Fertility Solutions

fertilitysolutions.co.za

Miscarriage & Pregnancy Loss

Support Guide

Grief, recovery, and preparing for the next step — for both natural conception and IVF/IUI loss

We are so sorry for your loss.

What you are feeling right now is real. Your grief is real. Your baby was real — regardless of how early, how it happened, or what anyone else says. This guide is here for whenever you are ready. There is no right order, no right pace, and no right way to grieve. Take what is useful. Leave what is not.

This guide covers the emotional experience of pregnancy loss, the seven truths nobody tells you, how to navigate grief with your partner, physical recovery for each type of loss, the medical evidence on when you can try again, and how to prepare your body and mind for the next step — in your own time.

Section 1 — Understanding your grief

> Your loss is real regardless of how early it was. Your grief is proportional to your love — not to the length of the pregnancy. Society often minimises early pregnancy loss. What you are experiencing is the loss of a baby you loved, a future you imagined, and a version of yourself you were becoming. All of that is real.

TYPES OF PREGNANCY LOSS — EACH IS DIFFERENT

Type of loss	Gestational age	What you should know
Chemical pregnancy	*Before 6 weeks*	Positive test, then early loss before a heartbeat or scan confirms. Often dismissed by others as 'not a real pregnancy.' To those who have been trying, it was real. Grief is valid regardless of gestation.
Early miscarriage	*6–12 weeks*	May or may not have seen a heartbeat. If a heartbeat was seen then lost, the grief is particularly acute. Managed expectantly, medically (misoprostol), or surgically (D&C).
Second trimester loss	*13–20 weeks*	More developed pregnancy. Physical recovery is more extensive. Milk may come in. Hormonal collapse is more pronounced. Profound grief. Medical and psychological support essential.
IVF/IUI chemical	*Post-positive beta*	Beta hCG rises then falls before a scan. Clinic may call this a 'failed cycle.' Patient has experienced a loss. These two framings are incompatible — the patient's experience of loss is primary.
IVF miscarriage	*After confirmed IVF pregnancy*	Compounds the grief of the entire infertility journey. After fighting to conceive, a brief pregnancy, then loss. Double bereavement: the pregnancy and the renewed infertility grief.
Ectopic pregnancy	*Variable, often 6–10 weeks*	Medical emergency. Pregnancy implanted outside the uterus (usually fallopian tube). May require surgery or methotrexate. Loss of the pregnancy AND potentially the tube. Specific medical restrictions apply before trying again.
Molar pregnancy	*Variable*	Abnormal pregnancy requiring specialist follow-up and monitoring (usually 6–12 months). Must not attempt conception until hCG has cleared and specialist confirms it is safe.

WHAT GRIEF AFTER LOSS LOOKS AND FEELS LIKE

Grief after pregnancy loss does not follow rules. It does not come in neat stages. It does not resolve on a timeline. What you are experiencing is a real bereavement — and it deserves to be treated as one.

- **Waves — not stages** — Grief comes in waves. Some days — or even hours — will feel more manageable. Then a due date, a scan reminder on your phone, a pregnant friend's announcement, or simply a quiet moment will bring it crashing back. This is not a setback. It is how grief works.
- **Shock and disbelief** — Especially in the early days. The world looks the same but everything is different. You may feel numb or disconnected.
- **Profound sadness** — Not just about the pregnancy, but about the baby you will not meet, the future that was taken, the person you were for those weeks.
- **Guilt** — The most common and most unfounded feeling. You will search for what you did wrong. The answer is almost always: nothing. Most losses are caused by chromosomal abnormalities. It was not your diet, your stress, your exercise, or anything you did or did not do.
- **Anger** — At your body, at the unfairness of this, at people who are pregnant without trying. Anger is a legitimate grief response.
- **Jealousy** — Of pregnant friends, of people pushing prams, of everyone for whom it seems easy. This is normal and does not make you a bad person.
- **Numbness** — Some people feel very little in the initial days. This is a protective response. It will not last.

