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ORIGINAL ARTICLE

PERINATAL BEREAVEMENT: NURSES' PERCEPTIONS IN AN OBSTETRICS AND GYNECOLOGY UNIT

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ABSTRACT

Objective: to explore nurses' perceptions of perinatal bereavement in an obstetrics and gynecology unit. **Methods:** qualitative descriptive study conducted with 15 nurses from the obstetrics and gynecology unit of a university hospital in Paraná, Brazil. Between June and October 2024, data were collected through semi-structured, audio-recorded interviews, which were transcribed and analyzed using Bardin's thematic content analysis. **Results:** the final sample included 15 participants, all women, aged 24–52 years, with time in practice ranging from 1 year and 2 months to 24 years. Three categories emerged: Feelings and lived experiences related to perinatal bereavement; Gaps in care in the context of perinatal bereavement; and Strengths in caring for bereaved families. **Conclusions:** findings indicate a lack of professional preparation compromises support for families. They also highlight the need for an approach integrating physical and emotional care, alongside training focused on compassionate care and empathetic engagement, to ensure high-quality, respectful care.

Keywords: Perinatal Death. Obstetric Nursing. Nursing Care. Parents. Family. Mourning.

INTRODUCTION

Motherhood is culturally regarded as a symbol of personal and family fulfillment. The birth of a child is celebrated as an event filled with joy and meaning for families. However, not all pregnancies end with the expected outcome[1].

The premature death of a new family member—due to pregnancy loss or neonatal death—is a singular and profoundly impactful event. The impact can be heightened when the loss is linked to potentially preventable causes and when it interrupts the expectation of welcoming a healthy baby, shattering plans and hopes that had been built for the future[2].

The World Health Organization (WHO) provides specific definitions that help clarify different types of loss: it defines stillbirth as fetal death before birth, with a minimum weight of 1,000 g and a gestational age of at least 28 weeks, or a body length of at least 35 cm. Neonatal death refers to the death of a newborn up to the 28th day of life. Perinatal death, in turn, includes both fetal deaths at 28 weeks of gestation or more and deaths of newborns up to the seventh day of life[3].

Following a loss, families enter a grieving process that affects them across biopsychosocial and spiritual domains. This process may be marked by guilt, irritability, profound sadness, posttraumatic stress disorder symptoms, isolation, loss of faith, fear of a future pregnancy, anger, disbelief, and apathy[1,4,5].

This phenomenon, known as perinatal bereavement, encompasses pregnancy losses from the 22nd week onward, neonatal deaths up to the 29th day of life, and the placement of a

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newborn for adoption[1].

In Brazil, neonatal mortality reaches approximately 8 deaths per 100,000 live births, and roughly 28,000 fetal deaths are recorded annually. However, despite the seriousness of these data, pregnancy and neonatal loss are rarely discussed and are often silenced; the bereavement resulting from these experiences frequently goes unrecognized and unsupported by health professionals[6].

This gap is evident in nursing practice, particularly in perinatal bereavement care, pointing to shortcomings in professional training—especially around caring for death in settings historically focused on preserving life[1].

Although comprehensive care includes emotional support, care for bereaved families remains limited and fragmented, reflecting inadequate technical preparation, resource constraints, and a lack of institutional protocols[5]. In this context, nurses play an essential role in providing compassionate care, supported by empathetic listening and up-to-date guidelines that inform perinatal bereavement care.

Therefore, this study aims to explore nurses' perceptions of perinatal bereavement in an obstetrics and gynecology (OB-GYN) unit.

METHOD

This qualitative descriptive study was guided by the Consolidated Criteria for Reporting Qualitative Research (COREQ)[7]. It was conducted at a university hospital in Northwest Paraná, Brazil, a referral center for high-risk pregnancies and legal abortion services. At the time of data collection, the hospital did not have a standard operating procedure (SOP) for perinatal death.

