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OBSTETRIC CARE TECHNOLOGIES BASED ON THE MERHY CONCEPT APPLIED TO HIGH-RISK PARTURIENTS

Tecnologías de cuidado obstétrico baseadas no conceito de Merhy aplicadas à parturiente de alto risco

*Tecnologías de atención obstétrica basadas en merhy aplicadas a las parturientas de alto riesgo*Ana Carolinne Alves do Nascimento¹ Amuzza Aylla Pereira dos Santos² Carla Andreia Alves de Andrade³ Wanderlei Barbosa dos Santos⁴ Selma Sabrina de Albuquerque Calheiros⁵ Mariana Maria Pereira Cintra de Carvalho⁶ 

ABSTRACT:

Objective: to describe the technologies applied to high-risk parturient women during labor and delivery in a high-risk maternity hospital. **Method:** cross-sectional, exploratory, observational study, with quantitative approach, carried out in a high-risk maternity hospital in Maceió-AL with 145 participants. **Results:** Based on the results of this study, we can identify that in the high-risk scenario studied, hard-soft technologies were the most used, so that, among the hard technologies, cesarean surgery was the one with the highest prevalence. **Conclusion:** The need for a better use of hard-soft technologies became evident to provide a better birth experience for women.

DESCRIPTORS: Pregnancy, high-risk; Labour, obstetrics; Obstetrics; Nursing care; Nursing.

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RESUMO:

Objetivo: descrever as tecnologias aplicadas à parturiente de alto risco durante o trabalho de parto e parto em uma maternidade escola de alto risco. **Método:** estudo do tipo transversal, exploratório, observacional, com abordagem quantitativa, realizado em uma maternidade de alto risco, em Maceió-AL, com 145 participantes. **Resultados:** a partir dos resultados desse estudo, podemos identificar que no cenário de alto risco estudado, as tecnologias leves e duras foram as mais utilizadas, de forma que, entre as tecnologias duras, a cirurgia cesariana foi a que apresentou maior prevalência. **Conclusão:** ficou evidente a necessidade do melhor aproveitamento das tecnologias leve-duras, a fim de proporcionar uma melhor experiência parturitiva para as mulheres.

DESCRITORES: Gravidez de alto risco; Trabalho de parto; Obstetrícia; Cuidados de Enfermagem; Enfermagem.

RESUMEN

Objetivo: describir las tecnologías aplicadas a parturientas de alto riesgo durante el trabajo de parto y el parto en una maternidad escolar de alto riesgo. **Método:** estudio observacional, exploratorio, transversal, con enfoque cuantitativo, realizado en una maternidad de alto riesgo en Maceió-AL con 145 participantes. **Resultados:** con base en los resultados de este estudio, podemos identificar que en el escenario de alto riesgo estudiado las tecnologías blandas y duras fueron las más utilizadas, de modo que, entre las tecnologías duras, la cirugía de cesárea fue la de mayor prevalencia. **Conclusión:** fue evidente la necesidad de hacer un mejor uso de las tecnologías blandas y duras, para brindar una mejor experiencia de parto a las mujeres.

DESCRITORES: Embarazo de alto riesgo; Trabajo de parto; Obstetricia; Atención de enfermería; Enfermería.

INTRODUCTION

Pregnancy and childbirth are physiological events as old as human existence, and the pregnant woman is the director and protagonist of this process.¹

Currently, in Brazil, the process of childbirth takes place mostly in hospitals, in a medicalized way, characterized by the use of health technologies aimed at making the care of the maternal-fetal binomial safer.²

According to the World Health Organization (WHO), health technologies must provide care that is proven to be safe, effective and cost-effective, and their use must be based on sound scientific evidence.³

In obstetric care, these technologies aim to ensure that care is based on technical knowledge and applied at the right time to make certain that care brings benefits without removing or diminishing the protagonism of the woman.⁴

In this sense, it is important that these technologies are used sparingly and that they meet the real needs of patients. The proliferation of interventions does not consider human aspects, such as the emotions that permeate the moment of labor and childbirth and the cultural aspects that surround this process and give it a unique character.^{5,6}

The idea of technology encompasses the instruments involved in the production of work, as well as technological knowledge and the way in which this knowledge is applied. On the other hand, according to Merphy, the health work process is mediated by care technologies that define the quality of the care provided.⁷