> If you are having thoughts of harming yourself, please reach out now — to someone you trust, to a crisis line, or to your doctor. You do not need to be alone in this. In South Africa: SADAG Helpline 0800 456 789. International: contact your local crisis service or go to your nearest emergency room.

DISENFRANCHISED GRIEF — WHEN OTHERS MINIMISE YOUR LOSS

People who love you will say the wrong things. 'At least it was early.' 'At least you know you can get pregnant.' 'You can try again.' 'It wasn't meant to be.' None of these are meant to hurt. Most come from helplessness — people do not know how to hold grief, so they try to resolve it. But these phrases minimise what you have experienced and can leave you feeling more alone.

Your loss does not require a minimum gestational age to count. You are not obligated to feel comforted by things that do not comfort you. You are allowed to say: 'I know you mean well. What I really need is just for you to be here.'

PREGNANCY LOSS AFTER INFERTILITY TREATMENT — A DIFFERENT GRIEF

If you fought hard to become pregnant — through IVF, IUI, or years of trying — this loss carries additional weight. You spent months or years and significant resources to get here. You finally saw those two lines or received that positive beta call. And then it was taken.

This is a compounded grief: the loss of the pregnancy itself, and the renewed grief of the entire infertility journey. The hope that had been carefully, cautiously rebuilt has collapsed again. The question 'will it ever work?' returns — harder to answer now. This grief is different, and heavier. Please do not face it alone.

THE GRIEF TIMELINE — WHAT TO EXPECT

- **FIRST 72 HOURS**

  ### Acute shock

  Survival mode. The most important thing in this window is not to be alone. Self-care basics — eating, drinking water, sleeping — are meaningful acts. There is nothing productive to do right now. Sitting with the loss is the only appropriate response.

- **DAYS 4–14**

  ### Emerging reality

  The shock begins to lift and the full weight of the loss often arrives. This is frequently the most difficult period. Many people describe feeling worse in week 2 than in the first days. This is normal. Practical life resumes but internally, the loss is enormous.

- **WEEKS 3–8**

  ### The long middle

  Life has largely resumed on the outside. Internally the waves continue. This is the period when people feel most alone — others assume you have moved on. Grief support, whether through therapy, a support group, or the FS Concierge, is most valuable here.

- **MONTHS 3–12+**

  ### Integration — not resolution

  Grief begins to become part of you rather than consuming you. Significant dates — the due date, the anniversary of the loss, Mother's Day — will bring it forward again. This is not regression. It is the ongoing relationship with a child you loved and lost.

Section 2 — Seven truths about pregnancy loss

These are evidence-based truths about pregnancy loss that often go unsaid. Read them in your own time, at whatever pace feels right.

1

You did not cause this.

The most common cause of first-trimester miscarriage — accounting for approximately 50–70% of early losses — is a chromosomal abnormality in the embryo. This is not caused by stress, exercise, sex, food, negative thoughts, a hot bath, or anything you did or did not do. Your body ended a pregnancy that could not have continued. This is biology, not failure.

2

Miscarriage is common — but common does not mean easy.

Approximately 10–20% of known pregnancies end in miscarriage. In women over 35 undergoing IVF, the rate is higher. The commonness of something does not reduce the grief of experiencing it. You are not unusual for being devastated. You are not weak. You are a person in pain after a real loss.

3

There is no grief too small to be real.

A chemical pregnancy is often dismissed — by clinics as 'a failed cycle,' by others as 'not a real pregnancy yet.' To those who have been trying to conceive, a positive test is a baby. A loss at any stage is a loss. You do not need a heartbeat or a scan image to have loved something and to be allowed to grieve it.

4

One miscarriage does not predict another.

The chance of miscarriage in the next pregnancy after a single loss is approximately the same as the baseline population risk — around 15–20%. Having one miscarriage does not mean you will have another. For those with recurrent pregnancy loss (2 or more), investigation is warranted — but a single loss is not predictive of a pattern.

5

The decision about when to try again is yours — not anyone else's.

