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Prenatal Care in Primary Health Care from the Perspective of Pregnant Women Who Use Psychoactive Substances

Pré-natal na atenção primária à saúde na perspectiva de gestantes usuárias de substâncias psicoativas

Atención prenatal en la atención primaria de salud desde la perspectiva de las gestantes usuarias de sustancias psicoactivas

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ABSTRACT

Objective: to understand how pregnant women who use psychoactive substances perceive the care provided by health professionals during prenatal care within a Family Health Strategy unit. **Method:** this is a qualitative, exploratory-descriptive study conducted with pregnant women who use psychoactive substances, and were attended at a Family Health Strategy unit. Data were collected between August and November 2022 through open interviews and subjected to thematic content analysis. The research protocol was approved by the Research Ethics Committee. **Results:** among 20 pregnant women aged 20 to 41 years, who reported having children and using multiple drugs such as tobacco, cocaine, crack, marijuana, and alcohol, three thematic categories were defined: "Here comes another one!"; "Establishing a subject-object order"; and "(Dis)Satisfaction with the Care Received". **Final Considerations:** in the perception of pregnant women who use psychoactive substances, prenatal care is impersonal, punctual, and top-down. Health professionals demonstrate a lack of knowledge and preparedness in assisting these women.

Descriptors: Primary Health Care; Maternal and Child Health; Pregnancy; Perinatal Care; Substance-Related Disorders.

RESUMO

Objetivo: compreender como as gestantes usuárias de substâncias psicoativas percebem o cuidado dos profissionais de saúde durante o pré-natal em uma estratégia da saúde da família. **Método:** estudo qualitativo, de abordagem exploratória-descritiva, realizado com gestantes usuárias de substâncias psicoativas, atendidas em uma unidade de Estratégia de Saúde da Família. Os dados foram coletados durante os meses de agosto a novembro de 2022, por meio de entrevista aberta e submetidos à análise de conteúdo temática. O protocolo de pesquisa foi aprovado pelo Comitê de Ética em Pesquisa. **Resultados:** entre 20 gestantes de 20 a 41 anos, que declararam já ter filhos, usuárias de múltiplas drogas, como tabaco, cocaína, crack, maconha e bebidas alcoólicas, definiram-se três categorias temáticas: Lá vem mais (a)!; Estabelecendo uma ordem sujeito-objeto; e Despreparo profissional. **Considerações finais:** na percepção das gestantes usuárias de substâncias psicoativas, a assistência pré-natal é impessoal, pontual e verticalizada. Os profissionais de saúde demonstram desconhecimento e despreparo para assisti-las.

Descritores: Atenção Primária à Saúde; Saúde Materno-Infantil; Gravidez; Assistência Perinatal; Transtornos Relacionados ao Uso de Substâncias.

RESUMEN

Objetivo: comprender cómo las gestantes usuarias de sustancias psicoactivas perciben la atención que les brindan los profesionales de salud durante el control prenatal en una Estrategia Salud de Familia. **Método:** estudio cualitativo, exploratorio-descriptivo, realizado con gestantes usuarias de sustancias psicoactivas, que reciben atención en una unidad de Estrategia Salud de Familia. Los datos fueron recolectados entre agosto y noviembre de 2022, por entrevista abierta, y sometidos a análisis de contenido temático. El protocolo de investigación fue aprobado por el Comité de Ética en Investigación. **Resultados:** a partir de 20 gestantes de entre 20 y 41 años, que declararon tener hijos, ser usuarias de múltiples drogas, como tabaco, cocaína, crack, marihuana y bebidas alcohólicas, se definieron tres categorías temáticas: ¡Ahí viene otro(a)!; Establecer un orden sujeto-objeto; y (In)Satisfacción con la atención recibida. **Consideraciones finales:** según la percepción de las gestantes usuarias de sustancias psicoactivas, la atención prenatal es impersonal, puntual y vertical. Los profesionales de salud demostraron falta de conocimiento y de preparación para atenderlas.

