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Nurses' and midwives' experiences of supporting parents following perinatal bereavement: A qualitative systematic review

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ABSTRACT

Background: Perinatal loss is a significant global health issue that affects millions of families worldwide and represents a profound emotional challenge for both parents and healthcare professionals. Nurses and midwives play a key role in providing care and support to parents during this difficult period. However, many report feeling underprepared and inadequately supported when delivering perinatal bereavement care.

Objectives: We sought to explore the experiences of nurses and midwives of supporting parents following perinatal loss, to examine the personal and professional impact of providing bereavement care on nurses and midwives, and to identify the key facilitators and challenges they encounter in this role.

Design: A qualitative systematic review of the literature.

Information sources: PubMed, CINAHL, Embase, PsycINFO, Web of Science, Medline, Scopus.

Methods: We conducted a systematic literature search, limited to English language publications, in the above databases from January 2015 to November 2025. Two reviewers independently performed study selection and data extraction and assessed methodological quality using the JBI Critical Appraisal Tool. The extracted data were then analyzed and synthesized using a thematic synthesis approach to identify patterns and generate comprehensive insights into the experiences of nurses and midwives providing bereavement care.

Results: A total of 15 studies met the inclusion criteria. From these, we identified three major themes: (1) a caring role in supporting bereaved parents; (2) the impact of bereavement care on nurses and midwives; and (3) facilitators and barriers to providing bereavement care. Each main theme included several sub-themes.

Conclusion: Perinatal loss had a profound impact on the psychological and physical well-being of nurses and midwives; a variety of coping strategies were used to navigate these challenges. Both bereavement care training and organisation support were seen as essential for them to prepare themselves. There **appears to be an** urgent need for an effective bereavement care training program created for nurses and midwives, as well as open discussion, informal debriefing sessions among colleagues working in maternity units. What's more, institutional support and managerial support **may be important as well.**

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What is already known

- Perinatal loss is a world-wide problem that has a significant psychological impact.
- Most researchers have focused on parents' experiences of perinatal loss, rather than on the impact on nurses and midwives.

What this paper adds

- Bereavement care has profound physical and psychological impacts on nurses and midwives, including sleep disturbance, emotional suppression, and feelings of professional helplessness.
- Key facilitators in providing bereavement care included training, organizational support, and peer debriefing, while lack of preparation and institutional support acted as major barriers.

1. Introduction

Perinatal loss refers to the loss of a pregnancy before or during birth or the death of a newborn within the first month of life (Charrois et al., 2020), which includes miscarriage, stillbirth, termination resulting from abnormal foetal development, and neonatal death (Haghighi et al., 2022). Perinatal loss represents one of the most devastating experiences that a family can endure and has been a topic of significant research and discussion in the field of psychology and healthcare. Perinatal loss is also a significant universal health issue affecting millions of families worldwide. Each year, almost 23 million miscarriages occur globally, which equates to about 44 pregnancy losses per minute (Quenby et al., 2021). Furthermore, around one quarter of pregnancies result in spontaneous abortion or foetal death (Hutti et al., 2013), and global neonatal deaths accounted for approximately 2.3 million in 2023.

The emotional consequences of perinatal loss are significant and often severe (Robinson, 2011). Parents who suffer from such a loss face an increased risk of developing poor psychological outcomes, including grief, depression, anxiety, and sleep disturbances (Burnett et al., 1997; Fernández-Basanta et al., 2020; Fernández-Férez et al., 2021), as well as relationship difficulties, with most couples suffering from a decline in intimacy (Allsop et al., 2025; Schwenck et al., 2025). Moreover, grief symptoms are also influenced by cultural and societal factors. In some cultures, such as in China, there is a significant social stigma attached to the loss of a baby (Zheng et al., 2024), and, in Spain, under the influence of social context, perinatal bereavement is not typically accepted as a death of the baby (Camacho-Ávila et al., 2019). Whereas in many Western settings, such as Australia and United States of America (USA), memory-making practices and rituals are encouraged to support the grieving process (Payne et al., 2025). The variation in cultural attitudes towards perinatal death requires nurses and midwives to be culturally-sensitive.

Given the significant psychological impact of perinatal bereavement, the role of healthcare providers, particularly nurses and midwives, becomes critical in addressing these needs. They provide not only medical care but also emotional support and guidance (Xie et al., 2025a). They often serve as emotional supporters to parents, providing comfort and a sense of empathy during this vulnerable time. Researchers have demonstrated that psychological support provided by nurses and midwives can significantly reduce the emotional burden on parents, improving their psychological outcomes (Fernández-Férez et al., 2021; Xie et al., 2024; Yıldız Karaahmet and Bilgiç, 2024). Cognitive therapy led by nurses can be beneficial for the prolonged grief disorder of parents following perinatal loss (Li et al., 2024). Individual counselling has been shown to be effective in alleviating symptoms of grief and post-traumatic stress disorder of parents (Haghighi et al., 2022; Hasani et al., 2021; Navidian et al., 2017). Moreover, in addition to supporting parents, nurses and midwives also assist in the logistical aspects of the loss, such as encouraging parents to make memories with their baby and arranging for burial or cremation, ensuring that parents feel their loss is respected and that they can take part in decision-making (Fernández-Férez et al., 2021).

Among maternity care providers, the proportion exposed to traumatic work events ranges from 67% to 90%, with many reporting moderate levels of secondary traumatic stress and burnout (Healy et al., 2025), and nearly one third of midwives have reported suffering from post-traumatic stress disorder, which is thought to be a complication of burnout (Segal and Kagan, 2025). Nurses have been reported as experiencing poor psychological outcomes; facing death can be challenging, and the grief and guilt of exposure to death may be detrimental to their mental health (DesJardin, 2025; Roche et al., 2025). Additionally, there remains a lack of clear and standardized guidelines for bereavement care. As a result, healthcare providers are ill-equipped to appropriately offer bereavement care to parents (Fernández-Alcántara et al., 2020). Many nurses and midwives report a lack of bereavement care experience, time, organizational support, and emotional support, which can prevent them from effectively supporting grieving parents (Fernández-Férez et al., 2021). The lack of adequate training in grief counselling and perinatal bereavement care further compounds this issue (Naef et al., 2020). In a summary, the emotional burden can negatively affect nurses' well-being, job satisfaction, and overall mental health (McIntyre et al., 2024).

Notably, most researchers have focused primarily on parents' emotions and their grief process (Obst et al., 2020; Payne et al., 2025). Most have explored interventions aimed at enhancing the emotional well-being of grieving parents (Haghighi et al., 2022; Pedraza et al., 2024), and researchers conducting a systematic review evaluated nursing interventions that facilitated the parents' grief process following perinatal loss(Fernández-Férez et al., 2021), However, there is a significant gap in the literature when it comes to understanding the experiences of nurses and midwives in providing bereavement care. Despite their crucial role in supporting grieving

parents, few researchers have examined the challenges, emotional burden, and psychological impact faced by healthcare professionals in this context.

