Miscarriage UK

Because every
loss matters

Miscarriage in the UK:

Still a ‘dismissive’ and ‘dehumanising’ experience

A State of the Nation report into women’s interactions across healthcare, employment and wider society.
Research findings published March 2026.

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Executive Summary

One in four pregnancies in the UK ends in loss. Yet many women and their partners continue to encounter gaps in care, understanding and recognition at a time of profound vulnerability.

To better understand what is working well, where care and support falls short, and how experiences vary across different settings, Miscarriage UK undertook a national survey exploring the experience of miscarriage across healthcare settings, workplaces and personal relationships.

This report presents findings from that research, capturing the experiences of over 1,000 individuals affected by pre-24-week pregnancy loss in the UK. Respondents included those who physically experienced miscarriage, as well as their partners. The scale of the response enabled a detailed and nuanced understanding of how miscarriage is currently experienced across all areas of life.

Participants shared experiences of pregnancy loss that occurred between January 2022 and June 2025, providing a timely picture of recent care and support, reflecting current systems, policies and social attitudes towards miscarriage.

While we acknowledge the limitations of this research, as participants were self-selecting and may disproportionately represent individuals with particularly strong experiences, the findings are concerning in their scope and seriousness.

They reveal systemic inconsistencies across healthcare, employment and social contexts. Some respondents described examples of compassionate, responsive and high-quality care, showing that good, even excellent, practice exists. However, many received care and support that did not meet their needs, highlighting significant and worrying gaps in provision, understanding and communication. Experiences often varied depending on setting or circumstance, leading to unequal access to appropriate support. For many, insufficient care or support compounded the emotional impact of miscarriage and contributed to feelings of isolation, distress and uncertainty.

This research builds on previous guidelines and recommendations, such as the 2023 Independent Pregnancy Loss Review and the Scottish Government's miscarriage care framework, by examining recent experiences of pregnancy loss across all aspects of life.

It provides an enhanced evidence base and key recommendations to further inform improvements across healthcare services, workplace policy and wider societal responses to ensure no one faces pregnancy loss without the care and compassion they deserve.

Miscarriage UK is the UK's leading charity dedicated to supporting people affected by miscarriage, ectopic pregnancy and molar pregnancy.

We provide confidential support services, evidence-based information and specialist training for healthcare professionals, alongside campaigning to improve care, policy and public understanding of pregnancy loss. We led the Leave for Every Loss campaign, which secured bereavement leave for pregnancy loss within the UK's Employment Rights Act, a landmark step in recognising the impact of miscarriage in the workplace.

Key research findings

- **The healthcare women received was inconsistent,** with examples of inadequate, and even distressing, support.

- Many recounted being sent home with **little or no guidance,** and some with **conflicting advice or even misdiagnosis.**

- **Aftercare and follow-up support were often insufficient for both the physical and emotional effects of miscarriage - with 65% stating they did not receive adequate follow-up care.**

- Many women experienced **unnecessary emergency surgery** for missed ectopic pregnancies and **loss of fertility was apparent**.

- Access to appropriate services such as Early Pregnancy Units (EPUs), scans, investigations and testing **was inconsistent and often dependent on location or clinical discretion.**

- Some women were **discouraged from certain treatment options,** or **not given the time or information needed** to make informed choices about their care.

- The physical realities of miscarriage were **often underestimated or poorly explained,** while the emotional and mental health consequences **were not adequately addressed.**

- More than two thirds of women said they experienced **mental health problems - including grief, depression, PTSD, and suicidal thoughts - post miscarriage,** yet seldom received the support they needed.

- A recurring theme was a **lack of dignity.** Some women were left without access to basic care, such as sanitary pads.

- Experiences were often **shaped by the way information was delivered:** the tone, timing, language, and validation of women's experiences mattered deeply.

- **Miscommunication, false reassurance and the questioning** of pregnancies and/or miscarriages were experienced by several women.

- Partners were routinely **overlooked for emotional support.**

- In **workplaces**, people reported that awareness and formal policies around baby loss remain **limited,** and employees' rights around pregnancy are **poorly understood. Fear of stigma or career impact** still prevents people from openly discussing miscarriage.

> Taken together, these findings highlight an urgent need for clearer information, follow-up support, more compassionate and consistent care and greater recognition of both the physical and emotional impact of miscarriage.

Recommendations for change

- **Introduce routine follow-up care after every miscarriage.** EPUs should offer a follow-up contact around three weeks after a pregnancy loss. This should cover physical recovery, complications such as infections or anaemia, psychological wellbeing and signposting/referrals for further support, where necessary.

- **Improve access to timely care.** Access to EPUs should be enhanced with direct referral available to all. Opening hours should be extended to include weekend opening wherever possible, but where clinically indicated, women should be seen and scanned within a maximum of 48 hours. When EPUs are closed, there should be clear pathways for alternative, appropriate care. Where women decide on surgical management of miscarriage, this should be available within a maximum of five days.

- **Expand provision of bereavement care** by training dedicated healthcare professionals (distinct from bereavement midwives whose focus is generally on later losses) to allow everyone who needs it to receive this important support.

- Promote compassionate communication by providing **protected time for healthcare professionals to access specialist training**, such as that offered free by Miscarriage UK. This training focuses on appropriate tone, compassionate language and clear communication that ensures clarity and avoids unnecessary medical jargon.

- **Uphold patients' dignity and privacy.** Hospitals must ensure access to pain relief, sanitary protection and appropriate private and quiet facilities for examination or sensitive discussions, including in emergency departments.

- Everyone across society – from government leaders to individuals – should help continue to **break down the taboos around pregnancy loss** by encouraging conversations and validating this experience, supporting people to feel less isolated and their grief less minimised.

- **The National Maternity and Neonatal Investigation** must ensure it spotlights pre-24-week care and loss in the same way as care and outcomes in later gestations.

- Workplaces must **implement the right to bereavement leave** in line with the forthcoming Employment Rights Act as an absolute minimum. They must also ensure they fully adhere to the protections within the Equality Act 2010. Employers should go further still by offering paid pregnancy loss leave, flexible return-to-work options, and manager training on pregnancy loss, such as that offered by Miscarriage UK. All organisations should be encouraged to take the **Pregnancy Loss Pledge** – a six-point standard which commits to providing the best practice support for their staff.

CEO: Urgent change is needed now

Pregnancy loss often inherently brings profound grief. But, as our research highlights, for too many women and their partners, that pain is compounded by systems that are inconsistent, fragmented and, at times, deeply dismissive. People told us they felt unheard and diminished, caught between gaps in healthcare, uncertainty at work, and a wider silence that leaves miscarriage poorly understood and acknowledged.

This is not about blaming individuals. Many examples of compassionate care exist, and we are working to build on these through our free, specialist training for health professionals working in pregnancy loss care. But when support depends on where you are, who you speak to, or how well systems join up, too many people are left facing additional physical harm and lasting psychological distress at an already vulnerable time.

For those who are pregnant or have had a baby, there is at least a recognised care pathway, albeit not always perfect. But for those who 'almost' had a baby, the system often does not know what to do, leaving people to be told to 'come back when you're pregnant again', and to navigate the aftermath of this loss alone.

Change must be systemic. Clear, consistent aftercare following pregnancy loss should be available to all, not dependent on postcode or persistence. While progress has been made - including baby loss certificates, new employment protections following our Leave for Every Loss campaign, and the development of national bereavement care pathways and care frameworks (in Scotland) - this report shows just how far we still have to go.

Securing this change will be a core focus of our work in the period ahead. Until pregnancy loss is properly acknowledged across healthcare, employment and society, too many people will continue to face miscarriage without the care, support and recognition they need and deserve. That would be unacceptable for even one person to endure. As a society, we must not accept it.

Vicki Robinson
Miscarriage UK Chief Executive

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Introduction

In the UK, pregnancy loss is estimated to affect one in four pregnancies. Despite its prevalence, research shows that miscarriage remains surrounded by silence, stigma and misunderstanding. As a result, many people experience pregnancy loss without adequate care or support, and are often left to navigate it in isolation.

The effects of miscarriage are often significant, with the impact for most extending far beyond the physical event. Miscarriage can profoundly affect emotional wellbeing, mental health, personal relationships, working life and social identity. Yet responses from healthcare providers, employers and wider social networks are often fragmented, and at times inadequate, failing to recognise the full weight and complexity of the experience. For many, this lack of joined-up support compounds the trauma of families' loss and can hinder recovery.

While growing public awareness and advocacy in recent years have begun to challenge the taboo surrounding pregnancy loss, support remains inconsistent and uneven.

This 'state of the nation' research sets out to provide a comprehensive and timely picture of care and support in the UK that examines experiences across healthcare settings, employment and society as a whole.* By bringing these three areas into a single, integrated study, it offers a unique and previously unexplored perspective on how miscarriage is experienced and where systems align, overlap or fall short.

The findings provide a robust and evidence-led foundation for improving miscarriage care and support.They are intended to inform national and local clinical standards, guide policymakers, and shape future service planning across healthcare systems and workplace policy, whilst also informing and wider societal responses, helping to ensure more consistent, equitable and person-centred support for everyone affected.'

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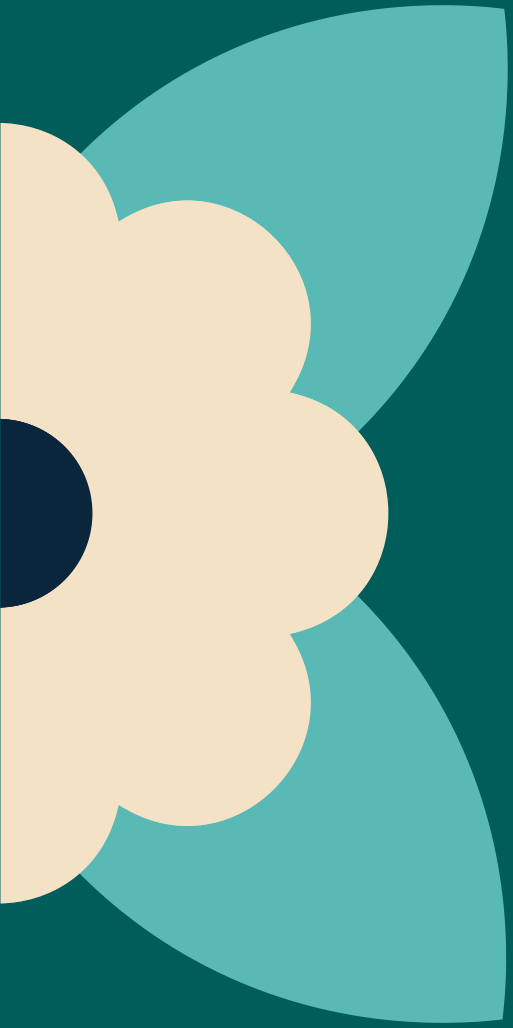
*Demographics can be found in the appendices.



Section 1

Healthcare

Physical & Psychological Effects of Miscarriage

Information from healthcare providers regarding miscarriage, including its symptoms and treatment options, was variable in both quality and clarity.

68% indicated that they did not receive enough information from healthcare professionals.

Respondents most often reported being unaware of what to expect physically during their miscarriage, with a lack of verbal explanation and/or printed resources. Some participants reported receiving only leaflets, without a full explanation of the essential details. Others received only verbal explanations. Leaflets were also criticised by some for containing medical jargon, adopting a cold tone and - in some cases - providing misleading information.