Descriptores: Atención Primaria de Salud; Salud Materno-Infantil; Embarazo; Atención Perinatal; Trastornos Relacionados con Sustancias.

INTRODUCTION

The pregnancy period is characterized as a unique experience in a woman's life, bringing about various physiological, psychological, and social changes that require individualized and multidisciplinary care. In this context, pregnant women need to be guided and supported by professionals who are sensitive and equipped to address the specific needs of each woman[1,2].

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A topic that has drawn global public attention is the issue of psychoactive substance (PAS) use among pregnant women. The use of these substances is considered a major public health concern, negatively impacting the mother-baby dyad[3,4]. Moreover, the rates of PAS use in this population continue to rise, particularly among certain groups[5].

PAS use during pregnancy interferes with fetal development due to chemical exposure, which can lead to alterations impacting the central nervous system, anomalies, heart malformations, among other issues[6,7]. Although pregnant women are aware of the consequences that substance use can cause to the baby, they do not use them with the intention of causing harm. Rather, due to the addiction they are unable to stop[8]. In light of this, it is crucial to identify the factors associated with PAS use during pregnancy in order to enable overcoming strategies and ensure favorable outcomes in childbirth and child development[7].

In addition to focusing on fetal development, it is essential that health professionals pay attention to how they provide care to pregnant women. Typically, pregnant women who use substances are in vulnerable contexts related to issues of gender, race, schooling, abusive family relationships, addictive behaviors in the family, and violence. They tend to seek health services less frequently due to a lack of support and weak bonds with health teams. They are often inadequately integrated into prenatal care and sometimes are not identified as substance users[9].

Prenatal care for pregnant women who use psychoactive substances needs to be differentiated and tailored to their specific needs, as they may exhibit denial of use and addiction, as well as delay or avoid seeking health care. Therefore, health professionals need to be trained to provide support and build a connection with this population to reduce the risks of maternal and infant morbidity and mortality[10,11].

In connection with this, the social representation of women who use PAS has a negative personal and familial impact. Thus, a support network for these women is crucial, as pregnant women internalize feelings of guilt and shame for having a baby under circumstances of substance use[12,13]. Situations like this further distance them from health services.

In this sense, understanding the perceptions of pregnant PAS users regarding the care they receive from primary health care professionals helps improve access to this population and also the way care is being provided to them during prenatal care. Thus, the guiding question of this study is: how do pregnant women who use psychoactive substances perceive the care provided by health professionals during prenatal care?

The objective of this study was to understand how pregnant women who use psychoactive substances perceive the care provided by health professionals during prenatal care within a family health strategy.

METHOD

This is a qualitative study conducted at a Family Health Strategy (FHS) unit in a municipality in southern Brazil, following the recommended items from the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines. At the time of data collection, the health team consisted of two nurses—one from a university residency program—one doctor, one nursing technician, and five community health agents.

The research participants were twenty pregnant women who used psychoactive substances and were receiving prenatal consultations at the mentioned service. The inclusion criteria for this study were: being a pregnant woman who used psychoactive substances, undergoing prenatal care with a doctor or nurse at the FHS, and being 18 years of age or older. Exclusion criteria included being under the influence of psychoactive substances at the time of data collection or having communication limitations.

The familiarization process and data collection took place between the months of August and November 2022 The familiarization process aimed to build a rapport between the researcher and the pregnant women in order to establish trust and a connection. During this period, the researcher participated in health group activities and prenatal consultations with the FHS nurse.

Data collection was conducted through open interviews, led by a member of the research team, an undergraduate nursing student who had prior experience in scientific research data collection. The interviews followed a predefined script, with the characterization of the pregnant women along with the following guiding questions: *How do you think health professionals view you as a pregnant woman using psychoactive substances?* and *How do you perceive the care you have received during your prenatal care?*

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The interviews were scheduled in advance, with invitations extended to the pregnant women throughout the familiarization period, immediately after their prenatal consultations or health education group activities. The interviews were conducted individually, some in a private room at the service and others at the participants' homes, depending on the pregnant woman's preference and availability. The recordings were made on digital media, with an average duration of 35 minutes.

