PLRG BINGO

There are 14,000 miscarriages every year in Ireland	Early pregnancy loss doesn't affect people	A miscarriage isn't like losing a baby	Men aren't impacted by pregnancy loss	
We shouldn't talk about pregnancy loss, it upsets people	Stillbirth can't be prevented	Talking about stillbirth scares pregnant women	Preventing stillbirths is too expensive	People can take sick leave if they have a pregnancy loss <23 weeks
People don't want to talk about their pregnancy or baby loss	People who choose to terminate a pregnancy don't need care		Miscarriage and stillbirth are the same	Stillbirth is just one of those things
External reviews into perinatal deaths are the answer	But we have already implemented the Bereavement Standards	Someone is always to blame for perinatal death	Having another baby will help people get over the loss	Stillbirth is very rare nowadays
	Only women with 'high-risk' pregnancies are at risk of stillbirth	Baby death numbers in Ireland are already very low	There is no return on investment from pregnancy loss research	

Myths about pregnancy loss

We hear these myths about pregnancy loss every day... through our research, clinical and advocacy work. We have created 'PLRG Bingo' to shine a spotlight on these myths and to present evidence as to why they are inaccurate. We hope that PLRG Bingo will be useful for a range of knowledge users, including policymakers, decision-makers, clinicians, journalists and all those advocating for better care and outcomes for people who experience pregnancy loss.

More information + references at:
www.ucc.ie/pregnancyloss
under 'Policy and Advocacy'

or

SCAN HERE

FACTS

Myths	Facts
There are 14,000 miscarriages every year in Ireland	The number of miscarriages in Ireland is unknown and is not formally recorded. National guidance on miscarriage management, published in 2012, reported that 14,000 early pregnancy miscarriages happen per year in Ireland. This statistic appears based on an estimate of miscarriages occurring in 20% of 'clinically recognised' pregnancies (20% of the 72,225 births registered in 2012) (1,2). HIQA's care experience programme report on early pregnancy loss in 2022 concluded that there was a lack of standardised recording and reporting of early pregnancy loss in Ireland (3).
Early pregnancy loss doesn't affect people	Early pregnancy loss can be a significant life event, or trauma, and involve a major disturbance of self-identity (4). Psychological consequences include increased risk of anxiety, depression, post-traumatic stress disorder, and suicide (5–7). These can be more pronounced for some, for example, in cases of recurrent miscarriage and/or infertility. Grief is also a highly individualised experience for male partners, not necessarily dependent on the timing of a pregnancy loss (8).
A miscarriage isn't like losing a baby	Miscarriage occurs before 23 weeks of pregnancy, but this does not mean that its impact is any less significant—physically or psychologically—for those who experience it (9). People have varying views and experiences within and across different forms of pregnancy endings. Some who experience pregnancy loss in the first trimester may not view their loss as the loss of a baby (4,10), whereas others might. Others may view the loss in the context of 'the loss of possibility' and what they imagined for their and their baby's future rather than the physical loss of a baby (4,10). People's experiences and preferences regarding how they term their pregnancy (as a pregnancy, or baby) should be respected.
Men aren't impacted by pregnancy loss	Pregnancy loss happens within the female body, and as a result many men/male partners (and others) perceive that it happens first and foremost to female partners (10). Men/male partners often feel that their role is primarily as a 'supporter' to female partners, and that this precludes recognition of their own loss (8,10,11). Men experience negative psychological outcomes including grief, anxiety and depression following pregnancy loss (8,11). While these can be less intense and less enduring than those experienced by women/people who carry the pregnancy, they are nonetheless important (11). Men and women can grieve differently (8,11).
