Original Article

Revista de Enfermagem do Centro-Oeste Mineiro
2024; 14/5141
www.ufsj.edu.br/recom

RECOM
Revista de Enfermagem
do Centro-Oeste Mineiro

Nurses' care rituals for women and babies due to pregnancy loss

Rituais de cuidado de Enfermagem com mulheres e bebês diante das perdas gestacionais

Rituales de cuidado de Enfermería a mujeres y bebés por pérdida de embarazo

ABSTRACT

Objective: To identify nurse care rituals for women who have suffered pregnancy loss. **Method:** this is a qualitative study, carried out in a university hospital in the south of the country, in a high-risk maternity hospital. Data collection took place between April and June 2022, with 11 nurses. the data were analyzed using the thematic content analysis proposed by Bardin and using the Webqda software. **Results:** the category of analysis presented care rituals offered to the woman/family and babies, which are bonding, through a welcoming and respectful attitude, individualization, communication, welcoming and active listening, detailed guidance on the procedures adopted and the creation of affective memories. **Conclusion:** Offering care rituals in the face of pregnancy losses should be a care practice to be discussed and carried out in maternity hospitals, since it is little discussed and offered in training centers and services.
Descriptors: Obstetric Nursing; Stillbirth; Fetal death; Nursing care.

RESUMO

Objetivo: Identificar rituais do cuidado de Enfermagem para a mulher que sofreu perda gestacional. **Método:** Trata-se de estudo qualitativo, realizado em um hospital universitário da região Sul do país, em maternidade de alto risco. A coleta de dados ocorreu entre abril e junho de 2022, contando com dez enfermeiras e um enfermeiro. Os dados foram analisados com a análise de conteúdo do tipo temática, proposta por Bardin, sendo utilizado o software Webqda. **Resultados:** A categoria de análise apresentou rituais de cuidado oferecidos à mulher/família e bebês, sendo estes a formação de vínculo, por meio da atitude acolhedora e respeitosa, individualização, comunicação, acolhimento e a escuta ativa, orientações detalhadas dos procedimentos adotados e a criação de memórias afetivas. **Conclusão:** Oferecer rituais de cuidado diante das perdas gestacionais devem ser uma prática assistencial a ser reflexionada e efetivada nas maternidades, visto que é pouco discutido e oferecido nos centros formadores e serviços.
Descritores: Enfermagem obstétrica; Natimorto; Morte fetal; Cuidados de Enfermagem.

RESUMEN

Objetivo: Identificar rituales de cuidado de enfermería para mujeres que han sufrido pérdida del embarazo. **Método:** se trata de un estudio cualitativo, realizado en un hospital universitario de la región sur del país, en una maternidad de alto riesgo. La recolección de datos se realizó entre abril y junio de 2022, con 10 enfermeros y 1 enfermera. Los datos fueron analizados con el análisis de contenido temático propuesto por Bardin y utilizando el software Webqda. **Resultados:** la categoría de análisis presentó rituales de cuidado ofrecidos a la mujer/familia y al bebé, siendo estos la formación de vínculos, a través de una actitud acogedora y respetuosa, la individualización, la comunicación, la acogida y la escucha activa, la orientación detallada sobre los procedimientos adoptados y la creación de vínculos afectivos. recuerdos.
Conclusión: Ofrecer rituales de cuidado ante las pérdidas del embarazo debe ser una práctica de cuidado a reflexionar e implementar en las maternidades, ya que es poco discutida y ofrecida en los centros y servicios de formación.
Descriptores: Enfermería obstétrica; Mortinato; Muerte fetal; Atención de Enfermería.

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INTRODUCTION

Prenatal care, through preventive actions, seeks to ensure the healthy development of pregnancy and enable the birth of a healthy baby while preserving the mother's health(1); however, sometimes, even with adequate management, pregnancy losses may occur.

In Brazil, comprehensive care for women only began in 1983, through the Comprehensive Women's Health Care Program (Programa de Assistência Integral à Saúde da Mulher - PAISM), which encompassed gynecological and obstetric complaints, prenatal control, childbirth and puerperium, sexually transmitted diseases, cervical and breast cancer, family planning and contraception, from adolescence to old age, with Nursing being present in all these processes(2). Since then, a process of developing, implementing and continuously implementing policies and programs has begun, analyzing and improving what has already been built, optimizing women's health policies and, more specifically, with guidelines aimed at women and family members who experience pregnancy loss(3).