People will tell you what they think you should do. Some will push you to try again quickly. Others will urge caution. Your body, your grief, your relationship, and your readiness are the only things that determine the right timing. There is no medically correct emotional timeline.

6

Your partner is grieving too — differently.

Men and other partners often grieve more quietly, or through practical action, or later. Neither way is more valid. The most common source of relational pain after pregnancy loss is not that one partner is grieving and the other is not — it is that they are grieving differently, without a shared language for it.

7

Seeking professional support is not weakness.

Pregnancy loss after infertility treatment is associated with elevated rates of clinical depression, anxiety, and PTSD. These are not character failings — they are documented clinical responses to significant trauma. A grief therapist who specialises in pregnancy loss can support you in ways that no amount of willpower or distraction can. This is the right time to seek professional help.

Section 3 — You and your partner

> The most common source of relational pain after loss is not that one partner does not care. It is that both partners are in grief — but expressing and processing it differently, often without the language to tell each other what they need.

HOW GRIEF DIFFERS BETWEEN PARTNERS

Women's grief tends to be more immediate and physically embodied — the bleeding, cramping, and hormonal collapse mean the loss is viscerally present from the first hours. Internal processing is usually immediate and ongoing.

Men and other partners often move into practical mode initially — managing logistics, supporting their partner — as their first response. This is not absence of grief. It is a different grief expression. Their deeper processing often comes later, and may surface as withdrawal, irritability, or apparent 'moving on' that can feel isolating to the person who experienced the physical loss.

Neither grief is more valid — but the difference in expression can create distance when both people need closeness. Naming this explicitly — 'I know we are both grieving differently' — is one of the most protective things you can say to each other.

WHAT ACTUALLY HELPS — COMMUNICATION THAT WORKS

1

Name what you need — specifically

'I need support' is too vague for grief. Try instead: 'I need you to just listen and not try to fix it.' 'I need to be held without having to say anything.' 'I need to talk about the baby — I need to say their name.' 'I need distraction right now — can we watch something?' Specific requests protect both of you from the exhausting cycle of unmet, unspoken needs.

2

Have the trying-again conversation — when you are both ready

The decision about when and whether to try again is one of the most loaded conversations a couple can have after a loss. Often one partner is ready before the other. This conversation is best had when neither person is in the acute phase of grief — not in the first weeks, not in a vulnerable moment. Both positions are legitimate. Neither person should be pressured.

3

Consider couples counselling — not because your relationship is broken

A grief therapist who works with couples after pregnancy loss provides something individual therapy cannot: a space where both of your grief is held simultaneously. Couples who receive support after pregnancy loss consistently report stronger communication and better relational wellbeing in the months that follow.

4

Protect the relationship from the outside

Decide together who you will tell, and when. Unsolicited advice, repeated questions, and comparisons to others' experiences are major stressors. Establish shared communication with family and friends — 'We are both doing the best we can and we will share updates when we are ready' — and refer everyone to that position.

Section 4 — Physical recovery

If you experience heavy bleeding (soaking more than one pad per hour for 2 consecutive hours), fever above 38°C, severe pelvic pain, or foul-smelling discharge, contact your clinic or go to an emergency room immediately. These can indicate complications requiring urgent care.

