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WALKING PATHS: THERAPEUTIC ITINERARIES OF WOMEN USING ALCOHOL AND/OR OTHER DRUGS DURING THEIR PREGNANCY-POSTPARTUM CYCLE

PERCORRENDO CAMINHOS: ITINERÁRIO TERAPÊUTICO DE MULHERES USUÁRIAS DE ÁLCOOL E/OU OUTRAS DROGAS DURANTE CICLO GRAVÍDICO-PUERPERAL

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ABSTRACT

Pregnancy, childbirth and postpartum care is provided in accordance with gestational risk factors, such as use of alcohol and/or other drugs by pregnant women. The objective of this study was to trace the therapeutic itinerary of pregnant women who use alcohol and/or other drugs in the health network of a city in the Mid-North of the state of Paraná. This is a qualitative, exploratory study conducted through individual interviews. Firstly, the therapeutic itineraries were built, then the speeches were analyzed in accordance with Bardin and discussed with the aid of current literature. Regarding the therapeutic itinerary, the interviewees accessed primary care, high-risk prenatal care, and hospital services. The results identified two categories: Considerations on the use of alcohol and drugs during pregnancy, and Strengths and weaknesses of the healthcare network's points of attention. From the statements, probable biological and social implications of using psychoactive substances during pregnancy emerged, such as complications during gestation, fetal alterations, and loss of legal rights over children. As for the points of attention, the importance of multiprofessionality and the role of nursing were highlighted. On the other hand, the network's disarticulation and professionals' inability, represented by inappropriate comments and lack of guidance, appear as weakness. It was concluded that it is necessary to provide comprehensive follow-up to pregnant and postpartum women who use alcohol and drugs, with the articulation of the healthcare network and professionals free from judgment to provide a care that meets their biopsychosocial demands.

Keywords: Alcohol. High risk pregnancy. Illicit drugs. Prenatal care. Unified Health System.

RESUMO

O cuidado oferecido durante a gravidez, parto e pós-parto ocorrem de acordo com fatores de risco gestacional, tais como o uso de álcool e/ou outras drogas por mulheres grávidas. O objetivo do presente estudo foi traçar o itinerário terapêutico de gestantes usuárias de álcool e/ou outras drogas na rede de saúde de uma cidade no centro-norte do estado do Paraná. Trata-se de um estudo qualitativo, exploratório, feito através de entrevistas individuais. Inicialmente, os itinerários terapêuticos foram construídos e, após, os discursos foram analisados segundo Bardin e discutidos com a ajuda da literatura atual. Em relação ao itinerário terapêutico, as entrevistadas acessaram os serviços de atenção primária, do pré-natal de alto risco e hospitalar. Os resultados identificaram duas categorias: Considerações sobre o uso de álcool e drogas na gravidez e Potencialidades e fragilidades dos pontos de atenção da rede de saúde. Das declarações, emergiram prováveis implicações biológicas e sociais do uso de substâncias psicoativas durante a gravidez, tais como complicações na gravidez, alterações fetais e perda dos direitos legais sobre as crianças. Quanto aos pontos de atenção, a importância da multiprofissionalidade e o papel da enfermagem foram destacados. Por outro lado, a desarticulação da rede e a inaptidão dos profissionais, devido a comentários inadequados e falta de orientação, aparece como fragilidade. Concluiu-se que é necessário dar seguimento integral às gestantes e puérperas que usam álcool e drogas, com articulação da rede de saúde e com profissionais livres de julgamentos para prestar os cuidados adequados às demandas biopsicossociais.

Palavras-chave: Álcool. Assistência pré-natal. Drogas ilícitas. Gestação de alto risco. Sistema Único de Saúde.

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INTRODUCTION

The health care provided to users of the Brazilian Unified Health System [*Sistema Único de Saúde*] (SUS) is supported by ethical-doctrinal and organizational principles that govern the actions of health professionals in the public network, in order to offer a quality, competent and humane assistance to all who seek SUS (PONTES; OLIVEIRA; GOMES, 2014). Thus, prenatal care must also be based on the aforementioned principles, providing pregnant women with a comprehensive and individualized follow-up.

