



CHARACTERIZATION OF FETAL DEATHS AND CARE IN A HIGH-RISK MATERNITY HOSPITAL: A CROSS-SECTIONAL STUDY

CARACTERIZAÇÃO DOS ÓBITOS FETAIS E DA ASSISTÊNCIA EM MATERNIDADE DE ALTO RISCO: ESTUDO TRANSVERSAL

CARACTERIZACIÓN DE LAS MUERTES FETALES Y DE LA ASISTENCIA EN UNA MATERNIDAD DE ALTO RIESGO: ESTUDIO TRANSVERSAL

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How to cite: Vicari K, Trigueiro TH, Peripolli LO, Arruda KA, Rabelo M. Characterization of fetal deaths and care in a high-risk maternity hospital: a cross-sectional study. Online Braz J Nurs. 2026;25(1):e20266926. <https://doi.org/10.17665/1676-4285.20266926>

RESUMO

Objetivo: Descrever e analisar o perfil dos óbitos fetais e da assistência prestada em uma maternidade de alto risco. **Método:** Pesquisa quantitativa, transversal, com coleta retrospectiva de dados secundários, realizada em uma maternidade de alto risco de Curitiba, Paraná. Foram analisados 36 registros de natimortos provenientes de 35 mulheres atendidas em 2022. A coleta ocorreu em 2023, com análise descritiva e aplicação do teste exato de Fisher (nível de significância de 7%; $p=0,07$). **Resultados:** Prevaleram mulheres entre 20 e 34 anos, com estratificação de alto risco e multigestas. Quanto à assistência, registraram-se 13 métodos não farmacológicos de alívio da dor, com atuação direta de enfermeiros e médicos. A maioria dos óbitos ocorreu no anteparto, com predominância de fetos de extremo baixo peso e do sexo feminino. Houve associação estatística entre a estratificação de risco materno e o momento do óbito ($p=0,06$), bem como entre a idade gestacional e o total de métodos não farmacológicos de alívio da dor aplicados ($p=0,01$). **Conclusão:** O estudo contribuiu para a visibilidade da assistência integral na perda gestacional, evidenciando como essencial a atuação da equipe multiprofissional, a oferta de cuidados para a ressignificação do luto e a implementação de protocolos para a uniformização de condutas.

Descritores: Morte fetal; Complicações na gravidez; Parto humanizado.

ABSTRACT

Objective: To describe and analyze the profile of fetal deaths and the care provided in a high-risk maternity hospital. **Method:** Quantitative, cross-sectional research with retrospective collection of secondary data, conducted at a high-risk maternity hospital in Curitiba, Paraná. Thirty-six stillbirth records from 35 women treated in 2022 were analyzed. Data collection occurred in 2023, featuring descriptive analysis and the application of Fisher's exact test (significance level of 7%; $p=0.07$). **Results:** Women aged between 20 and 34, classified as high-risk and multigravida, prevailed. Regarding care, 13 non-pharmacological pain relief methods were recorded, with direct involvement of nurses and physicians. Most deaths occurred in the antepartum period, with a predominance of extremely low birth weight and female fetuses. There was a statistical association between maternal risk stratification and the timing of death ($p=0.06$), as well as between gestational age and the total number of non-pharmacological pain relief methods applied ($p=0.01$). **Conclusion:** The study contributed to the visibility of comprehensive care in pregnancy loss, highlighting the essential role of the multidisciplinary team, the offering of care for the re-signification of grief, and the implementation of protocols for the standardization of procedures.

Descriptors: Fetal death; Pregnancy complications; Humanized childbirth.

RESUMEN

Objetivo: Describir y analizar el perfil de muertes fetales y de la asistencia prestada en una maternidad de alto riesgo. **Método:** Investigación cuantitativa, transversal, con recolección retrospectiva, realizada en una maternidad de alto riesgo de Curitiba, Paraná. Se analizaron 36 registros de mortinatos provenientes de 35 mujeres atendidas en 2022. La recolección ocurrió en 2023, con análisis descriptivo y aplicación de prueba exacta de Fisher (nivel de significancia del 7%; $p=0,07$). **Resultados:** Prevalieron mujeres entre 20 y 34 años, con estratificación de alto riesgo y multigestas. En cuanto a la asistencia, se registraron 13 métodos no farmacológicos de alivio del dolor, con actuación directa de enfermeros y médicos. La mayoría de las muertes ocurrió en el anteparto, con predominancia de fetos de extremo bajo peso y sexo femenino. Hubo asociación estadística entre la estratificación de riesgo materno y el momento de la muerte ($p=0,06$), así como entre la edad gestacional y el total de métodos no farmacológicos de alivio del dolor aplicados ($p=0,01$). **Conclusión:** El estudio visibilizó la atención integral en la pérdida gestacional, destacando la importancia del equipo multiprofesional, de los cuidados para ressignificar el duelo y de protocolos para uniformar conductas.