We shouldn't talk about pregnancy loss, it upsets people	Pregnancy loss happens and affects a large number of people. Silence adds to the stigma and means that pregnancy loss is not considered when prioritising resources and services (12). We talk about a lot of difficult things in public discourses, like child death, suicide, murder, domestic violence and road deaths, and pregnancy loss should be no different. Avoiding discussion of pregnancy loss can cause people to feel isolated, experience disenfranchised grief, and face poorer mental health outcomes (13–16). Public awareness campaigns, support groups, and open conversations reduce stigma (16). The stigma, sensitivities and silence, lack of awareness and understanding, and lack of relevance or priority afforded to pregnancy loss must be addressed as part of efforts to affect change in practice and policy (17).
Stillbirth can't be prevented	Although not all stillbirths can be prevented, a substantial proportion are avoidable through evidence-based clinical care, public health strategies, and timely interventions (18). Targeted stillbirth prevention care bundles in the UK and Australia covering public health, education and clinical practice have reduced stillbirth rates by 20% (19,20). Public health campaigns inform people about healthier choices before and during pregnancy, such as taking folic acid, quitting smoking, avoiding alcohol, being aware of the baby's movements, and sleeping on their side (19,21). Clinical guidelines and support systems help healthcare providers identify, manage, and discuss risk factors during pregnancy.
Talking about stillbirth scares pregnant women	Research shows that pregnant women generally welcome information about stillbirth prevention when that information is shared clearly and sensitively (22,23). Some healthcare professionals avoid discussing risk factors due to fears of causing distress, which can result in missed opportunities for prevention or effective risk management during pregnancy (23–25). They need training and support to do so (25,26). Some stillbirth risk factors are modifiable, including behavioural factors (e.g., smoking, alcohol use, substance use, sleeping position), some are medical (e.g. hypertension, diabetes, fetal growth restriction) and some are warning signs (e.g. reduced fetal movements) (27,28). Information and supports about how to reduce risk of stillbirth should be available to women in pregnancy.
Miscarriage and stillbirth are the same	Miscarriage and stillbirth are two different forms of pregnancy loss, with different definitions, clinical presentations and care pathways. In Ireland, stillbirth is defined as a baby born with no signs of life at 23 weeks gestation or later, or with a birthweight of 400g or more (43). Stillbirths can happen at any point after 23 weeks and, in Ireland, around a third (32%) happen at term (44). Stillbirths can be registered and full maternity and paternity leave entitlements apply. Miscarriage is the spontaneous loss of a pregnancy before it reaches 'viability', under 23 weeks, in Ireland. It can be described as 'early' if it occurs before 13 weeks (i.e. in the first trimester), or 'late' or 'second trimester loss' if it occurs between 13 and 23 weeks. Pregnancy endings under 23 weeks cannot be registered and there are no statutory leave entitlements. Second trimester loss and stillbirth have similar causes and usually involve labour and birth. Not all miscarriages are the same and people are often unprepared for the physical reality of pregnancy loss (12,45).