Technologies can be classified into three types: soft, which refers to the relational character between subjects that can be materialized through communication, reception, and bonding; hard-soft, which refers to well-structured technical knowledge in the health care work process; and hard, which are the instru-

ments, machines, norms, routines, and organizational structures.⁸

An example of hard technology is cesarean sections, which contribute to reducing maternal-fetal morbidity and mortality, but this mode of delivery, when performed without justification, brings complications to the maternal-fetal binomial. In Brazil, according to the WHO, the rate of cesarean section was about 56%, the second highest in the world.^{9,10}

However, there is a greater exposure of women to hard technology interventions.⁵

During this research, the importance of assessing the motivations that lead to the use of these technologies became apparent. To this end, the following objective was to describe the technologies used on high-risk parturients during labor and delivery in a maternity school.

The relevance of this study lies in the survey of the technologies used by parturients in this scenario, contributing to the generation of scientific evidence on the subject and serving as a basis for professionals working in these services to guide their care.

METHOD

This is a descriptive, exploratory, observational study with a quantitative approach, using primary data obtained from a form administered to postpartum women who gave birth in a high-risk maternity school.

The sample size was calculated using an electronic sampling calculator, with a margin of error of 5% and a confidence level of 95%, for a total sample of 145 participants.

Postpartum women in rooming-in situations and of any age group were included, and those who arrived during the expulsion period or had a delivery in transit because they were not

submitted to care technologies, or those who had a stillbirth were excluded. Postpartum women who had any physiological or psychological changes that would make it impossible for them to participate in the study were excluded.

The study followed the guidelines of the National Health Council (CNS) Resolutions Nos. 466/2012, 510/2016, and 580/2018, and was approved by the Research Ethics Committee of the Federal University of Alagoas (UFAL), Opinion No. 5,025,223. Data collection was carried out from May to October 2022.

RESULTS

Regarding the socio-demographic data of the participating women, 76 (52.41%) of them are between 20 and 29 years old, 63 (43.44%) have a high school education, 80 women (55.17%) are single, 99 (68.27%) are brown and 49 (33.79%) have a family income up to the minimum wage (R\$1.212,00 BRL).

The clinical-obstetric profile of the participants showed a prevalence of multiparous women (n= 87, 60%) compared to primiparous women (n= 58, 40%), 27 (18.62%) of the women who had more than one pregnancy had already had an abortion, 141 women (97.24%) had singleton pregnancies, and rooming-in was the most common neonatal outcome (n= 85, 58.62%).

Most participants (n= 108, 74.48%) had at least one comorbidity, with hypertensive syndromes being the main diagnosis (n=86, 79.62%), followed by 13 women (12.03%) diagnosed with diabetes mellitus/pregnancy. The mean length of hospital stay was 5.64 days and the majority (n=92, 63.44%) had a gestational age between 37 and 42 weeks.

Regarding the number of antenatal consultations, 102 participants (70.34%) had 6 or more antenatal consultations, while 16 of them (11.04%) had no consultations.

When analyzing the soft technologies individually in Table 1, it was observed that they were well used, with percentages ranging from 84.14% to 93.11% of parturients using these technologies.

Table 1 - Descriptive analysis of the use of soft obstetric care technologies in a high-risk maternity hospital, Maceió-AL, Brazil, 2024

Soft Technologies	n	%
Gentle treatment		
Yes	134	92,41
No	11	7,59
I don't want to respond	0	0
User Embrace		
Yes	135	93,11
No	10	6,89
I don't want to respond	0	0
Chaperone Information		

Yes	122	84,14
No	23	15,86
I don't want to respond	0	
Clinical picture guidance		
Yes	127	87,59
No	18	12,41
I don't want to respond	0	0
Freedom to clarify doubts		
Yes	129	88,97
No	16	11,03
I don't want to respond	0	0
Explanations and authorizations of procedures		
Yes	127	87,59
No	18	12,41
I don't want to respond	0	0

As for the hard-soft techniques, the partogram was used in 84 (57.6%) of the cases, followed by massage (n=9, 6.2%) and then by the perineum protection compress (n=8, 5.51%).