"The leaflets we were given described the medical management process as similar to a 'heavy period'. I believe this to be severely misinforming patients as I found it to be the worst pain I have ever experienced (contraction-like feelings) and significantly more bleeding than my periods which are usually quite heavy anyway."

Verbal interactions with healthcare professionals related to miscarriage information were also criticised by many respondents, notably for a lack of adequate information, minimisation, reliance on jargon and sometimes a dearth of compassion. Several respondents expressed that the information they received downplayed the significance of their experience. Comments often revealed that women were commonly unaware of the intensity of the pain and blood loss related to miscarriage, including the duration of bleeding.

"Not told what to expect physically at all. This led to such a traumatic experience because I was totally unprepared for what I'd see and go through. The bleeding was so much worse than I thought and I developed an infection - but there was zero follow-up unless you pushed. I was diagnosed over the telephone!! Never scanned or checked over. I had to go to A&E when I was grey from blood loss and couldn't even shower from weakness..."

Those who were not given adequate information often spoke of relying on their own research, forums, charities or asking friends for advice:

"I felt the information about what to expect physically was limited. I found a lot of information myself using online forums or talking to others who had experienced miscarriage. This added to the sense of confusion and uncertainty."

Respondents commonly reiterated the need for clear and honest information delivered in a sensitive and considerate way. Clear information appeared particularly crucial for people who are neurodivergent:

"I had to ask multiple times for the GP to clarify and give specifics about what constituted 'heavy/excessive bleeding and blood loss' because it's very unclear what that actually means. And I'm Autistic so I particularly need specifics..."

Some women also spoke of being uninformed regarding pain relief or what to expect during invasive procedures.

Additionally, some described being given information while under anaesthetic, which they deemed wholly inappropriate as they could not recall what guidance was given. Crucially, comments commonly noted the lack of information provided about grief:

"I had so little information about what would happen to me during my miscarriage and given zero information about the grief I would feel afterwards. I'm shocked that there is zero follow-up care or support after a miscarriage. All I was told was to take a pregnancy test after 3 weeks and if it was positive, get in touch."

Positive experiences included honest, accurate and clear explanations regarding the miscarriage process, including transparency of its symptoms:

"They were very clear that the medical management would be painful, I was grateful for that honesty and it allowed me to prepare myself somewhat... They prepared me for the amount of blood loss and when medical intervention should be sought. The guidance was clear and supportive."

Other positive experiences described healthcare professionals who took their time to explain the miscarriage process, each intervention type, offering choice of treatment and allowing time and space for patients to consider their options:

"We were then taken to the Early Pregnancy Unit where the staff explained our options to us, explaining the process of each option and giving us time to think. The staff in the EPU were incredible."

Sometimes intervention choice was removed due to unavailability of surgery within particular hospitals. Others experienced a natural miscarriage while waiting for intervention, and were unprepared for what to expect.

Information on Miscarriage Intervention/Treatment

Many respondents highlighted a lack of information regarding miscarriage management/intervention, including the potential advantages and disadvantages of each option, to help them make an informed choice.

"Very little information received on management - informed of the names of procedures but no information on choices, pros or cons. If I had received this information I would have chosen a completely different option..."

Some respondents also described feeling pressured into making certain choices regarding their miscarriage management due to resources and availability:

"Requested surgical procedure to remove the pregnancy and was told I was too far along (11 weeks) and would need to deliver myself with medical intervention - however it went very wrong and I haemorrhaged and should have been taken to surgery but there was no surgeon."

"...I wanted surgery but got told they only did surgery on Tuesday and Wednesday (this was on 28th) and the soonest they could see me was 6th May. I then opted for tablets..."

Jasmine

Another example involved a woman being denied the ability to make decisions about her own miscarriage care without her husband's consent, illustrating a clear instance of medical misogyny.

"I said at the appointment I wanted surgical management, and I was told I had to go away and talk about it with my husband. My husband said, 'it's her body, if that's what she wants then I will support her' to which the doctor said we still had to leave and call back with our decision."

Misdiagnosis

In addition to a lack of diagnosis for some women, there were also examples of misdiagnosis. Notably, several cases where ectopic pregnancies had been misdiagnosed which commonly resulted in emergency surgery, and the loss of a fallopian tube for some. Such experiences impacted significantly upon mental health, including depression, post-traumatic stress disorder (PTSD) and thoughts of suicide.

This builds on the findings of the MMBRACE-UK Report, which highlighted that between 2021-2022 in the UK and Ireland, 12 women died due to ectopic pregnancy. The current study indicates that misdiagnosis of ectopic pregnancies remains an issue. For nine of these women (75%), improvements in care could potentially have made a difference in the outcome.

"I went to A&E initially after collapsing at home with severe pain on one side of my abdomen. I was 9 weeks pregnant. The doctors did not think ectopic pregnancy was occurring and did not scan me that day. I had morphine for the pain and was diagnosed with round ligament pain and sent home. The next day I collapsed at home again with severe pain and nausea and arrived at A&E unconscious. I was eventually scanned and they found a ruptured ectopic pregnancy with 2.5 litres of blood in my abdomen. I had emergency surgery to remove the blood, the ectopic pregnancy and my right fallopian tube. I was given three blood transfusions."

Emily

"I ended up having a rupture and rushed via ambulance having emergency surgery losing my last remaining tube. I was incredibly depressed after. I was advised by their mental health nurse to have a bath or go for a walk. I could do neither as I was in pain. I almost ended my life from this experience. I... have complex PTSD..."

Charlotte

Some women also spoke of having their pregnancies and miscarriages questioned by healthcare professionals, which led them to feel silenced and mistrusted:

"The Dr argued with me that the test was negative and was I sure I was actually pregnant - showed him the 4 positive pregnancy tests I took photos of when I found out. Told me to go home and rest. No comfort at all. No advice."

Some respondents also noted being given conflicting information which often added to their trauma. For example, some participants were told that their miscarriage was 'complete' when it was not.

Others were told that they did not have symptoms of infection when they did:

"...After repeatedly being told my pain was "normal" (but at no stage was I examined or swabbed for an infection), I ended up having to go private where the consultant said she believed it was an infection and I was put on 2 lots of strong antibiotics. I saw 5 different consultants and 3 different radiographers all with conflicting opinions, I was told by one that I couldn't bleed naturally with retained products, by another that my body would clear them naturally with a bleed, by another that it would calcify and remain in my body but could cause problems, by another that I couldn't conceive with it remaining, and by another that it would be reabsorbed into my body. This is horrifically confusing for someone already going through the worst experience of their life... I probably had an infection for 6 weeks on top of this nightmare."

Some responses indicated a lack of healthcare professional understanding regarding specific types of pregnancy loss which subsequently impacted upon the patient's understanding and confidence in their care:

"999 operator - asked when I was due and what an ectopic pregnancy was. Ambulance service had to Google what ectopic was."

Dignity & Access to Basic Provisions

Some experiences described exemplary compassionate care with respect for dignity:

> *“The team were fantastic. I was worried about natural loss whilst waiting for MVA procedure - the midwife was honest about the levels of blood/clotting to expect and provided me with absorbent towels and bedpans ‘just in case.’... I was always reassured about where to turn for support if needed....”*

However, some women described a lack of access to essential provisions and dignified care. For instance, absence of basic resources to maintain personal hygiene, such as sanitary protection for blood loss:

> *“Paramedics had no idea how to help me. They had no pads for me to wear on the journey to A&E, I had to use gauze... They didn't give any emotional support at all. In A&E I was told it was really common, again they couldn't find any pads for me to wear...”*

Others spoke of receiving news of their miscarriage while undergoing internal scans or while undressed:

> *“The doctor who did the scan to confirm no heartbeat was completely lacking in empathy. Before I'd even put my knickers on she started talking to me through the curtain asking me do I want to wait and see, take a pill, or ‘suck it out’. ‘Suck it out’ her exact words. Just so shortly after finding out the baby I'd thought I'd been growing inside me had died 5 weeks ago... She was so in a hurry and showed no empathy. She also told me my partner would be able to come with me on the day of the procedure, but when we arrived they said it was a female only ward so he was sent away and I was on my own...”*
>
> Tolani

Crucially, some accounts illuminated the lack of dignity in the handling and disposal of their pregnancy/baby:

> *“I'm pretty sure I've just flushed my baby down the toilet. This is absolutely devastating so undignified and so traumatic. This was my baby...”*
>
> Nanci

In another instance, a woman spoke of not being informed at A&E what to do with her baby and the distress she endured placing her baby in a bin:

> *.”..I just cried, I’m crying now. I feel so guilty, there wasn’t really anybody there to help as it was late and we had to put it in the bin. We didn’t know what else to do, we put our baby in the bin. I wish somebody could have told us what our options were.”*
>
> Madeleine

Several women also highlighted the distress of being seen in inappropriate places, including being moved into waiting rooms for other pregnant women after receiving news of their miscarriage.

> *“During the 12-week scan, we were told very bluntly that there was no heartbeat and asked if we could go back to the main waiting room. This was not appropriate as we were both upset and there were a lot of pregnant women there. I asked if I could wait in the car, and he said then he would find us a room. Took us through to a room, where he didn’t even turn the light on, so we were sat in the dark.”*

> *“I was surrounded by male nurses and a that a female Dr who left me without any pain relief or modesty… I was wheeled to the ultrasound department and left with other healthy pregnant women. It felt as if the NHS had designed this whole treatment to amplify my pain and distress…”*
>
> Tita

27% of respondents attended Accident and Emergency for medical attention. A&E is not the most appropriate place for people experiencing miscarriage due to a lack of specific training and knowledge relating to pregnancy loss; limited, if any, access to ultrasound scans; waiting times and lack of private and dignified spaces.

Other issues included instances of bringing a baby/fetus into the hospital in containers deemed unsuitable:

> *“Dehumanising - I had to bring the sac into hospital in a Tupperware box where it was treated like a specimen.”*

Healthcare Language & Communication

Negative experiences of interactions with healthcare professionals commonly involved the following:

- **Minimisation based on gestational age:** “The first GP I saw said ‘I think it’s **just** a miscarriage’”
- **Comparisons:** “I passed extremely large clots and the consultant said ‘I have seen larger’ to me”; “‘This was the better way to miscarry than surgery’. This was said to me after I had miscarried my baby in front of my 8 year old”
- **Displays of emotion frowned upon:** “...the gynaecologist asked me why I was so emotional” and “was told ‘not to cry’ by a nurse...”
- **Loss of access to EPUs following confirmation of miscarriage:** “...when I attended the ward at the weekend for bloods (during my ectopic pregnancy) and was told ‘you're nothing to do with us, you'll have to call them tomorrow and find out’”
- **Insensitive wording and experiences:** “I was told my baby had been put in the incinerator with the rest of the medical waste by a junior doctor whilst recovering from a ruptured ectopic pregnancy”; “In the scan appointment... the language used was – ‘I am just looking for leftovers’”
- **Inappropriate humour and smiling:** “I had medical management and when the nurse came in to tell me I'd passed the fetus she was laughing”
- **Doubting women’s pregnancies and miscarriages:** “Sonographer when scanning said ‘well there’s definitely not a pregnancy there, are you sure your tests were positive?”
- **Condescending manner and tone:** “She told me to ask questions and when I did she would laugh as though I was stupid...”.