The fetal mortality rate is an indicator of the quality of care provided to pregnant women and during childbirth. In Brazil, this rate was 5.3 fetal deaths per 1,000 births from 2000 to 2016(4). There is a paradox between the high incidence of fetal deaths and the low attention that the issue receives in global politics. It is assumed that this is caused by the lack of data, the uncertainties regarding the cause of death or perhaps even the lack of advocates for babies born in silence(5).

A systematic review study showed that family members in situations of pregnancy loss described communication with health professionals as painful, disconnected and uncomfortable(6). Another study, which assessed the impact of anencephalic pregnancies on 20 women and four men, found that 18 of them experienced intense grief, and that a direct relationship between social support and interactions with health professionals may be associated with less intensity of grief. However, poor interactions can hinder this process, such as when they felt that they were no longer a priority for the health service and that their preferences and wishes were disregarded and ignored(7).

In the United Kingdom, the institution Saving babies lives. Supporting bereaved families, known as SANDS, has published a guide for health professionals on this subject. The institution highlights the following as the main requirements for offering specialized care: good communication, shared decision-making and individual care, in addition to an infrastructure that allows for accommodation away from other mothers with living children and allows or facilitates memory storage resources(8). It is estimated that around 4.9 million perinatal deaths occur each year worldwide, that is, deaths that occur intrapartum or up to 28 days after birth, including 2.5 million fetal deaths in 2019 alone and 2.9 million premature neonatal deaths, in which 1 million newborns die on the day they are born(9). In Brazil, in 2021, the most recent data presented by DATASUS indicate 29,325 cases of fetal deaths(10).

In 2019, the action "Why do we need to talk about the loss of a baby?" was launched, with the aim of transforming situations of miscarriage, stillbirth and neonatal death visible throughout the world, as well as to describe the need for better practices and qualified health professionals(11).

To date, there are no support guidelines

for stillbirths or neonatal death in Brazil. Health services and health professionals deal with each situation according to their own beliefs. Sometimes, professionals provide care based on what is convenient for them, since dealing with grieving patients causes stress and anguish(12). Thus, the care provided in these situations represents an issue that deserves visibility. The present study is justified because it seeks to raise elements to contribute to the improvement, qualification and dissemination of nursing care in scenarios of pregnancy loss. Thus, the objective was to identify nursing care rituals for women who have suffered pregnancy loss.

METHOD

This is an exploratory qualitative study conducted in a high-risk maternity hospital in the city of Curitiba, Paraná, Brazil. The study participants were ten nurses and one male nurse who care for women in situations of pregnancy loss in the emergency departments, obstetrics center, and rooming-in.

The inclusion criteria were those who had provided direct care to patients in pregnancy loss and who had worked in the service for at least three months, including residents; those who signed the Free and Informed Consent Form (FICF) but did not attend the scheduled interview would be excluded. As this did not occur, no participants were excluded.

Upon signing the FICF, the researchers offered the possibility of conducting data collection in person or remotely, at the time suggested by the nurses, and all participants opted for the remote method, via the Microsoft Teams application. Data collection took place through recorded semi-structured interviews between April and June 2022. Initially, two pilot interviews were conducted with obstetric nurses from other institutions, only to validate the script, and were not used in this study. The following guiding question was used: How do you provide care to patients and companions who have suffered fetal loss? If necessary, the following subsequent question was included: Do you identify the strengths and weaknesses of this care?

The interviews totaled 235 minutes of audio, the longest being 40 minutes and the shortest being 10 minutes; thus, the average duration was 20 minutes, and the full transcription resulted in 95 pages of document. The analysis used the thematic Content Analysis proposed by Bardin(13), consisting of three phases: pre-analysis, exploration of the material and treatment of the results. Concomitantly, the Webqda® software was used to assist in the organization and treatment of qualitative data for analysis. The category presented in this article was: Nursing Care in the Face of Pregnancy Losses, corresponding to 22 pages of the report generated by this software.