The study setting was a maternity unit with 28 beds and 2 delivery rooms. The nursing staff included 18 employed nurses and 1 volunteer nurse. Per shift, 2 nurses worked in the rooming-in unit, 1 nurse was assigned to each delivery room, and an average of 8 nursing technicians worked per shift.

Participants were selected through consecutive sampling. Inclusion criteria were: being a practicing nurse in the obstetrics and gynecology unit and working one of the four shifts (morning, afternoon, night 1, and night 2). Exclusion criteria were volunteer nurses and nurses on vacation or leave during the interview period.

Data were collected by the study's lead author, a nurse and, at the time, a fourth-year undergraduate nursing student, under the guidance and supervision of the faculty advisor, to support her undergraduate thesis.

The researcher/interviewer was already involved in maternal and child health research groups. During a curricular internship in the same unit the previous year, she developed an interest in the topic and had prior contact with the unit and the participants. Before and during data collection, the researcher sought guidance from her advisor, which helped ensure the interviews were conducted appropriately.

Data collection—from June to October 2024—covered the institution's four shifts (morning, afternoon, night 1, and night 2). Semi-structured interviews were audio-recorded and conducted with participants' prior authorization; participants also signed two copies of the Informed Consent Form, in line with ethical requirements for research involving human participants. Finally, this study is part of a broader institutional project titled "Comprehensive care across diverse child and adolescent health care contexts".

To protect participants' anonymity, each questionnaire was assigned an alphanumeric identifier beginning with the letter "N" (for nurse), followed by a number corresponding to the order in which questionnaires were completed and each participant's time in practice. Example: N1, X years in practice.

The interviewer approached participants in person during their work shifts to invite them to participate. Individual interviews were conducted in delivery rooms A and B when no patients were present, with only the interviewer and the participant. Interviews lasted an average of 24 minutes, and no second interview with the same participant was needed.

The interview guide included two parts: sociodemographic questions to characterize participants and open-ended questions addressing their experiences and perceptions of perinatal bereavement.

To encourage participants to elaborate without steering their responses—and to

maintain conversational flow and depth of data—the interviewer used probes such as: "What do you mean?" "Could you tell me more about that?" and "Could you explain that further?"

All audio-recorded interviews were transcribed using Gladia® software; however, transcripts and findings were not returned to participants for comments or corrections. Data were analyzed using Bardin's thematic content analysis, following the steps specified in the methodological framework: (1) pre-analysis—selecting the data and documents to be analyzed and developing assumptions to support the conclusions; (2) coding—interpreting the collected data and developing exploratory categories; and (3) categorization—processing the information and developing the results[8].

To strengthen methodological rigor, field notes were completed after data collection, and peers reviewed emerging findings during analysis. Researchers' prior assumptions were bracketed to avoid directly shaping the analysis. Data saturation was not achieved.

All ethical principles established by Brazilian National Health Council Resolution No. 466/2012 were strictly observed. The parent study was approved by the Research Ethics Committee of the State University of Maringá (CAAE No. 68786323.9.0000.0104).

RESULTS AND DISCUSSION

The final sample included 15 participants, all women, aged 24–52 years. Ten self-identified as White, nine were never married, nine had no children, and eight were Catholic. Time in practice ranged from 1 year and 2 months to 24 years, with a mean of 9 years and 1 month.

In-depth analysis of the interview content generated six codes and, ultimately, three thematic categories: Feelings and lived experiences related to perinatal bereavement; Gaps in care in the context of perinatal bereavement; and Strengths in caring for bereaved families.

Feelings and lived experiences related to perinatal bereavement

Perinatal bereavement is a complex and singular process, carrying profound meaning for both families and the health professionals who accompany this experience[1]. A cross-sectional study reported that, when caring for bereaved families, nurses face emotional and ethical challenges, often marked by difficulty coping with the loss and the need to provide support during a period of intense vulnerability[9].

