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Original article

Pregnant and postpartum women users of psychoactive drugs: the perception of the health team about hospital care

Gestantes e puérperas usuárias de substâncias psicoativas: percepções da equipe de saúde sobre assistência hospitalar

Gestantes y puérperas usuarias de psicoactivos: percepciones del equipo de salud sobre la atención hospitalaria

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Abstract

Objective: to describe the perception of health workers in regard to the influence of hospital care in clinical practice, involving pregnant and postpartum women who are users of psychoactive drugs. **Method:** qualitative study with 15 professionals from a maternity hospital in Zona da Mata, Minas Gerais, with a thematic content analysis. **Results:** professionals reported that, although the health care procedures were the same applied to all patients, psychoactive drug users must be watched more carefully in regard to certain aspects of clinical practice, such as breastfeeding follow up, care for the newborn, and the risk of evasion. The lack of specific tools to deal with the use of these substances limits the ability to provide broader care. **Conclusion:** the perception of professionals suggests that it is necessary to invest in continuous training and in the creation of specific protocols, in addition to improving the tools to ensure that pregnant and postpartum women users of psychoactive drugs receive quality and efficient care.
Descriptors: Illicit Drugs**;** Pregnant People; Postpartum Period; Patient Care Team; Hospitals

Resumo

Objetivo: descrever a percepção de profissionais de saúde sobre a influência da assistência hospitalar na prática clínica com gestantes/puérperas usuárias de substâncias psicoativas. **Método:** estudo qualitativo com 15 profissionais de uma maternidade na Zona da Mata mineira, com análise de conteúdo temática. **Resultados:** os profissionais relatam que, embora os procedimentos assistenciais sigam os mesmos protocolos aplicados a todas as pacientes, a condição de usuárias de substâncias psicoativas exige maior vigilância e atenção em aspectos específicos da prática clínica, como o acompanhamento da amamentação, os cuidados com o

recém-nascido e o risco de evasão. A ausência de ferramentas específicas para lidar com o uso de substâncias limita o cuidado ampliado. **Conclusão:** a percepção dos profissionais indica a necessidade de investir em capacitação contínua e criação de protocolos específicos, além de melhorar as ferramentas de trabalho para garantir um atendimento qualificado e eficaz a gestantes/puérperas usuárias de substâncias psicoativas.
Descritores: Drogas Ilícitas; Gestantes; Período Pós-Parto; Equipe de Assistência ao Paciente**;** Hospitais

Resumen

Objetivo: describir la percepción de trabajadores de la salud sobre la influencia de los cuidados hospitalarios en la práctica clínica, envolviendo gestantes y puérperas que utilizan psicoactivos. **Métodos:** estudio cualitativo con 15 profesionales de una maternidad en Zona da Mata, región de Minas Gerais, con un análisis de contenido temático. **Resultados:** profesionales reportaron que, aunque se tenga aplicado a los mismos procedimientos de cuidado a la salud a todas las pacientes, usuarias de psicoactivos deben ser observadas con más cuidado con respecto a ciertos aspectos de la práctica clínica, como la monitorización de la lactancia, el cuidado con el recién nacido, y el riesgo de evasión. La falta de herramientas específicas para lidiar con el uso de esas sustancias limita la habilidad de ofrecer un cuidado más amplio. **Conclusión:** la percepción de los profesionales sugiere que es necesario investir en entrenamientos continuos y en la creación de protocolos específicos, para allá de mejorar las herramientas existentes para garantizar que las gestantes y puérperas usuarias de psicoactivos reciban un cuidado eficiente y de calidad.
Descriptores: Drogas Ilícitas; Personas Embarazadas; Periodo Posparto; Grupo de Atención al Paciente; Hospitales

Introduction

The use or dependence on psychoactive drugs (PD) during pregnancy and puerperium can be a serious issue, given its physical and mental consequences for both the mother and the newborn. These include postpartum complications, psychological issues such as depression and anxiety, trouble forming an affective bond with the baby, risk of exposing the child to the substance through mother's milk, and even the risk of maternal death.[1-2]

