

Attention to women in situation of intrauterine fetal death: experiences of health professionals



Atenção à mulher em situação de óbito fetal intrauterino: vivências de profissionais da saúde

Atención a la mujer en la situación de muerte fetal en el útero: experiencias de los profesionales de la salud

Taynnara Caroline Serafim^a

Beatriz Helena Naddaf Camilo^{a,b}

Mariana Rodrigues Carizani^c

Mariana De Gea Gervasio^d

Diene Monique Carlos^b

Natália Rejane Salim^b

How to cite this article:

Serafim TC, Camilo BHN, Carizani MR, Gervasio MDG, Carlos DM, Salim NR. Attention to women in situation of intrauterine fetal death: experiences of health professionals. Rev Gaúcha Enferm. 2021;42:e20200249. doi: <https://doi.org/10.1590/1983-1447.2021.20200249>

ABSTRACT

Objectives: Understand the experiences of health professionals in obstetric care in relation to the situation of intrauterine fetal death.

Method: Study of a qualitative approach, in which 11 health professionals participated. Data were collected through semi-open interviews and submitted to thematic content analysis.

Results: The professionals' difficulty in dealing with the topic and its invisibility during the training proved to be challenging. The lack of ambience and the forms of organization of attention reflected in the care for women and families who are undergoing intrauterine fetal death. The lack of strategies and spaces for sharing among professionals was directly related to the suffering and feeling of helplessness in the cases.

Final considerations: There is a need to develop strategies for changes in the model and organization of the service in the face of situations of fetal death, promoting spaces that are welcoming producers.

Keywords: Fetal death. Bereavement. Patient care team. Humanization of assistance. Women's health.

RESUMO

Objetivos: Compreender as experiências de profissionais de saúde da atenção obstétrica em relação à situação de óbito fetal intrauterino.

Método: Estudo de abordagem qualitativa, do qual participaram 11 profissionais de saúde. Os dados foram coletados por meio de entrevista semiaberta e submetidos à análise de conteúdo temática.

Resultados: A dificuldade dos/as profissionais em lidar com o tema e a sua invisibilidade durante a formação se mostrou desafiadora. A ausência de ambiência e as formas de organização da atenção refletiram no cuidado a mulheres e famílias que atravessam a situação de óbito fetal intrauterino. A falta de estratégias e espaços para o compartilhar entre profissionais se relacionaram diretamente ao sofrimento e sentimento de impotência perante os casos.

Considerações finais: Existe a necessidade do desenvolvimento de estratégias para mudanças no modelo e na organização do serviço diante de situações de óbito fetal, promovendo espaços que sejam produtores de acolhimento.

Palavras-chave: Morte fetal. Luto. Equipe de assistência ao paciente. Humanização da assistência. Saúde da mulher.

RESUMEN

Objetivos: Comprender las experiencias de los profesionales de la salud en atención obstétrica en relación con la situación de muerte fetal intrauterina.

Método: Estudio de un enfoque cualitativo. Once profesionales de la salud participaron en el estudio. Los datos fueron recolectados a través de entrevistas semiabiertas. El análisis de datos se realizó a través del análisis de contenido temático.

Resultados: la dificultad para tratar el tema; la invisibilidad del tema durante el entrenamiento; La falta de ambiente las prácticas y la organización del servicio se presentaron como factores directamente relacionados con el cuidado de las mujeres y las familias que pasan por la situación de muerte fetal intrauterina. La falta de compartir entre el equipo revela que genera sufrimiento y un sentimiento de impotencia para los profesionales.

Consideraciones finales: Existe la necesidad de desarrollar estrategias para los cambios en el modelo y la organización del servicio ante situaciones de muerte fetal para promover espacios que sean productores anfitriones.

Palabras clave: Muerte fetal. Aflicción. Grupo de atención al paciente. Humanización de la atención. Salud de la mujer.

^a Santa Casa de Misericórdia de São Carlos. São Carlos, São Paulo, Brasil.

^b Universidade Federal de São Carlos (UFSCar), Departamento de Enfermagem. São Carlos, São Paulo, Brasil.

^c Universidade Estadual Paulista "Júlio de Mesquita Filho" (UNESP), Residência em Enfermagem Obstétrica. Botucatu, São Paulo, Brasil.

^d Universidade de São Paulo (USP), Faculdade de Saúde Pública. São Paulo, São Paulo, Brasil.

■ INTRODUCTION

The World Health Organization (WHO)⁽¹⁾ defines intrauterine fetal death (IUFD) as the death that occurs before the complete expulsion or extraction of a conception product from the woman's body, regardless the pregnancy duration. In this case, death is confirmed by the fact that the fetus, after this separation, does not have spontaneous breathing, heartbeat, pulsation of the umbilical cord or effective movements of the voluntary contraction muscles⁽²⁾.

It is estimated that 2.6 million IUFD occur worldwide each year. From these cases, 98% occur in low and middle income countries and are generally related to preventable causes. In the global scenario, fetal loss receives insufficient attention in the context of public health policies and sexual and reproductive rights; and the devaluation of this event is reflected in the scarcity of in-depth analyzes of the reality of obstetric care⁽³⁾.