- **Judgement, blame and guilt:** "...the consultant... stood over me with others in the room and proceeded to tell me how the miscarriage was more than likely my fault. He told me my age would have been a factor and my BMI. I felt so ashamed and angry...".
- **Denial of personhood:** "In the morning I was woken by a nurse who told me about having an anembryonic pregnancy using the phrase 'there was never a baby'. I found this very distressing".
- **Terms to describe the 'baby':** "The word 'tissue' devalued the life of my baby. I feel they should ask how you want it to be referred to". However, others preferred that the term baby was not used: "When they refer to 'the baby' when it was barely a foetus makes it more huge to have lost it. I know some people prefer making it more real and less matter of fact, but I don't want to get overly attached to it all".
- **Not reading notes/telling story again:** "I make no exaggeration in saying that I must have retold the horrific events before and during our pregnancy loss at least 10 times over 72 hours to health professionals. Reliving this over and over again was distressing for myself and husband". For some, this reflected a lack of communication between teams."

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"[We] were uninformed at our scan where we found out about the missed miscarriage. The sonographer was AWFUL! She was talking through the baby and showing us all the bits but didn't say there is no heartbeat until the very end when I asked."

Brooke

Positive Healthcare Language & Communication

While 65% of respondents felt language used by healthcare professionals regarding their pregnancy loss was sensitive and appropriate, 26% felt it was not and 12% were unsure.

"[They were] very understanding. Softly spoken. Genuine. Patient whilst I was upset. Gave me moments when I needed it. Was made the best experience it could've been under awful circumstances."

Positive experiences of interactions with healthcare professionals commonly involved the following:

- **Validation of the experience/grief and loss of baby:** *"When I was crying upon hearing the news the consultant... said 'don't apologise this will feel like you're grieving a person' ...That statement stayed with me and my partner"*
- **Compassionate care:** "All the staff at the EPU used mostly very compassionate language and showed real care. They validated how hard it was, used clear language to explain what was happening and were gentle in their tone and approach"
- **Offering time, space and the opportunity for questions:** " Saying 'I'll give you time to reflect on what we've discussed and come back in 20 minutes to see if you have any questions', offering water to drink. Gestures of kindness - leaning in and nodding to comments I made. Reassuring that it's ok to need time, no rush etc."
- **Removing blame:** "They kept telling me it wasn't my fault and to not blame myself, which was so lovely to hear in such a difficult situation..."; "'Something must not [have] been right' rather than saying something was wrong with our baby. This language was beautiful"
- **Breaking down/avoiding jargon**: "Rather than speaking medical terms, they broke it down and gave me examples...".
- **Supporting partners:** "They also spoke to my husband about any support he may need which I thought was great"

- **Asking for preferred language:** “She wanted to make sure that me and my husband were comfortable with the language she used and frequently checked”
- **Honesty:** “I was scared to see my child after I gave birth and the midwife explained to me he would be like a little doll and told me his skin colour would be redder, this helped me prepare me for what to expect and when I [saw] him I just felt in love”
- **Non-verbal communication:** “Looked at me, made eye contact and didn’t make lots of notes on the computer as I spoke, as I have found to be common practice at GP appointments. I felt that I was listened to”

Partners

We know that some partners can feel sidelined, dismissed, or as though their grief is not recognised, having not experienced the physical loss. However, pregnancy loss can be devastating, traumatic, and cause grief for both partners.

Our research found that support for partners was sometimes insufficient, with many being excluded from conversations and overlooked for formal emotional support:

“My husband's emotional support from the hospital was non-existent and it felt that they didn't recognise that he was grieving just as much as I was.”

“My husband ended up paying privately for counselling as men’s support just wasn’t there.”

“There was no support for my partner, he wasn't spoken to at all. Emotional support was not offered to either of us. Only talking to me and not my partner was very upsetting.”

Polly

69% of partners who said emotional support or guidance was relevant to them reported receiving none, while 31% said they did.

However, 79% of partners who identified inclusion in conversations and decisions about medical care as relevant to their experience reported feeling included, compared with 21% who did not.

> *"No support was offered to my husband and it would have helped for him to be encouraged to attend some sessions for emotional support rather than thinking it was only me who needed that."*

Aftercare & Support

65% stated that they did not receive sufficient follow-up care after their pregnancy loss.

Some participants described **compassionate follow-up care** after their miscarriage. This included being offered telephone calls for any questions they had related to symptoms, access to counselling and in-person appointments/check-ups.

However, many respondents spoke of the **absence of aftercare** for their miscarriage. A consistent theme across participant accounts was the **lack of follow-up for both the physical and psychological effects of miscarriage.** Many women emphasised the need for a routine, automatic follow-up appointment to discuss symptoms, infection, menstrual cycle changes, and fertility concerns. This appointment could have been delivered either through their Early Pregnancy Unit (EPU) or GP. Some were told to expect a telephone call which did not transpire.

Participants reported that this follow-up care would have reduced feelings of isolation, improved understanding of expected experiences and increased awareness of the severity of their symptoms. In the absence of structured follow-up care, many women felt compelled to seek care independently. However, respondents often felt unaware of where to turn.

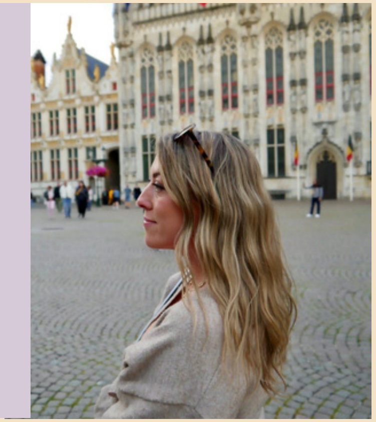
Many women were sent home to manage their symptoms alone without adequate information. This commonly led to confusion, trauma and minimisation of the experience. Many were no longer able to access care (including access to EPUs and midwives) due to not being considered pregnant anymore. Therefore, women often resorted to seeking support from their GP and these experiences were varied:

> *“..A&E made me feel like it wasn’t a big deal and I was being emotional over nothing but my GP provided me with reassurance and understood what a traumatic experience it was.*
> *When I did reach out to a GP 10 weeks after the miscarriage and explained my bleeding and [severe] bloating I was told to drink peppermint tea. A day later I was hospitalised for a week with a severe infection.”*

Some respondents had access to a bereavement midwife and formal counselling through the NHS. However, this was not always available in every Trust/Board, and sometimes only offered for later losses. Moreover, support for emotional and psychological needs following pre-24-week losses was lacking even when there was a history of mental health illness:

> *"All the care I did receive was fantastic, compassionate and thorough but no one has checked on my mental wellbeing, despite it being my 2nd miscarriage and having a history of depression and antidepressants."*
>
> Alice

> *"There's zero emotional or wellbeing checks after something so utterly traumatic. I have been in a very, very dark place with no support."*
>
> Jill



From the verbatim comments provided, respondents identified the following types of follow-up care and support as helpful (listed in order of frequency):

- A follow-up call/check-in/appointment from healthcare professional e.g., midwife.
- Counselling referral or some form of mental health/emotional support – including with bereavement midwife.
- Follow-up scan.
- GP appointment/check-in.
- Signposting to support groups.
- Recommendations of relevant websites/resources.
- Signposting to relevant charities
- List of helplines and forums.
- Referral for investigation.
- Partner check-in and partner counselling.
- Gynaecology appointment.

Respondents consistently highlighted the need for follow-up check-ins; indeed many were left to seek out support themselves. Follow-up care for the physical needs of miscarrying women, including physical examinations and general health checks, was often considered paramount. However, most respondents also noted that this should extend to emotional wellbeing. For instance, many women wanted access to bereavement midwives and wellbeing checks to help process the experience.

Other common areas of omitted support included, but were not limited to:

- Access to blood (and other relevant) tests.
- Clear explanations of test and surgery results (when conducted).
- Monitoring of hormone levels (including hCG).
- Advice on future fertility and likelihood of miscarriage recurrence.
- Managing recovery.
- Fit notes for work.

> *"[After I] miscarried I walked out of hospital bleeding without anyone even asking if I needed a fit note for work or further support. Just 'don't have a bath.'"*
>
> Megan

Routine check-ins at set intervals were commonly recommended by respondents due to many women stating that they had to seek follow-up support themselves.

Those who did have GP check-ins highly valued them:

> *"My GP offered wellbeing check-ins which was so helpful. It would have been helpful to have contact from EPU to ask how the home management was going and check if what was happening was normal."*

Some issues were thought to be prevented with adequate follow-up care as women could check their symptoms and be made aware about infection, haemorrhage, retained tissue, emergency surgery due to internal bleeding, anaemia etc.

Follow-up care was perceived to be especially crucial for those experiencing recurrent miscarriage:

"After 4 consecutive losses there should have been some emotional follow-up to check I was mentally okay. After each of my miscarriages there has been no follow-up to check on my mental health. [I] have not been okay! After one of my losses I had thoughts of self-harm."

Moreover, follow-up care was viewed as particularly useful for those with existing disabilities and mental health illnesses:

"Particularly as someone with multiple disabilities (Autistic, wheelchair user) and being older (40), some sort of check-in/follow-up would have been really useful. No emotional support was offered at all, it was very much 'It's only one loss, the stats are 1 in 4, don't worry too much about it', which I found quite upsetting as someone who's had mental health difficulties in the past and I had no idea if they might flare up again as a result of the miscarriage. I appreciate GPs are very busy but all it would have required was a quick 2-minutes-max phone call... and medical care is frequently less accessible to many disabled people, putting us at greater risk of long-term problems and complications through lack of follow-up."

"I was supposed to get a call at 3 weeks after my medical management but had to ring the hospital as they had forgotten about me. Some emotional follow up would have been nice too."

Aftercare & Support

Recurrent loss can leave patients wanting answers, and wary of trying again in future. Many of our community would like the option of further testing, so they can find out if there is a medical reason for their recurrent losses.

However, being offered, and being able to access these, can be difficult, with patients needing to have had three losses before investigations can begin.

> Of those who responded to say they had experienced recurrent miscarriage [1], 40% per cent said they had been offered tests, 41% said they had not and 19% were currently awaiting tests.

The Graded Model of Care, published in The Lancet's Miscarriage Matters series and developed by researchers at Tommy's National Centre for Miscarriage Research, recommends that after one miscarriage, women should receive mental health screening and personalised advice to reduce risk factors in a subsequent pregnancy. After two losses, it recommends some initial testing and access to reassurance scans, and after three, referral to consultant-led care and enhanced tests.

We support this model for recurrent miscarriage, which is presently being piloted by Tommy's - the pregnancy and baby charity - at their National Centre for Miscarriage Research. However, we would like to see routine follow-up care for every miscarriage, focusing on physical and psychological recovery for this specific loss, outside the context of another pregnancy.

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[1] This is an overrepresentation of recurrent miscarriage figures apparent within the general population.

Pregnancy After Loss

A reassurance scan is an ultrasound scan offered during early pregnancy to provide emotional reassurance, rather than because of a specific medical concern. This may be offered to women who have experienced a previous pregnancy loss to check for a fetal heartbeat and development.

Of those who had a subsequent pregnancy following recurrent loss, 26% said that they were offered a reassurance scan, whereas 25% were not. 48% selected 'not applicable' and 2% were unsure.

Research carried out by the Miscarriage Association in 2022 revealed that many women experience debilitating anxiety during pregnancy after loss.

It is often assumed that these worries will lift after the pregnancy passes the point of the previous loss, but women told us that the anxiety did not ease until the baby was born safely, and for some remained long after this. Reassurance scans can help alleviate some of these feelings which can significantly impact mental health and wellbeing.