Myths	Facts
People can take sick leave if they have a pregnancy loss <23 weeks	Whether or not people can take sick leave is complex, it depends on many factors. Length of time needed off work varies. Many people return to work following pregnancy loss earlier than they feel they are ready to due to a lack of leave entitlements (9). Statutory sick leave entitlements are limited, to 5 days in Ireland (36), and even where organisations provide additional benefits, taking sick leave in cases of pregnancy loss can reduce future leave entitlements. This can be particularly challenging for people who need to use sick leave in other related or unrelated circumstances (e.g. recurrent pregnancy loss, fertility treatments, etc). This is particularly discriminatory for women who experience pregnancy loss amongst other reproductive health issues which may necessitate leave from work. The need for dedicated leave for pregnancy loss in Ireland (and beyond) has been highlighted, with many noting that leave relating to pregnancy loss <23 weeks should not be called sick leave, and that it should not count towards sick leave allowance (9).
People don't want to talk about their pregnancy or baby loss	Parents want their loss to be acknowledged and appreciate opportunities to talk about their baby, even years later. This helps reduce stigma and normalise grief (37,38). Avoiding the topic of pregnancy loss often leads bereaved parents to feelings of isolation, and sometimes, disenfranchised grief. The absence of social recognition and support from others can intensify bereaved parents suffering, contributing to worse mental health outcomes (13–16). Increased public awareness through educational campaigns, as well availing of support groups that encourage conversations about pregnancy loss has shown to improve psychological well-being for parents (16).
People who choose to terminate a pregnancy don't need care	Many individuals who undergo termination of pregnancy, including those facing a diagnosis of fetal anomaly or who have an early abortion, may experience intense grief, trauma, and emotional distress (39,40). The sense of loss can be worsened by a lack of societal or institutional recognition, and minimal support for the logistics and emotional aftermath of termination of pregnancy. It is important to acknowledge that this doesn't mean people regret their decision to end the pregnancy; rather, they regret having to make the decision. Direct accounts from patients and clinicians reveal profound emotional challenges and isolation following termination of pregnancy, regardless of the reason or timing (41,42). National reviews, clinical research, and personal narratives show the importance of compassionate, accessible, and structured care for people who decide to have a termination of pregnancy (40). Studies show that appropriate bereavement support after termination of pregnancy helps people process loss, remember their experience in individually relevant ways (41,42).
Stillbirth is just one of those things	Historically, stillbirth was often viewed as a tragic, unavoidable event without an explanation as to why it occurred. However, advances in medical science and the uptake of post-mortems and placental examinations, have improved our understanding of the causes. A cause is now found in 95% of stillbirths in Ireland (46). The most common causes of stillbirth are: a placental condition meaning the placenta is not functioning as it should, and fetal anomalies. Identifying these causes provides parents with answers and offers valuable information that can be used to develop more effective prevention strategies (46). The reduction in stillbirth rates in the UK and Australia due to targeted prevention efforts also shows that stillbirth is a preventable issue, not an unavoidable tragedy (19,20).
External reviews into perinatal deaths are the answer	Many external inquiries into maternity services in Ireland have been carried out over the last 20 years, often after negative media reporting of adverse events in maternity hospitals, including baby deaths. However, inquiry recommendations have not been consistently or entirely implemented (47). The approach to review of perinatal deaths is not uniform or transparent across maternity units (48). Bereaved parents do not feel their concerns and opinions are being taken into account and they want to contribute to the hospital's review of their baby's death (49). A new, standardised, perinatal death review process and national confidential enquiry has been recommended by both the National Perinatal Epidemiology Centre (46) and the Health Service Executive National Standards for Bereavement Care (1). A standardised perinatal mortality review tool and review process may help strengthen perinatal death reviews, provide more information and opportunity for involvement for bereaved parents and help reduce future perinatal deaths, as evidenced in other countries (50–52).
Someone is always to blame for perinatal death	Most perinatal deaths occur before birth due to conditions such as placental issues or fetal anomalies, and sometimes there are a combination of factors involved. A very small number of baby deaths in Ireland occur during labour (46). Perinatal deaths are distressing and traumatic for families. Seeking answers as to why their baby died is a normal response (49). The investigation of the cause of a baby's death also examines contributing factors within the healthcare system. Reviews should be open, transparent and timely. Ideally reviews should be focused on improving care rather than fostering fears among staff of punishment or litigation (51). Media discourse and culture of blame can negatively impact staff personally and professionally and ultimately patient care (58,59).
Baby death numbers in Ireland are already very low	While the number of baby deaths (perinatal mortality rate) in Ireland has been relatively static in recent years, the most recent data shows a fall in rates from 5.3/1,000 births in 2022 to 4.3/1000 births in 2023 (72). Reasons for this are as yet unclear and we do not know if this decrease will be sustained. A review of trends in stillbirth rates from 2010 to 2021 placed Ireland 20th out of 24 countries in Europe (73). Internationally in high income countries, stillbirth rates range from 1/1,000 to 10/1,000 (29,73). Other countries (e.g. Australia, the UK) have been able to reduce their numbers of baby deaths, through dedicated investment in prevention strategies (74,75). Ireland's perinatal mortality rates still have room for improvement, and targeted investment could reduce the number of baby deaths.