A Brazilian study that traced a historical chain of fetal mortality in the country showed that, although the analysis indicates a stationary trend, there is a long way for the internationally recommended indexes to be reached⁽⁴⁾. It points out the lack of quality and information of the records and the need to understand the quality of obstetric care services in addition to ensuring access to services. According to the global strategy "Every newborn: an action plan", countries must achieve a rate of 12 stillborn children or less per thousand births in order to result in a global average of nine stillborns per thousand births⁽⁵⁾. The fetal mortality rate in Brazil, between 2001 and 2011, dropped from 12.3/1000 births to 10.7/1000 in the period⁽⁶⁾. According to data from DataSUS¹, in 2018 the country recorded 30,690 thousand cases of fetal death, of which 27,700 occurred before delivery, 1,361 during delivery and 1,629 ignored, presenting in 2018 the rate of 10.4/1000 births².

In this context, it is essential to take into account local differences and social determinants of health. Research carried out in remote areas of the North and Northeast regions of Brazil, with a large part of the population living in rural areas and in situations of poverty, showed inequities in access to health. The occurrence of IUFD during pregnancy was associated with inadequate prenatal care, lack of link between prenatal care and maternity and the delay in care during childbirth. The study indicated interactions between skin color, socioeconomic status, and pilgrimage

to childbirth. These women were more likely to belong to economic classes D or E⁽⁷⁾.

In this sense, fetal death is a complex public health problem that integrates social, economic, and political issues. It is necessary to give visibility to the impacts of this event on perinatal indicators and on the lives of people who experience these cases, especially women and their families⁽⁸⁾. Given the situation of fetal loss, the adverse reflexes on the mental health of mothers and their families can be moderated by empathetic attitudes of health professionals and the adoption of care practices that value the experiences of people who experience this situation⁽³⁾.

It is possible to observe the absence of space in the training processes to think and problematize the care practices in the context of cases of fetal death. An English study carried out with obstetrics graduates during the last year of training showed that they did not feel prepared to deal with situations of perinatal loss, expressing difficulties in communicating with families. It also identified that the participants indicated the need to change their role in view of their training largely focused on monitoring women and their healthy babies during pregnancy, delivery, and birth with a focus on facilitating the care relationships between women and the newborn. The participants reported that facing the birth of a stillborn baby inactivated this professional role, requiring a new posture⁽⁹⁾. Dealing with death is a challenge in obstetric care, therefore, understanding and problematizing these issues is essential for care to be based on the rights of women and the integrality of care, ensuring that they and their families to meet their needs⁽¹⁰⁾.

Considering the above, this study had the following principal question: how do professionals working in women's health have dealt with situations of fetal death? It is understood that the comprehension of the experiences of these cases and how health services are organized given the situation can illuminate paths for the qualification of care in obstetric care. Thus, the objective of this study was to understand the experiences of health professionals in obstetric care in situations of intrauterine fetal death (IUFD).

■ METHOD

It was a study with a qualitative approach, which allows greater knowledge and social interaction with the participants, resulting in a constructed knowledge, result of the exchange process between those involved⁽¹¹⁾. The theoretical framework was supported by the National Humanization Policy with a focus on the concept of ambience⁽¹²⁾. Associated with a set of initiatives that combine techniques and

¹ DATASUS. Technical notes. Fetal deaths – Brazil. Available at: <http://tabnet.datasus.gov.br/cgi/tabcgi.exe?sim/cnv/fet10uf.def>

² Calculation based on DATASUS data: $30.690 \times 1000 / \text{total births in } 2018: 2,944,932$

subjectivities, this concept promotes the construction of practices based on integrality, equity and rights in health care, having as one of its guidelines the organization of healthy and welcoming work spaces, considering both the physical and the social dimension, in which interactions and interpersonal relationships occur. In this perspective, health spaces must take into account cultural values, subjectivities, the socio-cultural context and the rights of users⁽¹²⁾.

Humanization in this context concerns the adoption of values of autonomy and protagonism of the subjects, co-responsibility, solidarity, established bonds and collective participation in the management process⁽¹²⁾. When the concept of humanization is translated into practices in the daily life of services, it leads to the identification of the needs for changes in health production processes. In this aspect, it is important to reflect on the relationship between professionals and users that happen in different care scenarios, with the ambience being a central concept to think about these interactions⁽¹³⁾. Thus, it is fundamental to problematize the reception of women and their families, as well as the organization of services in this process.

The study was developed in a city in the countryside of São Paulo. According to the profile of the São Paulo municipalities of the *Fundação Seade*⁽¹⁴⁾, it has a population of 242,632 inhabitants. Its infant mortality rate, in 2018, was 9.26 deaths per thousand live births. The health network is composed of 12 Basic Health Units (UBS); 3 Emergency Care Units (UPA); 21 Family Health Units (USF); 2 public hospitals, one of which has a maternity hospital⁽¹⁵⁾.