This research complies with the ethical precepts of Resolution No. 466/2012, which covers research with human beings, and was approved by the ethics committee of the place where it was conducted on January 18, 2022, opinion No. 5,204,118. To guarantee the anonymity of the participants, the names were replaced by the letters EO, followed by Arabic numerals, according to the order in which the interviews occurred.

This study is part of the dissertation entitled "Nurses' experience in caring for women in the face of pregnancy losses".

RESULTS

Of the 11 interviewees, ten were female and one was male, aged between 23 and 45 years old; eight nurses had specialized in Obstetric Nursing and three nurses were un-

dergoing training in this specialty. Of these, two were resident nurses in Women's Health. The specialists' training time varied between 5 and 9 years. One nurse worked in the rooming-in sector; one in the gynecological and obstetric emergency room; seven in the obstetric center and the residents worked in all the sectors described.

Bond formation: welcoming and respectful attitude

The category of nursing care in the face of pregnancy loss had 31% representation in the survey obtained through the software used and had the participation of all interviewees. In this survey, four themes were grouped together, based on similarity, involving the daily practices of nursing care performed on women in situations of pregnancy loss. Bonding, through a welcoming and respectful attitude, was highlighted in the discourse of four nurses, as can be seen, for example, in the two statements below:

> I try to feel what that loss is like for her, so I can offer some kind of comfort, some kind of welcoming word [...] But I never tell her that she'll get pregnant again soon, you know? I think it's very inhumane, because each child is a child for her, she'll always remember that pregnancy loss, so we have to feel it, right? (EO 4).

> If you don't know what to say, don't say anything, right? Just hug that woman, welcome that family, that's it. Right? Many times, not saying anything is much more symbolic for that family than talking a bunch of crap, right? So I think we need to start thinking more from that perspective, you know? [...] So, I start by introducing myself and I always tell them: "I can't imagine the pain you're feeling, but I'm available for anything I can do to help you at this moment." And, often, what they really ask for is a hug or they ask to be alone, or they ask to have a companion present (EO 9).

Women's perception of care

Nursing professionals are aware that empathetic care, in addition to being offered, also needs to be perceived by these women, through care instruments such as individualization, verbal and non-verbal communication, reception and active listening, among others, as pointed out by ten nurses and exemplified in the following reports:

> Because we must have our knowledge, but we also have to know how to touch this human soul that needs us so much and is so fragile at this moment that it is so difficult for her, right? If it is difficult for us, so imagine for her who is going through this. [...] I am very tactile, so I try to touch, I try to calm, I try to talk, breathe, I try to do clinical reasoning with her. I try to clear up her doubts, which they bring up a lot, right? What is going to happen? Even though we in Nursing do a risk classification (Emergency Obstetric Care), if she wants to show me a photo, a video, I will see her, even if it is not that important for my care [...] you have the patience to look at her, it is... to make this experience easier for her (EO 2).

> For me, providing care is also painful. I put myself in this woman's shoes and I confess that I try to see her reaction, her expression, through her eyes [...] Even though I have 5 or 10 cards, sometimes it piles up, you know, I let her talk, I let her vent, I ask her how she's feeling, how it's going for her, you know, I try to listen to her too, because welcoming someone isn't just about us saying what we think, you know? [...] You have to be careful to know how this woman is feeling, so as not to cause more suffering, you know? She has to see if she's giving you an opening, if she wants to talk more about the subject, whenever possible I always ask if she's religious, if she believes in God, you know, I end up asking more questions than talking much, because sometimes what we can say doesn't exactly fit her. So, you have to be careful, listen first to see how you can comfort her. [...] It's that moment when I have to hold myself back as a professional,

so as not to cry along with them, right, so I can give support (EO 4).