After data collection, the interviews were fully transcribed and reviewed by the research team's leader and advisor to ensure the accuracy and authenticity of the transcriptions and the veracity of the data.

The data were subjected to thematic content analysis in three stages: preliminary analysis, material exploration, and interpretation of the results[14]. To ensure participant anonymity, the statements were coded with the letter G, referring to the word 'gestante' (pregnant woman), followed by a numeral representing the order in which the interviews were conducted. Thus, the participants were identified from G1 to G20.

Throughout all stages of the planning and conduct of this study, whose protocol was approved by the Research Ethics Committee, the ethical principles outlined in the resolutions of the National Health Council (CNS), which govern research involving human subjects, were followed.[15]. The participants signed the Informed Consent Form (ICF).

RESULTS

The study included 20 pregnant women, aged between 20 and 41 years old, all of whom reported already having children. Of these, 18 have a family history of drug use involving parents, siblings, or current partners. In terms of education, one has completed high school, four have completed the Youth and Adult Education Program (EJA), and 15 have completed only basic education. In terms of occupation, seven reported being homemakers, five work in retail, and eight are unemployed.

As for the types of psychoactive substances, the pregnant women were users of multiple drugs, including tobacco, cocaine, crack, marijuana, and alcohol.

Decoded through content analysis, the data obtained from the interviews resulted in three thematic categories: 'Here comes another one!,' 'Establishing a subject-object order,' and '(Dis)Satisfaction with the care received.

Here comes another one!

The perception of being a pregnant woman and a user of PAS, from their perspective, is that they are seen as women who do not care about their baby's development and are weak for being unable to stop using drugs. It is evident that the relationship between the professional and the pregnant woman is perceived as judgmental, as expressed below:

> *They must think: Just think! Already on her third child and still smoking!' People think that, but when I went for a consultation, they treated me very well. (G10)*

> *I know they must think I am weak! They must wonder why I cannot stop using. That I do not care about my baby! But it is not that simple to quit, it is very hard; I have never been able to, but I know I should not use, and I pray that nothing happens because many people use, and everything turns out fine, but ideally, you should not use." (G13)*

This reflects the use of non-violent communication by health professionals, as they must demonstrate it not only through dialogue but also with welcoming expressions and active listening, so that the pregnant woman does not feel judged or withdraw, as seen in the following statement:

> *They tell me I should stop because it is bad for my baby, and I cannot stop using. I think they must believe I do not care about her, but I do; I just cannot manage it, and that makes me sad I feel powerless because I cannot control my urge to use. (G12)*

It is evident that these pregnant women are deeply self-critical regarding their inability to cease substance use. Furthermore, this criticism of their substance use during pregnancy is reinforced by health professionals in the way they approach and communicate with them. The testimonies also reveal that the pregnant women believe health professionals see them as incapable, powerless, and negligent—unable to care for their babies because they cannot even care for themselves.

> *I think I am seen as that mother who does not care about her child, just because I cannot follow everything correctly. I am late for appointments, I forget! Then I have to reschedule. And they do not say anything, they do not scold me, but they must think: 'that one is probably using all day and forgetting about everything, forgetting about the baby.' But it is not like that, I know I use, I miss days to come, but I try. Of course, after it is all over, I feel ashamed for missing the appointment. (G15)*

> *They treat me well, but they keep saying the same thing, that I should not use. They say it over and over, and I pretend I am not listening. So, on one hand, I do not give them a reason to talk badly about me or criticize*

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> *me. But on the other hand, they must think, 'How is she going to take care of a baby if she cannot even take care of herself? I feel this pressure from them because of that. (G17)*

They also express that the way they are approached by health professionals during prenatal care makes them feel pressured and judged, resulting in negative emotions such as shame, fear, and irritability. This suggests that there are gaps in the professional-patient relationship between health professionals and pregnant women who use psychoactive substances, emphasizing the need for communication facilitated by respect and empathy. Such an approach is crucial to foster dialogue, allowing these women to be better understood and feel supported according to their individual needs.