The Prenatal and Birth Humanization Program [*Programa de Humanização no Pré-Natal e Nascimento*] (PHPN), created by the Brazilian Ministry of Health [*Ministério da Saúde*] (MS) through Ordinance/GM No. 569 of 01/06/2000, guarantees access to the services necessary to identify and monitor pregnancy, whatever the expectant mother's biopsychosocial condition (BRASIL, 2000).

The perspective of an assistance with a broader view of the pregnancy and postpartum process must encompass all aspects that determine a pregnant woman's health condition, taking into account the paths that she takes beyond the biological process of pregnancy.

Social vulnerability is described as something inherent to human beings; its concept can refer to the fact that people who live in society are exposed to potential damage and risks that subject citizens to extreme conditions of survival (CARMO; GUIZARDI, 2018). Therefore, situations that characterize a person in social vulnerability are part of the social determinants of health, and being or having been a user of alcohol and/or other illegal drugs is one of the risks faced by pregnant women (SEGRE, 2019).

The use of psychoactive substances (PAS) can be classified in degrees and in accordance with the damage caused by consumption, going from routine use, through abuse, to dependence. Routine use is defined as any consumption of these substances, whereas abuse is when consumption starts to cause any biopsychosocial harm, and dependence, in its turn, is uncontrolled and unavoidable consumption (NÓBREGA; MUNHOZ; ROVAROTTO, 2018).

When legal or illegal substances are consumed during pregnancy, care providers should be extra cautious, as there are still no studies that determine safe doses of these substances during pregnancy, so women may be subject to some social risk and develop comorbidities associated with any exposure (SEGRE, 2019).

Considering that the national Healthcare Network [*Rede de Atenção à Saúde*] (RAS) is characterized by organizational arrangements of the service's points and health actions that use technologies to ensure comprehensive care, its articulation is one key point to capture pregnant women in accordance with their priorities and needs (BRASIL, 2010). In the case of monitoring a pregnancy in which the woman uses PAS, the articulation between the Stork Network [*Rede Cegonha*] and the Psychosocial Care Network [*Rede de Atenção Psicossocial*] must be well established so that she can transit through the available services in search of assistance, tracing her therapeutic itinerary (ALVES, 2015).

Therapeutic itinerary is described by the route that a user takes within health services while seeking care that meets the needs established by themself. Thus, professionals working in these services must know the route that the user takes through their reports, which choices they make, as well as their searches, acceptance of and withdrawal from the service, and treatment non-compliance (CABRAL *et al*., 2011).

Thus, this study aims to trace the therapeutic itinerary of pregnant women who use alcohol and/or other drugs within the healthcare network of a municipality in the Mid-North of the State of Paraná.

MATERIAL AND METHODS

This is exploratory research, with a qualitative approach, that uses the technique of individual interview and therapeutic itinerary. This study was approved by the ethics committee for research

involving human beings under CAAE No. 26715219.8.0000.5216; all participants read and signed the Free and Informed Consent Form.

It was carried out in a municipality in the Mid-North of the state of Paraná, and the participants were selected through the city's Specialized Center for Intermediate- and High-Risk Prenatal Care. The sample was composed at random; initially, data would be collected from five interviewees, but due to three women declining and the difficulty in approaching other possible women, since they do not seek the care service, two research participants were chosen, in accordance with the following inclusion criteria: women residing in the city, aged over 18 years old, in the postpartum period, from 45 days to 365 days, who were referred for prenatal care to the high-risk service due to use of alcohol and/or other drugs. The exclusion criteria were: women under 18 years old, who did not complete prenatal care in the city, and those who, at the time of the interview, were visibly under the influence of alcohol and/or other drugs.

Data were collected using an unstructured script consisting of interviewee characterization through: interview date, initials of the name, age, occupation, income, marital status, number of children, address, Health Unit to which she belongs, date of last delivery, and gestational age at childbirth. The following triggering question was asked as well: How was your prenatal care since the discovery of pregnancy?