Guidance on procedures and medications

Some of the care that nurses offer and emphasize the need to perform them focuses on detailed guidance on the procedures adopted and medications to be used, as well as direct assistance to the patient, as indicated by 10 interviewees:

> Yes, it has never been very difficult for me to help these women. There are people who prefer not to be around them because they don't know how to deal with it very well, they don't know how to behave, they can't hold back their emotions. So, I've never noticed any limitations on my part in this regard. Quite the opposite. [...] when they are late losses, right, considered fetal death and not miscarriage, I end up trying to put them in the delivery suites, so that the woman has more access to the ball, shower, bathtub, if she so desires, to ensure the minimum of non-pharmacological methods at least [...] The last one that I remember that was emotional was a pregnant woman who was almost 40 years old, her first pregnancy, a baby that was long awaited and she had a loss at 32/33 weeks, and it was a long induction, obviously emotionally painful, but it was a very beautiful birth. I turned off the lights, put on a playlist of waterfall sounds, it was a birth in the dark, they stayed with the baby. And so, it can be beautiful, it can be emotional, it can be, despite being sad. I try to go by feeling (EO1).

> "It is very important to always explain the procedures, always explain what you are going to do, ask if she has any questions, prepare the woman, guide her in the most humane way possible, right? That is what we try to do. [...] I think I am trying as much as possible to provide adequate support, talk to the woman, and think in this way, as I said before, to try to give her privacy, a nice environment, to welcome her as a human being, not as a curettage procedure, an abortion in progress, an infected abortion, a loss, an obstetric emergency, right? Treat her as a human being (EO 4).

> So I explain it to her in detail, look, it will be misoprostol every 4 hours, inserted through the vagina, there in your cervix, you will feel cramps. When you start bleeding, let me know, and then I can do the procedure. For now, I can give you a liquid diet because of the procedure you're going to go through. I'll explain what a curettage is and, if necessary, the type of anesthesia, how long the procedure will last. [...] I'll explain how the pill procedure will be, and I'll tell you if you need anything, I'm here. You can call me, ring the bell if you have cramps or nausea. You can also tell me that we'll give you medication to help, to ease the pain, and that's it. [...] And in the case of childbirth, you know, when it's a fetal death, then the woman goes through labor, we induce that labor, and I also explain that she's going to go through labor. Unfortunately, it's not like, the baby won't be born alive. There's a baby, you know, it won't be born alive, and when the baby is born, I ask if she wants to see it, if she wants to hold it (EO 11).

Rituals performed with the deceased baby

Another care approach addressed by the nurses refers to the rituals performed with the deceased baby after birth. Six nurses reported the care they found to assist their patients and families with the arrival and departure of the newborn, with the aim of helping them cope with the situation and create emotional memories:

> Especially when it's shaped like a baby, we usually make a memory, right? Some people call it a memory box, anyway. Whenever possible, try to make a stamp of the baby's foot or hand. If there's hair, try cutting a tuft of the baby's hair, or a piece of the umbilical cord, something like that. Yes, whenever I'm on duty I do this, I open a card, make a bracelet, get a hat and put together a little kit that reminds me of that moment. I even usually write what comes

> from my heart [...] I've already stamped the placenta when it comes out whole, you can do that too and it looks beautiful (EO 1).
>
> Prepare the baby if she wants to be held, right, in the least scary way possible, because there's a whole physical issue that ends up changing, explain to her that she can stay with the baby as long as she wants. We have a habit of painting the placenta, when possible, then placing the baby's feet, there are some texts there, I admit that I don't have anything like that in my head, but we have a pre-established one that we can use to make a more beautiful saying. I really like to offer everything that the baby would have if he had been born alive. I give the bracelet, the cap, the card with the birth data, with a memento of his birth. And if he wants this memento, right? Then I always offer a photo. If he wants to throw it away, that's fine. [...] we try to give all this physical support, you know? Of respect, of individualization (EO7).
>
> So I provide all the normal assistance, like during labor, of course with that bad atmosphere, that atmosphere of mourning, but at the same time I say, look how beautiful your baby is, and while he was with you in your belly, I'm sure you were a great mother, I call the baby by name, I pick up the baby, wrap him up, put on a diaper, a little cap, let him stay with the mother, I make a foot print on the baby, I write a little message. Then I do it, because I went and saw that it is well accepted by the mothers. And in fact, when they don't want to see it, I know that in a little while they will want to, so it's okay, I take him there or arrange the baby as if it were a living baby. There are some who want to take a picture, I take a picture of them and the baby and so on (EO 11).