Participated in this research eleven professionals who worked directly in women's health care and obstetric care (physicians, nurses, obstetric nurse, midwife, technicians and nursing assistants and psychologist). Most of the interviewees worked in hospital care. Only one participant worked as a nurse in primary care, in a Family Health Unit. The number of participants was defined during the development of the research, from the deepening of the issues of interest. These professionals were selected using the "snowball" approach and contact with the first participant occurred during a shift change. No intimate relationship was established with the participants prior to the development of the study. Professionals with at least one year of experience in obstetric care in the municipality were included, considering the importance of the time of experience in experiencing the situation of fetal death. Professionals who were away or on vacation during

data collection were excluded. Data were collected during the interviews, with the help of a form for characterizing the participants and a semi-open interview script.

The interviews were conducted by the first author, an undergraduate student in nursing, after orientation and training, from August 2018 to February 2019. The undergraduate received continuous supervision from the advisor.

The guiding questions were: "Tell me about your experiences in caring for cases of fetal death"; "How is assistance and what care practices do you employ in these cases?"; and "What needs do you identify in the service?".

The interviews lasted between 20 and 60 minutes and were recorded after reading and signing the Free and Informed Consent Form (ICF), in a place chosen by the participants: private room in the workplace, cafeteria and residence of the participants. Two participants requested the interviews to be sent in text form, justifying personal difficulties for face-to-face participation. In these cases, the ICF was sent by email and digitally signed.

The data were submitted to thematic content analysis, following the qualitative perspective proposed by Minayo⁽¹¹⁾. In this way, it was first sought to impregnate the data through the full transcription of the reports, followed by readings and re-readings. The processes of ordering and typifying the data were followed up in a reflective and comprehensive effort to value the field findings. The last stage included the synthesis exercise, with an emphasis on the relevant arrangements, in order to privilege the meanings expressed in the interviews.

The investigation, which followed the recommendations of Resolutions No. 466/2012 and 510/2016 of the National Health Council (NHC) on research involving human beings, started after approval of the study by the Research Ethics Committee of the *Universidade Federal de São Carlos* (CEP - UFSCar; CAAE: 64171417.5.0000.5504) and approval by the institution.

■ RESULTS

Table 1 presents characterization data, training, and performance of the professionals. The statements were identified with the initial occupation, taking into account the sequence that appears in the table.

Initially six topics were found, grouped into four central topics, after the analysis refinement, as shown in Table 2.

Table 1 – Characterization of participants

Age	Race/self-declared color	Gender	Position	Working time	Working service
37	Black	Female	Nurse (E1)	12 years	Primary care
26	Brown	Female	Nurse (E2)	3 years	Hospital care
30	White	Female	Obstetric Nurse (EO)	6 years	Hospital care
25	White	Female	Nursing technician (TE1)	4 years	Hospital care
40	Brown	Female	Nursing technician (TE2)	1 year	Hospital care
23	White	Female	Nursing technician (TE3)	4 years	Hospital care
40	Black	Female	Nursing assistant (AE)	3 years	Hospital care
30	White	Female	Psychologist (P)	4 years	Hospital care
24	White	Female	Obstetrician (O)	1 year	Hospital care
44	White	Male	Obstetrician Doctor (MO1)	12 years	Hospital care
47	White	Male	Obstetrician Doctor (MO2)	1 year	Hospital care

Source: Research data, 2020.

Table 2 – Initial and final topics

Initial topics	Final topics
Professional performance in the face of death	1. Facing fetal death: “I still haven’t learned to deal with it.” 2. Interpersonal communication: “I didn’t know what to say...”
Communication of bad news	
Challenges in care for cases of fetal death	
Service organization and care practices	3. The care practices and the place of the woman and the family: “The woman is only valuable when the baby is alive.” 4. Ambience as a meeting space: “A place without haste, where there is a minimum of privacy and comfort.”
Challenges in physical structure	
Professional and personal	

Source: Research data, 2020.

1) Facing fetal death: *"I still haven't learned to deal with it."*

The professional's performance in the face of cases of intrauterine fetal death is linked to values, beliefs, culture, and feelings. Loss situations are seen in multiple ways, taking into account subjectivities and the repertoires of experiences during each person's trajectory. The reports reveal the difficulties in dealing with the situation.

In the past, we used to make funerals at home. This was getting away from us more and more. We have tried not to deal with death and not to look at what hurts, and it is part of our culture. (P)

It is very bad, because it is difficult to deal with and we have not learned. If there's any technique, I don't know how to deal with it... We learned to do prenatal and prenatal care, children are born. And in that case, no. (E1)

In view of this situation, the professionals express a feeling of impotence, evidence the suffering of the health team and indicate the convergences between the professional and personal aspects.

The other nurse and I didn't know how to deal. Because she cried a lot, her husband cried a lot because they wanted this baby so much. I remember that I spent the shift crying and said I didn't want to go back... I still haven't learned to deal with it. (E2)

When we take care, our psychological has to be prepared to deal with the loss, to have an emotional balance. But in those moments, no matter how much we hold, we control, our human ends up surfacing and we are also in the same situation as the patient... because we never want that to happen [...] is something difficult to be able to face. (TE1)

The feeling of fear and the denial mechanism put their own conduct to the test and show the difficulties of the professional to confirm the death, when faced with the woman who goes through this situation.