The consequences for the baby may vary depending on the substance used and the frequency with which it is used, but can include low weight at birth, stillbirth, prematurity, neurological and cognitive development problems, Neonatal Abstinence Syndrome. Babies who are exposed to drugs may also have more trouble regarding their emotional and behavioral regulation. They also are at a higher risk of health issues in the long term, and more likely to develop disorders associated with drug use.[3]

A study carried out in the United States in 2023 warned that, in a single decade (2010-2019), there was a 190% increase in mortality associated with the use of drugs during pregnancy. Estimates suggest that, during uterine life, 300.000 NB were exposed to illicit drugs, more than 500.000 to alcohol, and more than one million to tobacco. The increase in PD abuse has become not only a worldwide health problem, but also a challenge for governments and, especially, for health professionals in their different contexts of care.[4]

As this is a global concern, it was addressed by item three of the 2030 Agenda of the Sustainable Development Goals (SDG). Regarding Health and Wellbeing, the World Health Organization (WHO) determined, for Brazil, the need to: "Strengthen the prevention and treatment of drug abuse, including narcotic drugs and the harmful intake of alcohol."[5]

In Brazil, data from the Ministry of Health (MH) show that, in 2017, nearly 4.9% of pregnant women reported consuming alcohol during their pregnancy. Furthermore, 1.2% of pregnant women are estimated to use some illegal drug during their pregnancy, although these statistics are notoriously underestimated.[6]

In the national context, actions of care, prevention, and rehabilitation of these women, seeking integral and humane care, are prescribed by public policies such as the National Drug Policy, the Psychosocial Care Network, and the Line of for the Integral Care to Pregnant and Postpartum Women under Social and Personal Risk due to the Use of Alcohol and Other Drugs, elaborated by the MH.[6]

Within hospitals, women care during pregnancy and puerperium requires considering their unique experiences and specificities. In this stage, the woman aims to develop her new role as mother, which increases their vulnerability and, potentially, their receptivity to support. Thus, health care requires must consider physical, emotional, and relational aspects.[7]

The vulnerability of these women is multifactorial, involving biological, psychological, social and institutional factors such as the effect of the drugs consumed, mental disorders, poverty, low educational levels, lack of support, barriers to access health services, in addition to stigmatization and discrimination.[7]

The perception of the health team about care to pregnant and postpartum women users of PD can vary. Some teams are prepared and sensitized to deal with the specific demands of these patients, recognizing the importance of a humane and integrated approach. Such an approach would include up-to-date knowledge about the effects of PD in pregnancy, the ability to manage clinical and psychosocial complications, and a compassionate approach, free from stigma, which provides the appropriate support to women and the newborn. On the other hand, other teams face difficulties to answer this demand, and must be trained about PD use during pregnancy and puerperium, which impacts fetal development, in addition to training on empathetic, judgment-free communication practices.[8]

To do so, it is essential to invest in continued education and specific training to attend to these clients. Furthermore, it is essential to promote an institutional culture that fights against stigma and prejudice, valuing empathy, respect, and patient-focused care. Similarly, establishing clear protocols and directives and creating specialized interdisciplinary teams are essential strategies to improve the care provided to these vulnerable women.[8]

Although there is a growing number of studies about care to women PD users during pregnancy and puerperium, there are still gaps in the knowledge about the perception of the health team involved in hospital care. The goal of this study was to describe the perception of health workers about the influence of hospital care in clinical practice with pregnant/postpartum women users of PD.

Method

This is a qualitative and descriptive research which followed the directives of the *Consolidated Criteria for Reporting Qualitative Research (COREQ).*

It was developed in the maternity ward of a general hospital in a city in the Zona da Mata, a region of the state of Minas Gerais, a hospital 100% dedicated to patients from the Single Health Systemic (SUS). The institution has approximately 311 beds and carries out a mean of 180 to 200 childbirths a month. The research included professionals from all health care units directly involved in pregnant and postpartum women care: obstetric nurses and the Vaginal Childbirth Center (NCC).