In summary, perinatal loss is an emotionally-challenging experience that affects both parents and healthcare professionals. Nurses and midwives play a key role in delivering care for parents during this difficult time, yet, they frequently report feeling underprepared and unsupported in providing bereavement care. The lack of standardized guidelines and adequate training further exacerbates these challenges.

Aim.

In this review, we sought to explore the experiences of nurses and midwives in supporting parents following perinatal loss, to examine how providing bereavement care impacted nurses' and midwives' personal and professional well-being, to identify the key facilitators and challenges they encountered in this role, and to offer practical recommendations and directions for future research to enhance care for nurses and midwives.

2. Methods

This review was conducted and reported in accordance with the JBI methodology for systematic reviews of qualitative evidence (Lockwood et al., 2015). A qualitative analysis and a thematic synthesis (Thomas and Harden, 2008) was completed in this systematic review.

2.1. Search strategy

A systematic search was conducted by using seven different databases (CINAHL, PubMed, Web of Science, Scopus, Medline, Embase and PsycINFO), and the review questions informed the development of a Population, Exposure, and Outcome (PEO) framework (Matthew J. Page et al., 2021), which was subsequently used to guide the selection of keywords in the search strategy (Table 1). To

Table 1
Key words, search terms & eligibility criteria using PEO (population, exposure, outcome) framework.

PEO framework	keyword	Search terms	Inclusion criteria	Exclusion criteria
Population	Nurses/midwives	"Nurs*" OR "nursing staff*" OR "midwife*"	Nurses, midwives	Patients, non-professional caregivers, or other healthcare workers
Exposure	Support to parents following perinatal bereavement	S1 "support" OR "therapy" OR "management" OR "counselling" OR "loss support" OR "intervention*" OR "care" OR "assistance" OR "grief support" AND OR "care" S2 "parent*" OR "mothers" OR "fathers" OR "families" OR "women" OR "men" AND S3 "perinatal loss" OR "stillbirth" OR "perinatal death" OR "miscarriage" OR "bereavement" OR "neonatal death" OR "abortion" OR "pregnancy loss" OR "spontaneous abortion" OR "termination" OR "perinatal bereavement" OR "infant loss" OR "late foetal death"	Focused on supporting fathers, mothers, or parents following perinatal loss, including spontaneous abortion, stillbirth, neonatal death, or termination of pregnancy	1.Mothers, fathers, parents suffered from Induced abortion for non-medical reasons 2.Parents suffered from infant mortality or child deaths
Outcome	Primary outcome: Nurses'/midwives' experiences Secondary outcomes: 1.Nurses' and midwives' feelings 2.Psychological impact on nurses and midwives 3.Challenges for nurses and midwives in bereavement	"Barriers" OR "obstacles" OR "challenges" OR "difficulties" OR "perspectives" OR "experiences" OR "views" OR "attitudes" OR "perceptions" OR "facilitators"	Focused on nurses' or midwives' perceptions, experiences, views, or perspectives regarding the provision of support to parents experiencing perinatal bereavement	Focused solely on parents' experiences without addressing nurses' or midwives' perspectives
Study/ publication type	N/A		primary empirical research with original data	Secondary research, including reviews, commentaries, or editorials.
Limits applied in database searching			1.English language 2.10-year time: from January 2015 to November 2025 3.Peer reviewed	

complement the database searches, a systematic search of grey literature was also undertaken. ProQuest Dissertations & Theses Global and the websites of key professional organisations, including the World Health Organization and the International Stillbirth Alliance, were hand-searched for relevant reports and guidelines.

There were three review questions: (1) What are the experiences of nurses and midwives when they support parents following perinatal loss? (2) How does providing bereavement care affect nurses and midwives? (3) What are the facilitators and barriers for nurses and midwives when they support parents following perinatal loss?

Keywords and their corresponding synonyms (as shown in Table 1) were searched. To refine, broaden, and connect search terms, the Boolean operators "AND" and "OR" were employed, truncation (using "*") was applied in capturing all words endings, and quotation marks were used to group phrases when appropriate. Additionally, Medical Subject Headings (MeSH) and CINAHL Heading were used in the database to create a more comprehensive search strategy. Due to the scarcity of the literature in the field of perinatal death, the reference lists in the relevant studies were searched to identify additional relevant studies. The 10-year time limit (January 2015 to November 2025) aimed to capture the experiences of nurses and midwives working within the current healthcare context, ensuring that we found articles that were relevant, applicable, and reflective of the challenges and supports present in the current practice environment. We also limited articles to those that were peer-reviewed and in the English language.

2.2. Eligibility criteria

2.2.1. Inclusion criteria

Studies were included if they met the following inclusion criteria: (1) focused on supporting parents following perinatal loss, including spontaneous abortion, stillbirth, neonatal death, or termination of pregnancy; (2) the support was provided by nurses or midwives; (3) focused on the nurses' and midwives' perceptions, experiences, views, perspectives regarding the provision of support to parents experiencing perinatal loss; and (4) reported primary empirical research with original data.

2.2.2. Exclusion criteria

Studies were excluded if they met the following criteria: (1) studies submitted in conferences and non-peer reviewed studies; and (2) secondary research, including reviews, commentaries, or editorials.

2.3. Study selection

All the studies obtained from the database were imported into Covidence for management and analysis. This process consisted of the removal of duplicates from seven databases, title/abstract review, and full-text screening. After the removal of duplicate literature, two reviewers did initial screening through title and abstract of all studies independently according to eligibility criteria, and irrelevant studies were removed. After title and abstract review, full-text screening was conducted by two reviewers; all disagreements between the two reviewers were discussed and resolved with a third reviewer to reach a consensus. All the discrepancies were resolved collaboratively after the title/abstract and full-text screenings.

2.4. Data extraction

Two reviewers used standardized data extraction forms to record the details of each study that met the inclusion criteria. Data were extracted according to the following items: author(s), year, country; aim; research approach and study design; sample approach, size, eligibility and setting(s); data collection methods; data analysis; and main findings. The extracted data were cross-checked by two reviewers, and, if there was any disagreement, a third reviewer was employed to discuss and finally reach consensus.

2.5. Quality assessment

Quality assessment aims to evaluate different methodologic approaches and identify potential bias in their research design, data collection, and data analysis (Furuya-Kanamori et al., 2021). An appraisal tool was chosen based on the design of the studies; each study that met the inclusion criteria and initial screening process underwent a thorough appraisal.

In this systematic review, The JBI Critical Appraisal Checklist for Qualitative Research (Lockwood et al., 2015) was selected because it is internationally recognized as a comprehensive and flexible tool for appraising qualitative studies (Munn et al., 2014). It enables systematic evaluation of methodological quality, focusing on congruence among the research question, methodology, data collection, analysis, and interpretation. This aligns well with the diversity of qualitative approaches included in this review (Lockwood et al., 2015). The checklist consists of 10 items that guided the evaluation process, focusing on methodological congruity and transparency.

