









Between invisibility and stigma: consumption of psychoactive substances among pregnant and postpartum women at three Argentine general hospitals



Entre la invisibilidad y el estigma: consumo de sustancias psicoactivas en mujeres embarazadas y puérperas de tres hospitales generales de Argentina



Manuelita Diez¹, María Pía Pawlowicz², Florencia Vissicchio³, Roxana Amendolaro⁴, Julia Carina Barla⁵, Analía Muñiz⁶, Leonardo Arrúa⁷

¹**Corresponding author.** Undergraduate degree in Psychology. Intern, Intercambios Asociación Civil, Ciudad Autónoma de Buenos Aires, Argentina.  


²Master's degree in Health and Social Sciences. Research area coordinator, Intercambios Asociación Civil, Ciudad Autónoma de Buenos Aires, Argentina.  

³Undergraduate degree in Psychology. Intern, Intercambios Asociación Civil, Ciudad Autónoma de Buenos Aires, Argentina.  

⁴Specialist Degree in Public Policies and Gender Justice. Intern, Gender Department, Municipio de Bariloche, Río Negro, Argentina.  

⁵Undergraduate degree in Psychology. Head of Mental Health Service, Hospital Felipe Heras, Concordia, Entre Ríos, Argentina.  

⁶Undergraduate degree in Social Work. Social worker, Hospital Dr. Alberto Balestrini, La Matanza, Buenos Aires, Argentina.  

⁷Undergraduate degree in Social Work. Social worker, Hospital Dr. Alberto Balestrini, La Matanza, Buenos Aires, Argentina.  

ABSTRACT The problematic consumption of legal and illegal substances in pregnant and postpartum women is a growing socio-sanitary concern that has infrequently been studied from a gender perspective. This article presents the results of a multi-center, cross sectional study employing a mixed qualitative-quantitative approach that was conducted between May 2018 and June 2019. The aim of this research was to describe the patterns of psychoactive substance use as well as access to healthcare services among pregnant and postpartum women. Semi-structured interviews were conducted with a purposive sample of 62 women attending Bariloche, Concordia, and La Matanza General Hospitals. Results showed evidence of the taboo associated with psychoactive substance use among pregnant and postpartum women, the discrimination that these women experience in healthcare services, and their lack of material support, which makes it difficult for them to take care of themselves.

KEY WORDS Substances Related Disorders; Pregnancy; Postpartum Period; Mental Health; Argentina.

RESUMEN El consumo problemático de sustancias legales e ilegales en las mujeres embarazadas y puérperas es un tema de creciente preocupación sociosanitaria, que ha sido escasamente estudiado desde una perspectiva de género. Este artículo presenta los resultados obtenidos a partir de un estudio multicéntrico cualicuantitativo y transversal llevado a cabo entre mayo 2018 y junio 2019. El objetivo fue describir los patrones y representaciones del consumo de sustancias psicoactivas, así como el acceso a la atención en mujeres embarazadas y puérperas. La muestra fue intencional, conformada por 62 mujeres que asistían a hospitales generales de Bariloche, Concordia y La Matanza, que participaron de entrevistas semiestructuradas. Entre los resultados se destaca el tabú asociado a los consumos de sustancias psicoactivas en mujeres embarazadas y lactantes, la discriminación que estas mujeres experimentan en los servicios de salud y la falta de apoyo material que enfrentan las mujeres a la hora de realizar las tareas de cuidado, lo cual limita para ellas la posibilidad de cuidar de sí mismas.

PALABRAS CLAVES Trastornos Relacionados con Sustancias; Embarazo; Período Posparto; Salud Mental; Argentina.

INTRODUCTION

Epidemiological situation

Problematic substance consumption in pregnant and postpartum women is a growing socio-sanitary concern for a number of reasons, among them the increase in consumption in this population, the social stigma that falls upon drug-using mothers and the lack of orientation that health teams report regarding how to handle such situations.

This phenomenon has installed itself as a problem around the world. Recent data from international organizations highlight that drug consumption patterns are changing: not only is the gender gap associated with drug use closing in many countries, but also drug consumption appears to be commencing at increasingly early ages.^(1,2)

In Latin America this same tendency can be observed. Argentina and Uruguay present the highest level of cocaine consumption in the region (1.6%),⁽²⁾ while Chile, Brazil, Colombia and Venezuela display an intermediate range of cocaine use (from 0.5% to 1.1%). Additionally, the difference between women and men is notoriously less in Argentina and Uruguay, with three male consumers for every female consumer, as opposed to countries like Venezuela, where the ratio is eight males for every female, or Columbia and Peru, where it is six males for every female. Women also show a greater nonmedical use of psychopharmacological drugs – such as prescription-controlled sedatives and stimulants, synthetic drugs and opioids – than men.⁽²⁾

According to data from the latest national study on substance consumption in the general population,⁽³⁾ for women between 2010 to 2017 the consumption of any illicit drug increased from 3.6% to 8.3%, with a doubling of cannabis use (4.7% to 13.9%) and a threefold increase in the use of cocaine (0.8% to 2.6%), hallucinogens (0.4% to 1.5%) and ecstasy (0.3% a 1.1%).