Waiting Lists

While some respondents were offered blood tests immediately following their miscarriage, many faced long waiting lists – **some up to three years.**

Waiting months or up to a year appeared to be common for accessing an appointment at a recurrent miscarriage clinic for fuller testing/investigations, and some paid privately for testing because of this. Others also opted for private investigations as they offered more comprehensive testing. Some women were offered scans, whereas others were not. Sometimes basic blood tests were conducted, but other times, more detailed blood testing was provided on the NHS. Thus, there appeared to be inconsistency with availability and access to testing following recurrent miscarriage.

Errors Prevented Testing

Two examples illuminated significant errors made by healthcare professionals which prevented testing for recurrent miscarriage, notably destruction of the pregnancy tissue:

"Due to infertility and recurring miscarriage, I was informed they would complete further tests. They didn't due to the baby being destroyed due to human error and I was only told via letter weeks later."

"...I was promised a genetic testing of the pregnancy tissue. However, the midwife made the mistake and put the pregnancy tissue in the wrong solution so it was contaminated and could not be tested."

Mental Health

Over 68% of respondents stated that they experienced mental health problems related to their pregnancy loss.

Most respondents said that they were not offered any support for their mental health following pregnancy loss (42% wanted this type of support). In addition, 10% were not offered support but said that they did not need it, and 17% did not consider that it would be provided for pregnancy loss.

Of those participants who received support for their mental health following pregnancy loss, **just 16% were offered support through the NHS**, while 27% accessed their own support (17% through a charity and 10% privately).

Only 16% said that they did not experience such issues, and similar numbers were unsure whether they did or not.

The most common mental health symptoms experienced following pregnancy loss related to anxiety (81%), depression (68%) and Post-Traumatic Stress Disorder (PTSD) (just under 50%).

10% experienced symptoms of obsessive-compulsive disorder and 8% selected 'other' which included: eating disorders, generalised anxiety disorder, suicidal ideation, prolonged grief disorder, phobias (including claustrophobia), panic attacks, Premenstrual Dysphoric Disorder (PMDD), self-harm, stress, health anxiety and trauma.

Just over 17% received formal diagnosis of their mental health symptoms. However, 78% did not.

66% did not receive any treatment for their mental health symptoms, while 31% did.

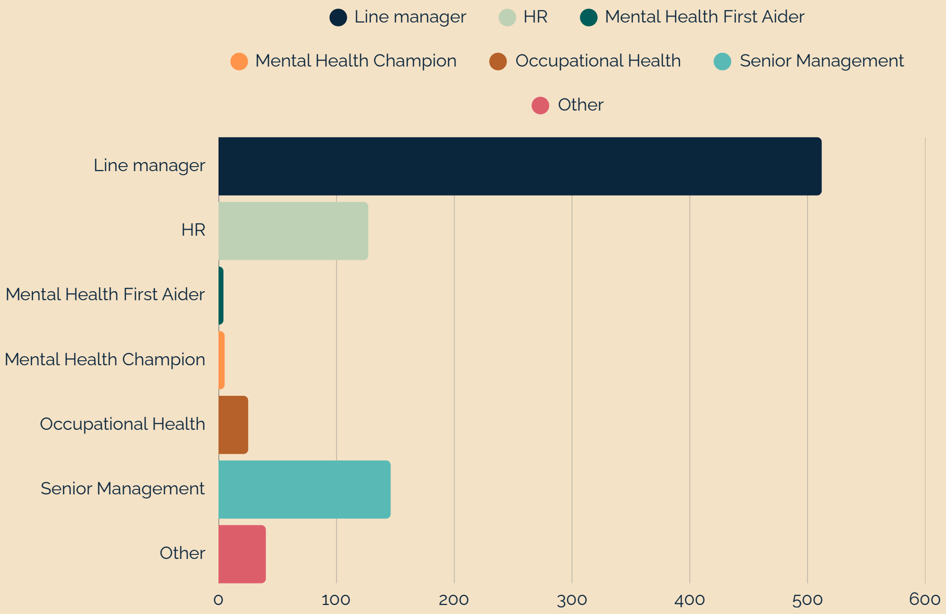
Section 2

The workplace

Almost 80% of respondents were in employment when they experienced their most recent pregnancy loss.

With an estimated one in four pregnancies ending in loss, the majority of workplaces have employees who have been affected by pregnancy loss. Yet policies and procedures remain inconsistent. There is a clear lack of formal support and many fear disclosing their loss due to professional discrimination.

Who respondents disclosed their pregnancy loss to at work



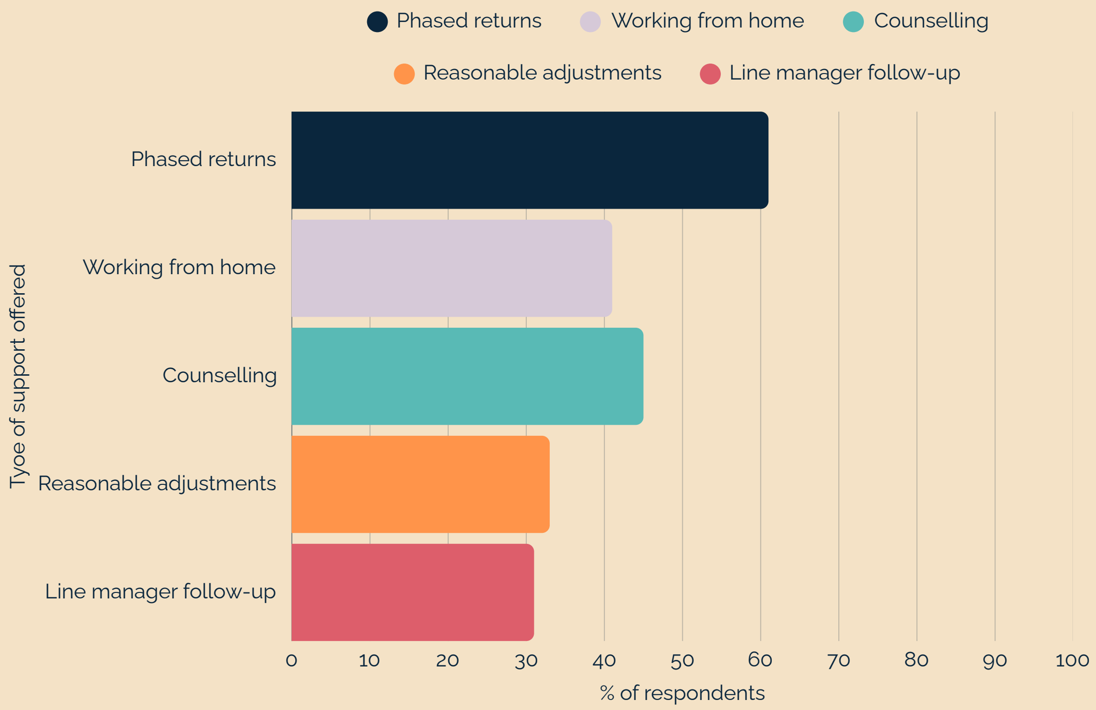
> *"I did not feel comfortable sharing it as I was up for promotion shortly after and thought (/knew) this would impact my chances if they knew I was trying for a baby. It is also incredibly personal so I did not want to share it with my work…"*

Those who did not disclose their pregnancy loss at work expressed a range of reasons for not doing so, including but not limited to:

- Potential negative impact on career e.g., promotion and permanency opportunities
- Discrimination
- Unsupportive management
- Unpredictable workplace e.g., redundancies
- Fear of a lack of empathy/understanding
- Recurrent miscarriage and already taken leave previously

Formal Support

Most (57%) were not offered any formal support at work following disclosure of their pregnancy loss. Only 37% were offered formal support.



For those who were offered formal support at work, the five most common types were:

- Phased returns (61%)
- Counselling (45%)
- Working from home (41%)
- Reasonable adjustments (33%)
- Line manager follow-up (31%)

Colleagues

Most respondents disclosed their pregnancy loss to colleagues, (25% to all, 60% to some).

15% did not disclose to their colleagues. The majority of those who did disclose to their colleagues felt 'very supported' or 'supported' (74%). 21% felt 'somewhat supported'. Only 5% felt 'unsupported' or 'very unsupported' by their colleagues.

Validation at Work

Most people felt that their pregnancy loss was validated at work (69%), however almost 20% did not and 12% were unsure.

Pregnancy Loss Policy

Many workplaces have yet to introduce a pregnancy loss policy to help guide employees through this difficult time. A significant amount of respondents (28%) were unsure if their workplace has a policy, which demonstrates a lack of awareness and/or signposting from employers to relevant support.

Most (48%) noted that their employer did not have a policy on pregnancy loss. Only 24% did and 28% were unsure.

Pregnancy Related Sickness

79% said that their employer had not made them aware of their entitlement to protected pregnancy-related sickness.*

*Indeed, only 13% were made aware of this and 8% were unsure.

Leave from work

69% reported having access to paid leave for their pregnancy loss. However, 9% took unpaid leave and 10% stated that they were unable to take any leave. 7% took a combination of paid and unpaid leave. Only 5% said they did not require any leave.

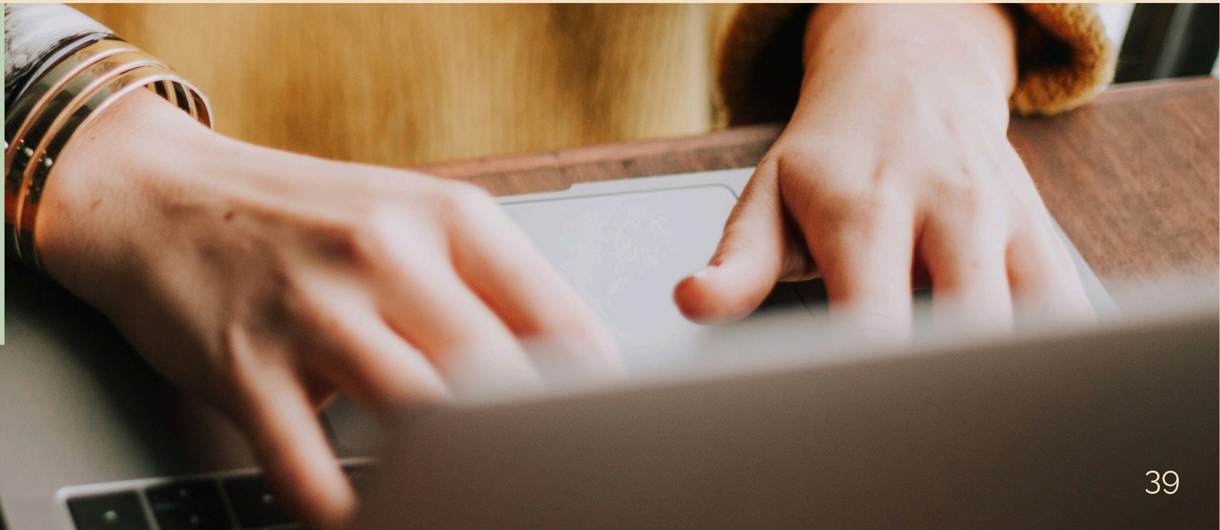
Common leave types included sickness, compassionate, pregnancy-related sickness and annual leave. A few respondents took bereavement leave.