Descriptores: Muerte fetal; Complicaciones del embarazo; Parto humanizado.

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What is already known:

- Fetal death directly impacts perinatal health indicators and the quality of obstetric care, in addition to profoundly affecting the mental health of those involved.
- Its causes are related to fetal, maternal, or placental factors, varying according to gestational age and the quality of prenatal care.
- Humanized care and bereavement support are recommended by international guidelines, although gaps still exist in clinical practice.

What this article adds:

- The relevance of understanding the specific obstetric profile of a population assisted in a high-risk maternity hospital, allowing for the detailed identification of current care practices in the context of fetal death.
- The identification of weaknesses in care, providing a foundation for actions that promote comprehensive care, such as continuous emotional support and the sensitization of the multidisciplinary team.
- The proposal for the development and implementation of humanized institutional protocols, aiming to standardize procedures and facilitate the experience and processing of grief by those involved.

INTRODUCTION

Fetal death has profound impacts on perinatal health indicators and the quality of life of those involved⁽¹⁾. Furthermore, the Fetal Mortality Rate (FMR) constitutes an important indicator of the quality of care provided during pregnancy and childbirth⁽²⁾.

Approximately 1.9 million stillbirths were recorded globally in 2023, corresponding to an estimated rate of 14.3 fetal deaths per 1,000 total births—a value significantly lower than those observed in previous decades. This declining trend highlights advances in reproductive health standards and access to obstetric services in many countries, although disparities between high- and low-income regions remain sharp⁽³⁾. In Brazil, the FMR has shown a state of relative stability in recent decades; data indicate that the index went from 8.19 per 1,000 births in 1996 to 9.5 in 2015⁽²⁾.

Conceptual definitions regarding fetal death vary and require terminological clarity. According to the World Health Organization (WHO), fetal death is defined as the death of a product of conception prior to the complete expulsion or extraction from the mother, regardless of the duration of pregnancy, characterized by the absence of breathing, heartbeat, umbilical cord pulsations, or voluntary muscle contraction movements^(4,5). Additionally, late fetal death (or stillbirth) refers to cases where the birth weight is 1,000 g or more, or with an estimated gestational age of 28 weeks or more⁽⁵⁾.

In Brazil, according to the Ministry of Health, the issuance of a Death Certificate (DC) is mandatory when death occurs from the 20th gestational week onwards and/or the fetus weighs 500 g or more and/or has a height of 25 cm or more (crown-heel), integrating it into the calculation of the stillbirth coefficient. Up to the 28th week of pregnancy, stillbirth is classified as early; after this period, it is termed late. Regarding the timing of delivery, death can also be classified as antepartum or intrapartum⁽⁶⁾.

Causes are related to fetal, maternal, or placental factors and vary according to gestational age. Infections, placental abruption, and fetal malformations predominate between the 24th and 27th gestational weeks, while from the 28th week onwards, a significant portion of deaths are of unknown origin. There are also risk factors that may lead to such an outcome, such as ethnicity (higher incidence in vulnerable populations), maternal diseases (hypertensive syndromes, diabetes, and thrombophilias), twin pregnancy, extremes of maternal age, history of stillbirth or complications in previous pregnancies, gestational age exceeding 41 weeks, and exposure to teratogens such as tobacco, alcohol, or illicit drugs⁽⁶⁾.

In this context, assisting the delivery of a lifeless fetus

constitutes a situation of extreme vulnerability for professionals, the woman, and her support network⁽⁷⁾. Thus, it is the responsibility of the healthcare team to offer humanized and holistic care to women diagnosed with fetal death⁽⁸⁾.

Given the above, this study is justified by the relevance of characterizing the population assisted in a reference unit under the circumstance of fetal death, aiming to identify diagnostic and care-related particularities in relation to current literature. The objective of this work is to describe and analyze the profile of fetal death cases and the care provided in a high-risk maternity hospital.