2.6. Data synthesis

A thematic synthesis was chosen due to the methodological heterogeneity of the included studies and the qualitative nature of the research questions. Thematic synthesis is a systematic method for identifying, analysing, and reporting patterns within data. It allows for detailed description and organization of data into well-structured themes and is considered a fundamental approach for qualitative analysis (Thomas and Harden, 2008). Following the procedures outlined by Thomas and Harden (2008), our analysis involved three

stages: (1) coding text. First, the findings or results sections of the included studies, including participant quotations and author interpretations, were extracted and entered into a standardized Excel spreadsheet. Two reviewers (HG and Chinyere) independently read and re-read the data to become familiar with the content. Line-by-line coding was then conducted, and initial codes were generated to capture meanings related to nurses' and midwives' experiences of supporting parents following perinatal loss; (2) developing descriptive themes. The initial codes generated from all included studies were then compared, discussed, and organized into a hierarchical structure. Codes that shared similar meanings or concepts were grouped together to form descriptive themes. This involved constantly moving back and forth between the codes and the original text to ensure the themes accurately reflected the primary data.

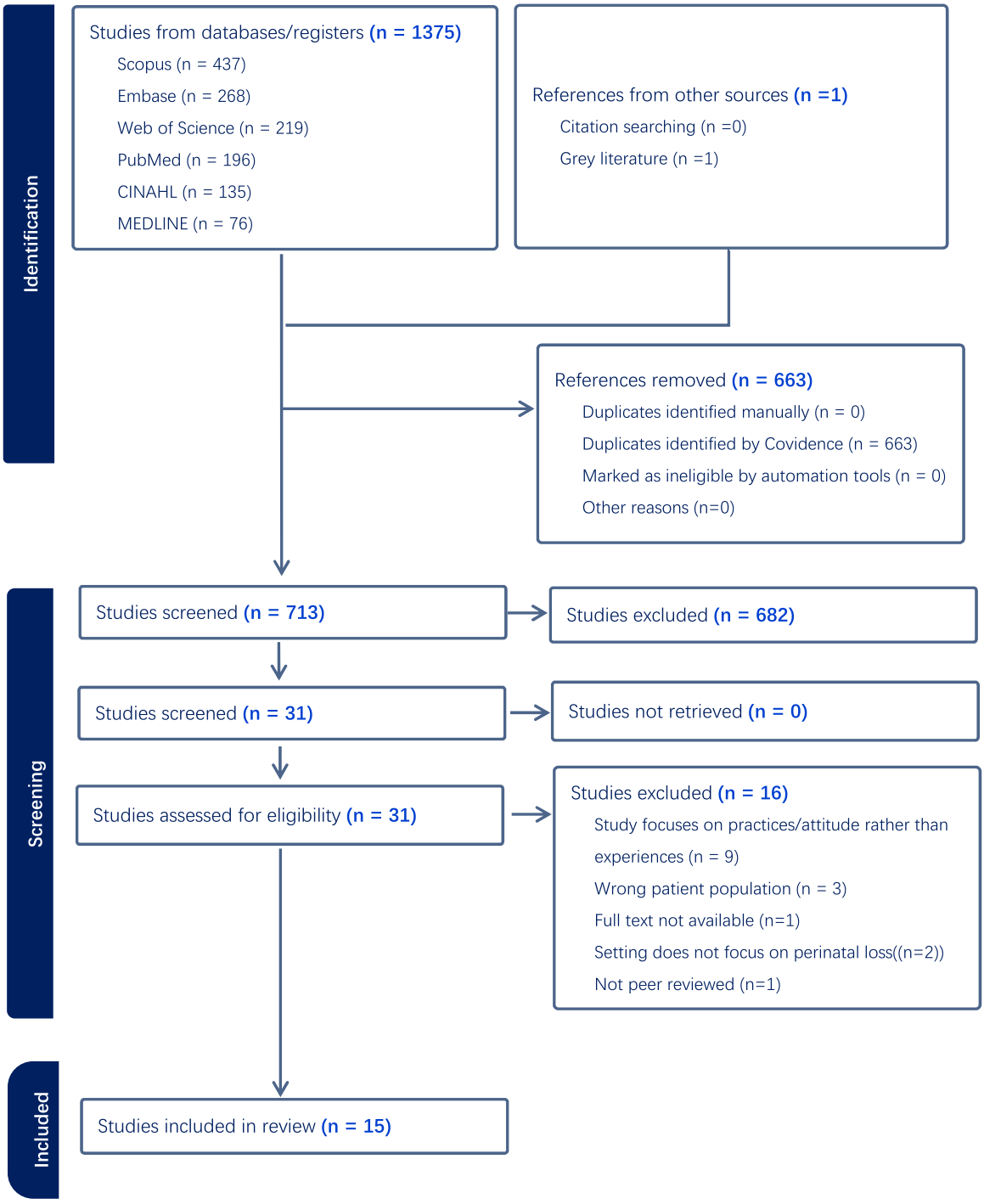


Fig. 1. PRISMA flow diagram demonstrating identification of studies via database searches(Matthew J. Page et al., 2021).

Disagreements between reviewers were resolved through discussion or consultation with a third reviewer (TZ); and (3) generating analytical themes. Finally, by reviewing the descriptive themes in the context of our review question, we aimed to go beyond the findings of the primary studies to develop higher-order interpretations and implications for practice. The findings were ultimately presented in both tabular and thematic formats.

2.7. Rigor and reflexivity

The review team has extensive experience and expertise in nursing, midwifery, and perinatal care. The first author and second author hold master's degrees in nursing from Ireland and have several years of clinical experience as midwives, including direct exposure to perinatal bereavement care. This clinical background provided the team with a deep understanding of the context of perinatal bereavement. The third author contributed a nursing management perspective, while the fourth and corresponding authors, as academic supervisors with expertise in women's and children's health, provided methodological oversight throughout the review.

Database searches, study selection, and data extraction were conducted independently by the first and second authors, with oversight from senior authors to ensure methodological rigor. Throughout the synthesis process, the team held regular reflexive discussions to critically reflect on how our own professional backgrounds and clinical experiences might influence the interpretation of findings. All decisions, including study selection, data extraction, and theme development, were systematically documented. Independent coding and verification by the first and second authors, followed by discussion with senior authors, helped maintain consistency and minimize bias. Together, these measures provided a transparent and auditable record of the synthesis process.

3. Results

3.1. Search results

Database searches yielded 1375 studies from seven databases and one additional record through grey literature sources. After removing 663 duplicates, 713 records were retained for title/abstract screening. A total of 31 full-text articles were assessed for eligibility, of which 15 studies met the inclusion criteria and were included in the review. One unpublished master's thesis identified through grey literature was excluded. The study selection process are presented in a PRISMA flow chart (Matthew J. Page et al., 2021) (Fig. 1).

