. 2024). We evidence how early pregnancy loss relates to broader issues regarding pregnancy at work, and how these issues are regarded. The provision of tailored supports is required as individual experiences and needs vary. As cautioned by Quental et al. (2023) in relation to menopause, it is important that well-intentioned efforts to raise awareness of pregnancy loss in the workplace do not contribute to stigma. This can occur by reinforcing hierarchies of loss or assuming that everyone experiences the loss of a pregnancy as a bereavement or by portraying people who experience pregnancy loss as lacking capacity or agency or ambition at work, or as more costly employees. In this paper, we make visible the tensions that need to be considered when developing and implementing workplace supports to ensure equity and that diverse needs and preferences are addressed. To mitigate these tensions, we need to begin by working from the perspectives of people who have experienced pregnancy loss.

Our research shows that supporting workers must include interventions such as leave—which is ideally statutory and paid to enhance equity—to support individuals' needs, whilst also acknowledging its symbolic power in generating broader awareness and recognition of early pregnancy loss. Organizational-level interventions are also needed however as leave, although important, is insufficient on its own. Organizational policies, procedures, and practical supports, with associated training and awareness-raising are needed. As observed in relation to pregnancy and maternity leave (Maxwell et al. 2019), leave and flexible working arrangements are too often governed by informal attitudes and practices rather than more formalized organizational policies and practices. Whereas individuals or teams within organizations can create supportive workplace environments, the creation and sustainment of organization-wide supportive cultures, structures, and practices is needed (Keep et al. 2023). It is important to also acknowledge the system within which people experience pregnancy loss and the intersection between work, family/community, society, and healthcare. It is not enough to make workplaces more compassionate; structural barriers and stigma more broadly need to be addressed and connected to broader struggles for social justice (Browne 2024). This necessitates broader

connections and input from other spheres such as healthcare, government, and society at large.

Whereas the importance of having statutory leave for early pregnancy loss cannot be over-stated, the wider issue relating to whether people access this leave, if available, needs further examination. For example, despite legislative paid compassionate and bereavement leave being available for all Australian employees, no participants in a recent study reported accessing this leave, and some reported being unaware of it (Donaghy et al. 2026). Implementation of reproductive health-related policies more generally can vary and evaluation is needed to examine their impacts, including potential unintended consequences (Reinhardt et al. 2025; Howe et al. 2023).

A strength of our study is the large number of responses across a range of different types of pregnancy losses under 24 weeks and the inclusion of fathers/partners. Although we tried various strategies to recruit more equity-owed groups, our sample is primarily composed of people (particularly heterosexual women) with higher socio-economic status. Future research should explore the experiences and needs of marginalized, low-paid, or precarious workers who may experience greater financial instability, including lack of entitlement or access to paid leave (Kelly-Harrington, Hennessy, et al. 2024; Keep et al. 2023; Obst et al. 2022), and multiple layers of stigma and discrimination (Rose and Oxlad 2023). The perspectives of managers/employers who play key roles in the implementation of workplace supports should also be examined.

In conclusion, workers who experience early pregnancy loss report varied experiences and needs regarding workplace supports. Attending to factors at individual, organizational, and societal levels and related tensions is crucial to realize meaningful supports. Importantly, making visible and addressing the inequities surrounding early pregnancy loss experiences in the workplace can be a catalyst for societal change and help to reduce the stigma surrounding early pregnancy loss.

Acknowledgments

We extend our thanks to everyone who participated in this research, and all the individuals/organizations who assisted with recruitment; members of the Pregnancy Loss Research Group for their input, advice and support regarding study materials and processes, in particular, Anne Marie Farrell and Tara Woulfe; the Department of Children, Equality, Disability, Integration, and Youth for commissioning and funding the PLACES Project.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Research data are not shared.

References

Acker, J. 1990. "Hierarchies, Jobs, Bodies: A Theory of Gendered Organizations." *Gender & Society* 4, no. 2: 139–158. https://doi.org/10.1177/089124390004002002.

Bevels Dunn, M. 2023. "'It's Really Hard to Stand in Front of the Class When You're Trying Not to Cry': Teachers' Emotional Labor Following a Miscarriage Experience." *Social Sciences & Humanities Open* 8, no. 1: 100513. https://doi.org/10.1016/j.ssaho.2023.100513.

Bloomer, F., D. Mackle, N. MacNamara, C. Pierson, and S. Bloomer. 2024. "The Workplace as a Site of Abortion Surveillance." *Gender, Work & Organization* 31, no. 6: 2549–2567. https://doi.org/10.1111/gwao.13100.