METHOD

This is a quantitative, descriptive, cross-sectional study with retrospective secondary data collection. Quantitative research utilizes ordered procedures to obtain information, while descriptive study aims to observe, describe, and document aspects of a specific situation⁽⁹⁾. Cross-sectional designs are employed to investigate phenomena at a single point in time and frequently have a retrospective character⁽¹⁰⁾.

The study was conducted in the high-risk maternity unit of a large university hospital in Curitiba, Paraná. In 2022, the unit recorded an average of 294 monthly births in the Obstetric and Gynecological Surgical Center (CCOG), a sector that includes obstetric nurses and obstetricians in the direct birth assistance team.

Data collection took place between July and December 2023, through the analysis of the birth indicators spreadsheet and the physical record book of admissions and fetal deaths at the CCOG. All antepartum and intrapartum fetal death cases whose births occurred at the institution between January and December 2022 were included. Duplicate records (n=1), cases with an Apgar score greater than or equal to 1 in the first minute (n=5), births occurring outside the maternity hospital (n=1) or home births (n=3), and gestational losses that did not fit the Ministry of Health's concept of fetal death (n=7) were excluded. Thus, the final sample consisted of 36 stillbirth records from 35 women treated.

To organize the data collection, an instrument was developed in Microsoft Excel containing variables related to: patients (age, risk stratification, parity, sector of origin, and reason for admission); care (induction methods, pharmacological and non-pharmacological pain relief methods, interventions, mode of birth, maternal birth position, presence of perineal laceration, assisting professional, postpartum care, multidisciplinary assistance, and length of stay); and newborns (timing of death, classification by weight and gestational age, sex, resuscitation maneuvers, skin-to-skin contact, time the body remained in the CCOG, and request for

autopsy).

Data were subjected to descriptive analysis in Microsoft Excel 2013. To verify the association between the variables "gestational age" and "total pain relief methods," as well as between "maternal risk stratification" and "timing of fetal death," Fisher's exact test was applied with a significance level of 7% (p=0.07) and adjusted standardized residual analysis. The adopted significance level is justified by the sample size, aiming to identify substantial correlations and ensure the inclusion of variables with relevant explanatory power.

To ensure methodological rigor, the study followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) checklist guidelines⁽¹¹⁾. The research complies with ethical precepts for studies involving human subjects, having been approved by the institution's Research Ethics Committee on January 18, 2022 (CAAE Opinion: 51476321.2.0000.0096), in accordance with current Brazilian resolutions.

RESULTS

Of the 35 (100%) women treated, the primary point of entry to the CCOG was the Gynecological and Obstetric Emergency Department in 31 (88.57%) cases, while four (11.43%) were referred from the Rooming-in units. Among the reasons for admission to the CCOG, labor induction due to fetal death stood out in 16 (45.71%) cases, and preterm labor in nine (25.71%). Other causes included fetal death (previous diagnosis) in three (8.57%), full-term labor in two (5.71%), and isolated cases (2.86% each) of hyperthermia, pre-eclampsia, suspected fetal death, post-term pregnancy, and premature rupture of membranes.

Regarding prenatal care, 18 (51.43%) women attended at least one consultation; in 16 (45.71%) cases, this information was not recorded, and one (2.86%) patient did not receive follow-up. Detailed maternal characteristics are provided in Table 1.

Regarding labor induction methods, vaginal misoprostol was used in 14 (40.00%) cases, intracervical Foley catheter in 12 (34.29%), and intravenous synthetic oxytocin in 10 (28.57%). Of the 21 (100%) patients who underwent induction, nine (42.86%) used only one method, while in nine (42.86%) there was an association of two methods, and in three (14.29%), all three methods were used in combination. It is noteworthy that 12 (34.29%) women did not undergo induction, and for two (5.71%), there was no record.

Regarding assistance during labor and birth (Table 2), 33 (94.28%) patients used at least one non-pharmacological pain relief method. In the pharmacological field, analgesia (spinal or epidural) was performed in only three (8.57%) cases and was not used in 19 (54.29%); however, there was a high absence of records regarding this intervention, corresponding to 13 (37.14%) patients.