3.2. Study characteristics

A summary of the study characteristics is presented in Table 2. All studies were published between 2015 and 2025 and were conducted across 11 countries, four in Spain (Martínez-Serrano et al., 2018; Fernández-Alcántara et al., 2020; Fernández-Alcántara et al., 2020), two in Ireland (Power et al., 2022; Xie et al., 2025b), one each respectively in USA (Willis, 2019), United Kingdom (Mills et al., 2023), Canada (Verdon and deMontigny, 2021), China (Shen et al., 2022), Brazil (Almeida et al., 2016), Turkey (Yenal et al., 2023), Ghana (Mohammed et al., 2024), and Australia (Obst and Due, 2019). All studies employed qualitative research designs, nine studies adopted a descriptive approach, and six used a phenomenological approach to explore the experiences of nurses and midwives in perinatal bereavement care. Please see further information in Table 2.

In addition, one study explored midwives' experiences of providing perinatal bereavement care during the COVID-19 pandemic in Ireland (Power et al., 2022). Pandemic-related restrictions influenced midwives' emotional experiences and their ability to communicate and provide support to bereaved parents. These findings should therefore be interpreted within the context of pandemic-related care conditions. Another study included 12 full-time midwifery undergraduate students who were interning in delivery wards, all of whom had experience in caring for a woman with perinatal loss (Shen et al., 2022).

The majority of participants were female, though some studies did not specify sex distribution. The sample size in the included studies ranged from 7 (Obst and Due, 2019) to 61 participants (Mills et al., 2023). The study settings included private hospitals, acute hospitals, public hospitals, maternal and child hospitals, primary healthcare centers, pregnancy loss support organizations, and community-based care. Ethnicity was reported in 13 studies(Almeida et al., 2016; Obst and Due, 2019; Fernández-Sola et al., 2020; Fernández-Basanta et al., 2021; Shen et al., 2022; Power et al., 2022; Yenal et al., 2023; Mills et al., 2023; Mohammed et al., 2024). Please see further information in Table 2.

3.3. Methodological quality

All studies demonstrated a high level of methodological consistency, encompassing alignment across data sources, collection procedures, analytical methods, and interpretative frameworks, while offering detailed and specific descriptions of the data collection process and the interpretation of findings. The results of the quality appraisal are detailed in Supplementary Material.

3.4. Experiences of nurses and midwives supporting parents following perinatal bereavement

Based on a Thomas and Harden (2008) thematic synthesis framework, the findings of this review were grouped under three main themes: (1) a caring role in supporting bereaved parents, (2) the impact of bereavement care on nurses and midwives, and (3) facilitators and barriers to providing support. Each main theme included several subthemes.

Table 2
Characteristics of included papers (data extraction table).

Author (s) (year)& country	Aim	1.Research approach 2.Design	1. Sample approach 2.Size 3.Eligibility 4.Setting	Data collection methods	Data analysis	Key findings
Almeida et al. (2016) Brazil	'To understand the experiences of nurses when caring for dying newborns and their families in the NICU' (p.2)	1.Qualitative 2.Descriptive exploratory study	1. Non-probability purposive 2.$N = 9$ 3. Nurses with more than 3 years of completion of their undergraduate degree (55.6%) and working in the NICU (66.7%), 4. In the ICU of a private hospital in Brazil	Semi-structured interviews	Collective subject discourse method	1)Nurses feel sadness and experience a difficult time. 2) Nurses express their suffering through crying or praying for the families. 3) Lack of knowledge in caring for parents suffering from perinatal loss. 4) Nurses feel empathy for parents.
Martínez-Serrano et al. (2018) Spain	'To explore the experiences of midwives regarding the attention given during labor in late foetal death.' (p.128)	1. Qualitative 2. Hermeneutic-interpretative phenomenological approach	1. Non-probability purposive 2.$N = 18$ 3. Having experience in attending cases of late foetal death. 4. 10 public hospitals and 1 primary health centre (Spain)	Focus groups	Hermeneutic phenomenological analysis	1) Describing the experience as distressing. 2) "Reporting low social awareness related to the possibility of antepartum death". (p.128). 3) Midwives recognize difficulties in coping with a process that ends in death. 4) Organizations are not prepared for these events (not suitable rooms)
Willis (2019) United States of America	'Describe the experience of caring for women with a perinatal loss from the perspective of the nurse and to determine the extent to which the response to perinatal loss reflects a process' (p.2)	1. Qualitative 2.Descriptive study	1. Non-probability purposive 2.$N = 9$ 3.All nurses who had experience caring for a woman who had a perinatal loss 4.Two acute hospitals in Northeastern United States	In-depth interview	Content analysis by using Rubin and Rubin (2005)	1) Struggling with emotions, such as anxiety, sadness, grief, and fear. 2) Nurses need to be present for patients and provide them with support and care. 3) Expressing conflict between personal beliefs and professional value and organizational value. 4) Nurses described frustration with the lack of managerial support. 5) Lack of formal education in caring for women with a perinatal loss made them anxious and fearful. 6) All nurses expressed their need for a debriefing, to gather together to share thoughts and feelings of providing bereavement care.

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Table 2 (*continued*)

Author (s) (year)& country	Aim	1.Research approach 2.Design	1. Sample approach 2.Size 3.Eligibility 4.Setting	Data collection methods	Data analysis	Key findings
Obst and Due (2019) Australia	'To explore service providers' experiences of supporting men following pregnancy loss, with a view to consider current and potential future practices when working with men whose female partners have experienced pregnancy loss.' (p.2)	1. Qualitative 2. Descriptive study design	1. Non-probability purposive 2.$N = 7$ (1 nurse, 1 midwife, 2 social workers, 1 parent supporter,1 grief counsellor) 3.Had an average of 12 years of experience working in grief and loss (range 2–20 years). 4.Australian pregnancy loss support organizations and a large maternity hospital	Semi-structured interviews	Thematic analysis	1) Individualized understanding of men's grief is essential for effective support provision. 2) Strong relationships between hospital staff and support organizations were also identified as vital for supporting men. 3) Nurses developed a special bond with parents. 4) Woman-centric care environment leads to men's isolation and perceived lack of support. 5) Men may prioritize their partners' needs over their own, further restricting nurses' access to support.
Fernández-Alcántara et al., (2020) Spain	'To identify and examine the subjective experiences and practices of experienced professionals attending to perinatal loss in the hospital context in Spain' (p.2)	1.Qualitative 2.Descriptive study design	1. Non-probability purposive 2.$N = 12$ (4 nurses, 4 midwives, 4 nurses assistants) 3. Participate at different phases in the process of perinatal loss 4. Three public hospitals in the province of Granada (Spain)	Individual semi-structured interview	Thematic analysis	1) Participants identified emotions, such as sadness, pain, dissatisfaction, or a need to share such moments with another team member. 2) Nurses, assistants, and midwives reported a lack of space and facilities in hospitals to accompany parents emotionally. 3) Lack of guidelines on care for parents after a perinatal loss; lack of continuing learning and training for perinatal loss. 4) Lack of emotional skills to cope with perinatal loss.
Fernández-Basanta et al. (2021) Spain	'To illuminate the experiences of primary healthcare midwives who care for parents who have suffered an involuntary pregnancy loss' (p.2)	1.Qualitative 2.Phenomenological hermeneutic approach	1. Non-probability purposive 2.$N = 11$ 3. Being a primary healthcare midwife and having experience in providing care to parents who have suffered from perinatal loss 4.In primary healthcare centres in Spain	Narrative interviews	Thematic analysis	1) Lack of training and knowledge on the experience of bereavement care; lack of guidelines for perinatal loss. 2) Being involved in bereavement care was a challenge for midwives. 3) Lack of support from organization; limited time for consultations for