I tried to reassure the mother, but then, when I didn't listen, I spent about 20, 30 minutes trying to listen. Because the

first thing you think is that something is wrong, but with my procedure, not that the baby is really dead. Then I realized that no, that I was feeling correctly, that it was right there that I had to listen, right? Scared to death! (E.1)

The difficulty in dealing with the situation, not knowing what to do and the lack of preparation are also present in the form of "outsourcing" care and lack of responsibility.

What I see a lot is that you pass the ball to another professional. You go there, you identify that that woman is not doing well or there is something that she is not doing, either because she is shaken or because she has not yet been able to process all the information. So it's always like this: "Ah, I call social assistance"; "Ah, I call the psychology service." But I, as a professional, do not approach this woman the way I should theoretically be prepared to approach. (O)

Facing the case quickly and performing the procedures considered necessary are also perceived as subterfuge by the professionals, since they can't face the situation of pain and suffering.

We enter the maternity ward and feel that atmosphere, and what happens is that the team itself is not prepared to face that pain. And then, nobody wants to see it and when you refuse to see it, you want to remove that problem right in front of you... In this case, it is taking the baby to the morgue right away, right? Get it out of there because they don't feel it, they don't suffer. (P)

The reports indicate that resistance in dealing with situations of fetal death is also related to the lack of contact with the theme in health education processes, whether in the academic or professional dimensions.

The team is not prepared at all ... Not only in terms of training, but also in terms of the institution: there is no work in relation to this. I think that even awareness raising does not exist. (O)

I never had any follow-up or training to be able to deal with it, (...) there is no preparation. I think there should be, I think continuing education is cool; as with other themes, there should be about fetal death as well. (E2)

The analysis also allowed to observe a general perception that there is a need for a space for exchange between the team to be protected, allowing the sharing of their experiences. This space would allow the discussion of new care strategies and approach to cases of fetal death.

It is necessary to talk more about this in the work environment... The worker needs protected spaces in his workload to talk about it. And we always need to talk because it shouldn't be a taboo or a veiled subject. (MO1)

2) Interpersonal communication: "I didn't know what to say..."

Communication as an inherent act of care relationships is shown in a conflicting way in reports about fetal death. Participants highlight the difficulties in communicating to women and their families the difficult news. In the face of early loss, speeches based on preconceived conceptions are also used as a form of comfort. The reports show a reflection on how this type of communication makes it difficult to interact with women who experience this process.

We have those way out, right? "Oh, see, this happened because he had some malformation that was incompatible with life, right? Think: a little baby could be born with a problem, that would last a short time"... But we know that it does not comfort. (E1)

When you think about these elaborate phrases, what to say or not to say, you end up hurting more than helping. This news needs to be given in a sustained manner. (P)

One of the participants shared the communication difficulties she had, when she was still a student, while attending a Haitian woman. Her experience brought to the conversation the need to think about strategies and forms of communication in front of different women and demands.

She did not understand that it had died, that the baby was no longer alive. Because people explained it, but they explained it in Portuguese and she didn't understand anything... she knew something was going on, but she didn't know what! I didn't speak her language and the first question was this, we received a patient diagnosed with fetal death who had barely understood the diagnosis, it was a very complicated situation. (O)

The professionals discuss different strategies to give the news about IUFD, what is important at that moment and how they happen in the daily life of services.

I try to put the pregnant woman and her family in the room with privacy; use objective language appropriate to their level of understanding. One of the strategies is to check if the pregnant woman, family members are prepared to receive the news and periodically evaluate the understanding of what was said, acting with empathy for the reactions that may arise. (MO2)

I remember I asked her, "How are you doing?" And I let her speak, because I had nothing to say, right? Nothing I said would comfort or change that situation. (E1)

Communicate the news of fetal death, in most cases, is the responsibility of the medical team, which leads to the understanding of a necessary reflection on the role of communication and the health team in these cases.

And then the initial news, at least in all the cases I witnessed, was the physicians who gave this first news. In my case, anyway, whenever I go back to this woman or when she comes back to me, after the diagnosis, I confirm that she understood, if they explained correctly. (O)
They [physicians] are used to it, you know? They have been in this profession for years. So, for them, it's more of a complication. But the people who are there in nursing, who have to be providing assistance with care and medications, we end up getting more involved. (AE)

3) The care practices and the place of the woman and the family: "The woman is only valuable when the baby is alive."

In this topic, the ways in which care practices take place in services in the face of the situation of fetal loss are presented. The reports show the tensions that emerge in the face of the dilemma between following prescriptions and protocols and promoting the necessary care for these women and their families during the difficult journey.

The person gets there, the doctor makes the prescription, the nurse goes there, does what it has to do, you know? It's very automatic... (AE)

When babies come with fetal deaths and there is no confidentiality, that question that everyone goes there to see the body and has no respect for the body or the family. (TE1)

I think people end up dealing with it as if it were routine, and not like, "Oh, this woman needs specific help!" It is more like: "Puts on Misoprostol, puts on Misoprostol, puts on Misoprostol and hopes to be born". (TE3)

And also to know if this induction was offered in a way that she understood and agreed, because she wanted to; or it was an induction proposed by the team like: "Look, this is better because, in the cesarean section, your baby is already dead, but then you can die too". Because this happens a lot... (O)

Conducts in the face of a fetal death situation implies dealing with a complex birth scenario, which often involves tensions that translate into practices. And this birth process needs to be problematized, including to enable the adoption of modes of care that contribute to pain relief and encourage labor.