> Perinatal bereavement is when a mother loses a child—no matter how old the baby was or how many weeks pregnant she was—because sometimes it was early in pregnancy, but she was still a mom. So she is a mother to an angel. (N9, 1 year and 2 months in practice)

> For me, it's a challenging moment. As a professional, I've already adapted. But looking at it from the patient's side, I think it's very sad because OB-GYN is usually about new life, right? So loss is hard. (N11, 2 years and 8 months in practice)

> I think bereavement includes everything from pregnancy loss and a baby who dies right after birth to mothers whose newborn is in the ICU for months—I also think that fits. (N12, 2 years in practice)

Participants described perinatal bereavement as a process experienced primarily by the woman who was pregnant or who gave birth, reflecting the strong bond formed with the baby during pregnancy. However, one participant emphasized that the suffering is not limited to the mother; it affects the entire family and underscores the importance of considering the impact on all family members, not only on the woman.

> It's suffering not only for the woman but for the whole family. A lot of the time, the focus is on the patient and the loss, and people forget everything that comes with it. So it's a huge loss for the family—not only for the woman, but for the family.(N2, 28 years in practice)

The present findings are consistent with a study conducted in the Brazilian state of Rio Grande do Sul involving 26 nurses working in a neonatal intensive care unit (NICU). In that study, nurses reported that parents experienced profound sadness and helplessness when their expectations were frustrated, especially as faced with the impossibility of taking their child home[10].

The loss of a child—whether early or late in pregnancy—can profoundly affect the entire

family structure, shifting dynamics and relationships, sometimes irreparably. The literature also points to the challenges many couples face in grieving together. For some partners, uncertainty about how best to respond—or about how long grief may last—can limit mutual emotional support, intensifying suffering[11].

Gaps in care in the context of perinatal bereavement

Because education directly shapes nurses' perceptions and emotional responses to perinatal bereavement, it is essential to invest in training that equips them to address this topic with sensitivity and competence. Accordingly, a solid theoretical foundation is needed, paired with practices that promote compassionate, respectful care and strengthen compassionate communication[9,12].

In the excerpts below, participants described limited preparation to provide this kind of support, pointing to gaps in training and in how the topic is taught—gaps that translate into shortcomings in perinatal bereavement care.

> Come on, honey. I'm old-school. I always say nursing school today looks at things totally different. Back in my day, it was extremely task-focused—the nurse wasn't someone who got emotionally involved. Life taught me. (N1, 28 years in practice)

> I can't remember this being addressed during my undergraduate training, and since internships aren't that long, I don't remember living through it. As nursing interns, given the delicate nature of the topic, we're kept a bit on the sidelines so we don't intrude on the woman's space. (N4, 6 years in practice)

> It's all theory, right? But in practice, it's different. You see everyone crying, everyone getting thrown off. How do you work like that? (N5, 1 year and 2 months in practice)

> You see this more in practice; you don't see it in nursing school. When you get to the unit and you're faced with a fetal death, that's when you, as a nurse, have to go study—build your knowledge—about how to support that patient. That's usually how it goes. (N7, 4 years in practice)

These accounts illustrate how a lack of adequate training directly affects professional practice in the face of pregnancy loss and reinforce the urgency of addressing perinatal bereavement more broadly and in greater depth in undergraduate nursing programs[5,12].

When this training gap persists over time, nurses often have to develop these skills on their own, in many cases reactively, only after encountering pregnancy loss in clinical practice. Over time, they are expected to build the emotional resources and technical competencies needed to manage perinatal bereavement more effectively, both for themselves and for families[10].

However, limited professional experience, a lack of continuing education focused on managing loss, and the pressure to avoid mistakes and achieve a cure at any cost can perpetuate inadequate approaches and expose professionals to intense emotional distress. These factors make it harder to cope with death and compromise the provision of effective, supportive care to bereaved families[12,13].

The present findings reveal a concerning discrepancy: in the unit studied, only a few nurses had received specific training; most, therefore, work without the preparation needed to manage the emotional impact of perinatal bereavement and its related demands.