The main researcher contacted the participants individually, in their workplace, during their shift. She presented them the goals of the research, the procedures involved, and the ethical aspects of the study, according to the directives of Resolution No. 466/12 from the National Council of Health, clarifying any doubts before they signed the informed consent form.

Inclusion criteria were: being a professional from the team and having worked in the field for at least six months. Exclusion criteria included: being on leave from the service during the research. No participant was excluded. The semistructured interviews were carried out from March to April 2020, in private environments within the hospital. They were scheduled individually, according to the availability of each professional. The entire process carefully followed all ethical norms and protocols applicable to research involving human beings.

Interviews were recorded and lasted fro a mean of 40 minutes. The interviews discussed issues related to the personal and professional identification of the participants, as well as their perception and knowledge about PD consumption by pregnant/postpartum women in the hospital context. There was also a discussion on the procedures adopted by professionals to address and follow-up with the dyad, including the care given to pregnant and postpartum women PD users. Additionally, interviewees were asked about participation in training sessions or refresher courses on the topic, in addition to the challenges and limitations faced when providing care to these women.

To ensure the reliability of data, interviews were transcribed by the researchers into Microsoft Word® documents. Then, the transcriptions were made available for reading and validation by each interviewee.

Data was treated using thematic content analysis, in three stages: pre-analysis - the text was skimmed, as a way to explore the entire transcribed material that give support to an interpretation; material exploration - the record units found in the previous stage were organized to categorize and treat results, including the inference and interpretation according to central themes.[9]

After reading, there was an initial coding, to identify units of meaning relevant to the topic at hand. Based on this coding, categories were organized and refined, considering the recurrence and relevance of the that emerged.

This research was conducted respecting all ethical principles of Resolution No. 466/2012, No. 510/2016, and No. 580/2018, from the National Council of Health, MH.[10] In accordance with all legal procedures, this research was evaluated and approved by the Research Ethics Committee, under opinion No. 3.888.909 and CAAE 27030319.0.0000.5103, in February 28, 2020. The anonymity of the participants was ensured through the use of alphanumerical codes, comprising a letter indicating the profession of the participant, followed by a number.

Results

This research counted on the following professional categories: nursing technicians (6), nurses (5), physicians (3), a social worker (1), and a psychologist. These professionals had work in their field from six months to seven years, in case of those with higher education, and from four to nine years, for those with technical courses. As for the specialized formation, three physicians had a specialization in obstetrics and gynecology, while three nurses specialized in obstetric nursing.

The analysis of the statements of the participants was organized in record units, represented by specific fragments of the statements that illustrate and support the thematic categories that emerged from the research. These categories are: The entrance of the pregnant/postpartum woman user of psychoactive drugs into the hospital; The relevance of integral, humane, and organized care; and The use of an approach focused on protecting and caring to newborns for the continuous monitoring of the woman.

The entrance of the pregnant/postpartum woman user of psychoactive drugs into the hospital

According to the perception of the professionals interviewed, providing care to the pregnant/postpartum PD user is the same as providing it to any other pregnant/postpartum woman.

> *The patient that uses PD is cared for in the same way as the others are. (RN 1)*

> *The early treatment is just like any other [...]. (RN 2)*

> *The care provided is normal, as it is for every other pregnant and postpartum woman, but with alcohol and drug users we have to be a bit more careful, since these patients may not come back.(TEC 2)*
>
> *It is the same care provided to all pregnant women. There is no difference, the protocol is the same for all of them..(TEC 3)*
>
> *[...] they are cared for just as any other pregnant/postpartum woman. There is not a special type of care or attention.(PHY 3)*
>
> *When attending pregnant/postpartum users of anything there is no difference in their reception, they are all treated as patients regardless of being users or not, because we are focused on the subject at hand, we cannot differentiate [...] (PSC 1)*