Myths	Facts
But we have already implemented the Bereavement Standards	While much work is being undertaken to implement the National Standards for Bereavement Care following Pregnancy Loss and Perinatal Death (53), demonstrating the commitment of the Health Service Executive's National Women and Infants Health Programme to high-quality care for bereaved parents and families, other barriers remain. These include maternity hospital infrastructure, staff recruitment/retention, and competing clinical services demands. The 2021 implementation report presented 40 recommendations as a priority for all maternity units – based on findings from sequential national audits of perinatal bereavement care services, expert opinion from multi-disciplinary healthcare professionals, learning from the experiences of bereaved parents and families and best practice (54). Perhaps the biggest issue, though, is awareness at the highest levels of our health services and in society about pregnancy loss and how important bereavement care really is (55). Research led by the Pregnancy Loss Research Group has consistently demonstrated the lack of awareness and knowledge around the different forms of pregnancy loss – amongst the general public, students and at a political level (56,57) which is reflected in policy delivery, resource allocation and research funding in Ireland.
Having another baby will help people get over the loss	Having another baby after a pregnancy loss does not simply "help people get over" the loss. While a subsequent pregnancy may offer hope and purpose, grief and complex emotions often persist and require tailored support from healthcare professionals (60–63). Research indicates that women embarking on another pregnancy following stillbirth or miscarriage often experience heightened anxiety, depression, and ambivalent emotions. Many report mixed feelings, including joy, guilt, and ongoing grief, and a new pregnancy /baby does not automatically resolve these feelings. Some parents describe greater vigilance and fear during subsequent pregnancies, including fear of another pregnancy loss, with unresolved grief sometimes re-emerging, especially at milestone moments (64,65). Another pregnancy does not erase feelings of loss or prevent complicated grief, so continuing support and acknowledgment of the loss remain crucial. Support from partners, healthcare providers, and peer groups who have experienced similar losses has been identified as particularly valuable for healing (66,67).
Stillbirth is very rare nowadays	Stillbirth is a tragic public health issue that affects about 200 families in Ireland each year (46). To appreciate the scale of this issue, this is the equivalent to losing nine full junior infants classes every year and is higher than the number of people who die on Irish roads (68). While successful public health campaigns have been effective in reducing sudden infant death syndrome (SIDS) deaths from 150 to fewer than 20 annually (69), stillbirth remains a hidden issue, and expectant parents are often unaware of the risks or preventative measures they can take (70). The lack of awareness and open discussion contributes to the misconception that stillbirth is a rare event when, in fact, it is a devastating reality for many families.
Only women with 'high-risk' pregnancies are at risk of stillbirth	Stillbirth can happen in any pregnancy, even seemingly 'healthy' pregnancies. Stillbirth isn't openly discussed due to concerns it might cause anxiety for pregnant people (15,23). Over a 12-year period in Ireland, the average age of women who had a stillbirth was 31.7 years, fewer than a quarter smoked, or had a BMI over 30. Half of the babies who died were average-sized, indicating even healthy babies are at risk (44). A common misconception is that stillbirths are primarily due to issues with medical care, the baby or mother (70). However, the most common cause of stillbirth is a problem with the placenta (46). Unfortunately, placental issues can affect any pregnancy but are currently difficult to detect (71).
Preventing stillbirths is too expensive	Preventing stillbirths is not only affordable but cost-effective, with every dollar invested delivering more than triple the return by reducing medical, economic, and legal costs, while saving families and society from lifelong emotional and financial hardship (29). The economic burden of stillbirth is substantial, extending far beyond the immediate tragedy. It includes increased healthcare use, long-term parental mental health needs, lost productivity at work, and significant costs from litigation (30,31). Preventive measures such as improved antenatal care, safer sleep campaigns, and early identification of risks are low-cost, evidence-based, and already proven in some countries to reduce stillbirths (24,32). Improving antenatal care also brings wider benefits, including better detection and treatment of risks that overlap with fetal growth restriction, preterm birth, and maternal mortality. While there are some costs involved in implementing such programmes—for example, the Saving Babies' Lives Care Bundle in the UK was estimated at £166,000 per stillbirth prevented (33)—these must be weighed against the far greater costs of doing nothing. Medical litigation alone is extremely expensive, with the US spending an average of $26 million annually over the past decade compared with just $12 million directed to stillbirth research (34). In Ireland, medico-legal cases related to perinatal deaths already contribute to an unsustainable financial trajectory for the health system (35).
There is no return on investment from pregnancy loss research	Policy reviews and expert consensus agree that increasing investment in this area is both clinically effective and beneficial for the health system (34,76,77). Research funding for pregnancy loss and newborn health is significantly lower than what is needed, especially given the scale of impact on families and healthcare systems. For example, for every £1 spent on pregnancy care in the NHS, only about 1p is directed to pregnancy-related research, even though stillbirths and newborn health issues are major contributors to perinatal mortality (76). Despite newborn health and stillbirths representing major causes of perinatal mortality, research spending lags substantially behind other areas (77). Global analyses confirm that these areas receive far less investment than other health topics, despite enormous human and societal costs (77). Evidence consistently shows that targeted funding improves care, leads to better prevention and detection of risk factors, and helps reduce rates of adverse outcomes as well as reducing long-term healthcare and litigation costs (34).