Early pregnancy losses

It is worth noting that a nurse reflects that some care practices do not occur in cases of early pregnancy losses, and deserve more attention:

> I ask: "Do you want to see it?" I can make several assumptions, but one of them is because, often, during curettage, it ends up being a bit shattered, you can't see any shape of anything and people end up assuming that, well, who would want to see that, right? When in fact I think it should be, it should be a common practice, right? Because after all, it's hers, it came out of her body, regardless of whether it's in the shape of a baby or not. [...] normally when we have a situation like this, regardless of whether she was admitted on my shift or not, I not only ask but I reinforce to the woman that it's her right to see it. So, normally, I'll say that, like, it's a practice that they should do more with early abortions, right? But I don't see people saying: "Do you want to see the gestational sac?" (EO 1).

DISCUSSION

This research highlighted the importance of creating a bond between nursing professionals and women and family members who experience pregnancy loss, in an empathetic and respectful manner; as well as the need for these women to perceive care in a humanized manner. To this end, care instruments can be used, such as individualization, verbal and nonverbal communication, welcoming and active listening; the need to provide detailed guidance on the procedures adopted, care provided and medications to be used; the need to provide rituals with the deceased baby in order to create affective memories; and the reflection of these rituals in the face of earlier pregnancy losses.

Among the various manifestations of care reported by nurses, communication was one of the elements that stood out. Therapeutic communication is an essential intervention, achieved through the nurse's total availability, constant presence, eye contact and appropriate tone of voice, ac-

tive listening, demonstrating empathy and understanding, as well as silence, when preferable. The first contact established between the nurse and the woman will often determine the quality of the communication established(14).

Caring is an act of life, in the sense of maintaining and sustaining it; thus, it is an individual act that we provide to ourselves, in the same way that it is an act of reciprocity that is provided to another person. For Nursing, as a profession, the care process is constructed from the constant mobilization of elements that interact with the aim of defining the vital needs of a person, family and/or group that need to be met. It is a process that is part of a system of exchanges, coming from various sources that require knowledge, technologies, beliefs and values on which the provision of Nursing care is based(15).

Nurses are responsible for helping individuals find their own strength to deal with the challenges and adversities of everyday life, since, when faced with challenges, human beings respond as a whole, in all aspects of being. The way to deal with the complexity of the human response to adversity is to repair and restore the whole, developing care that honors the uniqueness of each person and developing an environment that supports people's innate healing mechanisms(16).

Caring for a woman who has suffered a pregnancy loss is a challenging experience for health professionals. Knowing how to communicate, respect, and welcome family members is essential knowledge for promoting humanized care; therefore, it is necessary not only to have knowledge about the demands and particularities of perinatal grief, but also to have planning and technical preparation that can guide professionals through such a challenging event as managing a death in this context(17).

Considering the feelings involved in providing care to grieving women, it was found in the statements that the participants adopt a posture of approaching the woman who suffered the loss, reflecting feelings of solidarity and empathy. In addition to sensitivity, it is necessary to have empathy and effective communication with the woman who has experienced fetal loss. It is also necessary to maintain a lack of prior judgment, receptive and attentive listening and care with non-verbal communication, offering adequate care based on humanization and comprehensiveness(18).

The nurses emphasized the need for guidance regarding all possible conduct and care offered, and to detail the interventions that the woman may undergo during the birthing process. Furthermore, when the pregnancy is more advanced, it is routine to offer memories and moments for the reception and care of that family.

It is also important to note that women will experience physiological changes that are common to any woman who goes through the birthing process, such as changes in the abdomen and uterine involution, lochia, stitches and the involution of lactation. This is a process that is often overlooked or not discussed during this process, overlapping with the grieving process experienced by women(19). The care plan must be in line with the woman's choices and consider her uniqueness in order to provide respectful care throughout the birthing process and postpartum(20).

Contact with the baby after birth and the act of recording/keeping a memory have been widely encouraged as they have a po-

sitive impact on the grieving process. Therefore, the role of the healthcare team in encouraging the creation of memories through videos and photos, locks of hair, seeing and holding the baby after birth, bathing and changing the baby, as well as ensuring that the baby is called by name and introduced to the family is essential(21,22).