Boncori, I., J. Brewis, J. Davies, et al. 2024. "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)." https://business-school.open.ac.uk/sites/business-school.open.ac.uk/files/files/Early%20Pregnancy%20Endings%20research%20report%20FINAL.pdf.

Boncori, I., and C. Smith. 2019. "I Lost My Baby Today: Embodied Writing and Learning in Organizations." *Management Learning* 50, no. 1: 74–86. https://doi.org/10.1177/1350507618784555.

Braun, V., and V. Clarke. 2021. *Thematic Analysis: A Practical Guide*. SAGE Publications Ltd.

Braun, V., V. Clarke, E. Boulton, L. Davey, and C. McEvoy. 2021. "The Online Survey as a Qualitative Research Tool." *International Journal of Social Research Methodology* 24, no. 6: 641–654. https://doi.org/10.1080/13645579.2020.1805550.

Brewis, J., V. Newton, J. Davies, A. Middlemiss, K. Mullan, and I. Boncori. 2023. "Early Pregnancy Endings and the Workplace." *Open University*. https://business-school.open.ac.uk/research/projects/early-pregnancy-endings-workplace.

Browne, V. 2018. "The Politics of Miscarriage." *Radical Philosophy* 203: 62–72. https://www.radicalphilosophy.com/article/the-politics-of-miscarriage.

Browne, V. 2024. "How to Defeat Miscarriage Stigma: From 'Breaking the Silence' to Reproductive Justice." *Feminist Theory* 26, no. 1: 14647001241266173. https://doi.org/10.1177/14647001241266173.

Burr, V., and P. Dick. 2025. "Social Constructionism." In *The Palgrave Handbook of Critical Social Psychology*, edited by B. Gough, Springer Nature. https://doi.org/10.1007/978-3-031-80533-2_4.

Citizens Information. 2025. "Sick Leave and Sick Pay." *Citizensinformation.ie. Ireland*. https://www.citizensinformation.ie/en/employment/employment-rights-and-conditions/leave-and-holidays/sick-leave-and-sick-pay/.

Civil Registration (Electronic Registration) Act 2024. 2024. *Houses of the Oireachtas*. https://www.oireachtas.ie/en/bills/bill/2024/26.

Conlon, C., K. Antosik-Parsons, and É. Butler. 2025. "Experiences of the Irish Model of Community Medical Abortion: Adherence to Self-Managed, People-Centred Abortion Care." *Irish Political Studies* 40, no. 1: 6–28. https://doi.org/10.1080/07907184.2024.2369335.

Daly, K. L., G. Pike, V. Clarke, and V. Beck. 2024. "'Difficulty Mentioning the M Word': Perceptions of a Woman Disclosing Negative Menopause Symptoms in the Workplace." *Qualitative Research in Organizations and Management: International Journal* 19, no. 3: 163–181. https://doi.org/10.1108/QROM-07-2023-2562.

Dennehy, R., M. Hennessy, S. Meaney, et al. 2022. "How We Define Recurrent Miscarriage Matters: A Qualitative Exploration of the Views of People With Professional or Lived Experience." *Health Expectations* 25, no. 6: 2992–3004. https://doi.org/10.1111/hex.13607.

Department of Social Protection. 2025a. "Maternity Benefit." https://www.gov.ie/en/service/apply-for-maternity-benefit/.

Department of Social Protection. 2025b. "Paternity Benefit." https://www.gov.ie/en/service/apply-for-paternity-benefit/.

Donaghy, J. A., S. Lewis, M. Keep, and J. E. Carland. 2026. "'I Was Told I Either Came Back or I Lost My Job': A Qualitative Study of the Experiences of Australian Women Navigating the Return-to-Work Following Early Pregnancy Loss." *Community, Work & Family* 29, no. 1: 86–100. https://doi.org/10.1080/13668803.2024.2350550.

France, E. F., K. Hunt, S. Ziebland, and S. Wyke. 2013. "What Parents Say About Disclosing the End of Their Pregnancy Due To Fetal Abnormality." *Midwifery* 29, no. 1: 24–32. https://doi.org/10.1016/j.midw.2011.10.006.

Frost, J. 2006. "Older Women and Early Miscarriage: Leaky Bodies and Boundaries." In *Exploring the Dirty Side of Women's Health*. https://doi.org/10.4324/9780203967348.