> We always have talks and facilitated group discussions, and we talk a lot about pregnancy loss. A psychologist has also come to talk with us about how we should respond. (N4, 6 years in practice)

> I haven't received any training, and it's complicated because you have to have a lot of empathy for what the other person is going through. (N15, 2 years and 6 months in practice)

> We attended a talk with a psychologist, and she spoke about perinatal bereavement. I don't think it counts as a course, but it was a talk, and I think there should be more about this topic. (N13, 6 years in practice)

> We need to improve a lot. And talking with you now, I realized not everyone there has been trained.(N14, 18 years in practice)

Participants also described carrying the burden of witnessing other professionals' neglect when sensitive care was needed after a loss and said they were often affected by institutional silence and by the indignation they felt about

inappropriate conduct they experienced or observed.

> The patient came in with first-trimester bleeding; they said it was a miscarriage in progress. They took her in for a curettage without an ultrasound. Long story short, they took herin for a curettage, and the baby was alive. The nursing technicians themselves told the family. We did everything to try to stop labor, but she was fully dilated, her water broke, and a 21-week breech baby was born alive. The on-call physician didn't want to intervene; he just turned to the parents and said, "When it stops, I'll issue the death certificate." (N10, 10 years in practice)

> She was a first-time pregnant patient at 39 weeks, admitted because of a concerning cardiotocography tracing. The tracing remained category II, and an ultrasound showed some abnormalities. That night, we repeated the cardiotocography, and there was no heartbeat. It was a fetal death, and she went for an emergency cesarean. We tried neonatal resuscitation for 40 minutes, but without success. And if you look at the literature, delivery is indicated after two category II tracings, regardless of the route of delivery. So to me, yes, it was negligence, because if something had been done in the morning or afternoon, maybe that baby would be alive.(N3, 12 years in practice)

The gravity of this issue is also reflected in Brazilian legislation, which imposes strict penalties on health professionals who engage in negligent practices or inappropriate conduct. Under Brazilian Law No. 7,498/1986, negligence in professional practice may lead to revocation of professional registration, as provided in each profession's Code of Ethics[14].

A history of coercive institutional practices does not exempt the participating nurses, who described pivotal moments in their careers that served as a warning to change their professional stance when dealing with this phenomenon.

> When I was a new graduate, a patient called me over and showed me something in the toilet. I saw it was a clot. What did I do? I flushed it. But after that, that woman didn't pass anything else, and an ultrasound showed the miscarriage was complete. What did I, as a nurse, do with her child? I flushed it. You can be sure that woman, to this day, must still say, "A nurse flushed my child." Even if I apologized for the rest of my life, she wouldn't accept it. (N4, 6 years in practice)

> I wasn't even thinking about the baby—I was only thinking about the woman, because she was at risk. When the baby was born—when the fetus was expelled—I said, "Bring the bag." My God, am I going to say I'm going to put her child in a bag? I thought, "I always do it like this. Maybe I don't have that sensitivity with the baby." After that day, I said, "Never again." (N14, 18 years in practice)

These findings reflect a reality reported in other settings. A study involving 100 women aged 20–47 years undergoing miscarriage found not only a lack of effective measures to relieve physical pain, but also emotional neglect and a lack of psychological support, reinforcing the holistic nature of the suffering experienced[15].

Participants also reported a lack of privacy during examinations and procedures, episodes of verbal abuse, a lack of compassionate support, and being blamed for the pregnancy loss. In addition, they highlighted the absence of a companion of their choosing, limited humanized care practices, and the need to seek care across multiple health services[15].

When a perinatal loss occurs, care ideally should be delivered by a multidisciplinary team[1]because these events call for integrated approaches that address the physical, emotional, and psychological dimensions of affected families. However, a gap is evident between this recommendation and the practice observed at the institution studied.

Study participants reported difficulty securing timely involvement from other members of the multidisciplinary team, which often leads to management centered on a single professional.