Regarding interventions, 22 (62.86%) records indicated that the Kristeller maneuver was not performed; however, in 13 (37.14%) cases, this data is unknown due to incomplete information. Furthermore, 14 (40.00%) women did not receive any of the interventions described in Table 2, seven (20.00%) underwent at least one of them, two (5.71%) underwent two, and in 12 (34.29%) medical records, this information was not registered. Additionally, 12 (34.29%) patients underwent curettage during the postpartum period.

Regarding postpartum care, pharmacological inhibi-

Table 1 - Maternal characteristics of patients treated at the CCOG in 2022. Curitiba, PR, Brazil, 2023

Variables	N	%
Age (years)	35	100.00
15 † 19	2	5.71
20 † 24	8	22.87
25 † 29	14	40.00
30 † 34	7	20.00
35 † 39	2	5.71
40 † 44	2	5.71
Risk Stratification	35	100.00
High risk	21	60.00
Low risk	13	37.14
Not stratified	1	2.86
Number of pregnancies	35	100.00
Primigravida	12	34.29
Multigravida	23	65.71

Source: prepared by the authors, 2025.

Table 2 - Characteristics of labor and birth care for patients treated at the CCOG in 2022. Curitiba, PR, Brazil, 2023

Variables	N	%
Non-pharmacological pain relief methods	35	100.00
Companion/Support person	31	88.57
Ambulation	11	31.43
Shower	10	28.57
All-fours position	10	28.57
Massage	8	22.86
Squatting	6	17.14
Dim lighting	6	17.14
Birth ball	3	8.57
Birth stool	3	8.57
Bathtub	2	5.71
Spinning babies®	2	5.71
Music	1	2.86
Birth chair	1	2.86
Interventions	35	100.00
Amniotomy	6	17.14
Forceps	4	11.43
Episiotomy	1	2.86
Mode of birth	36	100.00
Vaginal birth	28	77.78
Cesarean section	8	22.22
Laceration	28	100.00
Grade I	2	7.14
Grade II	3	10.71
Intact perineum	19	67.86
Unknown	4	14.29
Birth position	36	100.00
Supine position	10	27.78
Semi-sitting	9	25.00
Unknown	6	16.66
All-fours	2	5.56
Standing	2	5.56
Lithotomy position	2	5.56
Sitting	2	5.56
Birth stool	1	2.77
Lateral recumbent (Side-lying)	1	2.77
Attending professional at birth	36	100.00
Physicians and medical residents	23	63.89
Nurses	6	16.66
Physicians	2	5.56
Nurses and nursing residents	2	5.56
Nurses and medical residents	2	5.56
Nurses and physicians	1	2.77

Source: prepared by the authors, 2025.

tion of lactation was administered to 32 (91.43%) women. After discharge, 12 (34.29%) were referred for psychological follow-up in Primary Health Care. Multiprofessional care during hospitalization was characterized by medical assistance to all 35 (100%) women, nursing care to 34 (97.14%), social services to 30 (85.71%), and psychology to 21

(60.00%); occupational therapy, physiotherapy, dentistry, and nutrition provided care to one (2.86%) patient each. The average length of hospital stay was over 46 hours, with an interval ranging between 7 and 218 hours.

Fetal characteristics are detailed in Table 3. The presence of a pediatrician was observed in 17 (47.22%) births and their absence in one (2.78%); in 18 (50.00%) cases, there was no record of this assistance.

There was also a statistically significant association between the total number of non-pharmacological pain relief methods used by the women and the classification of the newborns (NB) according to gestational age (p=0.01). The

adjusted standardized residual analysis showed a positive association when the NB is classified as very preterm and there is a record of only one pain relief method applied, as well as in cases of full-term NB with the application of eight and nine methods. Conversely, a lower frequency of cases was observed when the NB is late preterm and only one method was performed. These data are detailed in Table 4.

Additionally, Fisher's exact test demonstrated a statistical association between the variables "maternal risk stratification" and "timing of fetal death" (p=0.06). The analysis of adjusted standardized residuals between these variables is detailed in Table 5.