Gatrell, C. 2011. "Policy and the Pregnant Body at Work: Strategies of Secrecy, Silence and Supra-Performance." *Gender, Work & Organization* 18, no. 2: 158–181. https://doi.org/10.1111/j.1468-0432.2009.00485.x.

Gatrell, C., J. J. Ladge, and G. N. Powell. 2024. "Profane Pregnant Bodies Versus Sacred Organizational Systems: Exploring Pregnancy Discrimination at Work (R2)." *Journal of Business Ethics* 192, no. 3: 527–542. https://doi.org/10.1007/s10551-023-05518-6.

Gilbert, S. L., J. K. Dimoff, J. M. Brady, R. Macleod, and T. McPhee. 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.

Griffiths, H. 2021. "Invisible People: A Story of Fertility Treatment and Loss During the Pandemic." Supplement, *Gender, Work & Organization*, 28, no. S2: S397–S404. https://doi.org/10.1111/gwao.12665.

Hazen, M. A. 2003. "Societal and Workplace Responses to Perinatal Loss: Disenfranchised Grief or Healing Connection." *Human Relations* 56, no. 2: 147–166. https://doi.org/10.1177/0018726703056002889.

Hennessy, M., R. Dennehy, J. Doherty, and K. O'Donoghue. 2022. "Outsourcing Transcription: Extending Ethical Considerations in Qualitative Research." *Qualitative Health Research* 32, no. 7: 1197–1204. https://doi.org/10.1177/10497323221101709.

Hennessy, M., and K. O'Donoghue. 2024. "Bridging the Gap Between Pregnancy Loss Research and Policy and Practice: Insights From a Qualitative Survey With Knowledge Users." *Health Research Policy and Systems* 22, no. 1: 15. https://doi.org/10.1186/s12961-024-01103-z.

Houses of the Oireachtas. 2021. "Organisation of Working Time (Reproductive Health Related Leave) Bill 2021 – No. 38 of 2021." *Houses of the Oireachtas*. https://www.oireachtas.ie/en/bills/bill/2021/38.

Houses of the Oireachtas. 2025. "Pregnancy Loss (Miscellaneous Provisions) Bill 2025 – No. 23 of 2025." *Houses of the Oireachtas*. https://www.oireachtas.ie/en/bills/bill/2025/23.

Howe, D., S. Duffy, M. O'Shea, et al. 2023. "Policies, Guidelines, and Practices Supporting Women's Menstruation, Menstrual Disorders and Menopause at Work: A Critical Global Scoping Review." *Healthcare* 11, no. 22: 2945. https://doi.org/10.3390/healthcare11222945.

Hutson, D. J. 2025. "The Silent Shift: Pregnant Women Doing Aesthetic and Emotional Labor at Work." *Gender, Work & Organization* 32, no. 1: 281–301. https://doi.org/10.1111/gwao.13146.

Hvala, T., and K. Hammarberg. 2025. "The Impact of Reproductive Health Needs on Women's Employment: A Qualitative Insight into Managing Endometriosis and Work." *BMC Women's Health* 25, no. 1: 216. https://doi.org/10.1186/s12905-025-03726-y.

Keep, M., S. Payne, and J. E. Carland. 2023. "Experiences of Australian Women on Returning to Work After Miscarriage." *Community, Work & Family* 26, no. 2: 258–267. https://doi.org/10.1080/13668803.2021.1993140.

Kelly-Harrington, R., M. Hennessy, S. Leitao, et al. 2024. *PLACES | Pregnancy Loss (Under 24 Weeks) in Workplaces: Informing Policymakers on Support Mechanisms*. Department of Children, Equality, Disability, Integration and Youth. https://www.gov.ie/en/publication/0e7d5-places-pregnancy-loss-under-24-weeks-in-workplaces-informing-policymakers-on-support-mechanisms/.

Kelly-Harrington, R., M. Hennessy, S. Leitao, et al. 2026. "PLACES | Pregnancy Loss in Workplaces: Informing Policymakers on Support Mechanisms." https://osf.io/zyq3c.

Kelly-Harrington, R., S. Leitao, K. O'Donoghue, et al. 2025. "Workplace Supports for Early Pregnancy Loss: A Scoping Review of International Literature." *Work* 81, no. 1: 2021–2047. https://doi.org/10.1177/10519815241305007.

Kelly-Harrington, R., C. Murray, M. Hennessy, et al. 2024. "Statutory Leave for Early Pregnancy Loss: A Comparative Study." *European Labour Law Journal* 15, no. 4: 695–710. https://doi.org/10.1177/20319525241263177.