The interviews were conducted from June to July 2020, with a length of two hours and thirty minutes; one was held at the interviewee's home, and the other, in the psychosocial care room at the local hospital. Both were recorded and transcribed in full, using fictitious names to identify the interviewees, ensuring the privacy of their real identities and generating a ludic meaning to designate their speeches. The data were subjected to the content analysis technique proposed by Bardin (2011). In this type of analysis, the author suggests carrying it out in three phases: pre-analysis, material exploration, and processing of results, which comprises inference and interpretation. The data were discussed with the help of current literature related to the topic.

RESULTS AND DISCUSSION

The results of the present study were structured so that, first, the two interviewees' profile was characterized and, then, the therapeutic itineraries followed by them were described. Subsequently, the categories emerging from the content analysis were described and discussed.

Itinerary 1: Walking with Moon

Moon, 21 years old, is single and a stay-at-home mother of two children – one is five, and the other is two months old. She studied up to the ninth grade of elementary school and lives in a peripheral area of the city. Moon, her children and her maternal grandmother live at the house; she considers the latter as her mother and has no direct contact with or any help from the boys' father. She is diagnosed with bipolarity and, according to herself, is not undergoing psychiatric or drug treatment because she quitted:

> *"After my oldest son was born, I had bipolar disorder, I still have it actually, but when he was born, I quitted because of the treatment with the CAPS Doctor, and I never went back."*

She became a mother for the first time at 16 years old and, between 14 and 15 years old, when she met the father of her first child, she started using alcohol and drugs.

> *"My first contact was before I got pregnant with my first child, fourteen to fifteen years old, when I met his father, in this kind of life we'd go out a lot, to parties.... that's where I tried these harder drugs. I used the softer ones with him in the beginning."*

As shown in Figure 1, at the sign of suspicion of pregnancy, Moon sought a private laboratory to take the blood test that would confirm the gestation; it was the first service she accessed:

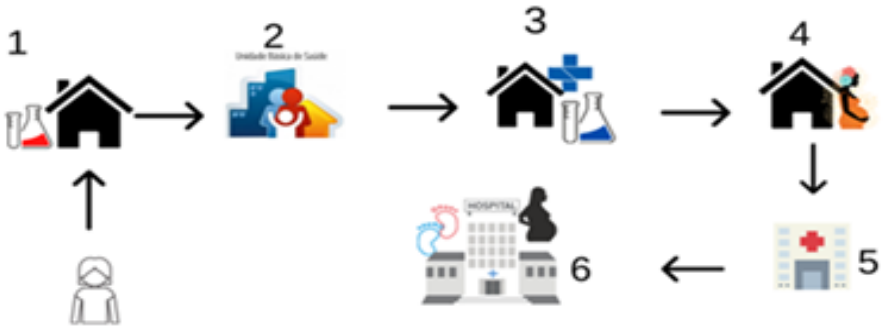
> *"One day I had to borrow money from my friend, I went to this private laboratory and talked, paid, took the test, and when I got the result it read 'reactive', so I thought what is this?! I went back inside and said "lady, what does reactive mean?", she said "positive".*

For her, it was a moment of fear, distress, and because she had not planned this pregnancy, she was worried about her family's reaction. On top of that, there was also the fact that she was using alcohol and drugs.

The next service she accessed in the network was the Basic Health Unit [*Unidade Básica de Saúde*] (UBS) in the area where she lives; after starting prenatal care, she was sent to the municipal laboratory to undergo the exams for the first trimester of pregnancy. Afterwards, she was referred to an outpatient service specialized in intermediate- and high-risk pregnancy in the city. The referral was necessary because her health unit does not offer regular prenatal appointments, and not just because of her gestational-risk classification.

Moon also had to seek an Emergency Care Unit [*Unidade de Pronto Atendimento*] (UPA), due to complications during pregnancy. She had to be admitted to the obstetric sector due to a diagnosis of restricted intrauterine growth during the final period of pregnancy and, lastly, returned for delivery at the city's reference maternity hospital.