Establishing a Subject-Object Order

The pregnant women report that they are aware of the potential consequences that psychoactive substance use during pregnancy can have on their baby's development. However, despite this awareness, they struggle to cease use. The constant guidance from health professionals to stop using weakens the relationship between them, as the advice to quit is perceived by the women as an imposition, creating a subject-object dynamic.

> *I am treated well; the only thing is that they advise me to try to stop using. Because we know it is not good. We try, we listen, but it's hard for me to stop. We try, we listen, but it is hard for me to stop. I feel frustrated! (G1)*

> *The first thing is the drug issue, which they always talk about: 'You have to stop!' In that part, I understood that they want to help so that there will not be any problems, so it will not affect the child. (G7)*

The pregnant women express the difficulty they have in their relationship with health professionals when discussing substance cessation. However, they mention that they have tried to quit but have not succeeded, which leads to feelings of frustration, sadness, and irritation, while also heightening their fear that something negative could happen to the baby's development:

> *I get a moral lesson: 'You have to stop smoking marijuana, or the baby will be born with problems!' I do not need them to tell me that, I already know it by heart. These are things we do, knowing that they can cause problems. Of course, we are not happy about the possibility of problems, but we still do it. (G3)*

> *They take good care of me here, but there is always this thing of: 'You are harming the baby! You need to try harder and think about the baby!' [...] I know they need to speak the truth, that is why they are there. But for the person listening, it is really hard. And I know it can cause problems, but I cannot stop. (G16)*

The health team's repeated efforts to urge pregnant women to stop using PAS can feel oppressive, as it reveals the professionals' difficulty in addressing this issue and highlights the need for more effective and humanized communication:

> *They [health professionals] keep urging me to stop using. The truth is, I cannot stop; it causes fear and frustration, which makes it even harder to quit. (G17)*

It is important to note that the pregnant women did not express receiving specialized care or being offered the possibility of care from other services within the Psychosocial Care Network. As a result, their mental health is neglected by health professionals, with a distant relationship lacking strong bonds being established. Prenatal care predominantly focuses on PAS use and the baby's development, without considering the unique needs of the pregnant woman.

(Dis)Satisfaction with the Care Received

Regarding satisfaction with the care received, the pregnant women report that they receive important information and guidance, as well as explanations about the transformations that occur during pregnancy. In addition, they emphasize the importance of the care provided by the nurse:

> *"I was well attended to by the nurse. They always guide me on how to take the medication, which is for anemia. Always using repellent, and so on. They are always providing advice; they are excellent professionals. I listen carefully to their guidance. (G1)*

> *I do not care much for the doctor getting close to me. It is better with the nurses, because they know more about pregnancy than a general practitioner. There was no need to press down on this huge belly, because it is really big. So with the nurse, I feel safe around her (G3)*

Another relevant factor is that they feel well taken care of regarding the pregnancy itself, but in relation to the issue of PAS use, they report a persistent insistence on quitting:

> *I have really good support at the clinic. The nurses always explained everything to me very clearly; they have a lot of patience and remain calm when explaining. Since it was my first pregnancy, I did not know anything, and they always explained everything that happens during pregnancy. They are very good and very attentive. But they always told me to try to stop, but I was not able to. (G9)*

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Thus, regarding dissatisfaction with the care received, they report the lack of technology in Primary Health Care (PHC) services to monitor the baby's development, difficulty in receiving care due to overcrowding of the service, and long wait times to be seen:

> *To be honest, here at the clinic, they schedule an appointment for you at a certain time. Then you arrive, and 500 people go ahead of you, leaving you waiting for a long time to be seen. (G4)*
>
> *Sometimes I want to schedule an appointment. Then I get there, and I cannot because the schedule is full. I cannot leave here today, do my prenatal, and then come back tomorrow. What I want is for the scheduling process to improve. (G6)*
>
> *At the clinic, it is more or less the same, there is not much technology to really see if anything is happening. I just come so she can check my exams. This prenatal care is not exactly wonderful. (G8)*

In light of the above, this category reveals both the satisfaction with the care provided by nurses, highlighting the importance of support, dialogue, and the provision of guidance and explanations to the pregnant women, as well as the dissatisfaction regarding the work process, such as the lack of technology and the difficulty in accessing care.

DISCUSSION

The perception of the pregnant women regarding how they believe health professionals see them brings forth an image of women who are incapable of caring for their baby or even for themselves, leading to feelings of powerlessness and negligence. Studies indicate that feelings of guilt and insecurity, coupled with not fitting the idealized social image of a mother, reinforce the stigma and prejudice faced by pregnant women[12,16].

In this context, it is understood that pregnant women who use psychoactive substances avoid seeking health services because they feel labeled, have had negative experiences in certain services, or due to stigma and prejudice. As a result, they stop actively participating in prenatal care or build a barrier to accessing health care[3,8].

Additionally, the constant pressure from health professionals for pregnant women to stop using substances amplifies negative feelings such as shame, guilt, irritability, and a sense of weakness for not being able to quit. This also reinforces the stigma that women who use psychoactive substances are incapable of caring for themselves or their baby, which may lead them to withdraw from health services and weaken the trust between them and health professionals. Substance use also interferes with social and family relationships[17].

Despite the risks that pregnant women who use PAS may face, their desire to become mothers and concern for the baby's well-being and development still predominate. Although they are aware of the consequences that substance use can have on their baby, the use is not driven by an intent to harm, but rather by addiction[18]. Furthermore, when health professionals impose and pressure pregnant women to stop using psychoactive substances, they fail to offer harm reduction strategies.

Given the reports from pregnant women about their inability to quit, an important strategy to consider is harm reduction. It is the responsibility of health professionals to provide guidance and discuss this possibility with them. Achieving abstinence in women during the pregnancy-postpartum period is difficult, leading them to live with dependency[19].

It is important for health professionals to understand that hormonal changes, lifestyle adjustments, uncertainties, and the frustration of trying to quit but failing intensify negative feelings in pregnant women. In this context, harm reduction should be addressed during prenatal care. However, due to the pregnancy period, some professionals may feel insecure or unsupported in recommending it. To ensure individualized care, health professionals must build rapport and understand the woman's circumstances[20].

It is also important to note that primary care health professionals are responsible for promoting, preventing, protecting health, and reducing harm across their various areas of assistance, coordinating the Health Care Networks (HCN), which serve as the main entry point for health services. Therefore, it is essential to guarantee the rights of pregnant women from prenatal care through childbirth and the postpartum period, according to their specific needs[18-21]. Thus, referrals and counter-referrals within the HCN must meet the expected standards[22].

Referring pregnant women to other services within the Health Care Network and the Psychosocial Care Network is necessary, if the pregnant woman wishes. Additionally, through prenatal nursing consultations, nurses can provide health guidance to the patient, offering solutions through clinical interventions and referrals aimed at reducing maternal, perinatal, and neonatal morbidity and mortality.

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Regarding satisfaction with the care received, nurses play a key role, as pregnant women reported receiving specialized care that addresses their concerns, offers explanations, and provides guidance that meets their needs[23]. The active involvement of nurses in conducting and following up on prenatal consultations helps pregnant women resolve their doubts and insecurities during the pregnancy-postpartum period[24]. The exchange and sharing of information and knowledge foster adherence to health services, aimed at reducing potential complications and improve the quality of care provided[25].