RECOVERY BY LOSS TYPE AND MANAGEMENT

Loss type	Physical recovery — what to expect
Chemical pregnancy (before 6 weeks)	Physical recovery is typically rapid — bleeding similar to a period, often lasting 4–7 days. hCG levels return to zero within 2–4 weeks. A follow-up blood test to confirm hCG has dropped is standard. Ovulation can return within 2–4 weeks.
Early miscarriage — expectant management	Cramping and bleeding (which can be significant) occurring over several hours to days as the body passes the pregnancy naturally. Heavy bleeding and pain are expected. If bleeding is very heavy or does not resolve, contact your clinic.
Early miscarriage — medical management (misoprostol)	Medication induces cramping and bleeding over 4–8 hours. The process is physically painful and emotionally demanding — seeing the tissue pass is an experience many describe as traumatic. Have support with you.
Early miscarriage — surgical (D&C)	Procedural recovery typically takes 1–2 days. Light bleeding for 1–2 weeks. A follow-up scan to confirm the uterus is clear is standard. The first period usually returns within 4–6 weeks.
Second trimester loss (13–20 weeks)	Recovery is more extensive — similar to labour and delivery. Milk may come in briefly. Hormonal changes are more pronounced and prolonged. Physical recovery takes 4–8 weeks. Medical follow-up and psychological support should begin immediately.
After IVF/IUI miscarriage	Progesterone and oestrogen supplementation must be stopped only on clinical instruction — never independently. Hormonal recovery takes longer when assisted conception medications were involved. Your fertility clinic manages the medical aspects and schedules follow-up.
Ectopic pregnancy	Recovery depends on treatment — surgical (laparoscopy or salpingectomy) or medical (methotrexate). Surgical recovery: 2–4 weeks. Methotrexate: follow-up hCG monitoring essential until levels reach zero. Strict contraception required for 3 months after methotrexate.

PHYSICAL MILESTONES TO BE AWARE OF

1 hCG monitoring

Your clinic will monitor hCG levels until they return to zero. This confirms the pregnancy tissue has cleared and rules out ectopic pregnancy. Do not skip this follow-up — it is a safety step, not just administrative.

2 The hormonal crash and its effects

The rapid drop in pregnancy hormones after a loss causes significant physical and emotional effects: intense fatigue, mood swings, weepiness, insomnia, and breast tenderness. These are physiological — your hormone system is recalibrating. They are not 'just' emotional.

3 First period after miscarriage

The first cycle is often longer or shorter than usual. Ovulation may occur at an unexpected time. A single natural period provides a useful baseline before beginning to try again — but if you conceive before a period returns, that is clinically acceptable in most cases.

4 When bleeding stops and infection risk

Doctors advise avoiding penetrative sex until bleeding has fully stopped (typically 2–4 weeks) to reduce infection risk. Tampons and menstrual cups should also be avoided until bleeding resolves. Sanitary pads only during recovery.

Section 5 — When can I try again?

This is one of the most asked questions after a miscarriage — and the answer is more encouraging than many people expect. The medical evidence and the emotional readiness question are two separate conversations, and both matter equally.

> This section provides general guidance based on current published evidence. Your specific clinical situation — gestational age, management type, results from investigation, emotional readiness — should always be discussed with your RE or GP before deciding when to try again.

WHAT THE EVIDENCE SAYS — THE 'HOW LONG TO WAIT' QUESTION

The traditional recommendation — wait 3 to 6 months — was based on limited data and was largely for the practical purpose of accurately dating a subsequent pregnancy before ultrasound was widely available. Current evidence tells a more nuanced story.

Context	What the evidence shows
Natural conception after early miscarriage (before 12–14 weeks)	Multiple studies show no physiological reason to delay. Women who conceive within 3 months of an early miscarriage have comparable or better outcomes — including lower repeat miscarriage rates and higher live birth rates — than those who wait longer. (PMC4780347; JAMA Netw Open 2023.)
IVF frozen embryo transfer (FET) after clinical pregnancy loss	More complex evidence. A 2023 cohort study (JAMA Network Open, 2,433 women) found that delaying FET for at least 6 months after a clinical pregnancy loss was associated with better live birth rates. For medicated FET cycles, a 6-month interval may benefit outcomes. Discuss with your RE before scheduling the next transfer.
After second trimester loss (13–20 weeks)	Allow full physical recovery (at least 2–3 menstrual cycles). Psychological readiness is particularly important after a late loss, which carries a heavier grief burden. RPL investigation should be completed before the next attempt.
After ectopic pregnancy — surgical management	Most clinicians recommend waiting until after 2–3 natural menstrual cycles and until the remaining tube has been assessed. Discuss with your RE.
After ectopic pregnancy — methotrexate treatment	Wait 3 full months after the last dose before attempting conception. Methotrexate affects folate metabolism and embryo development — this interval is a clinical requirement, not a precaution.
After molar pregnancy	Mandatory waiting period during specialist follow-up monitoring (6–12 months depending on hCG clearance pattern). Must not attempt conception until specialist confirms it is safe. hCG must reach zero and remain stable.
After D&C procedure	Most clinicians recommend waiting for at least one complete natural menstrual cycle to confirm uterine lining recovery before attempting conception.