> Overall, it's lacking. A lot of the time, we call the physician because we can tell... if we're calling, something is going on... and often they don't come. At night, we really struggle with that part. (N15, 2 years and 6 months in practice)

> At night, we deal with these issues, and unfortunately, there's no support. We don't have support. Everything happens at night, but we don't have enough support from a multidisciplinary team—for example, a social worker or a psychologist—we don't have that.

(N2, 28 years in practice)

> We're short on psychologists. Having a psychologist involved is extremely important, and that's what we struggle with. For example, if it's a fetal death overnight, on a weekend, we're the ones trying to calm the woman down.(N14, 18 years in practice)

Nurses play a broad and complex role in caring for bereaved parents; however, this role tends to overburden them. In many cases, they assume responsibilities beyond their core scope of practice, underscoring insufficient structural support[16].

In this context, an integrative review highlights the importance of building competencies for effective communication among everyone involved, developing a care plan that addresses the family's needs, and using tools such as the Perinatal Bereavement Care Confidence Scale to better understand and support families, enabling a multidimensional assessment[16].

It is also important to note the absence of standard operating procedures for multidisciplinary management of perinatal death, a reality also confirmed in this study[17]. A lack of clear guidance led to improvised practices, and in any situation, each professional's approach tends to reflect individual judgment[17]. This issue is also evident in the present study, as one participant stated:

> [...] There's no specific protocol; it depends on how we act with the patient.(N15, 2 years and 6 months in practice)

This similarity to the present study highlights a broader problem and suggests that the lack of standardization in perinatal bereavement management is a structural difficulty across different institutional contexts. Therefore, Permanent Health Education (Educação Permanente em Saúde [EPS]) is indispensable for these professionals because it supports continuing education in care delivery in situations of perinatal loss. This need is underscored by findings from the TEARDROP program, which showed many professionals did not feel sufficiently prepared to communicate with bereaved parents or provide care in the face of loss, pointing to substantial training gaps[18].

Beyond strengthening practice and increasing the confidence and sensitivity of the care provided to families, EPS also protects workers' mental health by reducing feelings of insecurity, emotional distress, and the risk of professional burnout. Accordingly, it is a key strategy for improving care delivery and promoting safer, more humanized care environments[18].

Strengths in caring for bereaved families

When delivered with sensitivity and compassion, care during perinatal bereavement can help transform the pain of loss into meaningful memories, supporting families in making sense of this experience. Practices of genuine emotional support—including memory-making and empathetic support—help families feel respected and understood[19,20].

In the present study's context, the hospital is recognized as a Baby-Friendly Hospital, which entails an even greater responsibility for perinatal bereavement management[21]. The institution is encouraged to align its practices with principles of respect, supportive care, and empathy, meeting families' expectations as well as humanized care guidance[21].

The interviewed nurses' narratives highlight their recognition of the value of allowing parents brief contact with their deceased baby as a humanized care practice.

> It's happened with larger babies—almost term—where they stayed as long as the patients wanted. There won't be another moment later. I remember a Romani patient. She said, 'I want to change the baby.' She opened the diaper, changed it, closed it, took off the hat, took off the shirt—I gave her the time she felt she needed. (N6, 1 year and 3 months in practice)

> Recently, a patient here spent some time being induced. The baby was born alive, but anencephalic, and she asked us not to intervene. The team respected her wishes, placed a little ribbon on the baby, identified the baby, and preserved the baby's dignity. Even though the baby survived briefly—about an hour and a little more—the mother was able to have that contact; the father came, he held the baby, and they blessed the baby. (N10, 10 years in practice)

According to the literature, enabling parents to spend time with the baby even after death—

allowing them to meet the baby and say goodbye—and offering keepsakes associated with the baby support memory-making and farewell rituals. These practices contribute to families' adjustment and to moving forward with life after the loss[2].