I try to drive as if it were really labor: I try to relieve the patient's pain, I try to stimulate some movements so that this delivery can happen more quickly. (TE3)

I have the whole issue of opening a partogram, of actually having a follow-up because it is labor; you don't have fetal parameters, but you have maternal parameters. I do not see any other professional opening a partogram, this in the maternity ward, for fetal death. I never saw. (O)

The peculiarities of the labor of a stillborn baby demand different forms of attention. The absence of routine practices, such as monitoring fetal heartbeats, often leads to the perception that these women are neglected.

It seems a lot, therefore, that the woman is only valuable when the baby is alive; if the baby is dead, the woman is ignored - and this from the moment of admission. Because when you have a live baby, you are worried about that auscultation issue [...] you have to be there all the time. And when the baby is not alive? People do not go to the woman, they often take the evolved case and continue without due attention to that woman. (O)

The difficulties in dealing with IUFD end up shaping the thesis that some health care practices are "inhuman". At this

point, birth and contact with the baby are seen as events that generate more suffering.

Sometimes childbirth is induced. I don't think it should be induced, it's a lot of suffering. I saw the delivery, she had the baby by normal delivery, suffered all the pain, and I think that part is inhuman. Then, she stayed with the baby there, the father was crying, the mother was crying, the whole family there watching, right? I think that there is no need for it. (TE2)

It was a FD of a twin. She [mother] wanted to be kissing this baby, taking a picture with this baby, and we couldn't even take her baby. It was a very sad thing: she was on the table at the obstetric center, she was crying, crying and crying... she wanted me to photograph, but the two talked and then they didn't photograph. (E2)

On the other hand, the importance of contact with the baby and respecting the time and desire of the woman and the family are also placed as care practices that must be prioritized.

Two things I pay close attention to: the question of the evolution of labor and, after birth, what the mother wants to do with the body: if she wants to have access to it, if she wants to send it to the DVS [Death Verification Service] or not. It has already happened of a fetal death, which I followed here, of the woman stay with the baby for more than an hour in the room; then she said: "Look, now you can take it". (O)

We act according to the wishes of the parents and family, leaving the body for a certain time in the room with the parents or in the obstetric center, if so desired by both. (EO)

Thus, when there is death and a cesarean section or normal delivery is performed, the baby nursery girls usually prepare the body and go to the mother and her family and ask if they want to see it; and this is where they take the conduct: if they say no, they wait a little longer, because it can often happen that they go back and want to see the body. (TE1)

This moment when the mother stays with the baby who passed away is important, because she saw it, she could stay, she could take it, she could dress, put a diaper, she could smell the baby's little things. This moment is very important for the elaboration of her grief, for her to understand what happened, because it is a very fast process, right? She was pregnant, had dreams and expectations, desires, suddenly this will not happen. (P)

The reports indicate the existence of procedures and rules that need to be followed after death, but even at these moments, the particularities of women and their families who experience IUFD must be taken into account.

There is also the issue that, sometimes, family members are not present at the time they show the mother; and then they want to see it. But then it was already packed the body. And then, it's sad because you have to go down to talk to see if you can open it again. If the body is still there, you can open it to show to the relative; but if the body is not there, there is no way. (TE1)

Difficulties during the execution of post-death bureaucratic processes show a direct relationship with the way services are organized in the face of these cases.

Because you have to take this little baby from the maternity hospital, cross the street with him to the EMS [Emergency Medical Service]. I don't think that's right, but unfortunately this is the dynamic that we have here. There is no place here for the baby to stay, so he is taken to the morgue. Then, after changing this child, the father has to go with the employee to the EMS with the baby's body; go on the lap, go wrapped in the cloth. (E2)

They [nurses in the neonatal unit] prepare this body to send or to the ditch or, in the case of a funeral, there is a term that both one of the family members, who is usually the father, takes to the EMS signed, proving that he saw the preparation and for ensure that they have no problem, afterwards, with the paperwork and even to prove the death, that they have to give... the death certificate. And then it is also a difficult thing, because sometimes this mother has no one close who can be helping. It's a very bureaucratic part. (TE1)

The continuity of care provided to these women and families is placed as the role of primary health care, which must think about strategies and actions in a multiprofessional perspective.

Shortly after she was discharged from the maternity ward, we made a visit; she was quite shaken. Because in fact we suffer with them, when we visit the house. Primary care has this a lot, right? The maternity does the procedure, she stays 2 or 3 days, and then she comes back. And it's us who will deal with this woman, right? In her life. Because we are still a reference for her, but we have no support thinking about other tools, a multidisciplinary team. (E1)

Another issue expressed concerns the investigation of death outcomes and the practices involved in them, especially in cases where intrapartum occurs, as a means of understanding the situation in depth and not of blaming people. The statements indicate the need to think about institutional devices for monitoring these events.