THE EMOTIONAL READINESS QUESTION — EQUALLY IMPORTANT

> Emotional readiness and physical readiness are not the same thing. You may be physically cleared to try again before you feel emotionally ready. Equally, you may feel ready before your body has fully recovered. Both dimensions matter equally. There is no right answer — only your answer, arrived at in your own time, ideally in conversation with a therapist or the FS Concierge.

- **Signs physical readiness** — hCG has returned to zero (confirmed by blood test). Bleeding has fully stopped. At least one natural period has returned (for early loss; 2–3 for later loss). Medical follow-up complete. Any indicated investigations (RPL workup) completed.
- **Signs emotional readiness** — You have had space to grieve and do not feel you are rushing to 'replace' the loss. You feel cautious hope rather than raw terror at the thought of another pregnancy. You have a counsellor or support structure in place for the next attempt. You and your partner are broadly aligned on timing.

Section 6 — Preparing for the next step

Whether you decide to try again naturally, through IVF, through a different path, or simply need more time — the following supports your physical and emotional recovery and, when you are ready, your preparation for the next attempt.

IF YOU HAVE HAD 2 OR MORE LOSSES — RECURRENT PREGNANCY LOSS (RPL) INVESTIGATION

If you have experienced 2 or more pregnancy losses, an RPL investigation is appropriate. You do not need to wait for a third loss before seeking investigation. Most specialists recommend beginning a workup after 2 consecutive losses. A cause is found in approximately 50% of cases — and most causes that are found are treatable.

RPL investigations typically include	Common treatable causes
• Karyotype — both partners • Antiphospholipid antibodies (ACA, LA, anti-β2GP1) • Thrombophilia screen (Factor V Leiden, prothrombin mutation) • Thyroid function (TSH — target <2.5 mIU/L) • Uterine cavity assessment (saline sonogram or hysteroscopy) • Sperm DNA fragmentation — male partner • Allow 2–4 weeks for results — order before starting next cycle	• Antiphospholipid syndrome → low-dose aspirin + heparin • Thyroid dysfunction → levothyroxine or antithyroid medication • Uterine abnormality (septum, polyp) → surgical correction • Chromosomal translocation → PGT-SR (preimplantation genetic testing) • Thrombophilia → anticoagulation during pregnancy • 50% of RPL: no identifiable cause found — prognosis for next pregnancy still 60–70% success (ESHRE RPL Guidelines 2023)

PHYSICAL PREPARATION FOR THE NEXT ATTEMPT

1

Continue or restart supplements

Folic acid (400–800 mcg) and a prenatal vitamin should continue or restart as soon as medically cleared. CoQ10 (ubiquinol, 200–400 mg) for egg quality — particularly important if age is a factor. Vitamin D if levels are low. Male partner: CoQ10, Vitamin C, Vitamin E. See the Fertility Solutions 3-Month Pre-Treatment Checklist for the full protocol.

2

Thyroid — give it particular attention

Thyroid dysfunction is a significant and often overlooked contributor to recurrent miscarriage. Even a mildly elevated TSH (above 2.5 mIU/L) is associated with higher first-trimester miscarriage rates. Have TSH retested before starting the next cycle — the target for fertility patients is more stringent than the general lab reference range.

3

Ask your RE about progesterone supplementation

There is evidence that vaginal progesterone in early pregnancy may reduce miscarriage risk in women with a history of loss. The PRISM Trial (NEJM 2019) showed significant benefit for women with early pregnancy bleeding and prior loss. Ask your RE directly: 'Am I a candidate for progesterone supplementation in the next pregnancy?'