Table 2 - Descriptive analysis of the use of hard-soft obstetric care technologies in a high-risk maternity hospital, Maceió-AL, Brazil, 2024

Hard-soft Technologies	N	%
Swiss Ball		
Yes	3	2,32
No	81	56,19
Not Applicable	60	41,49
I don't want to respond	0	0
MUSIC THERAPY		
Yes	6	4,8
No	78	53,71
Not Applicable	60	41,4
I don't want to respond	0	0
MASSAGE		
Yes	9	6,2
No	76	52,4
Not Applicable	60	41,4
I don't want to respond	0	0
WARM BATH		
Yes	8	5,51
No	76	52,41
Not Applicable	60	41,4
I don't want to respond	0	0
PARTOGRAM		
Yes	84	58,9

No	13	8,9
Not Applicable	47	32,2
I don't want to respond	0	0
PLACE OF BIRTH		
Yes	2	1,37
No	20	13,8
Not Applicable	123	84,83
I don't want to respond	0	0
LING'S LADDER		
Yes	2	1,37
No	81	55,88
Not Applicable	62	42,75
I don't want to respond	0	0
PERINEAL MASSAGE		
Yes	1	0,68
No	81	55,88
Not Applicable	63	43,44
I don't want to respond	0	0
PERINEUM PROTECTION COMPRESS		
Yes	8	5,51
No	74	51,05
Not Applicable	63	43,44
I don't want to respond	0	0

Source: Research Data (2023).

Subtitle: Not applicable: surgical birth

Regarding the use of hard technologies, the most used instruments were intermittent auscultation (86.2%, n=125) and cesarean section (84.13%, n=122).

Table 3 - Descriptive analysis of the use of hard obstetric care technologies in a high-risk maternity hospital, Maceió-AL, Brazil, 2024

HARD TECHNOLOGIES	N	%
INTERMITTENT AUSCULTATION		
Yes	125	86,2
No	6	4,1
Not Applicable	11	7,58
I don't want to respond	3	2,12
CONTINUOUS ELECTRONIC FETAL MONITORING		
Yes	53	36,55
No	77	53,1
Not Applicable	11	7,6
I don't want to respond	4	2,75
FORCEPS		
Yes	0	0
No	95	65,52

Not Applicable	48	33,2
I don't want to respond	2	1,37
EPISIOTOMY		
Yes	2	1,37
No	94	64,74
Not Applicable	48	33,2
I don't want to respond	1	0,69
CESAREAN		
Yes	122	84,14
No	0	0
Not Applicable*	23	15,86
I don't want to respond	0	0
OXYTOCIN		
Yes	19	13,1
No	102	70,34
Not Applicable	23	15,87
I don't want to respond	1	0,69

Source: Research Data (2023).

Subtitles: Not applicable*: vaginal delivery.

DISCUSSION

Although most of the participants were young adults, there was a significant percentage of pregnancies over the age of 30 and 40, indicating a trend toward postponing motherhood.¹¹

In terms of the ethnic/racial composition of the participants, the majority were brown, followed by black and white women. Studies have shown that although all women are at risk of pregnancy-related complications, there is a clear association between socioeconomic status and increased risk of maternal morbidity and mortality. Such complications continue to reflect inequalities of gender, ethnicity and education, with black women and those living in rural areas most vulnerable to adverse outcomes.¹²

Thus, the identification of these conditions and their possible impact on the course and outcome of pregnancy ensures the proposal of appropriate protocols and timely interventions aimed at the well-being of the maternal-fetal binomial.^{11,12}

Regarding the marital status of the participants, most are single, which may indicate a lack of family and/or social support network during pregnancy and postpartum. Studies have shown that the presence of a partner can make a significant contribution to pregnancy, influencing adherence to antenatal care and positively influencing breastfeeding duration.¹³

In terms of clinical profile, most women had more than six antenatal visits, which supports the Ministry of Health's recommendation of at least six antenatal visits between a doctor and a nurse.¹⁴

However, a significant number of women in the sample did not have any antenatal consultations or had fewer than six consultations. It is known that antenatal care can reduce ma-

ternal, fetal and neonatal morbidity and mortality by detecting complications early or preventing them from developing into serious, life-threatening situations.¹⁵

Therefore, it is possible to consider the relationship between the number of pregnant women who had six or more antenatal consultations and the profile of the participants, considering the scenario in which the study was conducted, where antenatal care is shared between Primary Health Care (PHC) and the high-risk referral hospital services.¹¹

Regarding gestational age (GA), most participants gave birth between 37 and 42 weeks, considered full-term pregnancies, which reduces neonatal risk factors resulting from prematurity. Thus, the most common neonatal outcome, rooming-in, may be related to GA at birth.¹⁶

Regarding the days of hospitalization, the mean number of days of hospitalization was 5.64, which may be a consequence of maternal comorbidities presented by puerperal women.