(*continued on next page*)

Table 2 (*continued*)

Author (s) (year)& country	Aim	1.Research approach 2.Design	1. Sample approach 2.Size 3.Eligibility 4.Setting	Data collection methods	Data analysis	Key findings
						patients. 4) Providing bereavement care is a professional responsibility inherent to nursing practice. 5) Personal losses motivate midwives to get more involved in caring.
Verdon and deMontigny (2021) Canada	'To describe the experience of nurses who support parents during perinatal death' (p.2)	1.Qualitative 2.Desccriptive study design	1. Non-probability convenience 2.$N = 25$ 3. Registered nurses who worked with parents who experienced perinatal death 4. Hospital-based maternity units, emergency departments, birth centres, and community-based follow-up care in Canada	Semi-structure interviews	Interpretive description	1) Nurses experience negative self-awareness. 2) Struggling with emotions, such as sadness, helplessness.
Mills et al., (2022) United Kingdom	'To explore the lived experiences of midwives, doctors and others, caring for women after stillbirth in Kenya and Uganda' (p.2)	1.Qualitative, 2. Heideggerian phenomenology study design	1.Non-probability purposive 2.$N = 59$ (12 midwives, 37 nurse-midwives, 10 doctors) 3.Nurses/midwives who regularly providing care for women and families after the death of a baby 4. Five urban, peri-urban, and semi-rural maternity facilities in Kenya and Uganda	One-to-one interviews	Thematic analysis	1) It's a bad and sad experience, working with these parents is quite challenging. 2) Nurses were highly empathetic to women's and families' grief. 3) They lacked the right words to comfort women. 4) They feel guilt, blame and fear. 5) Resource shortages added to stress around communication for health workers during labor. 6) Lack of support from organization. 7) Nurses and midwives don't have enough time to take care of bereaved mother. 8) Health workers also encountered pressure from families to withhold information about the baby.
Shen et al. (2022) China	'To explore the experiences of undergraduate midwifery students facing perinatal death during their internships' (p.2)	1.Qualitative 2.Interpretive phenomenological approach	1. Non-probability Purposive 2.$N = 12$ 3.Full-time midwifery undergraduate students interning in delivery wards	Semi-structured in-depth interviews	Thematic analysis	1) Midwifery students feel sadness and anxious when faced with death. 2) Midwifery students avoid in-depth discussion with patients.

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Table 2 (*continued*)

Author (s) (year)& country	Aim	1.Research approach 2.Design	1. Sample approach 2.Size 3.Eligibility 4.Setting	Data collection methods	Data analysis	Key findings
			4. Medical university in Guangzhou, China			3) Lack of perinatal bereavement care training. 4) Students face ethical conflict. 5) Perinatal loss had a strong negative impact on their psychological state.
Power et al. (2022) Ireland	'To explore the experiences and perceptions of midwives providing perinatal bereavement care during the COVID-19 pandemic and to identify the barriers and facilitators to providing compassionate bereavement care.' (p.2)	1. Qualitative 2. Descriptive study design	1. Non-probability purposive 2.*N* = 11 (11 midwives) 3.Had experience of caring for bereaved parents during the COVID-19 pandemic 4. A stand-alone Regional Maternity Hospital	Semi-structured interviews	Thematic analysis	1) Midwives struggled to provide adequate emotional support to unsupported bereaved women in busy clinical settings. 2) Midwives experience fear of cross infection during pandemic. 3) A sense of cognitive dissonance between their pre-pandemic bereavement care practices and the care permitted under COVID-19 restrictions. 4) Colleague support and mindfulness were found to be helpful and most effective for midwives. 5) Personal protective equipment, visitor restrictions, lack of touch were significant barriers for midwives to providing compassionate care. 6) Lack of resource, like rooms, space for perinatal loss.
Yenal et al. (2023) Turkey	'To determine the experiences of Turkish midwives and nurses when caring for families with perinatal loss' (p.3)	1.Qualitative 2.Descriptive study design	1. Non-probability purposive 2.*N* = 15 (10 midwives, 5 nurses) 3.Nurses/midwives who worked for at least 2 years in the perinatology clinics or labour and delivery, and had experience of caring for women who had experienced perinatal loss 4.Perinatology clinics of the government hospital in Turkey	Semi-structured interview	Thematic analysis	1) Feeling of helplessness in the face of loss. 2) Lack of guidelines and lack of knowledge for perinatal loss. 3) Emotional effect: the loss was painful and distressing for nurses and midwives. 4) Being a mother and having experienced perinatal loss increased their feelings. 5) Nurses would provide care to patients with different religions in accordance with their beliefs. 6) Sharing with colleagues, prayer are

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Table 2 (*continued*)

Author (s) (year)& country	Aim	1.Research approach 2.Design	1. Sample approach 2.Size 3.Eligibility 4.Setting	Data collection methods	Data analysis	Key findings
						the ways they tried to cope with their emotion.
Farrugia et al. Malta	'To delve into the midwives' challenges when caring for parents having a stillbirth, explore the midwives' practices and identify their interpersonal skills when caring for these couples' (p.2)	1.Qualitative 2. Descriptive study design	1. Non-probability purposive 2.$N = 8$ 3. Midwives had to have a minimum of 2 years of work experience in the central delivery suite 4. Malta's main public hospital	Semi-structured, face to-face interview	Thematic analysis	1) The experience of providing bereavement care as a negative one. 2) The midwives expressed feeling scared, lost, and anxious. 3) Facing the parents' emotional reactions and answering all their questions, while dealing with their emotional conflicts, were described as internal struggles. 4) The midwives indicated the need to discuss their thoughts with other teammates, crying in the shower to let their emotions out, or seeking professional support services. 5) Lack of resource, like rooms, space for perinatal loss. 6) Staff shortage and a lot of paper work, documentation was seen as time consuming. 7) Lack of knowledge and guidelines. 8) Midwife showing empathy and compassionate towards the couple's experience.
De Los Ángeles Linares-Gallego et al. Spain	'To explore the perceptions and experiences of midwives caring for couples who experience a stillbirth' (p.2)	1.Qualitative study 2.Gadamer's hermeneutic phenomenology	1. Non-probability purposive 2.$N = 18$ 3. Midwives who had attended to at least one stillbirth and had a minimum of 3 years of professional experience. 4.Maternal and Child Hospital in Jaén (Spain)	Personal semi-structured interviews	Phenomenological analysis	1) Midwives perceived the loss as complex and difficult to manage emotionally. 2) Midwives use the available resources to provide the best possible assistance to the families. 3) Lack of professional support provided by the hospital. 4) For the midwives, providing bereavement care are considered as "very tough" experiences.
Mohammed et al. (2024) Ghana	'To explore the experiences of nurses and midwives who support	1.Qualitative 2.Descriptive phenomenological approach	1. Non-probability purposive 2.$N = 12$ (6 midwives, 6 nurses)	Semi-structured interview	Thematic analysis	1) Nurses feel sadness, guilt, demoralization, stress and blame. 2) Nurses empathized