4

Optimise nutrition

The Mediterranean dietary pattern is associated with better IVF outcomes and reduced miscarriage rates. This is not about perfection — 80% adherence over 2–3 months produces meaningful benefit. See the Fertility Solutions IVF Nutrition Plan. Particular emphasis: folate-rich foods, oily fish, leafy greens, and reduction of ultra-processed foods and added sugar.

EMOTIONAL PREPARATION — WHAT ACTUALLY HELPS

1

Seek specialist grief support — not general counselling

Pregnancy loss grief is specific. A therapist who specialises in perinatal loss will understand the experience of losing a pregnancy after infertility treatment, the fear of the next pregnancy, and the relational complexity that follows. This is not a one-off session. Meaningful grief work typically takes 3–6 months of regular sessions. It is the most important investment you can make for your own wellbeing.

2

Honour the baby you lost

Some people find that giving their baby a name, creating a small memorial, or marking the due date helps to acknowledge the reality of who was lost. A plant or tree, a piece of jewellery, a letter you do not send, a candle on the due date. Whatever feels right — there is no obligation, and no right way.

3

Have a counsellor in place before the next pregnancy

Pregnancy after loss is emotionally different from a first pregnancy. The hypervigilance — checking for bleeding, unable to celebrate, terrified at every scan — is a normal trauma response. Having a psychologist in place before the next positive test — not only after — is the most protective thing you can do. The Fertility Solutions Concierge offers dedicated pregnancy-after-loss support for this reason.

4

Protect significant dates in advance

The due date of the pregnancy you lost, the anniversary of the loss, Mother's Day, Father's Day — these dates will bring grief forward. Naming them in advance, and having a plan for how you will spend them, is more protective than being ambushed by them.

Sources, resources and disclaimer

EVIDENCE BASE

- **PMC4780347** — Trying to Conceive After an Early Pregnancy Loss — inter-trying interval and fecundability (secondary analysis of EAGER trial)
- **JAMA Network Open 2023** — Interpregnancy Interval After Clinical Pregnancy Loss and Outcomes of the Next Frozen Embryo Transfer (Wang et al.; 2,433 IVF patients)
- **PRISM Trial, NEJM 2019** — Progesterone supplementation in women with unexplained recurrent miscarriage and early pregnancy bleeding
- **ESHRE RPL Guidelines 2023** — European Society of Human Reproduction and Embryology recurrent pregnancy loss guidelines
- **ASRM Practice Committee Guidelines** — Evaluation and treatment of recurrent pregnancy loss
- **Tommy's Miscarriage Research** — UK charity dedicated to pregnancy loss research and support
- **Miscarriage Association UK** — Guidance on trying again after loss

SA SUPPORT RESOURCES

- **SADAG** — South African Depression and Anxiety Group — crisis line 0800 456 789 (toll-free, 24 hours)
- **Lifeline South Africa** — Crisis counselling — 0861 322 322
- **Fertility Solutions Concierge** — fertilitysolutions.co.za/concierge/ — specialist support for pregnancy loss, RPL investigation, and preparing for the next step

INTERNATIONAL CLIENTS

- **International Association for Pregnancy Loss** — iaplb.org
- **Tommy's** — tommys.org — UK-based; global resources
- **The Miscarriage Association** — miscarriageassociation.org.uk
- **SANDS** — sands.org.au (Australia/New Zealand) — stillbirth and neonatal death support

Medical and psychological disclaimer

This guide provides educational information and emotional support guidance. It does not replace professional grief counselling, psychological support, or personalised medical advice. If you are experiencing thoughts of self-harm, please reach out to a crisis line or medical professional immediately. All clinical guidance in this document — including timing recommendations for trying again — should be discussed with your reproductive endocrinologist or GP, who will advise based on your individual clinical history. This document requires review by a specialist psychologist and a reproductive endocrinologist before clinical or client-facing use.