Hypertensive and hemorrhagic disorders of pregnancy are the main causes of maternal mortality in Brazil and worldwide. In this sense, the risk stratification performed in antenatal care is responsible for identifying women who are more at risk of presenting some adverse health effects that culminate in an increase in hospital admissions.^{11,17}

Regarding technologies, it is possible to observe that there was a prevalence of the use of soft technologies to the detriment of other types of obstetric care technologies. From this perspective, the use of soft technologies reinforces a concern for humanization and patient acceptance. It is also linked to the recovery of the dignity of the human person, with a focus on reproductive rights.¹⁸⁻¹⁹

The use of non-invasive technologies, combined with hard-soft technologies, reduces the need for interventions and their appropriate use, increasing the degree of satisfaction of women through the adoption of Non-Pharmacological Methods of Pain Relief (NPMR). In this sense, NPMR should be encouraged, as they are an option to analgesia, helping women with pain complaints and favoring the ability of the parturient to exert force during the expulsive period.²⁰⁻²¹

Techniques such as warm baths, which help reduce pain during labor and promote relaxation of the body, and massage, which promotes increased release of endorphins and oxytocin, have low rates of use despite high levels of recommendation.²²

Hard-soft techniques, such as perineal massage and perineal protection compresses, are used to relax muscles and increase vasodilation at the site, making muscles more flexible, preventing trauma, and performing episiotomies. However, WHO classifies such practices as B-rated procedures that should be discouraged because they are harmful or ineffective.^{10,23}

Regarding hard-soft technologies, such as fetal monitoring with intermittent auscultation and the use of partograms, among others, they have a grade A recommendation by the WHO and their use should be encouraged during labor and delivery care.²⁴

The use of the partogram is an effective strategy to improve the quality of obstetric care, being the graphic representation of labor. Its use allows the appropriate actions to be taken to correct the deviations that occur during labor, avoiding the adoption of unnecessary measures, in addition to allowing the effective exchange of information between professionals and ensuring more coordinated care.^{10,24-25}

Despite these advantages, the use of the partogram in maternity hospitals is still quite limited and, when it is used, it ends up not being completed in its entirety, indicating the need for measures to train professionals involved in the care of labor and delivery on the importance of this tool.²⁶⁻²⁷

In this study, the percentage of partogram use was 58.9%, but only a few of them were filled out completely. Thus, the use of the partogram as a positive obstetric practice, as recommended by the WHO, should be promoted in the context studied.²⁶

Among hard technologies, we can highlight the technique of continuous fetal monitoring, which is widely used. This technique is the method of choice for fetal monitoring during normal labor at usual risk¹⁰ and, although the study population does not fit into this classification, a high use of this technology was observed.

A satisfactory result in terms of hard technology is linked to the low percentage of episiotomies (1.37%), which demonstrates a decrease in this practice, which used to be so widespread¹⁸ and which reveals an unequal power relationship between the professional and the patient, which is more at the service of those who assist in childbirth than at the service of the woman and her baby.²⁸

On the use of oxytocin, the results of the study show a prevalence of use of 13.1%, which is considered to be a low percentage, although it is not possible to know from the study whether this use was correct, with a cervix favorable to induction¹¹. In this sense, it is worth emphasizing that the administration of exogenous oxytocin has a level of recommendation B, considered a practice that should be discouraged.¹⁰

Finally, it is worth noting that although high-risk pregnancies may predispose to negative diagnoses related to maternal-fetal care, this does not mean that cesarean section is the recommended outcome in all cases, since high rates of cesarean section are associated with high rates of maternal and neonatal mortality.¹¹

The prevalence of cesarean section in the context studied was 84.14%, higher than the 30% rate recommended by WHO, which underscores that even in high-risk cases, surgical delivery should be used only when indicated, as it can cause significant and even permanent complications for mother and baby.²⁹

CONCLUSION

Based on the results obtained in this study, it can be observed that soft technologies were widely used in most parturients, which indicates a concern regarding the reception and huma-

nization of health care. In the same way, hard technologies also had a high prevalence of use, especially in relation to caesarean section. On the other hand, hard-soft technologies were not well used at the study site, as most women reported not having had the experiences described.

It is therefore important that managers in this scenario enable their professionals to use obstetric care technologies, especially on a hard-soft basis, always respecting the physiology of childbirth and the uniqueness of each woman, and always trying to keep the professional's critical eye on the changes that may be present in this care scenario.

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