This case entered the London protocol and, then, it identified that it took a long time to perform the surgical intervention. The objective is not to appoint people, but to discuss what could have been done more or less, or which, in short, measures that could have been adopted to avoid that outcome [...] I have never seen feedback from the committees [of maternal death]. So, like this: "We, as a committee, detected that no such thing is being done for these women". I never saw a return. I know it goes from the maternity hospital to there, but there is never anything back. (O)

4) Ambience as a meeting space: "A place without haste, where there is a minimum of privacy and comfort."

Institutions do not always have an appropriate place to communicate and welcome the family in a situation of fetal death. Thinking about new forms of service organization presents itself as a challenge.

There is a point that is very important: a place where the couple or family can manifest themselves, be minimally comfortable, cry, wait, have their time [...], a place without haste, where there is a minimum of privacy and comfort. (MO1)

The woman who experiences IUFD does not always have the opportunity to stay in a single room during the hospitalization period, separated only by curtains or screens from other pregnant women or those with their healthy babies.

I've seen situations in which the mother has a fetal death and having to put the screen on because she is sharing a room with two more pregnant patients. (TE1)

[...] we should have a place in the hospital a little further away from the maternity hospital, because in the room you can hear baby crying. So, maybe if she had a bed farther away, the mother would be more comfortable. (P)

Regarding the environment, it is important to say that the institution does not have a support room, either for the woman and her family to remain after receiving the news, or even until she is moved to an inpatient room. As a result, women are often forced to stay in the same place where other pregnant women are waiting for care.

[...] I think, yes, that we should have a support room, until this room is released, and we can take this woman there. Because the woman is already suffering, she just discovered that the baby is no longer alive, and she still has to go through this trauma of seeing other people arriving [in the emergency room]. (E2)

They stay in the same place as other women in labor, and often do not have a room to leave them alone. And then they have to share a room with another patient, who have to listen to fetal heartbeats every hour. They are separated only by a screen or curtain, when there is one. So, I think that structurally speaking it is much worse. (TE3)

Professionals report the discomfort that this lack of privacy brings to them and to women and their families, interfering with the quality of interaction with them.

[...] there is that unpleasant situation that you have to take the body to the mother to see there in the room where there are two more pregnant patients and the companions of these two patients, [...] there is no structure for what I see, especially the location. (TE1)

■ DISCUSSION

The findings of this study show that multiple elements are involved in the way the health team deals with situations of fetal death and how care is provided to women and families who experience this situation. Culturally, motherhood is associated with happiness, so the loss of a baby has a challenging impact on all the actors involved in this process. Difficulties in dealing with the situation are evidenced and translated into the adoption of a defensive posture by the professionals. In the health field, studies show that attitudes such as detachment and hostility are related to a self-protection mechanism, as a result of the difficulty of these professionals to deal with their own emotions and concomitantly perform their role⁽¹⁶⁻¹⁷⁾. The lack of repertoire and support to act in face of these situations was present in the daily work.

Impasses are shown at the moment of give the difficult news and establishing an interaction with women and families who experience death. Communication difficulties are related to the lack of awareness and training on the topic during professional formation^(9,10). According to this and other studies, in addition to the lack of preparation, there are barriers related to the physical environment of services and the forms of work organization that hinder the development of different ways of welcoming. This negatively impacts the creation of bonds between the family and the health team, which perpetuates the feeling of loss, guilt and abandonment^(10,17).

The need to think about care practices considering factors related to the dynamics and form of organization of obstetric care is revealed in the statements of the health team. At the international level, guiding protocols for action in situations of fetal death and care guidelines are found, such as the guideline on IUFD of the Royal College of Obstetricians & Gynaecologists⁽¹⁸⁾. One of the central points pointed out in the document is that the health team must identify and recognize the feelings and emotions of women and families, as well as an understanding of their needs and desires. For this it is necessary that care is based on empathy and valuing experiences. It also discusses the use of ways that enable the continuity of care, being alert to the fact of the risk of psychological disorders including post-traumatic stress⁽¹⁸⁾.

According to the participants, there is little space to discuss care strategies for women and their families in situations of fetal death. Ambience as a fundamental component of care interactions is little valued in everyday health services. Other studies have indicated that, often, the lack of privacy and of protected spaces and welcoming facilitators reflects negatively on the experience of mourning^(10,17). In this context, the concept of ambience proposed by the National Humanization Policy is more than a physical apparatus; it is a social space that goes beyond technical compositions, taking into account the situations that are constructed in everyday life through practices that allow for comfortability and the production of subjectivities⁽¹²⁾.

The care practices developed and grounded in the ambience are capable of promoting the rights of women and the family, such as the right of more than one companion to stay as the woman wishes and the guarantee of a private room. According to a study developed with couples who experienced fetal death, the sensitivity of the professional to explain the situations, the options available and the possibility of creating memories are crucial during the process of adaptation and elaboration of mourning⁽¹⁰⁾.

Contact with the baby after birth and the act of recording/keeping a memory have been encouraged and encouraged

in obstetric care spaces as it has a positive impact on the mourning process. Studies discuss the role of the health team in encouraging mothers and their partners to have the possibility to create memories of their children, either through videos and photos and locks of hair, or through the act of seeing and picking up the baby after birth, bathe and change clothes, ensuring that it is called by name and presented to the family⁽¹⁷⁻¹⁸⁾. In this reflection, it is essential that women and their families know their rights, their possibilities of choice and that they are guaranteed to receive specific and accessible information.