An international study conducted in Spain with 117 nurses found 94% of participants considered it essential to allow the couple to remain together with the baby for a period of time as a good practice in supporting perinatal bereavement. In addition, 95% reported using empathetic listening as a care strategy, while 47% said they performed actions—washing, dressing, and preparing the baby after death. Only 33.3% of professionals reported that permission for other family members to be present was a practice used in caring for bereaved families[22].

In a systematic review of nursing interventions to help people cope with grief, the authors identified several strategies, including encouraging the expression of feelings, psychosocial support, distraction techniques, group sessions, physical activity, and family education. These interventions are essential to promote a healthier grieving process and reduce symptoms of depression and post-traumatic stress. The range of effective approaches also underscores the importance of individualized care tailored to each family's specific needs[4].

In Brazil, there is currently no enacted law establishing an approach to perinatal bereavement. Existing Brazilian perinatal bereavement guidelines represent an adaptation of Canadian standards published by the Public Health Agency of Canada in the document *Family-Centred Maternity and Newborn Care: National Guidelines*, which emphasizes the importance of offering families tangible and sentimental mementos of the baby to support the grieving process[23,24]. Consistent with this, the nurses viewed this practice as a standard approach applicable to all cases of perinatal bereavement occurring in the unit.

> When a woman experiences a loss, that's the only record she has. So she won't have any other record going forward. I ask while she's here, "Do you want to take a photo?" Because she won't have a record after that. (N4, 6 years in practice)

> We've also been working a lot on the letter, so we've been improving our care around losses here, and it's really good. (N8, 15 years in practice)

> There's the standardized keepsake card we fill out. We write the baby's weight, we take a footprint, and sometimes I can do a handprint too. And sometimes I offer a little knit hat for the baby, you know? (N12, 2 years in practice)

The literature indicates that parents recognize the dedication of health professionals who facilitate closeness and family togetherness—understood as meaningful farewell rituals—supporting both the grieving process and the bond with the baby they were expecting[16].

In this context, several strategies stand out: photographs, collecting locks of hair, encouraging physical contact with the baby, using the family's own clothing, expressing spirituality, and connecting families with support groups—practices considered essential for compassionate support and for promoting a healthier grieving process, which should be encouraged by nurses[25].

This understanding is also reflected in some participants' accounts. Having experienced perinatal bereavement in their own lives, they began incorporating these practices into their work, offering care that is more sensitive, empathetic, and humanized.

> We're doing the letter, we have the print, if she wants the little photo of the feet, if she wants the memory box, a little lock of hair, you know? That's something I wish I'd had from my children, you know? The two I lost, because they're only in my memory, you understand? I couldn't have that, and I wanted it. Just as I have photos of the two who are alive, I wanted a handprint and a footprint. Nothing aggressive, nothing that would be hard for people to look at, because I didn't want it to be like that. But something that showed he was part of my life, you know? And they've improved a lot in that sense here. (N1, 28 years in practice)

> My daughter was born at 32 weeks, and she didn't survive. During that process, they took me out of the ICU, brought me to her, and placed her skin-to-skin with me. I prepared her body; I was able to hold her and take photos. And I try to offer that to mothers who are going

through their own grief as mothers. (N10, 10 years in practice)

The nurses' accounts align with findings from another study[17]: interactions between health professionals and patients, especially in the context of grief, are often shaped by gender dynamics. Historically, women have been more closely associated with caregiving and motherhood, which can lead female nurses to identify with a bereaved mother. This identification can strengthen the emotional bond and facilitate recognition of the patient's emotional needs. However, it can also pose challenges because it may lead to overinvolvement and undermine the professional distance needed for balanced practice[17].

In this context, the literature underscores the importance of health professionals recognizing and integrating, in their practice, each patient's and family's beliefs, individual values, and the multiple meanings they attribute to spiritual and religious experiences in the context of death and dying[26].

A limitation of this study is that data collection was conducted in a single high-risk maternity unit. Therefore, the findings reflect this setting and may differ from the reality of other healthcare institutions with different characteristics or levels of complexity.