In regard to the protocol to care for pregnant and postpartum woman users of PD, professionals were receptive to the idea of implementing a specific protocol, in case it was introduced:

> *There is no specific protocol, and if there was one, it would give a better support and orientation for us[...].(RN 3)*
>
> *There is no protocol, and if there was one it would help a lot, because we wouldn't be lost without knowing what to do [...]. (RN 5)*
>
> *There is no protocol. If there was one it would help a bit because we would have more knowledge.(TEC 3)*
>
> *As far as I know there is no protocol, and if there was one would help us be more prepared to care for these patients.(TEC 1)*
>
> *In the institution there is no specific protocol for alcohol and drug users, and therefore there is no specific care[...]. (PHY3)*
>
> *We do have a care protocol, but it is focused on gynecological and obstetric psychological care, it isn't specifically directed for patients with chemical or alcohol dependency.(PSC 1)*

The relevance of integral, humane, and organized care

Research participants highlighted services such as health units, social workers, and community initiatives, considering them as part of an interconnected network, essential to ensure integral care to the mother-child dyad. This network

goes beyond referrals, involving a continuous communication between all its points, in order to provide humane care:

> *Our Network is well articulated, whenever there is vulnerability in a situation, we contact the Network to see if the mother has been referred and where is she going to be referred to, we have a lot of success, the communication with the Network is really effective[...]. If there is a family being supported behind it there's a network supporting it, the mother leaves here with her child. (SW 1)*

> *In some cases, relatives and institutions are contacted to make this connection, but it always depends on the patient to continue outside. Their path, we give them direction, but their path follows their own wishes.(PSC 1)*

However, there are gaps in assistance at the time of prenatal, which make it more difficult to provide care and puts the mother-child dyad at risk.

> *A mother who was a user was so afraid that the social worker would take her baby that she wouldn't let him in the crib, he'd stay in the corner of her bed. Whenever we entered her room she would ask: Do you think you'll take my baby? Do you think you'll take my baby? [...] when the Social Worker took her baby, she would punch the door so much [the baby was taken to be raised by another family]. She was discharged and one year later was pregnant again. She didn't have prenatal care, if she had had that opportunity, maybe she would have another way out.(TEC 6)*

> *[...] these patients are usually more aggressive, with incomplete prenatal cards, which requires us to investigate for other pathologies that were not identified in the prenatal care, they have a serious deficiency in regard to pregnancy follow up.(PHY2)*

The use of an approach focused on protecting and caring to newborns for the continuous monitoring of the woman

When asked about the approach to women users of PD that enter maternity, it was found that much attention was given to aspects related to caring for the child, to the detriment of any attention for the pregnant/postpartum woman. Participants were almost exclusively concerned with the woman's ability to ensure that the child was safe and protected, as the following excerpts show:

> *I think we try to provide better care because of the baby, postpartum women who are not drug users give their babies all this care, attention and affection, but the users do not - because of their abstinence. (RN 4)*

> *We have to be more careful with how these patients breastfeed, clean, and care for their babies, and regarding evasion, with or without the child, because when they don't want the child they don't treat it with any importance, we have to be attentive(RN 5)*

> *When the use of illegal drugs becomes clear, we have to be careful when discharging the newborn,[...] we investigate in order to gather information about the mother and if we find any risks, we get in touch with Child Protective Services or the Juvenile Courts. (SW1)*

> *All the guidance we provide in regard to drug use or alcohol are meant to benefit the baby. [...] they are capable of doing anything that could harm the baby, we have to be always careful and observe their faces, as they will demonstrate when they are in a crisis.(PHY 1)*

> *[...] We call Social Services to evaluate the risk of that baby staying with the mother. There is no procedure to deal with the postpartum woman. (PHY 3)*

> *When it comes to the baby, the team is more careful, especially the doctors and nursing team. The Social Workers also help in legal aspects and ensures the safety of the baby, getting in touch with the family and any relevant institutions to follow up, while psychology is more focused on the intentions of the mother. (PSC 1)*

The lack of confidence of the professionals regarding these mothers often leads to a separation of the mother-child dyad. They are only allowed to be together when the mother seems to be calm, with no signs of abstinence, or when they have someone that accompanies them.