> *"They forced me to take any time I had off as holiday. Even the day I had my appointment to go into hospital for the medical management had to be used as holiday. They wouldn't allow any sick leave or compassionate leave at all."*
>
> Olivia

Some respondents said their absence was unfairly recorded and used against them:

> *"Firm policy is pregnancy loss leave for 2 weeks. In reality they instead recorded as sick and held against me during subsequent appraisals by male line manager."*

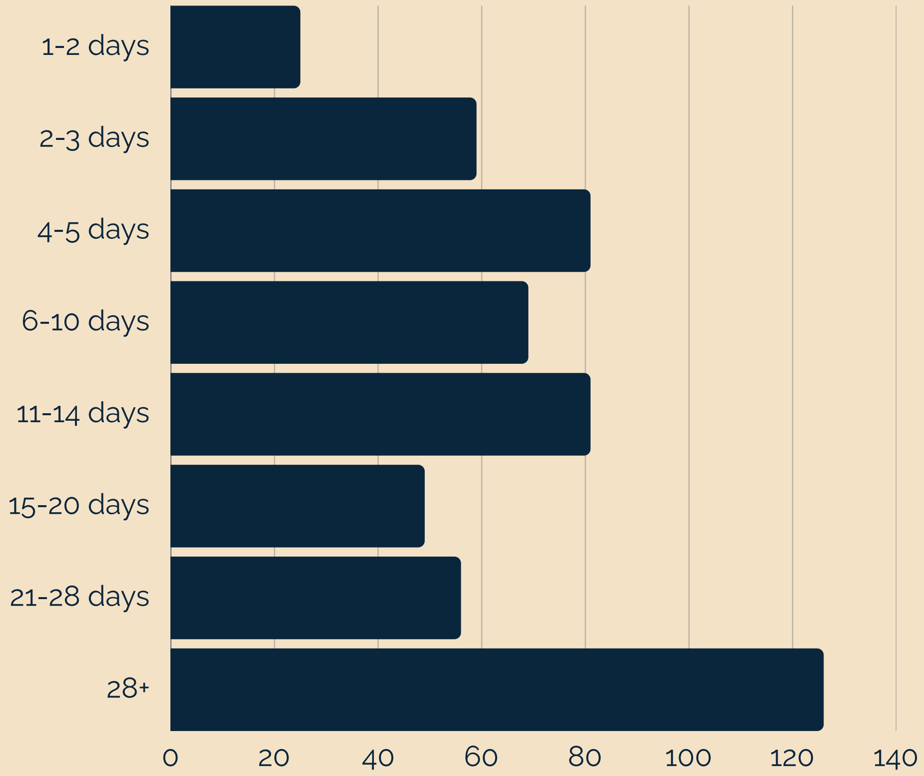
The Government will be bringing in a right to unpaid bereavement leave for pregnancy loss in **2027,** following the passage of the Employment Rights Act.



Leave Duration

The duration of leave required (and permitted) varied significantly. The most common pattern was around four weeks or more (23%), while others took between a few days and two weeks. A smaller number reported taking only a single day.

How much leave did respondents take from work?



Returning to work

The majority of people have felt supported in their return to work - but only 37% were offered formal support.

For those who were offered formal support at work, the most common types were phased returns (61%), counselling (45%), working from home (41%), reasonable adjustments (33%), line manager follow-up (31%), flexible hours (30%), adjusted duties (26%), extended breaks (20%), hybrid working (19%), access to Mental Health First Aider/Champion (17%), referral to external services (17%) and Occupational Health referrals (16%). Some were offered access to peer support groups (13%), Employee Assistance Programmes (12%), resources (11%), compressed hours (5%) and secondments (2%).

> For those who took a period of leave for their pregnancy loss, many felt ‘very supported’ or ‘supported’ upon their return to work (58%). However, 26% felt ‘somewhat supported’ and 17% felt ‘unsupported’ or ‘very unsupported’.

Workplace triggers

Most (60%) said that they found their job role and/or working environment triggering in some way.

Certain roles and sectors were noted to be particularly difficult following pregnancy loss and included: primary/nursery teaching, midwifery, gynaecology, HR (managing maternity leave for others), and social services, among others

> *"I'm a social worker and at one point a trigger for me was babies crying which set off my PTSD symptoms... My manager told me to get another job if I couldn't do mine."*

Common triggers included:

- Pregnant colleagues, clients and patients.
- Pregnancy and birth discussions, announcements and celebrations.
- Working with children/babies.
- Being asked if/whether they had children/are pregnant.
- Work environment itself due to miscarrying at work, including office and toilets.
- Conversations about children and family life at work.
- Visits from babies and children in the workplace.
- Being asked about having a second child.
- Working in abortion care/education.
- Working with patients who are dealing with loss.

Work Opportunities

Recent data from the Office for National Statistics (ONS, 2025) illuminated the **long-term individual financial implications of pregnancy loss, notably in relation to income and employment.**

Women who experienced miscarriage were found to face an **average total income loss of nearly £4,000** compared to those who had not, and some also experienced adverse effects on their employment prospects.

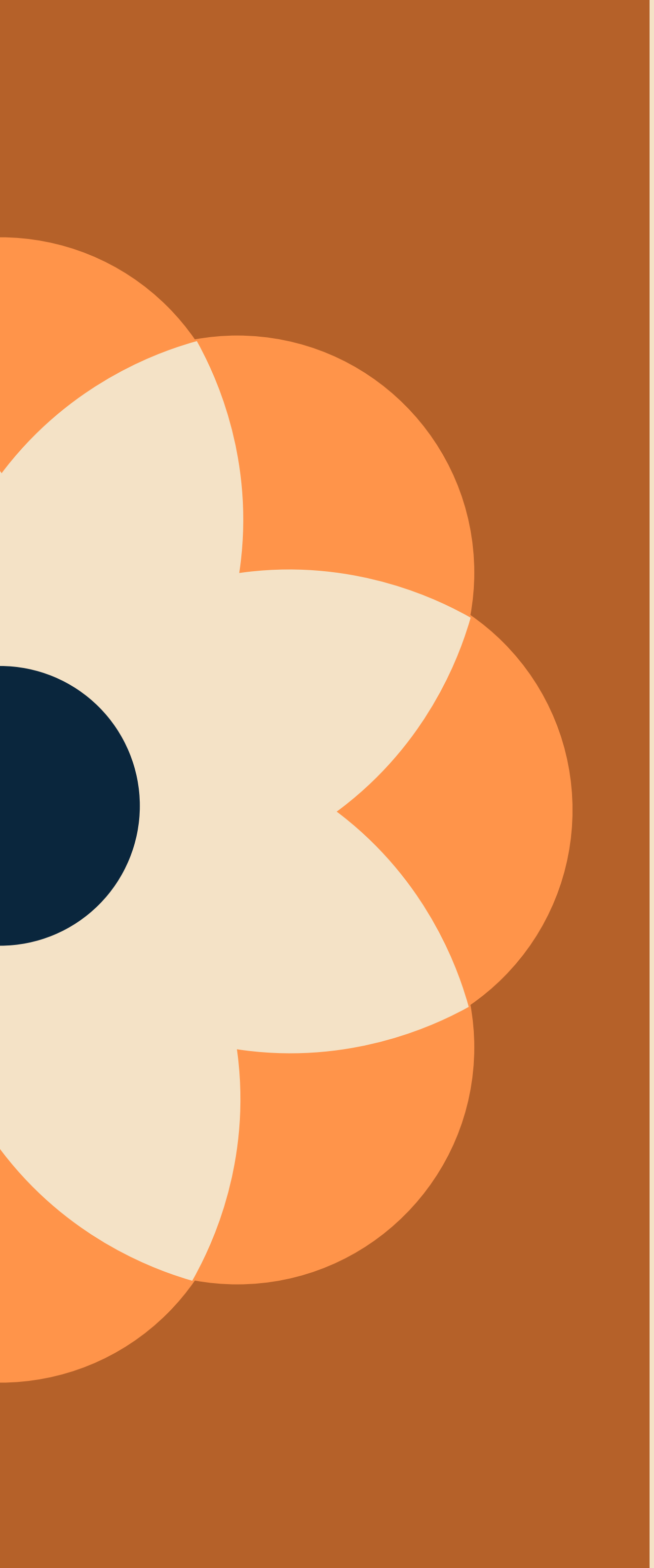
Within the current study, most (61%) respondents felt that their pregnancy loss did not negatively affect their opportunities at work. However, 24% stated that it did and 15% were unsure.

For those who felt that their pregnancy loss negatively affected them at work, some of the issues cited were:

- Reduced access to promotion opportunities, pay rises or being demoted.
- Projects/tasks taken away.
- Resignation or redundancy following pregnancy loss disclosure.
- Negative appraisals/performance reviews.
- Self-employed respondents losing contracts/work.
- Taking a reduction in hours/going part-time.

"My employer was great in terms of support and time off but I do feel after announcing the losses and the fact we were trying for a baby that any potential development plans for me were put to one side."

"People don't give you opportunities because they think you will go on maternity leave soon. Or in my case they think you will go off sick for yet another miscarriage (I'm on no. 4 now). It's not an obvious discrimination because it's subtle but it's there. I know I'm not working at my best since the losses and I've dropped a day to work on myself and my health so 100% this has impacted my career in many ways."



Section 3

Societal attitudes & recognition

Most respondents disclosed their pregnancy loss to their family and friends (30% disclosed to all their family and friends, 37% to most and 31% to a select few).

Many respondents indicated that friends were supportive initially and then became less so longer term. Others noted that friends and family did not know what to say or made insensitive comments. Some women lost friendships because of their pregnancy loss. Moreover, sometimes intimate relationships broke down as a result of miscarriage.

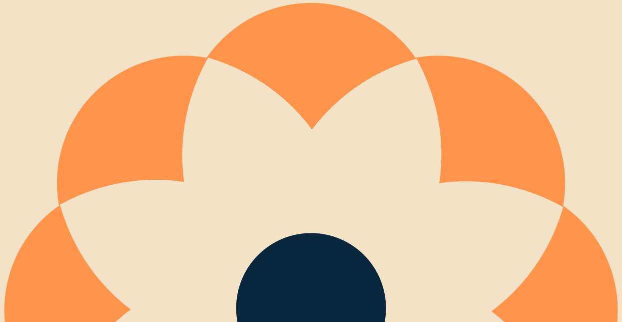
> *"Friends supportive at first but [no] longer spoken about. Very emotional and lonely journey. Partner wasn't as emotionally supportive as I thought he would have been."*

Several women spoke of turning to friends who had their own experiences of pregnancy loss for advice and support. Some appreciated validating gestures, such as a listening ear or being sent flowers.

> *"The most supportive friends were those that had been through it themselves. Some people, who I thought would be supportive, basically just ignored me and those relationships have been damaged as a result."*

> *"I think there's a big stigma around pregnancy loss - I didn't tell anyone at work or most of my friends and family about it, although now, 2 years and 1 baby later, I do feel like I should talk about it more, to make other people realise how common it is and give other people the space to talk about their own experiences."*

The majority found their family and friends to be 'very supportive' or 'supportive' (74%). Only 4% stated that their close circles were 'unsupportive' or 'very unsupportive'. However, 22% indicated that they were 'somewhat supportive'.