Figure 1 – Summary of the accessed services and illustration of the itineraries taken by user Moon.



1 - Moon sought a private laboratory to take a pregnancy test
2 - With the positive result, she went to the UBS to start prenatal care
3 - She was referred to the municipal laboratory to undergo exams
4 - With the exams, she continued with prenatal care at the Pregnancy School (outpatient clinic for intermediate-and-high risk prenatal care)
5 - She used the UPA for gestational complications
6 - She used the hospital service, the reference maternity hospital for admission during pregnancy and for C-section.

Source: The authors.

Itinerary 2: Walking with Star

Star is 26 years old, single, mother of a three-month-old boy and retired on disability due to a congenital physical condition; she has no knowledge of the diagnosis that led to it because she was adopted as a child. She studied the early years at the city's Association of Parents and Friends of Exceptional Children [*Associação de Pais e Amigos dos Excepcionais*] (APAE), and is currently attending the 1st grade of high school. Star lives with two brothers, and her son is under the care of the social assistance for the protection of children and adolescents, in a municipal shelter. It was not a planned pregnancy, and she has no contact with or help from the child's father:

"I didn't plan on getting pregnant and I have no contact with my baby's father."

The report on the use of alcohol and drugs by Star is succinct. She does not deny it, but does not go into details about the issue.

When Star was suspicious of the pregnancy, she took a quick pregnancy test (TRG), bought at a drug store, and the next day she went to the UBS in her neighborhood, where she was asked to take the Beta-HCG test via the municipal laboratory. With the laboratory confirmation of her pregnancy, prenatal care began at the UBS. Star says that she was informed that her prenatal care would only be possible through the usual-risk service:

"I only used the health unit, they said I didn't need another place".

At the end of her pregnancy, she received care at the outpatient service specialized in high-risk pregnancy, due to an obstetric complaint. During this gestational period, she was followed up by a project intended to monitor pregnant women in a situation of social vulnerability, conceived by the city's maternity hospital, in partnership with a highway concessionary company.

The last service the interviewee accessed in the network during her pregnancy-postpartum cycle was the maternity hospital of reference for childbirth.

Figure 2 – Summary of the accessed services and illustration of the itineraries taken by user Star.

1 - Start took a quick pregnancy teste (TRG)
2 - With the positive result, she went to the UBS to start prenatal care, where the laboratory pregnancy test at the municipal laboratory was scheduled
3 - She went to the city's reference laboratory service to undergo the exam
4 - With the pregnancy confirmed, she continued with prenatal care at the UBS
5 - She resorted to the Pregnancy School once due to a gestational complication
6 - She attended sessions of the Life Bonds (Elos de Vida) project while pregnant
7 - She used the reference maternity hospital for C-section.

Source: The authors.

The paths taken in the interviewees' therapeutic itineraries, from the discovery of pregnancy to delivery, were different from those recommended by the Stork Network, the Paraná Mothers Network [*Rede Mãe Paranaense*], the Psychosocial Care Network, and even by the municipality's Reference Grid for Pregnant Women.

The Stork Network is characterized as a network of care that guarantees women's right to have a gestation, childbirth, postpartum period and reproductive planning in a humanized and comprehensive way. This means that, based on the gestational risk classification, the flow will be adjusted and expanded in accordance with the pregnant woman's needs (BRASIL, 2011).

Thus, healthcare services aimed at pregnancy in the Municipal Network, especially high-risk ones, which present risk factors for the gestation, with possible complications for both the mother and the baby, must provide follow-up with regular appointments and specific exams, and comply with the recommendations regarding the classification of gestational risk of the Paraná Mothers Network, which is characterized by a set of actions that encompass all services that provide maternal and child care (PARANÁ, 2018). The Paraná Mothers Network recommends that pregnant women who are drug and/or alcohol users be followed up by the municipality's Intermediate- and High-Risk Reference Outpatient Clinic and at the UBS, and be entitled to seven prenatal care appointments and one postpartum appointment, being linked, beforehand, and referred, when necessary, to the intermediate- and high-risk pregnancy reference hospital (PARANÁ, 2018).