> *[...] if the mother is under the influence of drugs or alcohol, is alone or has no one with her, we don't let her stay with the baby. When the mother is calm, and she wants to stay with the child, the bond is allowed to continue, we don't separate mother and child. The care we give them is the same we give to others, always orienting them about breastfeeding, [...] how to care when bathing and in the postpartum. (RN 1)*

> *We follow these postpartum women closer because they are patients whose risk of abstinence is very high, with psychomotor agitation, and if the baby is in a joint accommodation, the mother can represent some type of risk, so they have to be watched closely. (RN 5)*

> *We provide the same care as we do to other patients, who are not users, but when the baby is born we observe him, when was the last time the mother used some type of drug, and whether there was any type of influence on the premature childbirth.(TEC 1)*

Another characteristic that is intrinsic to the attitude of health workers, especially nurses, is the continuous monitoring of these women, out of fear and concern about how they care for the baby and due to the risk of evasion, which can harm their health and that of the child, as the following excerpts show:

> *We have to redouble our care with the newborn, due to their risk of evasion, especially when they don't want to breastfeed because they are uninterested in the baby[...].(RN3)*
> *[...] sometimes, the vulnerability of the mother herself shows that she does not give much attention or care to the baby, we must stay vigilant and attentive[...], since they are more agitated, nervous, they scream, they disturb the sector and the team, they verbally abuse the team, there are many cases of evasion and they do not accept the rules of the hospital. (RN4)*

> *The assistance is not unique, we do not discriminate, but we end up giving them more attention because of the disease. These patients are more agitated and try to evade and to kill the baby.. (TEC3)*

One of the participants also stated that what leads them to pay more attention, the condition that changes the care they provide, is when the mother has some comorbidity. Otherwise, a specific type of care is not necessary:

> *We provide normal care, the same we give to all other patients, the procedures and attention is the same, it will only change if there's some different type of disease, such as hypertension or diabetes. (TEC 5)*

The present findings show that the professionals have different perceptions and practices, showing their efforts to care as well as the gaps in the care they provide to the woman user of PD, when it comes to provide integral and customized care.

Discussion

The results of this research suggest that the participants give the same type of care to pregnant and postpartum women users of PD as they do to other patients.

The approach adopted by the team sees these women as "normal" and "equal' to any other pregnant woman, which may reflect an attempt not to stigmatize these patients, which is positive. Nonetheless, it can also be seen as a lack of understanding about the specific needs of this population, while it also suggests that the health team does not know well the complexities and risks associated with this group.

A perception that the same type of care should be provided to all pregnant women may hide important risks associated to the use of substances, such as complications in childbirth or behavioral issues during puerperium which require a more attentive and specialized approach. This setting can compromise the plan of care, decreasing the quality of the multidisciplinary care, especially when it comes to providing attention to pregnant and postpartum women who use PD.

Most statements found stated that the health team needed to carefully follow the health team, while professionals mentioned constant communication in the health team, between Obstetrics, Pediatrics, and Social Services. It is also worth noting that professionals expressed the feeling that their responsibility is watching the mothers to ensure the safety of the NB, considering that the mother, as a user of PD, could enter in a state of abstinence. It was found that, despite the effort to treat these mothers the same as others, in the end, it is not possible to manage them equally.[11-12]

A specific approach from the team should involve professionals from different fields of action, a unique and valuable opportunity to investigate and discuss, with women in the postpartum or pregnancy period, about the inappropriate use of PD, instead of waiting for them to bring up the subject, seeing as most pregnant women are reluctant to show their addiction (especially the use of alcohol and illegal substances) to the health worker because they fear being stigmatized, or that confidentiality will be broken and their spouses/family would learn about it, in addition to concerns about legal issues and their rights of caring for their children and being their guardian.[12]