(*continued on next page*)

Table 2 (*continued*)

Author (s) (year)& country	Aim	1.Research approach 2.Design	1. Sample approach 2.Size 3.Eligibility 4.Setting	Data collection methods	Data analysis	Key findings
	bereaved parents during perinatal deaths in Ghana' (p.3)		3. Nurse or midwife who had experienced at least one perinatal death 4. A district hospital in the Upper East Region of Ghana			with bereaved parents and using their own experiences to provide support and counseling. 3) Nurses reported lack of experience and knowledge for providing bereavement care. 4) Perinatal bereavement had a long-lasting impact on healthcare providers, such as psychological distress. 5) Nurses point out that the emotional toll can affect their mood, work output, and overall well-being.
Xie et al. (2025b) Ireland	'To explore midwives' experiences of providing psychosocial interventions to parents following perinatal bereavement in maternity care settings.' (p.2)	1. Qualitative 2. Descriptive study design	1. Non-probability purposive and snowball sampling 2.$N = 22$ (22 midwives) 3. Had experience of caring for bereaved parents 4. Three publicly funded hospital in Ireland	Semi-structured interviews	Reflexive thematic analysis	1) Midwives used creative strategies—such as playing background music—to soften the sensory environment. 2) Emotional and practical barriers: including fear of saying the wrong thing, parental anger, and language differences. 3)Time pressures, staff shortages, limited resources, lack of clear guidelines were act as challenges. 4) Midwives highlighted the need for flexible, practice-informed tools to help them meet parents' needs, reduce emotional risk, and ensure equitable care.

Note: ICU= Intensive Care Unit; NICU= Neonatal Intensive Care UnitThe included studies reported a combination of 248 participants in total, consisting of nurses ($n = 63$), midwives ($n = 170$), and other healthcare providers ($n = 15$) who provided care for parents experienced perinatal loss. These participants had at least 1 year of experience in bereavement care, with the longest reported work experience being 48 years. A small number of studies included mixed professional samples. One study included doctors alongside nurses, and nurses' experiences could not be separately identified (Mills et al., 2023). Another study comprised a multidisciplinary group of one nurse, one midwife, two social workers, one parent supporter, and one grief counsellor, with participants having an average of 12 years of experience in grief and loss care (range 1–20 years) (Obst and Due, 2019); although the findings from these studies were not exclusive to nurses or midwives, they were retained because they provided relevant insights into the context of perinatal bereavement care.

3.4.1. Theme 1: A caring role in supporting bereaved parents

3.4.1.1. Compassionate care. Five papers (Almeida et al., 2016; Fernández-Basanta et al., 2021; Mohammed et al., 2024) emphasized the compassionate approaches adopted by professionals, including active listening, gentle physical contact, and empathetic verbal support. Nurses and midwives often held patients' hands, made eye contact, tried to speak slowly, and answered question in a language that they understood (Yenal et al., 2023). However, a significant challenge highlighted was communication; nurses and midwives felt

pressure from families when delivering bad news, answering emotionally charged questions, and offering continuous information to parents and families (Mills et al., 2023; Xie et al., 2025b).

3.4.1.2. Professional commitment. Five papers (Willis, 2019; Fernández-Basanta et al., 2021; Shen et al., 2022; Yenal et al., 2023) indicated that, although the provision of care was a challenge for nurses and midwives and entailed personal costs to get involved in the care, bereavement care was still perceived as a fundamental part of their professional responsibility. Many emphasised the need to be emotionally present, respectful, and communicative, even when no words could offer comfort(Mills et al., 2023). The importance of communicating with the mother and family, respecting their silence, showing availability to provide the information they require and encouraging the expression of emotions in these moments was highlighted (Willis, 2019).

3.4.1.3. Building bonds with parents. Some studies (Obst and Due, 2019; Fernández-Basanta et al., 2021; Yenal et al., 2023) found that strong interpersonal bonds developed with parents, especially in primary care settings, facilitated more empathetic and patient-centred care. These bonds often encouraged nurses or midwives to go beyond routine tasks and engage with families on a deeper emotional level (Fernández-Basanta et al., 2021). In particular, professionals who had experienced perinatal loss themselves were motivated to get more involved in caring (Fernández-Basanta et al., 2021; Yenal et al., 2023). Notably, Obst and Due (2019) pointed out that the woman-centric care environment can inadvertently isolate men, leaving them feeling unsupported. These researchers emphasized the need for healthcare staff to actively engage with fathers throughout the bereavement process.

3.4.1.4. Tensions in the caring role. Several studies (Fernández-Basanta et al., 2021; Shen et al., 2022; Mills et al., 2023) described feelings of fear and self-blame among nurses and midwives, as bereavement care was often perceived as conflicting with the traditional life-affirming focus of midwifery practice (Fernández-Basanta et al., 2021). Some professionals questioned whether different clinical decisions could have prevented death, leading to rumination and emotional distress, with some practitioners describing feelings of demoralisation and even consideration of leaving the profession (Mills et al., 2023). For undergraduate students and less experienced practitioners, witnessing stillbirth or neonatal death without adequate emotional preparation was not only shocking but also led to self-blame for not knowing what to do or what to say, leaving lasting feelings of inadequacy (Shen et al., 2022).

The tension was further intensified during the COVID-19 pandemic. Midwives not only shared in parents' grief but also faced the fear of transmitting the virus to themselves or their families. Infection-control restrictions limited physical contact and altered usual care practices, creating tension between their desire to provide emotional support and pandemic constraints, resulting in feelings of helplessness and frustration (Power et al., 2022).

There was also fear of legal repercussions, especially in cases of advanced foetal demise (Fernández-Basanta et al., 2021). This legal and emotional fear often hampered open, empathetic communication with families. Mills et al. (2023) reported that in low-resource settings, like Kenya and Uganda, midwives and doctors sometimes faced aggressive or violent reactions from bereaved families, leading to trauma and fear for personal safety.

3.4.1.5. A sense of accomplishment. Despite the emotional burden, some professionals found meaning and fulfilment in bereavement care (Almeida et al., 2016). Nurses encouraged parents to engage in meaningful interactions, such as cuddling or changing the baby, with great respect. Moments when parents later returned to express their gratitude reinforced the sense that their care had lasting value.

3.4.2. Theme 2: the impact of bereavement care on nurses and midwives

3.4.2.1. Grief and sympathy. All the researchers reported that nurses and midwives experienced intense emotional reactions — grief, sadness, helplessness, anxiety, and psychological pain— when supporting parents through perinatal loss. The death of a newborn was consistently described as more difficult to accept than the loss of an adult or elderly patient. Some participants reported crying alongside parents or staying beyond their shift to provide emotional support (Willis, 2019; Fernández-Basanta et al., 2021).