These findings underscore the importance of expanding the scope of future studies to include diverse settings and larger samples, enabling a more comprehensive understanding of the phenomenon under investigation.

FINAL CONSIDERATIONS

Perinatal bereavement is an inherently complex phenomenon, requiring nurses to adopt an approach grounded in sensitivity and humanized care. In the maternity setting, this is even more challenging because care is typically oriented toward celebrating life, growth, and development, and loss runs counter typical expectations in obstetric and neonatal care.

Care in the context of perinatal bereavement should, therefore, encompass both physical and emotional support, extending not only to affected families but also to nurses, who often face emotional challenges of their own. In sum, it is essential to invest in continuing education to better prepare nurses to respond appropriately to these situations.

Finally, the relevance of this topic is evident across teaching, research, and community outreach, including in-depth reflection on perinatal bereavement, recognition of families' emotional needs, and the promotion of supportive care and empathetic listening.

LUTO PERINATAL: PERCEPÇÃO DE ENFERMEIRAS DE UM SETOR DE GINECOLOGIA E OBSTETRÍCIA

RESUMO

Objetivo: conhecer a percepção das profissionais enfermeiras de um setor de Ginecologia e Obstetrícia acerca do luto perinatal. **Método:** estudo qualitativo e descritivo realizado com 15 enfermeiras do setor de Ginecologia e Obstetrícia de um hospital universitário no Paraná. Entre junho e outubro de 2024, coletaram-se os dados mediante entrevistas semiestruturadas e audiogravadas, que foram transcritas e submetidas à análise de conteúdo na modalidade temática proposta por Bardin. **Resultados:** a amostra final foi composta por 15 participantes, todas do sexo feminino, cuja idade variou de 24 a 52 anos, e o tempo de atuação na profissão foi de 1 ano e 2 meses até 24 anos. Na análise, foram evidenciadas três categorias: Sentimentos e vivências relacionadas ao luto perinatal; Fragilidades na assistência prestada diante do luto perinatal; e Potencialidades no cuidado às famílias enlutadas. **Considerações finais**: a pesquisa apontou que a falta de preparo profissional compromete o suporte às famílias. Também destacou a necessidade de uma abordagem que integre cuidado físico e emocional, com formação humanizada e acolhimento empático para garantir a assistência respeitosa e de qualidade.

Palavras-chave: Morte perinatal. Enfermagem Obstétrica. Cuidados de Enfermagem. Família. Luto.

LUTO PERINATAL: PERCEPCIÓN DE ENFERMERAS DE UN SECTOR DE GINECOLOGÍA Y OBSTETRICIA

RESUMEN

Objetivo: conocer la percepción de las profesionales enfermeras de un sector de Ginecología y Obstetricia acerca del duelo perinatal. **Método**: estudio cualitativo y descriptivo realizado con 15 enfermeras del sector de

Ginecología y Obstetricia de un hospital universitario en Paraná/Brasil. Los datos, recogidos en los meses de junio a octubre de 2024, mediante entrevistas semiestructuradas grabadas en audio, fueron transcritos y sometidos al análisis de contenido, en la modalidad temática propuesta por Bardin. **Resultados**: la muestra final estuvo compuesta por 15 participantes, todas del sexo femenino, cuya edad varió de 24 a 52 años, y el tiempo de actuación en la profesión fue de un año y dos meses hasta 24 años. En el análisis se evidenciaron tres categorías: sentimientos y vivencias relacionados al duelo perinatal; fragilidades en la asistencia prestada ante el duelo perinatal; y potencialidades en el cuidado a las familias de luto. **Consideraciones finales**: la investigación señaló que la falta de preparación profesional compromete el apoyo a las familias y destacó la necesidad de un enfoque que integre cuidado físico y emocional, con formación humanizada y acogida empática para garantizar la asistencia respetuosa y de calidad.

Palabras clave: Muerte perinatal. Enfermería Obstétrica. Cuidados de Enfermería. Familia. Duelo.

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