Another follow-up option would be the Reference Grid for Pregnant Women, material available to all services in the municipality, which is based on the Municipal, State and Federal Prenatal, Childbirth and Postpartum Care protocols, with guidelines for referrals and counter-referrals, depending on the services available in the local network. Primary healthcare should be responsible for this classification and referral, in accordance with the demand for specialized services (NEVES *et al*., 2019).

Category 1: Considerations on the use of alcohol and drugs during pregnancy

It is known that having made regular use of alcohol and drugs during the gestational period is one of the criteria that classify a pregnancy as being high risk. This classification is defined as "the one in which the life of the woman or fetus is more likely to be interfered with compared to pregnancies with a normal course" (BRASIL, 2012).

The use of alcohol and drugs was openly debated by one of the interviewees, whose speech was clear when identifying that consumption brought distress and concerns about her health and pregnancy on the part of her family:

> *"Well, this pregnancy, at the same it was calm, it was also turbulent [...] because I'd go out from the beginning, go to parties and drink, I'm not going to lie. I did drugs, but nothing on a daily basis, so at first there was a lot of concern on the part of my family."* (MOON)

During her pregnancy, there were changes in fetal development, and the interviewee needed early hospitalization.

> *"My baby was not developing; after a while, growth began, but it went on until it reached the point where the baby was not putting on weight [...] and the doctors were already saying that they would try to wait up to 37 weeks to take the baby out, I was aware."* (MOON)

According to Tacon, Amaral and Tacon (2018), the effects of legal and illegal drugs on the development of pregnancy and fetal repercussion have similar mechanisms of action, crossing the placental barrier and causing maternal complications such as tachycardia, hypertension, respiratory complications, placental abruption and miscarriages, in addition to fetal alterations, such as

anomalies, restricted intrauterine growth, neurological damage, low birth weight and Apgar score, as well as signs of neonatal abstinence, such as irritability, tremors and crying spells.

Even with the presence of possible complications, most pregnant women do not stop consumption, and can only change their pattern of use; one likely explanation is the satisfactory effect, of momentary pleasure and euphoria that the drug brings to the central nervous system (TACON; AMARAL; TACON, 2018).

The use of these substances is related to the altered understanding that the interviewee shows about the severity of consumption during pregnancy, as she considers them as substances with mild and severe effects.

> *"Oh, marijuana and loló are soft, the hard ones are cocaine and crack. I'm not going to lie, I used it while pregnant of my son, at the beginning of the pregnancy. I only stopped after I was sure I was pregnant. I thought, I'll wait for the tests, the ultrasound, and when I'm sure I'll stop."* (MOON)

Tacon, Amaral and Tacon (2018) report that the proper classification of "soft and hard" drugs by the users is common, with the distinction being based on the effects that each one causes in the body during and after use. The authors argue that marijuana is one of the most used drugs in the gestational period and that it causes damage to fetal development and psychological consequences that can induce the consumption of this substance in childhood and adolescence. It also leads to initiation to the consumption of other types of illegal drugs, with consequences being boosted by the type of drug.

Moon mentions that she has had contact with "*loló*", which is a drug made of ether and, in its liquid form, is inhaled. One of the main harms of this chemical, both for the pregnant woman and the fetus, is respiratory discomfort and neurological alterations. With regard to the use of cocaine and crack, which also appear in the interviewee's speech as drugs considered "hard", consumption can cause long-term damage, such as visible malformations of limbs and bones, microcephaly, mental retardation and neuropsychomotor problems (TACON; AMARAL; TACON, 2018).

The reports suggest that the interviewee clearly defines what she considers a type of drug that can cause harm, and that her exposure to risk situations may not be intentional, but addiction means that there is no conscious recognition of the damages to gestational development.