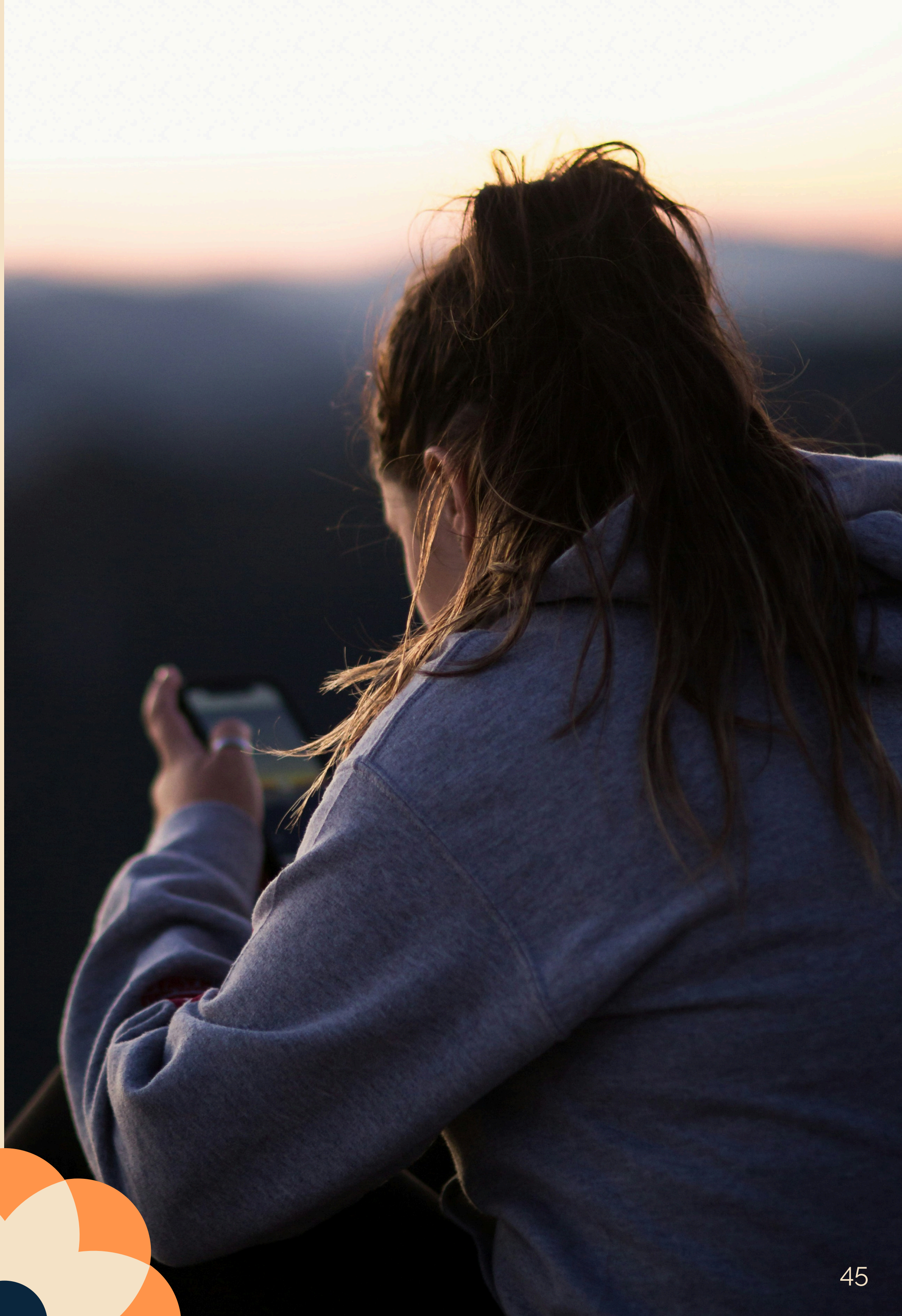


"Some friends and family [have] no idea what to say or do. [Saying] accidentally unhelpful or hurtful comments, but all from a good place."

"The feeling of isolation is something I never thought would be a thing. Losing friendships as people don't know how to communicate and I've become less social as a result."

"Family and friends whilst initially supportive have since made it clear that I should just 'get over it' and 'stop talking about it'. It ultimately led to the breakdown of my relationship as my ex-partner said I 'changed' since the loss of the baby."

"Disclosing to my best friend was brutally hard, but she has been my rock. Those closest sent flowers - however since then I feel like nobody wants to talk or mention it. It happened - I am not ok, and I would appreciate people recognising it's not gone away for me, it will always be part of me. But people do not want to upset me or are unsure of how to approach the situation which I understand."



Conclusion

The healthcare women received for miscarriage was inconsistent, and often inadequate. Examples of exemplary care were in good supply, but many other respondents described inadequate or even distressing support. **Notably, there were significant gaps in aftercare and follow-up support.** Access to appropriate services such as Early Pregnancy Units, scans, investigations and testing was inconsistent, and often dependent on the location or the discretion of individual healthcare professionals. Many women reported being sent home with little or no guidance, discouraged from certain medical options, or not given the time or information needed to make informed choices about their care. This was especially detrimental to patients with disabilities.

Miscommunication, false reassurance, conflicting advice, and even misdiagnosis undermined trust. This also led to significant physical and psychological harm for some women. Some had the existence of their pregnancies or miscarriages questioned. The physical realities of miscarriage were often underestimated or poorly explained. Meanwhile, the **emotional and mental health consequences** - including depression, PTSD, and suicidal thoughts - **were often not adequately addressed.**

A recurring theme was a **lack of dignity, empathy and compassion.** People's experiences were shaped not only by the availability of treatments and follow-ups but also by the way information was delivered. **The tone, timing, language, and validation of women's experiences mattered deeply.**

With regard to employment, managers and colleagues were often supportive, but formal workplace support was limited. Few employers had clear policies and most employees were unaware of their entitlements to pregnancy-related sickness leave. For some, **non-disclosure was linked to fears about the impact on their career.**

Experiences around leave and returning to work varied widely. Although many took paid leave, some had to use annual or unpaid leave. Crucially, some had time off recorded against them. **Return to work support was inconsistent,** and many found their roles or working environments emotionally triggering.

The findings highlight the lack of consistent workplace policies, the need for **clearer communication** regarding rights and entitlements, and the importance of **supportive return-to-work and broader workplace practices.** This situation should improve when the new right to unpaid bereavement leave is implemented in 2027, but clear guidance will be required.

Across society, our data shows that most respondents disclosed their loss to family and friends, who were often initially supportive; however, **many were unsure what to say, and that support frequently diminished as time passed.**

This highlights the need for wider societal acknowledgement of pregnancy loss, the breakdown of stigma, and more open conversations, so that support is informed, confident and sustained beyond the immediate aftermath of loss.

Above all, the experiences of our respondents show that while there are compassionate healthcare professionals and supportive employers, there is still a long way to go before there is consistency of care, information and understanding across the UK for those experiencing miscarriage and pregnancy loss.

Crucially, the National Maternity and Neonatal Investigation must give pre-24-week care and loss the same prominence as care and outcomes in later gestations. Early pregnancy loss cannot remain overlooked. Without parity of focus and accountability, preventable harm will persist.

As our recommendations make clear, meaningful change requires mandatory, routine follow-up care, timely access to appropriate services to prevent misdiagnosis, healthcare professionals being trained in compassionate, best-practice communication, dignity and privacy as a given, and bereavement leave in the workplace as a minimum standard.

Next steps

Following publication of ***Miscarriage in the UK: A State of the Nation report,*** the Miscarriage Association will launch a public-facing campaign later in 2026 focused on securing mandatory aftercare following miscarriage.

Our research demonstrates why this change is urgently needed. Two thirds of women told us they did not receive the aftercare and follow up support they needed to help them recover, physically and emotionally, after miscarriage.

As outlined in our report recommendations, we will be advocating for the introduction of routine follow-up care after miscarriage. We believe Early Pregnancy Units (EPUs) should play an important role by offering proactive follow-up contact approximately three weeks after pregnancy loss. This contact should provide an opportunity to review physical recovery, identify any complications such as infection or anaemia, consider psychological wellbeing, and offer appropriate signposting or referrals for further support where needed. We will work collaboratively with policymakers, clinicians and service leaders to explore how routine, proactive follow-up can be strengthened and embedded within existing care pathways.

Alongside this, we will continue to support the effective implementation of bereavement leave for pregnancy loss under the Employment Rights Act, ensuring that the new entitlement translates into meaningful, compassionate practice in workplaces. Legislation is a critical step, but awareness, guidance and culture change will be essential to ensure that no one feels unable to take the time they need following a loss.

We will also continue our work to challenge stigma and silence around miscarriage. While attitudes are beginning to shift and public conversation is growing, our findings show that many people still feel isolated, misunderstood or unsure how to talk about their experience.

We will also continue to engage with and apply pressure to the National Maternity and Neonatal Investigation to ensure that pre-24-week pregnancy loss — and the voices of our community — are fully represented in its scope, scrutiny and recommendations.

We aim to drive meaningful improvements so that no one faces pregnancy loss without the care, follow-up and compassion they deserve. Because every loss matters.

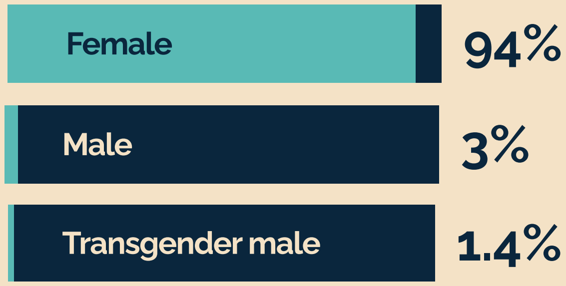
Appendix

Demographics

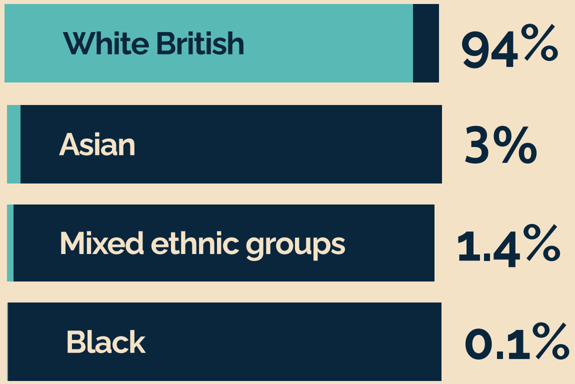
Data collected May - June 2025

1,062 survey respondents

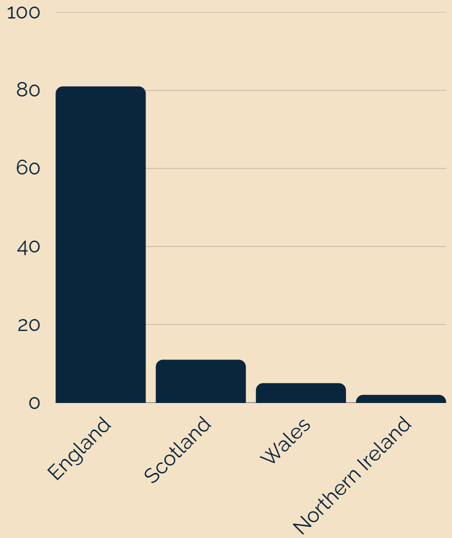
Identity



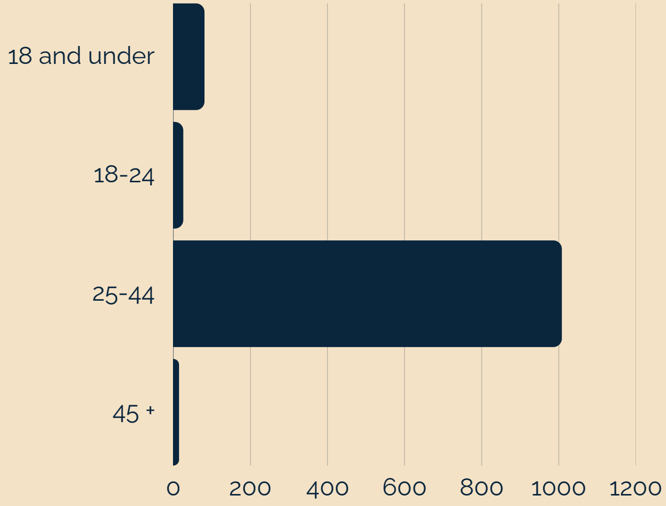
Ethnic background:



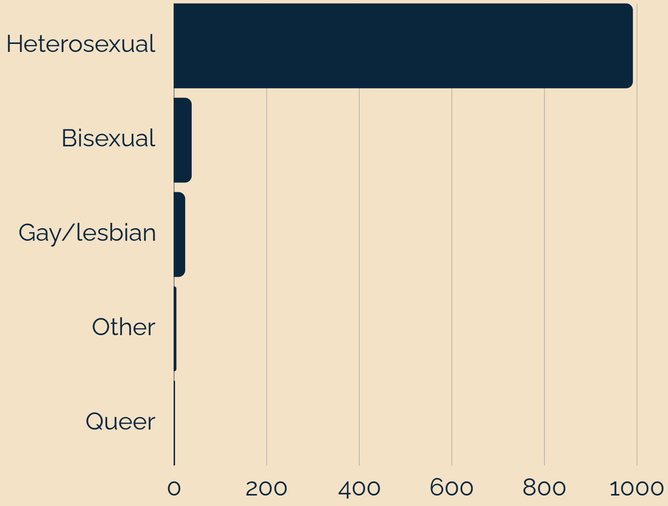
Location:



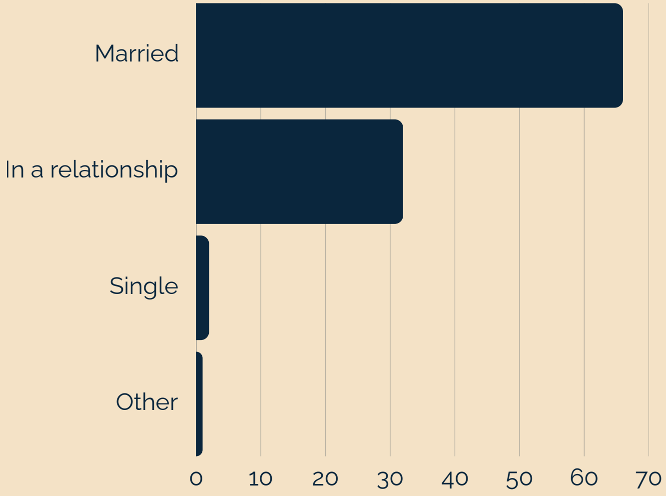
Age:



Sexual Orientation:



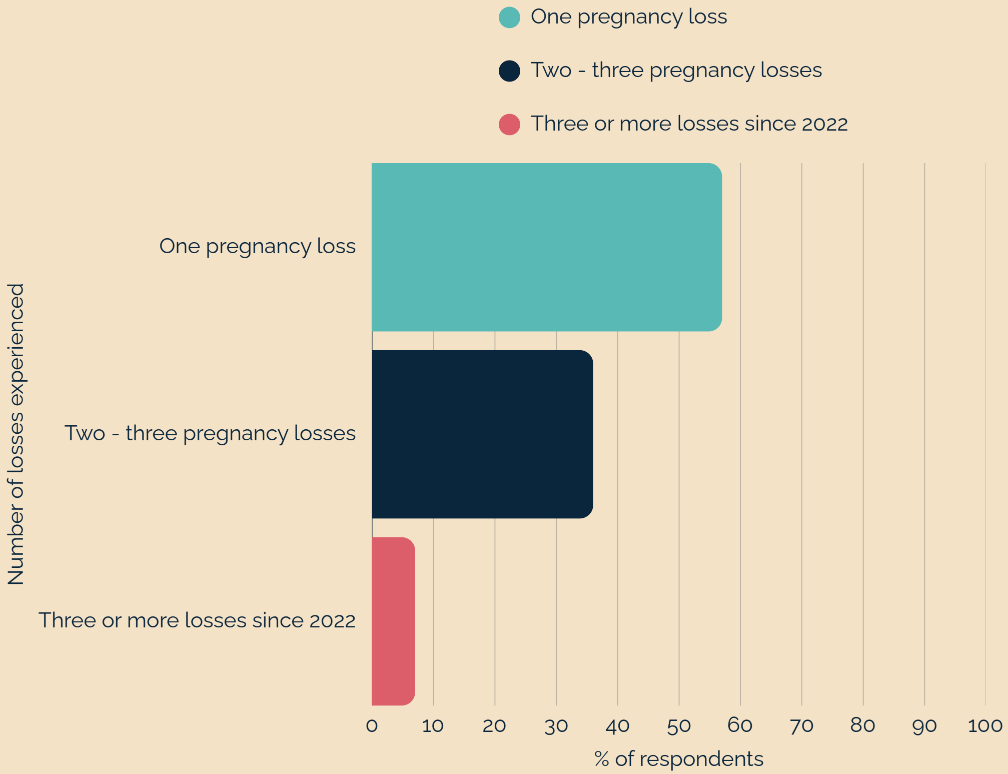
Relationship status:



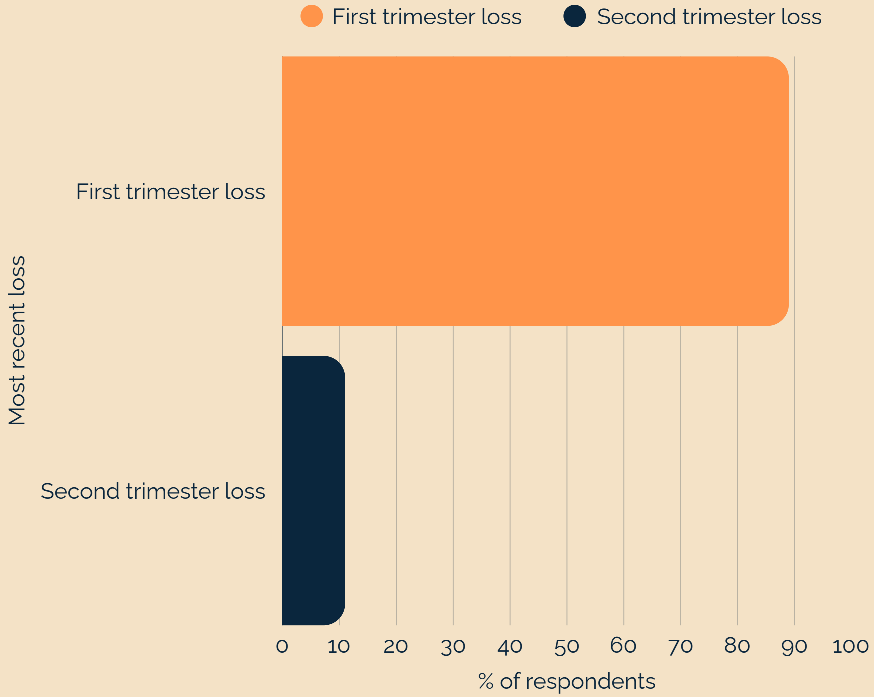
Nature of the Pregnancy Loss

- 1,024 of respondents (99%) experienced the physical pregnancy loss.
- 13 (1.25%) were a partner of someone who physically experienced the pregnancy loss.

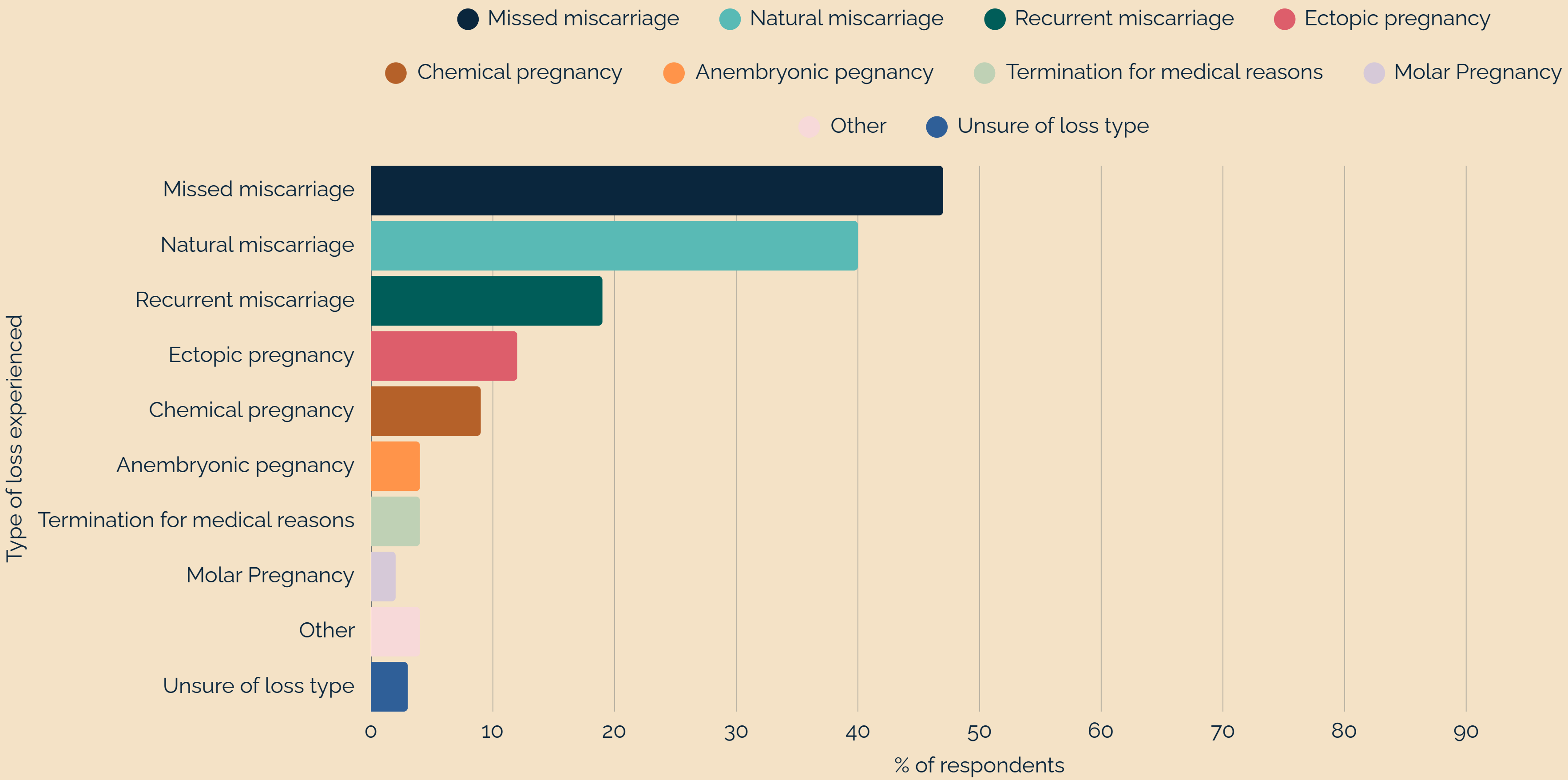
Number of losses experienced:



Trimester of most recent loss



It is important to note that some women may have multiple experiences, for example, a missed, natural miscarriage.



Definitions:

Missed miscarriage: A missed (or silent) miscarriage is one where the baby has died or not developed, but has not been physically miscarried.

Natural miscarriage: Also known as expectant management, this is letting the miscarriage happen naturally without intervention – hospitals may recommend this too, especially in the first three months of pregnancy.