To help these women reduce and, ideally, stop their use of alcohol and other PD, the health team must provide broad and coordinate care, being especially effective in the context of pregnancy and puerperium, when the difficulties they face can be complex and multidimensional. Each member of the team can bring a unique perspective to address the particularities of the use of PD, developing efficient treatment strategies.[3,12]

Nonetheless, this study showed the lack of protocols to attend this specific group, which can lead to a general approach, not really addressing issues specifically associated to the use of PD during pregnancy and puerperium. This can affect the quality of the care provided, considering the specific needs and challenges faced by these women,

such as: late detection of health issues; lack of appropriate referrals; and, finally, putting the health of the mother at risk. Specific protocols can help ensure an effective triage, and the appropriate referral for specialized services, as well as the monitoring of the health of both mother and baby, providing support and customized care for this population in an effective and safe manner.[12]

The implementation of specific protocols is recommended, as it can include continuous training for the health team in order to raise awareness about the challenges faced by these pregnant/postpartum women, while enabling them to conduct the best practices for an appropriate care.

To this end, although participants of the health team see the care provided to pregnant and postpartum women users of PD as being the same to that of other patients, this perspective reflects an understanding that still predominates in many different contexts, a vision according to which care should only be different when there are clear comorbidities, such as hypertension or diabetes (something noted in some interview extracts), not considering the specific needs and complexities of these women.

In the extracts related to their practice, however, their condition as PD was found to lead to more intensive monitoring. This approach, despite being motivated by concerns about the risks of abstinence or complications, can affect the autonomy of the woman, putting the baby safety above maternal wellbeing and mental health.

Mothers undergoing abstinence from PD use can have several behavioral disorders, such as refusing the NB, threatening the health team; refusing treatment; in addition to trouble providing self-care and NB care. Thus, the health team must provide care that goes beyond merely conducting procedures, embracing them and providing them with education in health, essential tools for the practice of the nurse.[11-13] Therefore, care should be focused on the person as a whole, integrating the needs of mother and baby, without letting one of them overshadow the other.

In the setting of this research, the actions to provide care to the pregnant/postpartum women users of PD who are in a situation of vulnerability, considers the specialized care provided by psychology and social services as a routine. For some women, the maternity hospitals are the first contact they have with a health services, since many of them do not go to prenatal consultations, and when they do, do

not report that they use PD, given that they do not consider themselves to be addicted. Therefore, this is the first service in which they report that they are PD users, in order to diminish the risks and complications in childbirth.[12-13]

Although the participants of the research recognize that each person is unique in their context and regarding their needs of health, and that it is important to provide equal care, it was also noticeable that they perceive that the woman who is in abstinence from PD use should receive a different, specialized type of care. Nonetheless, this understanding is not in line with the general approaches adopted in practice, which often mean that care does not consider the particularities of this group, treating them as they do any other pregnant and postpartum women, which could compromise the quality and integral nature of the care provided.

Therefore, health workers must be trained to understand the logic behind the articulation of their work object, in such a way that, in the context of care to pregnant and postpartum women users of PD, the hospital team is not the first service to attend these women, despite being prepared and trained to receive them.[13-14]

In this regard, the health team has an important role in providing integral care to women in the gestational and postpartum periods, as well as to their children, since the goal is to provide attention focusing on psychosocial care, and the treatment and follow up of these women should not be restricted to medical and psychiatric conducts, but involve a set of factors that include biopsychosocial aspects of each subject, in order to segment assistance in a continuous network of care and ensure longitudinal follow up and a long-lasting bond with the users that takes their integral care into account.[13-15]