Table 3 - Characteristics of stillborn infants treated at the CCOG in 2022. Curitiba, PR, Brazil, 2023

Variables	N	%
Timing of death	36	100.00
Antepartum	23	63.89
Intrapartum	12	33.33
Unknown	1	2.78
Weight classification	36	100.00
Extremely low birth weight	15	41.67
Very low birth weight	5	13.89
Low birth weight	8	22.22
Above 2500g	7	19.44
Unknown	1	2.78
Gestational age classification	36	100.00
Extremely preterm	13	36.11
Very preterm	8	22.22
Moderate preterm	2	5.56
Late preterm	8	22.22
Full-term	5	13.89
Sex	36	100.00
Female	21	58.33
Male	11	30.56
Unknown	4	11.11
Neonatal resuscitation maneuvers	36	100.00
Performed	8	22.22
Not performed	10	27.78
Unknown	18	50.00
Skin-to-skin contact	36	100.00
Immediate	8	22.22
Not immediate	5	13.89
Not performed	10	27.78
Unknown	13	36.11
Time interval of the body in CCOG	36	100.00
Less than 1 hour	3	8.33
Between 1 to 3 hours	7	19.44
Between 3 to 6 hours	10	27.78
Between 6 to 9 hours	4	11.11
More than 10 hours	2	5.56
Unknown	10	27.78
Autopsy request	36	100.00
Yes	13	36.11
No	21	58.33
Unknown	2	5.56

Source: prepared by the authors, 2025.

Table 4 - Analysis of adjusted standardized residuals between newborn classification by gestational age and the quantity of non-pharmacological pain relief methods performed in 2022. Curitiba, PR, Brazil, 2023

Number of methods	Very preterm	Extremely preterm	Moderate preterm	Late preterm	Full-term
	N / (p-value)	N / (p-value)	N / (p-value)	N / (p-value)	N / (p-value)
None	0 / (-0.54)	0 / (-0.76)	0 / (-0.24)	1 / (1.89)	0 / (-0.40)
1	7 / (2.06)	9 / (1.24)	2 / (1.30)	1 / (-2.77)	1 / (-1.72)
2	0 / (-0.96)	1 / (-0.10)	0 / (-0.43)	2 / (1.93)	0 / (-0.72)
3	0 / (-0.77)	1 / (0.42)	0 / (-0.35)	1 / (0.97)	0 / (-0.58)
5	0 / (-0.77)	1 / (0.42)	0 / (-0.35)	0 / (-0.77)	1 / (1.51)
6	0 / (-0.54)	0 / (-0.76)	0 / (-0.24)	1 / (1.89)	0 / (-0.40)
7	1 / (0.48)	0 / (-1.36)	0 / (-0.43)	2 / (1.93)	0 / (-0.72)
8	0 / (-0.54)	0 / (-0.76)	0 / (-0.24)	0 / (-0.54)	1 / (2.52)
9	0 / (-0.77)	0 / (-1.09)	0 / (-0.35)	0 / (-0.77)	2 / (3.62)
Unknown	0 / (-0.54)	1 / (1.34)	0 / (-0.24)	0 / (-0.54)	0 / (-0.40)

Source: prepared by the authors, 2025.

Table 5 - Analysis of adjusted standardized residuals between the timing of fetal death and maternal risk stratification in 2022. Curitiba, PR, Brazil, 2023

	Antepartum N / (p-value)	Intrapartum N / (p-value)	Unknown N / (p-value)
High Risk	14 (-0.03)	8 (0.48)	0 (-1.27)
Low Risk	9 (0.50)	4 (-0.24)	0 (-0.76)
Not stratified	0 (-1.34)	0 (-0.71)	1 (6.00)

Source: prepared by the authors, 2025.

DISCUSSION

Regarding the obstetric profile, the predominant age group (25 to 29 years) accounted for 40% of fetal death cases, with a significant density in the 20 to 34-year range. These data corroborate the 2021 national scenario, in which this age group was prevalent in almost all regions of the country, except for the North region⁽¹²⁾. In the South region specifically, it is observed that women between 25 and 29 years old present fetal death rates higher than those between 20 and 24 years old⁽¹²⁾.

In relation to the type of pregnancy, for the same year, the number of fetal deaths in single pregnancies in Brazil was higher than in multiple pregnancies, corresponding to 91.91%⁽¹²⁾. Considering the above, the results of this research align with the national reality. Regarding prenatal care, although 51.43% of the women attended at least one consultation, the high rate of incomplete records compromises a reliable analysis of this factor. It is worth noting that the Ministry of Health recommends a minimum of six consultations, with early initiation in the first trimester and increasing frequency as gestational age advances, alternating care between physicians and nurses in low-risk prenatal care⁽¹³⁾.