3.4.2.2. Physical and psychological consequences. Five studies (Almeida et al., 2016; Power et al., 2022; Shen et al., 2022; Mohammed et al., 2024) described the prolonged impact of perinatal loss on nurses and midwives, including emotional exhaustion, insomnia, and diminished work performance. Providers often found it difficult to detach from the emotional weight of the care they had given; some of them described continuing to think for hours and days about the woman they cared for and worried about her (Almeida et al., 2016). Mohammed et al. (2024) highlighted a case in which a nurse, after caring for a woman overnight whose baby later died, experienced depression and physical symptoms, such as dehydration, ultimately recovering with her husband's support.

3.4.2.3. Struggles in managing emotions. Managing emotions proved to be particularly challenging. Five studies (Almeida et al., 2016; Willis, 2019; Fernández-Basanta et al., 2021; De Los Ángeles Linares-Gallego et al., 2025) reported that staff experienced internal conflict when forming close emotional bonds with grieving mothers. The inability to alleviate parental pain often created a sense of failure. Some professionals found it difficult to separate these experiences from their personal lives and sought assistance from colleagues to help with tasks such as presenting the deceased infant to the parents; others described emotionally withdrawing or avoiding deep conversations to protect their own mental well-being (Almeida et al., 2016).

3.4.3. Theme 3: facilitators and barriers to providing bereavement support

3.4.3.1. Facilitators to effective bereavement care. To cope with the psychological challenges, participants adopted various emotional regulation strategies. Across seven studies (Almeida et al., 2016; Willis, 2019; Fernández-Sola et al., 2020; Power et al., 2022; Yenal et al., 2023), nurses and midwives expressed the importance of detaching from traumatic events. Common strategies included prayer (Almeida et al., 2016; Yenal et al., 2023), crying (Almeida et al., 2016), confiding in colleagues (Willis, 2019; Fernández-Sola et al., 2020; Power et al., 2022; Yenal et al., 2023), psychological therapy (Fernández-Basanta et al., 2021), mindfulness (Power et al., 2022), playing background music (Xie et al., 2025b) and reflective discussions (Shen et al., 2022). For some participants, praying was a way for them to deal with emotional burdens; they prayed for the woman who experienced loss, for themselves, and for other people not experiencing the same thing (Yenal et al., 2023).

Spending time with family was also considered an effective way to manage grief (Willis, 2019). Some nurses returned home and engaged in activities, such as watching movies or boating with their families, which helped them cope with the emotional impact of the loss. These activities helped staff regain emotional balance and continue their work (Willis, 2019).

3.4.3.2. Barriers to effective bereavement care

3.4.3.2.1. Lack of knowledge and guidelines. Nearly all reviewed studies (Almeida et al., 2016; Martínez-Serrano et al., 2018; Willis, 2019; Fernández-Sola et al., 2020; Fernández-Basanta et al., 2021; Shen et al., 2022; Mills et al., 2023; Yenal et al., 2023; Mohammed et al., 2024) noted a significant lack of training and institutional guidance on perinatal bereavement care; many participants reported feeling ill-equipped to provide emotional support. According to Farrugia et al, junior staff requested hands-on simulation training from experienced colleagues, whereas senior staff believed that practical exposure and reflective experience were more beneficial than formal instruction alone. They argued that formal training would not improve their ability to provide bereavement care.

3.4.3.2.2. Organizational constraints. Seven studies (Fernández-Sola et al., 2020; Fernández-Basanta et al., 2021; Power et al., 2022; Mills et al., 2023) highlighted a lack of institutional support. Bereavement rooms were often physically isolated and inadequately equipped (Martínez-Serrano et al., 2018; Power et al., 2022). Staff shortages meant midwives sometimes had to attend both routine deliveries and bereavement care simultaneously. These limitations left little time or space for providing holistic, compassionate support.

Pandemic-related restrictions also created additional barriers to bereavement care, as personal protective equipment and physical distancing measures constrained non-verbal communication, including facial expressions and eye contact, which were mentioned as being important for conveying empathy to bereaved parents (Power et al., 2022).

3.4.3.2.3. Ethical dilemmas. Ethical tensions were observed among student midwives and when supporting fathers.

Student midwives experienced moral distress when confronted with gaps between their training and reality of stillbirth management where medical resources were limited. Participants witnessed practices they perceived as disrespectful to deceased infants, including disposal in garbage bags without ritual care and the placement of bereaved mothers alongside parturients with live births, experiences that triggered ethical conflict and critical reflection on professional standards (Shen et al., 2022). Supporting fathers presented a systemic ethical dilemma. Participants recognized that grief was individually variable and not dictated by gender, yet societal expectations consistently positioned men as practical supporters rather than grieving parents. Fathers often faced gendered pressures to care for partners, manage practical tasks, and return to work quickly due to lack of bereavement leave, which led to their grief been overlooked. Staff expressed uncertainty about supporting fathers equitably, highlighting emotional and moral challenges in providing balanced care (Obst and Due, 2021).

4. Discussion

We synthesized the multifaceted experiences of nurses and midwives involved in supporting parents following perinatal loss. We have highlighted the complex and emotionally demanding nature of bereavement care in maternity settings. While professionals demonstrated deep compassion and strong professional commitment, they also faced significant emotional, ethical, and organisational challenges. We suggest that perinatal bereavement care is not only a clinical responsibility but also an emotionally intensive form of work shaped by professional values, workplace structures, and broader cultural expectations. Although the phenomenon of interest has been explored both in qualitative and quantitative literature, most research has been conducted in western countries, which highlights the need for greater cultural diversity in future research.

Bereavement care in maternity settings is inherently relational. Nurses and midwives were found to provide compassionate, person-centred care. These practices echo the conclusions of Jansens et al. (2024), who emphasized the importance of sensitive communication and presence in perinatal bereavement care. Small gestures, including remaining present, acknowledging grief, and facilitating meaningful interactions with the baby, may therefore have long-lasting psychological significance for families. Beyond these relational practices, professional commitment also emerged as a key aspect of the caring role. Despite the emotional burden associated with perinatal bereavement care, many participants perceived it as a moral and professional responsibility. This reflects the ethical foundations of nursing and midwifery practice, which emphasise compassion, presence, and holistic care during critical life events (Manookian et al., 2025). Notably, some professionals reported that previous personal experiences of perinatal loss enhanced their empathy and motivation to support families, a finding consistent with Totland et al. (2024), who reported that professionals with lived experience of grief were better able to connect with bereaved families.

In addition, another important finding relates to the gendered nature of bereavement care. We found that maternity services often

prioritise maternal needs while inadvertently overlooking fathers. However, researchers have demonstrated that fathers experience profound grief following perinatal loss, even though their grief may be expressed differently (Obst and Due, 2019). We, therefore, highlight the importance of adopting a more inclusive family-centred approach that acknowledges the emotional needs of both parents.