Lafrance, M. N., and B. Wigginton. 2019. "Doing Critical Feminist Research: A Feminism & Psychology Reader." *Feminism & Psychology* 29, no. 4: 534–552. https://doi.org/10.1177/0959353519863075.

Layne, L. L. 2003. *Motherhood Lost: A Feminist Account of Pregnancy Loss in America*. Routledge. https://doi.org/10.4324/9780203948040.

Lumivero. 2023. *NVivo*. Version 14. Lumivero: released. https://lumivero.com/products/nvivo/.

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, no. 4: 489–496. https://doi.org/10.1136/medhum-2021-012373.

Malterud, K., V. D. Siersma, and A. D. Guassora. 2016. "Sample Size in Qualitative Interview Studies Guided by Information Power." *Qualitative Health Research* 26, no. 13: 1753–1760. https://doi.org/10.1177/1049732315617444.

Maxwell, N., L. Connolly, and C. Ní Laoire. 2019. "Informality, Emotion and Gendered Career Paths: The Hidden Toll of Maternity Leave on Female Academics and Researchers." *Gender, Work & Organization* 26, no. 2: 140–157. https://doi.org/10.1111/gwao.12306.

Meunier, S., F. de Montigny, D. Lalande, J. Lord-Gauthier, and M. Lauzier. 2026. "Exploring the Experience of Presenteeism Among Fathers Returning to Work Following a Perinatal Death." *Community, Work & Family* 29, no. 1: 72–85. https://doi.org/10.1080/13668803.2024.2345889.

Meunier, S., F. de Montigny, S. Zeghiche, et al. 2021. "Workplace Experience of Parents Coping With Perinatal Loss: A Scoping Review." *Work* 69, no. 2: 411–421. https://doi.org/10.3233/WOR-213487.

Middlemiss, A. L., I. Boncori, J. Brewis, J. Davies, and V. L. Newton. 2024. "Employment Leave for Early Pregnancy Endings: A Biopolitical Reproductive Governance Analysis in England and Wales." *Gender, Work & Organization* 31, no. 1: 75–91. https://doi.org/10.1111/gwao.13055.

Middlemiss, A. L., and S. Kilshaw. 2023. "Further Hierarchies of Loss: Tracking Relationality in Pregnancy Loss Experiences." *OMEGA - Journal of Death and Dying* 92, no. 1: 284–302. https://doi.org/10.1177/00302228231182273.

Mullin, A. 2015. "Early Pregnancy Losses: Multiple Meanings and Moral Considerations." *Journal of Social Philosophy* 46, no. 1: 27–43. https://doi.org/10.1111/josp.12085.

Mumford, C., K. Wilkinson, and M. Carroll. 2023. "'Potential Parenthood' and Identity Threats: Navigating Complex Fertility Journeys Alongside Work and Employment." *Gender, Work & Organization* 30, no. 3: 982–998. https://doi.org/10.1111/gwao.12953.

Obst, K. L., C. Due, M. Oxlad, and P. Middleton. 2022. "Australian Men's Experiences of Leave Provisions and Workplace Support Following Pregnancy Loss or Neonatal Death." *Community, Work & Family* 25, no. 4: 551–562. https://doi.org/10.1080/13668803.2020.1823319.

Percival Carter, E. 2024. "Power and the Perception of Pregnancy in the Academy." *Gender, Work & Organization* 31, no. 5: 1951–1975. https://doi.org/10.1111/gwao.13001.

Porschitz, E. T., and E. A. Siler. 2017. "Miscarriage in the Workplace: An Authoethnography." *Gender, Work & Organization* 24, no. 6: 565–578. https://doi.org/10.1111/gwao.12181.

Quental, C., P. Rojas Gaviria, and C. del Bucchia. 2023. "The Dialectic of (Menopause) Zest: Breaking the Mold of Organizational Irrelevance." *Gender, Work & Organization* 30, no. 5: 1816–1838. https://doi.org/10.1111/gwao.13017.

Reinhardt, A., H. Adler, D. Howe, A. K. Mardon, M. O'Shea, and M. Armour. 2025. "Good Intentions, Poor Execution? Why Current Workplace Policies on Menstrual and Menopausal Health Fall Short." *Women's Reproductive Health*: 1–12. https://doi.org/10.1080/23293691.2025.2520331.

Remnant, J., K. Sang, K. Myhill, T. Calvard, S. Chowdhry, and J. Richards. 2023. "Working It Out: Will the Improved Management of Leaky Bodies in the Workplace Create a Dialogue Between Medical Sociology and Disability Studies?" *Sociology of Health & Illness* 45, no. 6: 1276–1299. https://doi.org/10.1111/1467-9566.13519.