In the scope of childbirth care, the presence of a companion stands out in 88.57% of cases as a non-pharmacological method of pain relief. This is a right guaranteed by law since 2005 and reinforced in 2023, ensuring the presence of a person of the woman's choice in public and private units throughout the entire period of care^(14,15). Literature demonstrates that emotional support from a companion strengthens family bonds and humanizes professional conduct, assisting in patient safety and the physiological evolution of the process, as well as in pain alleviation⁽¹⁶⁾.

The research evidenced that the lower the gestational age at the time of death, the lower the number of pain relief methods used. It is imperative that holistic and humanized care be guaranteed regardless of fetal viability. A study conducted in a public maternity hospital in Southern Brazil pointed out that, in a situation of gestational loss, labor assistance is perceived as difficult to monitor by professionals; the fragmentation of care and the limited offering of guidance on pain relief methods result in the restriction of women's choice regarding the mode of birth⁽¹⁷⁾.

Regarding the multidisciplinary team, its importance is based on both prevention and the outcome of fetal death care. Quality prenatal monitoring and comprehensive health care are fundamental to preventing unfavorable outcomes, as well as for providing support in facing grief. The need for research investigating high-risk pregnancy monitoring—the group that represented the largest number of antepartum deaths in this study—is emphasized to identify weaknesses in the care network and improve assistance.

Comparative studies between Brazil and Canada highlight differences in care, mainly regarding support for preventing complicated grief. Physical contact with the baby,

interaction, and the act of keeping mementos (objects, photos, or videos), in addition to professional support after the loss, are means that assist the family in processing grief⁽¹⁸⁾. Other studies address the team's responsibility in encouraging the creation of memories: seeing, touching, bathing, changing, and naming the baby are fundamental care rituals⁽¹⁹⁾. The need to respect each family's culture and their possible refusal of contact is emphasized, leaving it to the team, with an emphasis on the nurse, to offer such care sensitively.

Although the institution does not have formal records of these rituals, the data show that the baby's body remains in the sector between 1 and 6 hours in 47.22% of cases—a viable interval for the team to offer support. Furthermore, indicators demonstrated that skin-to-skin contact occurred in 36.11% of cases; this care could be further encouraged so that more families benefit. It is noteworthy that assisting the birth of a lifeless fetus represents a delicate experience for professionals, whose discomfort may reflect on the quality of care, especially due to the lack of institutional support to deal with such situations^(7,20). Protocols such as SPIKES and the Royal College of Obstetricians & Gynaecologists guideline can guide the team in this process^(21,22).

In this study, it was observed that 91.43% of the women underwent pharmacological inhibition of lactation, 60.00% received institutional psychological care, and 34.29% were referred to primary care. The lack of a specific institutional protocol results in psychological care coverage that may reflect structural limitations or the number of professionals available to meet the demand.

Regarding fetal characteristics, 63.89% of deaths occurred in the antepartum period, which corroborates 2021 IBGE data (89.84%)⁽¹²⁾. However, there was a divergence regarding sex: in this research, female prevailed (58.33%), while in the national scenario, male prevails⁽¹²⁾. Regarding weight and gestational age, this study pointed to a predominance of extreme preterm and extremely low birth weight infants, opposing the national trend of moderate preterm and low birth weight⁽¹²⁾.

Among the study's limitations, the difficulty in data collection due to the segmentation of records and the absence of an institutional protocol stand out, which hinders the compilation of information. The incompleteness of data demonstrates weakness in the recording process by professionals and the inefficiency of the current method of capturing information in cases of fetal death.

CONCLUSION

It is emphasized that humanized care must begin with the reception provided by the nurse at the service's entry point, permeating pre-birth, birth, and the postpartum period. It is essential that these patients have access to holistic care, regardless of fetal viability.

This study contributes to giving visibility to bereavement care, highlighting as essential the multidisciplinary

monitoring, the offering of care rituals for the re-signification of the process, and the implementation of protocols that standardize procedures in gestational loss.

Finally, it is inferred that the proposed objective was achieved, suggesting a reorganization of care and the recording of losses. Such a measure aims to provide greater visibility to these cases, considering the close relationship between

the fetal mortality rate and the quality of care provided in the health network.

CONFLICT OF INTERESTS

The authors declare that there is no conflict of interest.

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All authors are responsible for the textual writing and critical review of the intellectual content, for the final published version, and for all ethical, legal, and scientific aspects related to the accuracy and integrity of the study.



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