However, one study shows that primary care health professionals face challenges in caring for individuals who use psychoactive substances, as many are unable to communicate effectively with this population or lack the necessary training to provide adequate care[10]. The difficulties in providing health care to pregnant women who use psychoactive substances are compounded by prejudice, along with the lack of knowledge and training among professionals, which leads to the weakening or breakdown of the bond between the pregnant woman and the health care provider[8].

Given the above, the need for continuous education for primary care teams on mental health approaches is clear, especially when dealing with pregnant women who use substances, as this is already a highly stigmatized and discriminated population[10]. Therefore, professional development in mental health, coupled with an understanding of the HCN's workflow, ensures comprehensive care for this group[22].

Regarding dissatisfaction with the care received from health professionals in PHC, the difficulty in scheduling appointments, combined with long wait times due to excessive demand for services, and the low availability of technology, were significant negative aspects of the care provided. As such, this level of care should be a space for qualified attention, focused on improving the workflow with existing resources, while also ensuring humane and respectful care for pregnant women who use psychoactive substances.

Study limitations

The limitations of this research include the difficulty in accessing pregnant women who use psychoactive substances, as well as the data collection being confined to a specific region, which restricts the generalizability of the results.

FINAL CONSIDERATIONS

In the perception of pregnant women who use psychoactive substances, prenatal care is viewed as impersonal, punctual, and top-down. Health professionals demonstrate a lack of knowledge and preparedness in assisting these women. It is evident that the way health professionals view and assist pregnant women who use psychoactive substances during prenatal care does not align with the comprehensive care and health needs they require.

The way these women perceive themselves, based on how they believe health professionals see them, reveals feelings of incapacity and negligence, intensifying stigma and prejudice, which can ultimately lead them to abandon prenatal care. This reflects the social expectations placed on women, as the burden of being a psychoactive substance user weighs more heavily on them, reinforcing the gender disparities still prevalent in society.

The pressure and insistence in communication to stop using psychoactive substances dominate the consultations, removing the possibility of effective communication and a deeper understanding of the need for attention to the pregnant woman’s mental health and autonomy. Additionally, the lack of networked care and harm reduction strategies is often trivialized by health professionals. In light of this, continuous education for health professionals is essential to ensure that prenatal care addresses the mental health of pregnant women.

Nursing care during prenatal consultations was shown to be effective, as nurses guide, explain, and address the concerns of pregnant women, demonstrating the possibility of establishing effective communication. On the other hand, the excessive demands placed on the work process hinder access to health services and delay consultations. Furthermore, the limited use of technology in primary care was noted as another significant point of dissatisfaction with the care received.

This study emphasizes the importance of understanding how pregnant women who use psychoactive substances feel about the care they receive and how they are being assisted in PHC. It is inferred that there is an urgent need for professional training to improve maternal, infant, and mental health care for pregnant women who use these substances.

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Authors' contributions

Conceptualization, M.V.Z., J.V. and K.L.S.S.; methodology, M.V.Z., J.V. and K.L.S.S.; validation, M.V.Z., J.V., D.S.B., Z.L.T., M.R.C.T.M. and K.L.S.S.; formal analysis, M.V.Z., J.V., D.S.B., Z.L.T., M.R.C.T.M. and K.L.S.S; investigation, M.V.Z., J.V. and K.L.S.S; data curation, M.V.Z., J.V., K.L.S.S, D.S.B., Z.L.T. and M.R.C.T.M; manuscript writing, M.V.Z., J.V., D.S.B., Z.L.T., M.R.C.T.M. and K.L.S.S; writing – review and editing, M.V.Z., J.V., D.S.B., Z.L.T., M.R.C.T.M. and K.L.S.S; visualization, M.V.Z., J.V., D.S.B., Z.L.T., M.R.C.T.M. and K.L.S.S; supervision, M.V.Z., J.V. and K.L.S.S; project administration, M.V.Z., J.V. and K.L.S.S. All authors read and agreed with the published version of the manuscript.