Romanis, E. C. 2020. "Is 'Viability' Viable? Abortion, Conceptual Confusion and the Law in England and Wales and the United States." *Journal of Law and the Biosciences* 7, no. 1: lsaa059. https://doi.org/10.1093/jlb/lsaa059.

Rose, A., and M. Oxlad. 2023. "LGBTQ+ Peoples' Experiences of Workplace Leave and Support Following Pregnancy Loss." *Community, Work & Family* 26, no. 2: 268–284. https://doi.org/10.1080/13668803.2021.2020727.

Russell, H., D. Watson, and J. Banks. 2011. "Pregnancy at Work: A National Survey." *Economic & Social Research Institute*. https://www.esri.ie/publications/pregnancy-at-work-a-national-survey.

Sang, K., J. Remnant, T. Calvard, and K. Myhill. 2021. "Blood Work: Managing Menstruation, Menopause and Gynaecological Health Conditions in the Workplace." *International Journal of Environmental Research and Public Health* 18, no. 4: 4. https://doi.org/10.3390/ijerph18041951.

Sayers, J. G., and D. Jones. 2015. "Truth Scribbled in Blood: Women's Work, Menstruation and Poetry." *Gender, Work & Organization* 22, no. 2: 94–111. https://doi.org/10.1111/gwao.12059.

Scambler, G. 2009. "Health-Related Stigma." *Sociology of Health & Illness* 31, no. 3: 441–455. https://doi.org/10.1111/j.1467-9566.2009.01161.x.

Sick Leave Act 2022. 2022. *Houses of the Oireachtas*. https://www.irishstatutebook.ie/eli/2022/act/24/enacted/en/html.

Steffan, B. 2021. "Managing Menopause at Work: The Contradictory Nature of Identity Talk." *Gender, Work & Organization* 28, no. 1: 195–214. https://doi.org/10.1111/gwao.12539.

Steffan, B., and W. Loretto. 2025. "Menopause, Work and Mid-Life: Challenging the Ideal Worker Stereotype." *Gender, Work & Organization* 32, no. 1: 116–131. https://doi.org/10.1111/gwao.13136.

Steimel, S. 2021. "Communication Privacy Management and Pregnancy Loss in Interpersonal Workplace Communication." *Women's Studies in Communication* 44, no. 3: 397–418. https://doi.org/10.1080/07491409.2020.1843579.

Sunstein, C. R. 1996. "On the Expressive Function of Law." *University of Pennsylvania Law Review* 144, no. 5: 2021–2053. https://doi.org/10.2307/3312647.

Trump-Steele, R. C. E., C. L. Nittrouer, M. R. Hebl, and L. Ashburn-Nardo. 2016. "The Inevitable Stigma for Childbearing-Aged Women in the Workplace: Five Perspectives on the Pregnancy-Work Intersection." In *Research Perspectives on Work and the Transition to Motherhood*, edited by C. Spitzmueller and R. A. Matthews, Springer International Publishing. https://doi.org/10.1007/978-3-319-41121-7_5.

Van Tuyl, R. 2024. "Improving Access, Understanding, and Dignity During Miscarriage Recovery in British Columbia, Canada: A Patient-Oriented Research Study." *Women's Health* 20: 17455057231224180. https://doi.org/10.1177/17455057231224180.

Whiley, L. A., A. Wright, S. E. Stutterheim, and G. Grandy. 2023. "'A Part of Being a Woman, Really': Menopause at Work as 'Dirty' Femininity." *Gender, Work & Organization* 30, no. 3: 897–916. https://doi.org/10.1111/gwao.12946.

Wilkinson, K., and J. Rouse. 2023. "Solo-Living and Childless Professional Women: Navigating the 'Balanced Mother Ideal' Over the Fertile Years." *Gender, Work & Organization* 30, no. 1: 68–85. https://doi.org/10.1111/gwao.12900.

Wong, A., M. Oxlad, and D. Turnbull. 2025. "Exploring Australian Women's Attitudes Towards Paid Menstrual Leave: A Mixed-Methods Study." *Australian and New Zealand Journal of Obstetrics and Gynaecology* 65, no. 6: 766–777. https://doi.org/10.1111/ajo.70031.

Supporting Information

Additional supporting information can be found online in the Supporting Information section.

Supporting Information S1: gwao70165-sup-0001-suppl-data.docx.