> *"Well, I think it's like, drugs not so much right, it's not very normal, but a lot of people drink, I don't think it's a big deal [...] And I don't think it had any consequences, because the baby was born perfect, it wasn't born with any problem at all."* (MOON)

Looking at the consequences caused by the use of alcohol and drugs can become distorted most of the time, especially if, after birth, the child shows nothing different physically. It is imperative that health teams equip pregnant women with information about all types of biological, psychological and social damage generated by abuse of psychoactive substances. Attention should also be paid to cases of postpartum depression, situations of violence, child abuse, and the psychological consequences in childhood, adolescence and adulthood of the child of a mother who uses drugs, due to the effects of consumption and the break of family bonds (RODRIGUES *et al*., 2018).

While one of the interviewees spoke openly about using alcohol and drugs in the pregnancy-postpartum cycle, the other had trouble talking about the matter.

When asked about her experience using psychoactive substances before, during and after pregnancy, she responded with a negative tone, even evading the subject. However, it was previously known, based on information obtained from the service specialized in high-risk prenatal care, in accordance with inclusion criteria, and also from professionals who monitored her in a social project, that the interviewee has a history of use of psychoactive substances.

> *"Oh, I don't know, sometimes. [...] Only at the beginning of the pregnancy, but I don't like to talk."* (STAR)

This denial resumes the premise that consumption of psychoactive substances is a major public health problem, especially during pregnancy. Kassada *et al.* (2013) state that, because many of the substances used are not authorized for consumption, open reporting on the subject is often suppressed, thus making it difficult for health teams to work with pregnant women.

One of the women goes through the context of having the care for and bond with her child suppressed by the care service for children in a situation of vulnerability, and the other remains under constant surveillance by the entity that protects children's interests.

> *"He's in a shelter, I go there on Mondays and Fridays to visit him. Before, I'd stay the whole day, but yesterday I went and could only spend 15 minutes with him, because of the coronavirus."* (STAR)

> *"Since I was using drugs, drinking, I used to be gone for days. For this baby now, I was subpoenaed by the Guardianship Council, so my grandmother is always nagging me."* (MOON)

Women who make pathological use of alcohol and drugs, harming their biological, psychological and social functions, are automatically stripped by society of their role as mothers, caregivers and supporters in the life of that family. This makes the legal loss of custody of their children a close reality, generating a direct impact on the lives of these women and kids (MENANDRO; GARCIA; ULIANDRA, 2019).

The following statements from the interviewees report that, despite the surprise at the decision of the public authorities to take their children to a shelter for minors and the constant surveillance by the guardianship council, both are clear about the conditions to which these children were subjected, and which led to the complaints.

> *"The social worker talked to me, she was realistic, she said I wasn't taking good care of him because I was staying at a friend's house, and she said we weren't taking good care of him there, so much so that I even brought him to the hospital because he got pneumonia, then after that they took him."* (STAR)

> *"Oh, I think that's why the council subpoenaed me. Because I was with a friend and took the baby for his father to watch. When I came back, I had had some drinks and argued with my grandmother; in order for me not to do things in the heat of the moment, I left again and stayed for a couple of days with my friend, then she got worried. [...] There must have been a complaint, but we're fine now and I'm taking care of him."* (MOON)

Menandro, Garcia and Uliandra (2019) also state that women who use alcohol and drugs prefer that care be first provided by family members or have their children taken to public institutions because, despite the suffering they experience for being far away, care will be better applied, as the children will not be with them when they are under the influence of psychoactive substances.

The Child and Adolescent Statute [*Estatuto da Criança e do Adolescente*] (ECA) stresses that the family is the core institution "for the promotion and guarantee of the rights of children and adolescents" together with the State, which is responsible for providing conditions for the exercise of the rights of children and teenagers, but when one fails to fulfill family duties, the Guardianship Council [*Conselho Tutelar*] (CT) can be called in order to take measures to guarantee the rights of minors, resulting in institutional care, as well as loss of parental power (BRASIL, 1990).