Through the experiences of the professionals, this study demonstrated that there is a lack of assistance guidelines for monitoring cases of intrauterine fetal death. An issue that generates tension and disagreement is related to the mode of delivery, since the IUFD alone does not characterize cesarean section. The cesarean section without indication can bring health problems and complications to women, specifically in situations of fetal death, when they are added to the difficult process of mourning in the postpartum period, the postponement of planning and the possibility of a new pregnancy and the increased chances of cesarean delivery in a later pregnancy⁽⁸⁾. It is important to say that there are challenges in the labor of a baby who died and in the interaction with all the processes involved in it, which reinforces the need for awareness and training of the team. The possibility of dealing with and accompanying this process as an obstetric labor. As reported by one of the participants in this study, the provision of techniques for pain relief and the recording of the evolution of childbirth allows for the detection of risks, in addition to making it possible to approach women and family, which can reflect positively on mourning.

Given the fact that obstetric care services deal with more term and healthy baby births, women who experience fetal death are often neglected during the birth process; there is a scarcity in the registration of information about these accompaniments. Thus, the surveillance of IUFD cases is an essential component for the investigation and identification of factors related to the cases because it helps in the improvement of information, enables discussion among the multidisciplinary team and defines preventive measures and improvements in obstetric care⁽¹⁹⁻²⁰⁾.

By emphasizing the concept of ambience as a facilitator of the work process, the construction and availability of support networks and interprofessional exchange spaces are essential to facilitate the interaction between the health

team, allowing the sharing of experiences in care and the identification of needs for changing practices⁽¹²⁾.

Discussing this topic is a way to strengthen care practices. This is because the ambience in the perspective of humanization favors the model of care centered on women, babies and families who experience this process and, at the same time, expands the possibilities for understanding the anxieties, challenges and barriers that teams face in the daily lives of services. It is important to emphasize that the cases of fetal death need specific and continuous attention so that investments in prevention and care can take place at the different levels of care for the event.

■ FINAL CONSIDERATIONS

Health professionals working in obstetric care face many difficulties when dealing with cases of fetal loss and with the grieving process. This is related to the lack of visibility of the theme in the training processes. The absence of training, fragmentation of care, poor infrastructure, the absence of institutional protocols and the lack of spaces for collective exchange express the absence of a model of comprehensive and humanized care in these cases. The need for continuing education and institutional support for professionals was evident in the lack of emotional and psychological support for women and their families and for the professionals involved in their care. In addition, it is necessary to foster in the assistance the opportunity for the team to discuss and reflect on the events that occur in the daily lives of health services.

The insertion of the theme in the training of professionals is also urgent. The construction of a strengthened care network for these cases is of fundamental importance. This study had limitations related to the refusal of some primary care professionals to participate in the research due to the theme, whether due to shyness or discomfort in reliving these situations - only one participated. Thus, listening to more primary care professionals is essential to think about the continuity of care for women and families who experience fetal death.

Despite the limitations, the results bring important contributions to the field of Nursing and health through care experiences. The construction of strategies based on the reception and qualification of care for women needs to be continuously guided. It is evidenced the need for further research to analyze the perceptions and experiences of women and families experiencing mourning due to intrauterine fetal death at different levels of health care.