Regarding the safety of the NB, which was mentioned by most participants, health workers understand these actions as a practice of protection and care. By watching and monitoring the environment and the postpartum mothers, the team feels safe to protect themselves from physical and verbal aggression and to help the NB in case there is any attack from the mother, showing they have no specific knowledge about the relationships that should guide psychosocial mental health care, fragmenting assistance. The team hopes to reduce the tension of this postpartum woman, which involves not only abstinence, but also the specificities produced by this postpartum stage, in addition to transformations related to physiological and hormonal changes,

making it necessary to provide humane care and actions targeted at specific issues in this stage.[16-17]

Therefore, it is important to understand that health workers must be watchful of themselves, meaning they should not step back in regard to ensuring that human rights are guaranteed, yielding to perspectives riddled with stigma and prejudice to a population that is vulnerable due to the use and abuse of PD.

Considering these issues, it is essential to discuss the peculiarities of hospital care for this population, since it is possible to identify the rupture in the bond between the mother-child dyad, considering the interferences carried out via consensus of the interdisciplinary team, such as: the introduction of dietary complements interfering in the breastfeeding process; the medication of the postpartum woman during crises; the separation of mother and NB; and sometimes, the evasion of the mother, leading to the abandonment of the child.[18-19]

It is essential to consider whether interdisciplinary health teams are indeed prepared, technically and scientifically, to notice the behavior of pregnant women who are users of PD, diagnosing their habit earlier and developing care and intervention strategies to form bonds for qualified listening.[19-20]

Despite the perception of the health team, according to which attending to this population would be "similar" to attending other pregnant women, international directives, such as those from the World Health Organization and the American College of Obstetricians and Gynecologists recommend adopting specific measures for the clinical and psychosocial management of these women.[21-22]

These recommendations include universal early triage using validated instruments; referrals for specialized treatments; psychosocial interventions and assisted drug therapies (such as methadone and buprenorphine in case of opioid addiction); and the specialized monitoring of NB for Neonatal Abstinence Syndrome.[21-23]

These directives reiterate how important it is to have humane, integral care, based on scientific evidence, in order not only to reduce mother-child risks, but also to promote the bond between them and the continuity of care. The absence of these

practices in the services analyzed show there is an important gap between the perception of the professionals and the international recommendations regarding the care for pregnant and postpartum women users of PD.

A limitation of this study includes the fact that it may be impossible to generalize part of this study, since it was carried out in a maternity with its own specific characteristics and social, cultural, economic, political, and regional determinants. However, the results can give support to reflections and to the development of new research on the topic, to strengthen and disseminate it, enabling its adequate application for interventions in the reality of this specific group.

This study helped understand the care provided to pregnant and postpartum women users of PD, showing the need of a unique and specialized approach. It also shows the importance of training health teams to deal with the complexity of the use of PD during pregnancy and puerperium, ensuring humane and efficient training through continuous education and specific protocols, capable of improving the quality of care, from diagnoses to follow up.[23]

The reflections and results presented here can give support to the construction of efficient public policies and care strategies, that can attend pregnant and postpartum women users of PD equally, respecting their rights and the complexity of their health needs.

Conclusion

The care provided to pregnant and postpartum women users of PD requires a specialized and unique approach, considering the physical, emotional, and social particularities of this population. This research showed that, although the care provided to these women is perceived to be the same as that provided to other pregnant women, multidisciplinary clinical practices show the need to regard them with a more attentive and integrative perspective, involving a health team that can identify and deal with the complexities associated to the use of PD during pregnancy and puerperium.

The continuous training of health workers and the implementation of specific protocols are essential for the care provided to be adequate and efficient, involving the health of both mother and baby, while never neglecting psychosocial aspects.

Furthermore, the health team must be prepared to establish open and empathetic communication with these women, minimizing the stigma and promoting humane and free-from-judgment care.

Finally, the lack of appropriate protocols and the general approach may compromise the quality of care, risking the health of mothers and babies. Therefore, the elaboration of specific strategies, which consider the particularities of each case, as well as an efficient articulation between the different professionals in the team, is essential to ensure integral, continuous, and respectful care.

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