The social context in which women are inserted is closely related to consumption of alcohol and drugs. Their experiences influence their behavior, such as going through situations of violence at

home, low level of education, precariousness of housing, income, and being influenced to use substances by partners and friends. Thus, a cycle begins, propagating in their adult life the same psychosocial conditions they had in childhood, which are reflected in the care of their children (RODRIGUES *et al*., 2018).

Category 2: Strengths and weaknesses of the healthcare network's points of attention

The interviewees' positive and negative considerations permeate the care they expect from the prenatal and postpartum care for women using alcohol and drugs and the care provided by health services.

The speech below shows that good assistance was offered in the prenatal care routine, but there is a counterpoint in the report, as she realizes that the concern was focused on the gestational course and fetal well-being, generating the feeling of abandonment, as a pregnant woman.

> *"Oh, it was very good, yes, I did my exams all right at the health unit, everyone was worried. I just felt they cared more about the baby, about things that could happen to him."* (MOON)

Care focused only "on the belly", according to Marcolino *et al*. (2018), shows that some health service professionals who care for pregnant women using alcohol and drugs, even though they try to provide the best possible gestational care, they still build a barrier in their ways of connecting and communicating with them. Moreover, they fail to understand that the act of not discriminating and of providing autonomy to pregnant women goes far beyond offering an exemplary routine of exams and regular visits, and that these criteria are already basic needs of prenatal care.

Therefore, in addition to the routine of exams provided by primary health care, another relevant aspect of care that was highlighted by the interviewee is the bond established with the health professional, who is part of the city's Multiprofessional Mental Health Residency Program.

> *"When I was pregnant with my oldest son, I had bipolar disorder, I still have it, actually, but when he was born, I stopped the treatment with the CAPS Doctor on my own, and I never went back. Now that I was talking to the nurse here, getting all the information, I'm thinking about doing it again. [...] these conversations with her make me think that I know I messed up with the cigarettes, drinking, but I'll be honest, I'm smoking only and I'm going back to treatment because I'm bipolar."* (MOON)

Having a member of reference in the health team led her to reflect on points that she had neglected. For this reason, the need for a multidisciplinary team for the care of pregnant women using alcohol and drugs is highlighted. The bond in these cases is usually established with a professional of reference. Therefore, the intervention of professionals with technical and psychosocial skills to meet such demands or understand when this relationship is flawed is imperative. Thus, it is possible to find ways and/or other services that can absorb these demands, generating a stimulus for monitoring to be resumed, complied with and not abandoned (COUTINHO; COUTINHO; COUTINHO, 2014).

The hospital service's actions also appear in the reports, being pointed out as a strength.

> *"At the hospital I felt more seen, the nurses became my friends."* (MOON)

Nursing is one of the professional classes that most contribute to the reception of and positive interventions aimed at pregnant women who use alcohol and drug, within the hospital environment. This formed bond can be related to the female figure of the nursing professional, which generates a connection between nurse and patient (CAPELETTI; LINS; GIOTTO, 2019).

Within the hospital context, another strength mentioned by one of the research subjects was the possibility of participating in a social project provided by the city's hospital.

The project receives, in weekly meetings, pregnant teenagers in a context of social vulnerabilities. This is done in order to guide them by bringing guests from various professional fields, addressing issues involving pregnancy, childbirth, care for the newborn, donations, psychological care and referrals, based on the demands.

> *"The project coordinator called me and said 'Hi, we have a project here at the hospital, do you want join?", then he explained everything about the project to me and I said I did want to, so I came the first time and I liked it. [...] I've participated during almost every pregnancy until today, after I already had the baby I come here, I feel welcomed here, I'm not judged."* (STAR)

Again, the importance of all instances counting on multiprofessionality is seen, as the bond may not be formed with just one professional or with only one health service (COUTINHO; COUTINHO; COUTINHO, 2014).

In addition to the moments in which they felt welcomed by the health network, the interviewees reported that there were also weaknesses that caused embarrassment during the search for assistance.

The speeches below reveal a feeling of judgment, shame for comments made at the specialized high-risk prenatal care service and an anticipated fear of going to appointments at the Basic Health Unit.