The caring role was also characterised by internal tensions. Perinatal loss challenges the life-affirming ethos traditionally associated with maternity care. Encountering death within this context may trigger feelings of failure, self-blame, or professional inadequacy. Such experiences reflect contemporary understandings of moral distress, a phenomenon increasingly documented in healthcare when professionals are constrained from acting in ways they perceive to be ethically or professionally appropriate (Ding et al., 2025; Rost et al., 2025). Importantly, the extent and expression of this distress may also be shaped by cultural and organisational contexts. In settings where perinatal loss remains socially stigmatized or where institutional guidelines for bereavement care are limited, healthcare professionals may experience heightened uncertainty and emotional burden. These contextual variations highlight the need to interpret experiences of bereavement care within broader cultural and systemic frameworks.

Providing perinatal bereavement care also had negative impact on the psychological well-being of nurses and midwives as they felt grief, depression, and anxiety. Similar findings were reported in previous studies where nurses and midwives worked in oncology units (Kayalar and Hiçdurmaz, 2025) or palliative care centres (Alruwaili et al., 2024; Cuchet et al., 2025), where exposure to death negatively affected nurses' and midwives' psychological well-being. It is imperative to identify those who struggle with this process, as grief may lead to psychological and physical symptoms to nurses and midwives (Qian et al., 2024). Furthermore, many nurses and midwives reported insomnia, anxiety, and lingering emotional distress, consistent with the concept of compassion fatigue (Swanson et al., 2020). Perinatal loss caused suffering for nurses and midwives; at the same time, some nurses described a sense of professional accomplishment in being present for grieving families. This paradox, feeling both drained and fulfilled, reflects the complexity of bereavement work. Previous researchers have shown that meaningful relationships with patients can lead to emotional rewards, even in painful contexts (Beck and Gable, 2012).

Fear and self-blame emerged as strong sub-themes that complicate the caregiver-parent relationship. Midwives expressed anxiety over potential legal consequences or being blamed for adverse outcomes. Such fears can hinder open communication and emotional expression, essential components of compassionate care (Mills et al., 2023). These concerns are echoed by Heng and Gringart (2025), who noted that litigation anxiety may lead to emotional distancing, ultimately affecting the quality of bereavement support.

In response to these psychological challenges, nurses and midwives employed a variety of coping strategies, including talking and sharing with colleagues, psychological therapy, crying or praying for the families, and seeking professional support services. Similar strategies were used in a previous study to discuss coping strategies for nurses who experienced aggression at work (González-González et al., 2025). Additionally, Piras et al.(2024) confirmed that positive coping strategies, like mindfulness, physical activity, and journaling, significantly reduced vicarious trauma and improved mental health among nurses. Religious or spiritual practices have also been recognised as important coping mechanisms in some cultural contexts (Joseph et al., 2026).

Equally significant were the organizational and structural barriers identified; many participants reported relying on personal experiences. However, personal coping strategies cannot fully compensate for structural limitations within healthcare systems (Mohammed et al., 2024). Lack of training and clinical guidance emerged as a major barrier to effective bereavement care. Many professionals reported feeling unprepared to support grieving parents, particularly in relation to communication and emotional support. This finding is consistent with previous researchers suggesting that bereavement care receives limited attention within nursing and midwifery education (Qian et al., 2022; López-Ibernón et al., 2025). In addition, a global consensus on bereavement care emphasized that the provision of comprehensive and ongoing education and support for healthcare professionals was essential to ensuring high-quality bereavement care (Shakes et al., 2020). Thus, structured training programmes, including simulation-based learning and reflective practice, may, therefore, play a critical role in improving professionals' confidence and competence.

Organisational constraints, such as staff shortages, limited time, and inadequate facilities, further complicated the provision of compassionate care. In some cases, midwives were required to care simultaneously for bereaved families and women experiencing healthy births. Such situations may create moral and emotional tensions, as professionals struggle to balance competing responsibilities. Dedicated bereavement rooms and protected time for supporting families may therefore be essential components of high-quality care.

We have highlighted as well how broader contextual factors, including public health crises and resource limitations, influence bereavement care practices. During the COVID-19 pandemic, infection control measures restricted physical contact and non-verbal communication, elements that are often central to compassionate care. These restrictions intensified professionals' feelings of helplessness and frustration, as they were unable to provide the level of emotional support that they considered appropriate.

Ethical dilemmas were particularly evident in resource-limited settings, where participants described witnessing practices that conflicted with their professional values regarding respectful care for deceased infants. Such situations may intensify moral distress and highlight the need for institutional policies that support dignified bereavement care regardless of resource constraints.

4.1. Implications for practice and research

We have identified possible implications for clinical practice and future research. Clinically, there may be an urgent need for healthcare organisations to implement structured bereavement care training that integrates communication skills, emotional support strategies, and culturally sensitive practices. Evidence-based approaches, including simulation-based learning, structured reflective practice, and peer-support networks have been shown to enhance both professional competence and psychological resilience (Almomani et al., 2025; Sicora, 2025). At the organisational level, institutional mechanisms could ensure regular access to

psychological support, such as debriefing sessions, counselling, and mindfulness interventions, to prevent compassion fatigue and safeguard long-term professional well-being of nurses and midwives.

4.2. Strengths and limitations

This review has several strengths. A comprehensive search strategy was conducted across multiple databases, and studies from diverse geographical contexts were included, allowing a broad understanding of nurses' and midwives' experiences of providing bereavement care following perinatal loss. In addition, the use of thematic synthesis enabled the integration of findings from studies with different methodological approaches, facilitating a deeper interpretation of shared experiences across settings.

Several limitations should be acknowledged. All the studies included were qualitative, with findings shaped by special healthcare contexts and settings. There was a lack of studies exploring the long-term mental health outcomes for nurses and midwives. Another limitation was the language restriction, as only studies published in English were included. This may have resulted in the exclusion of relevant literature published in other languages. Future researchers could include both longitudinal and qualitative studies focusing on healthcare professionals' mental health and seek formal interventions designed to promote emotional resilience among healthcare providers involved in bereavement care.

5. Conclusion

We have provided a comprehensive synthesis of the experiences of nurses and midwives involved in supporting parents following perinatal loss. In this systematic review, we outlined the experiences and impact on nurses and midwives in bereavement care and highlighted the facilitators and challenges to effective care. Like other disciplines, including oncology and palliative care, nurses and midwives from maternity units experienced grief and helplessness that had a physical and psychological impact on them. A variety of coping strategies were used to manage the emotional and psychological impact. Both bereavement care training and organisational support were seen as essential for nurses and midwives. Lastly, institutional support and managerial support are important as well.

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During the preparation of this work, the authors used DeepL in order to improve language and readability. After using this tool, the authors reviewed and edited the content as needed and take full responsibility for the content of the publication.

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CRediT authorship contribution statement

Hong Gao: Writing – review & editing, Writing – original draft. **Chinyere Justina Iwunze:** Data curation. **Xuemei An:** Methodology. **Ting Zhou:** Validation. **Margaret Curtin:** Supervision.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Supplementary materials

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Data availability

All data generated or analyzed during this study are included in this manuscript and its supplementary information files.

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