■ REFERENCES

1. Ministério da Saúde (BR). Secretaria de Vigilância em Saúde. Secretaria de Atenção à Saúde. Manual de vigilância do óbito infantil e fetal e do Comitê de Prevenção do Óbito Infantil e Fetal. 2. ed. Brasília: Ministério da Saúde; 2009 [cited 2019 Aug 10]. Available from: http://bvsm.sau.gov.br/bvs/publicacoes/manual_obito_infantil_fetal_2ed.pdf
2. World Health Organization (CH). The WHO application of ICD-10 to deaths during the perinatal period: ICD-PM. Geneva: WHO; 2016 [cited 2020 Jul 5]. Available from: <https://apps.who.int/iris/bitstream/handle/10665/249515/9789241549752-eng.pdf;sequence=1>
3. De Bernis L, Kinney MV, Stones W, ten Hoop-Bender P, Vivio D, Leisher SH, et al. Stillbirths: ending preventable deaths by 2030. *The Lancet*. 2016;387(10019):703-16. doi: [https://doi.org/10.1016/S0140-6736\(15\)00954-X](https://doi.org/10.1016/S0140-6736(15)00954-X)
4. Barros PS, Aquino EC, Souza MR. Mortalidade fetal e os desafios para a atenção à saúde da mulher no Brasil. *Rev Saúde Públ*. 2019;53:12. doi: <https://doi.org/10.11606/S1518-8787.2019053000714>
5. World Health Organization (CH). EveryNewborn: an action plan to end preventable deaths. Geneva: WHO, UNICEF; 2014 [cited 2020 Jul 5]. Available from: https://apps.who.int/iris/bitstream/handle/10665/127938/9789241507448_eng.pdf?sequence=1
6. Barbeiro FM, Fonseca SC, Tauffer MG, Ferreira MSS, Silva FP, Ventura PM, et al. Fetal deaths in Brazil: a systematic review. *Rev Saúde Públ*. 2015;49:22 doi: <https://doi.org/10.1590/S0034-8910.2015049005568>
7. Leal MC, Bittencourt SDA, Torres RMC, Niquini RP, Souza Jr PRB. Determinants of infant mortality in the Jequitinhonha Valley and in the North and Northeast regions of Brazil. *Rev Saúde Públ*. 2017;51:12. doi: <https://doi.org/10.1590/S1518-8787.2017051006391>
8. Gonçalves R, Brigagão JJ, Silva BM, Oliveira CG, Lima Santos JD. Análise dos fatores associados ao óbito fetal intrauterino nos casos atendidos em um hospital público. *Revista Saúde-UNG-Ser*. 2019;30(13):22-31. doi: <https://doi.org/10.33947/1982-3282-v13n3-4-4149>
9. Alghamdi R, Jarrett P. Experiences of student midwives in the care of women with perinatal loss: a qualitative descriptive study. *BJM*. 2016;24(10):715-22. doi: <https://doi.org/10.12968/bjom.2016.24.10.715>
10. Nuzum D, Meaney S, O'Donoghue K. The impact of stillbirth on bereaved parents: a qualitative study. *PLoS One*. 2018;13(1):e0191635. doi: <https://doi.org/10.1371/journal.pone.0191635>
11. Minayo MCS. Qualitative analysis: theory, steps and reliability. *Ciênc Saúde Coletiva*. 2012;17(3):621-6. <https://doi.org/10.1590/S1413-81232012000300007>
12. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Núcleo Técnico da Política Nacional de Humanização. *Ambiência*. 2. ed. Brasília, DF: Ministério da Saúde; 2010 [cited 2019 Aug 10]. Available from: http://bvsm.sau.gov.br/bvs/publicacoes/ambiencia_2ed.pdf
13. Ferreira LR, Artmann E. Pronouncements on humanization: professionals and users in a complex health institution. *Ciênc Saúde Coletiva*. 2018;23:1437-50. doi: <https://doi.org/10.1590/1413-81232018235.14162016>
14. Fundação Seade (BR). São Paulo; c2018-2020 [citado 2019 out 10]. Perfil dos municípios paulistas; [about 1 screen]. Available from: <https://perfil.seade.gov.br/#>
15. Secretaria de Saúde de São Carlos (BR). São Carlos; c2019- [cited 2019 Dec 10]. Programa Saúde da Família – PSF; [about 1 screen]. Available from: <http://www.saocarlos.sp.gov.br/index.php/saude/115417-programa-saude-da-familia-psf.html>
16. Heazell AE, Siassakos D, Blencowe H, Burden C, Bhutta ZA, Cacciatore J, et al. Stillbirths: economic and psychosocial consequences. *The Lancet*. 2016;387(10018):604-16. doi: [https://doi.org/10.1016/S0140-6736\(15\)00836-3](https://doi.org/10.1016/S0140-6736(15)00836-3)
17. Shorey S, Andre B, Lopez V. The experiences and needs of healthcare professionals facing perinatal death: a scoping review. *Int J Nurs Stud*. 2017;68:25-39. doi: <https://doi.org/10.1016/j.ijnurstu.2016.12.007>
18. Royal College of Obstetricians and Gynecologists (UK). Late intrauterine fetal death and stillbirth. London: RGOG; 2010 [cited 2019 Aug 10] Available from: https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_55.pdf
19. Rêgo MGS, Vilela MBR, Oliveira CM, Bonfim CV. Perinatal deaths preventable by intervention of the Unified Health System of Brazil. *Rev Gaúcha Enferm*. 2018;39:e2017-0084. doi: <https://doi.org/10.1590/1983-1447.2018.2017-0084>
20. Kerber KJ, Mathai M, Lewis G, Flenady V, Erwich JJHM, Segun T, et al. Counting every stillbirth and neonatal death through mortality audit to improve quality of care for every pregnant woman and her baby. *BMC Pregnancy Childbirth*. 2015;15 Suppl 2:S9. doi: <https://doi.org/10.1186/1471-2393-15-S2-S9>

■ **Acknowledgment:**

FAPESP - *Fundação de Amparo à Pesquisa do Estado de São Paulo* for the Scientific Initiation scholarship granted (Process No. 17/02172-4).

■ **Authorship contribution:**

Investigation; Data curation; Writing-original draft:

Taynnara Caroline Serafim.

Writing-original draft: Beatriz Helena Naddaf Camilo.

Writing-original draft: Mariana Rodrigues Carizane.

Formal analysis; Writing-review & editing; Visualization: Mariana De Gea Gervasio.

Formal analysis; Writing-review & editing; Visualization: Diene Monique Carlos.

Supervision; Methodology; Formal analysis; Writing-review & editing: Natália Rejane Salim.

■ **Corresponding author:**

Natália Rejane Salim

E-mail: nat.salim@ufscar.br

Received: 07.10.2020

Approved: 10.05.2020

Associate editor:

Helga Geremias Gouveia

Editor-in-chief:

Maria da Graça Oliveira Crossetti