> *"Look, since I came back, I'm going there again, the nursing ladies remembered me a little, because I'm not going to lie, I'm a lot of work, I became a mother early, I used some things [...] they seemed surprised, looked at me and said "you're that little 15-year-old girl who was pregnant with another little boy", then I said that now another boy was coming, I even understand because it took me by surprise too, and there is a whole thing involved, but I felt embarrassed."* (MOON)

> *"So, they treated me well, only at the beginning I was kind of like... you know, because a neighbor of mine works there, I feared she'd criticize me, criticize me for being pregnant..."* (STAR)

Such inappropriate comments, some even sounding like a joke, reinforce the way society judges those who use psychoactive substances, and the judgment tends to be even harsher towards pregnant women, as they are responsible for their own life and for the fetus's life. Such statements, when coming from professionals in pregnancy care, whether in primary, prenatal or hospital care, bring with them chances of pregnant women omitting information and quitting treatments for fear of being criticized and going through embarrassment at future visits (KASSADA; MARCON; WAIDMAN, 2014).

Regarding the service at the UBS, Moon says that she felt forced to go to the unit, but on the other hand, her speech shows that the team insisted on establishing a bond with her.

> *"Here at the neighborhood health unit, I was more just following the development of the pregnancy, the nurse asked me to go there, check my pressure, glucose things. So, I had to and wouldn't just not go."* (MOON)

According to Kassada, Marcon and Waidman (2014), the feeling of obligation may be associated with fear of judgment and criticism. They mention that women, when seeking health services, are given the weight of duties to stay healthy and the fear of going through situations that cause embarrassment.

Even with the report that the UBS team insisted on closely following the pregnancy, one of the interviewees claims that counseling on the use of psychoactive substances and the possibility of continuing treating her bipolar condition at the specialized mental healthcare service were never put on the agenda by the team.

> *"Oh, I think they knew I used something, but I never said it openly myself, I'd talk more about cigarettes, I used it a lot while pregnant and so far, but I'm trying to take it easy because of the milk, and the people at the CAPS were the ones who'd most talk about it, since I didn't go anymore, no one annoyed me with that. I was afraid of being told off."* (MOON)

This speech brings up a big problem, as it evidences that, despite knowing the interviewees' history of psychiatric issues and abuse of alcohol and drugs, the staff, directly responsible for the care, did not approach the matter, or did so in a superficial manner, acting in such a way that fragmented the follow-up of those women.

In this scenario, we see that Moon's and Star's therapeutic itineraries were taken in similar times, their pregnancies occurred in the same period, and social and economic difficulties were faced by both. They were also subjected to the fragility of the healthcare network, which failed to identify early their needs, classify their gestational risk and proceed with the necessary referrals so that they could be taken care of by specialized services.

CONCLUSION

The study made it possible to know, from the interviewees' perspective, what therapeutic itinerary was taken by users of alcohol and/or drugs during their pregnancy-postpartum cycle, and it can be suggested that this consumption brings about biological changes in fetal development during the gestation, as well as social repercussions, such as the care and surveillance of children by child protection services in the puerperium.

It also highlights the points of attention of the healthcare network and the attitudes of professionals during the research subjects' therapeutic itinerary, making it possible to identify the strengths and weaknesses of the assistance provided to them. For the care of these women to occur in a comprehensive, ethical and humanized way, one must be clear about the importance of multiprofessionality, of the role of nursing, and of the need for better articulation of the healthcare network, with a follow-up and referral capable of meeting pregnant women's biopsychosocial needs. Moreover, there must be professionals trained to deal with the situation by speaking clearly about the issue and providing relevant guidance.

A greater exchange of information is necessary, as women declined being interviewed, and at times, one of the participants was embarrassed about reporting aspects of her life. Therefore, it is proposed that further research on the topic be conducted with a larger sample in order to better characterize the therapeutic itineraries of women using alcohol and/or drugs in the pregnancy-postpartum cycle, in addition to their perceptions.

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