Recurrent miscarriage: Experiencing three or more miscarriages.

Ectopic pregnancy: An ectopic pregnancy is one that develops outside of the uterus, or womb (the word ectopic means 'out of place'). Around 1 in 80 pregnancies is ectopic and for some women, it can be life-threatening.

Chemical pregnancy: A chemical pregnancy (sometimes called biochemical pregnancy) is a very early pregnancy loss which usually happens just after the embryo implants (before or around 5 weeks).

Anembryonic pregnancy: An anembryonic pregnancy is characterised by a gestational sac that forms and grows while an embryo fails to develop.

Molar pregnancy: A molar pregnancy, also called a hydatidiform mole, is one where an abnormal fertilised egg implants in the uterus (womb). The cells that should become the placenta grow far too quickly and take over the space where the embryo would normally develop.

Seeking medical support

Most respondents sought medical support from an NHS hospital, notably an Early Pregnancy Unit (EPU) (79%). Among other sources of support, other respondents attended Accident and Emergency (A&E) (27%) or their General Practitioner (GP) (26%), and this was often due to the limited opening hours or unavailability of a nearby EPU.

Almost 7% selected 'other' which included fertility clinics, private ultrasound clinics, NHS gynaecology units, and other sources of support. Some people may also have received support from more than one source, for example, an EPU and NHS 111.

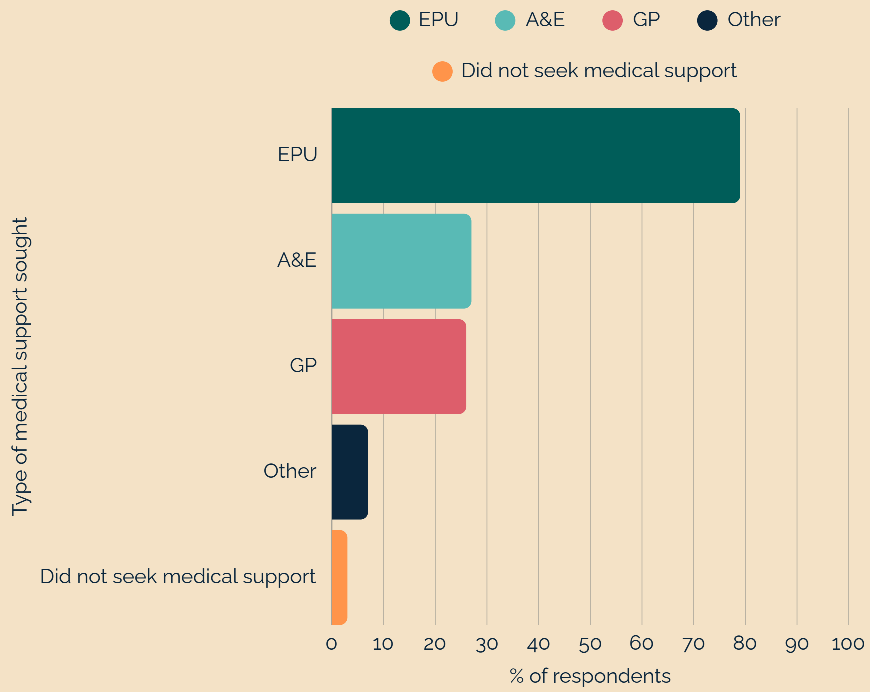
Some did not seek any medical support at all (3%) and this was sometimes due to experiences of inadequate care for previous pregnancy losses.

Appointment type

Most respondents attended an in-person appointment (92%), and a significant number (32%) received a phone consultation. 5% of respondents selected 'other' which included 'none'/'no support', 'text message'/'text consultation', 'GP app' and 'ambulance'. Some comments also noted that medical appointments had been refused for miscarriage[1].

The majority (84%) of respondents felt that their appointment type was appropriate for their needs. However, 16% did not. Around half of the women were seen on the same day (47%), while some had to wait one/two days (30%), 7% waited for three days and 16% waited for more than three days for medical support.

Where did you seek medical support?



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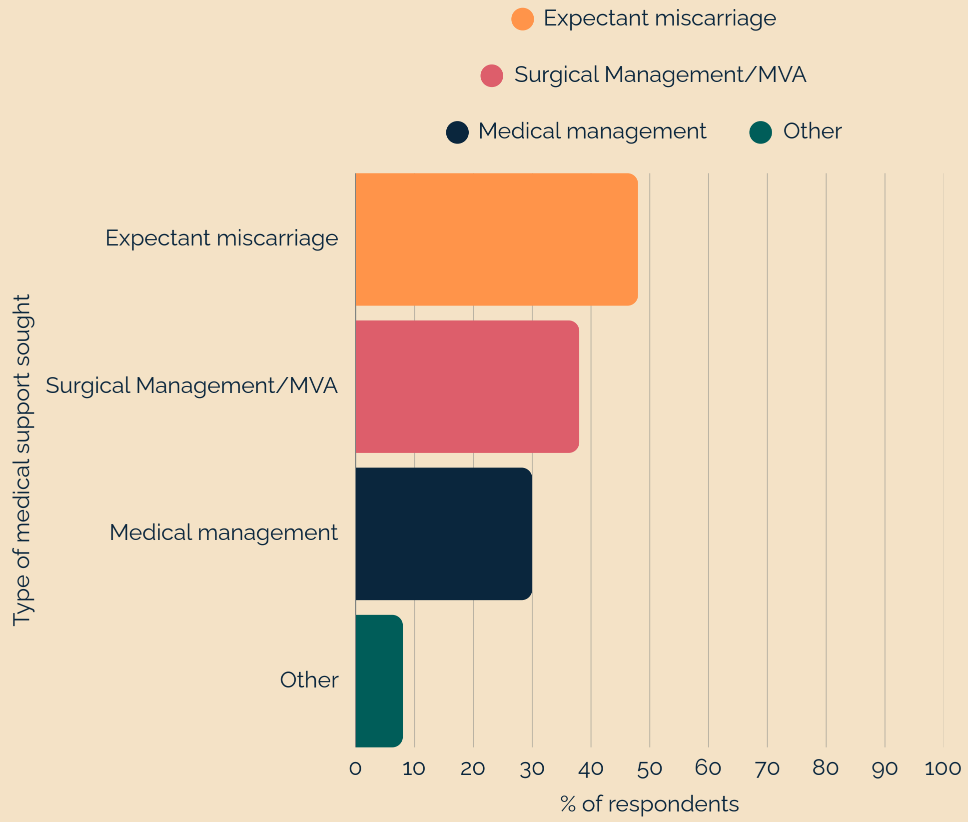
[1] For example, 'None – GP refused appointment' and 'None - EPU dismissed'.

Treatment/Intervention type

What support did respondents receive?

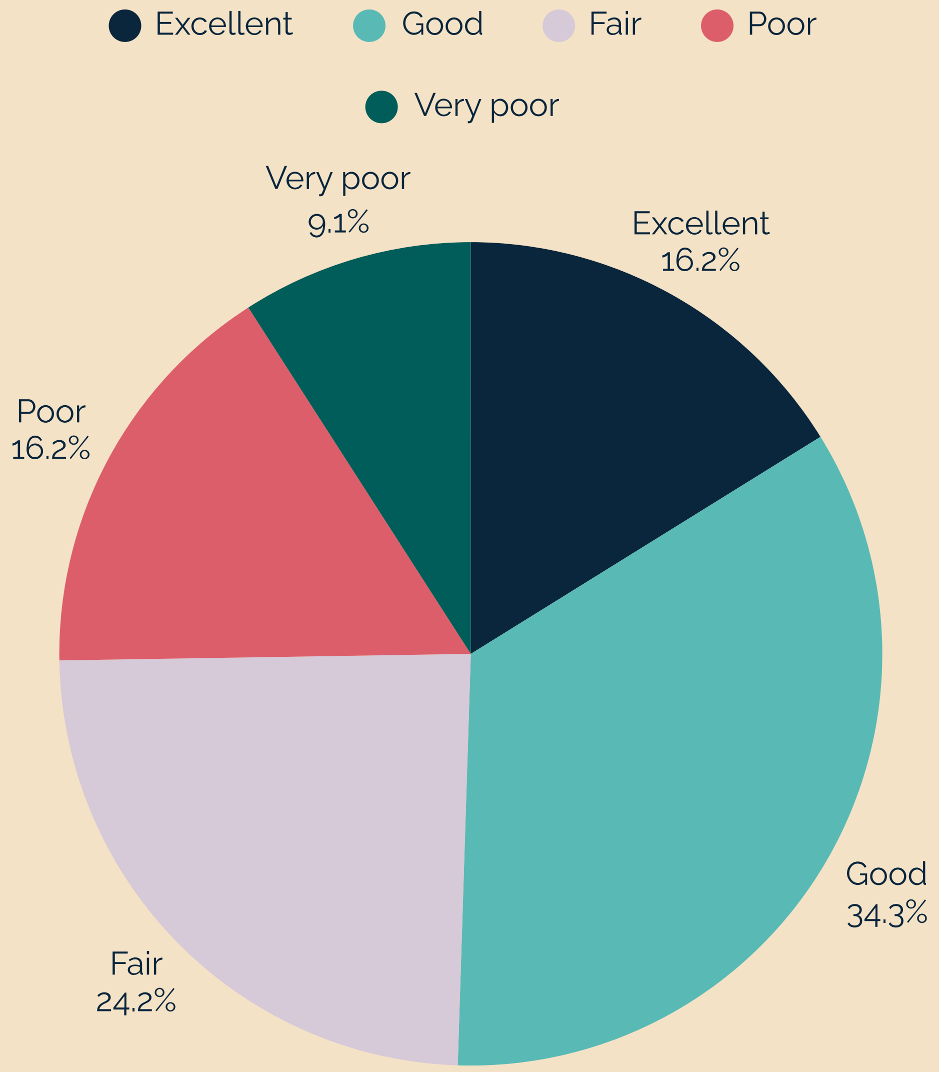


- Most women (48%) underwent expectant management (waiting for the miscarriage to happen naturally without medical intervention) for their pre-24-week loss.
- 38% received surgical management/MVA (a surgical procedure to remove the pregnancy tissue).
- 30% undertook medical management (medication used to start or speed up the process of miscarriage).
- 8% selected 'other', which included a range of treatments including the miscarriage beginning naturally before planned intervention, induction of labour for TFMR, or keyhole surgery for ectopic pregnancy.

> The majority (70%) stated that they received their preferred choice of treatment for their pregnancy loss.

10% did not and 20% were unsure. Sometimes the choice of intervention was removed due to the lack of availability of surgery within their hospital. For others, they experienced a natural miscarriage while waiting for intervention, and so were unprepared.

Overall, how would you rate the level of care you received from healthcare for your pregnancy loss?



The overall level of care received from healthcare provided mixed results demonstrating inequalities/inconsistences.

Half of all respondents (50%) felt the healthcare was good or excellent (34% and 16% respectively), with over a quarter saying it was poor or very poor (25.3% in total).

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Limitations of research

It is important to acknowledge that our research and data has its limitations. For example, the survey was self-selecting and distributed to our existing community via social media and email.
Additionally, the diversity of the demographics within the survey is limited and not fully representative of those affected by pregnancy loss, nor the demographics of the UK. This goes for both experience (limited feedback from partners, and over-representation of recurrent miscarriage for example) and identity (gender, ethnic background, sexuality and relationship status). We plan to commission additional research to further examine these important themes.

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