Positive experiences in the grieving process after pregnancy loss were related to nurses who gave parents options, asked their opinions and preferences, helped create memories such as footprints and handprints, used the names that parents had chosen for their newborns, allowed parents to hold and spend time with the baby, provided isolation for parents who had healthy babies, and allowed visits from family and friends(7). These elements of care rituals can also be seen in the reports of the nurses interviewed, with visits being allowed daily at the hospital at predetermined times.

Studies show that this help, effectively, in expressing and validating feelings during mourning is part of a rite of passage to the phase of acceptance of what happened. In it, parents and family members can place the important and meaningful items that they collected during pregnancy, birth and the baby(8,23).

A systematic review on nursing interventions to facilitate the grieving process after perinatal death showed that individual care actions for women/families are effective in the grieving process if they are carried out before (if predictable) and after the death of the baby. The interventions are mainly focused on the woman, although parents also feel the loss. This effective care refers to the support of health professionals, the participation and involvement of parents in the loss, openness to express feelings and emotions, use of distraction methods, group sessions, social support, physical activity and family education. Furthermore, health professionals must feel safe and well trained, as it is necessary for nurses to face these circumstances with compassion and confidence(24).

The need for services to establish a protocol can be a useful tool in developing team training and guiding care for a family experiencing grief. A well-known instrument when it comes to communicating bad news is the SPIKES protocol, which was adapted for clinical use in the Brazilian setting. Using it as a basis, a team of Brazilian researchers proposed the PATIENT protocol (prepare; assess how much the patient knows and wants to know; invite reality; inform; emotions; do not abandon the patient and outline a strategy)(25). Thus, discussion groups, knowledge of the strengths and weaknesses in the care offered to families who have suffered pregnancy loss, as well as knowledge of local networks that provide support after hospital discharge, are essential in health services.

FINAL THOUGHTS

The nurses participating in this research indicated care offered that involves aspects of therapeutic communication and care practices that can be offered to women/family members and babies in the face of death, these known as care rituals. In addition, they are concerned with promoting a respectful environment, making themselves present so that the woman feels supported and welcomed to experience the grieving process and can give new meaning to the birth of a stillborn baby or the early loss in cases of miscarriage. It is also worth highlighting here the need for obstetric nurses to know, in addition to life support, elements of the grieving process, as they can be a facili-

tator of this, a positive element that will contribute to the path of the woman/family in a situation of pregnancy loss.

From the perspective of the care of those who provide care, the importance of training and moments of reflection among the teams themselves is highlighted, which provide opportunities for professionals to speak, listen, exchange knowledge and encouragement, and provide conditions for them to be heard about their experiences. Actions such as these promote care in cases of pregnancy loss, providing those involved in the process with the opportunity to express their concerns and ensure that they can cope with fetal death or other adversity that may be present in daily practice.

Through this research, it is proposed that institutions in this area of knowledge reflect on the care rituals offered to women/families and babies in cases of pregnancy loss and assess the need to develop care protocols so that care can be instituted. The limitations of this research are that data collection was carried out remotely due to the pandemic period and that the data cannot be generalized, as it is only one scenario. As this is a subject that has been little discussed and investigated in the study scenario, this work opens the door for other research, discussions, and training to be carried out on site.

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Authors' contributions:
Conception and design of the research: APR, THT
Acquisition of data: APR, THT
Analysis and interpretation of data: APR, THT
Obtaining funding: Not applicable
Writing of the manuscript: APR, THT, HH
Critical revision of the manuscript for intellectual content: APR, THT, MLW e THV

Responsible editors:
Patrícia Pinto Braga – Editor in chief
Edilene Aparecida Araujo da Silveira – Scientific editor

Note:
Excerpt from the dissertation "Nurses' experience in caring for women facing pregnancy loss", Federal University of Paraná, 2023.

Received in: 06/08/2023
Approved in: 18/03/2024

How to cite this article:
Rosa AP, Trigueiro TH, Hornung H, et al. Rituais de cuidado de enfermagem com mulheres e bebês diante das perdas gestacionais. Revista de Enfermagem do Centro-Oeste Mineiro. 2024;14:e5141. [Access_____]; Available in:_____. DOI: http://doi.org/10.19175/recom.v14i0.5141.