Nevertheless, information regarding drug use in pregnant and postpartum women is

scarce and centers primarily on the consumption of legal substances, such as alcohol and tobacco, and not illegal substances. In a study carried out in Uruguay and Argentina,⁽⁴⁾ nearly half of the 1,512 pregnant women who had a prenatal appointment at one of 12 public hospitals had been or were at the time smokers (44% in Argentina y 53% in Uruguay). During pregnancy, 11% of the women from Argentina and 18% from Uruguay continued smoking.

A research team from the National Scientific and Technical Research Council [*Consejo Nacional de Investigaciones Científicas y Técnicas*] (CONICET) based at the Universidad Nacional de Mar del Plata has published a number of articles regarding health issues resulting from alcohol consumption in gestating women and women of reproductive age.⁽⁵⁾ One study carried out in Santa Fe⁽⁶⁾ showed that 75% of the 614 women interviewed in two prenatal centers reported having consumed alcohol during pregnancy, 15% reported having had at least one episode of excessive consumption (five or more drinks) during pregnancy and 27.6% had had such an episode in the year prior to pregnancy. The omission of pregnant women in the construction of statistics and data is another important aspect of this problem. In the nationwide study carried out by Argentina's National Secretariat of Integrated Drug Policy [*Secretaría de Políticas Integrales sobre Drogas de la Nación Argentina*] (SEDRONAR) in 2013, the data pulled from emergency rooms at 24 public hospitals in the county excluded "all women who had obstetric or maternity-related consultations," and therefore does not offer data regarding this population.⁽⁷⁾ Such invisibility increases the vulnerability of these women, inaugurating a vicious cycle.⁽⁸⁾

Processes of stigmatization, invisibility and vulnerability

To this interaction between invisibility and vulnerability, the literature adds the issue of

stigmatization, as drug use is one of the areas of social life most subject to prejudice.^(9,10) The processes of stigmatization are manifested as hostile attitudes towards a person who belongs to a certain group solely because they belong to that group, due to the negative qualities attributed to it.⁽¹¹⁾ These attitudes are constructed through social representations, that is, a series of beliefs and practical knowledge that are socially constructed and intersubjectively shared. Faced with the fear of being judged, stigmatized and rejected, women hide their consumption and internalize the negative vision that society has of them, often showing low self-esteem.⁽¹²⁾

Socialized within a patriarchy, women who use substances diverge from the expectations surrounding their role as women, protective and submissive mothers who live for others. For this reason they are rejected and doubly stigmatized: for breaking with the constructed and idealized model of “female identity” that was socially assigned to them^(13,14,15) and for being drug consumers. If women also use illegal drugs, the rejection is greater due to the illegality of the substances⁽¹⁶⁾ and they become the object of moral and social penalization for their transgression.^(17,18)

Added to this, the majority of studies continue to omit a gender perspective as fundamental in the analysis of the problem,⁽¹⁹⁾ and existing data therefore centers more on the effects that consumption has on the women’s families and those close to them than on the women themselves, proposing linear associations that do not incorporate the sociohistorical conditions of complex problems.⁽²⁰⁾ Such theoretical and methodological approaches to the phenomenon preclude analyses of the patriarchal mandates regarding “care of others” before “care of oneself” among women. As Setién and Parga⁽²¹⁾ highlight, there are “biopolitical strategies for rechanneling the ‘divergences’ of women,” that exert control over their bodies, desires and practices. One of these strategies is the hypervisibilization of drug users who are pregnant and the consequent stigmatization of their practices according to the moral categories of “good” or

“bad” mother. Another important aspect to highlight here is the problematic conceptualization of maternity as a natural, instinctive and generalizable experience, as this is not biological fact but rather a social construction.⁽²²⁾ Perceptions and representations of maternity vary according to generation, place of origin and place of socialization.^(23,24)

Omitting a gender perspective additionally implies that the patterns of drug use are explained from an andocentric perspective.⁽²⁵⁾ Romo Avilés and Camarotti⁽¹³⁾ maintain that although cocaine base paste is a substance with serious effects given its toxicity and the manner and context of its consumption, female users show a need to “construct gender” through concern with their appearance, the effects on their bodies and/or maternity, demonstrating how gender is performative in their actions. According to the authors, “they adopt a masculine world and within it incorporate feminine strategies to face the double rejection they experience.”⁽¹³⁾

In research examining the social representations of consumption, a tendency can be observed, in accordance with the punitive paradigm, to highlight primarily the problematic aspects of substance use, that is, when use negatively affects physical or mental health, family and social relations, work/school, or relations with the law,⁽²⁶⁾ leaving out recreational or religious uses that encompass different meanings and benefits for people as well as the dimension of pleasure that this practice can provide. Indeed, substance use, in addition of being part of the social practices of cohabiting groups, are ascribed meaning in different ways according to, among other dimensions, the social group one belongs to, one’s generation, gender position and social class, as well as the particular configuration of meaning in certain spaces and moments in time.

Specificities of health care strategies

These gender constructions also structure the care strategies surrounding women’s health issues. As Menéndez suggests,⁽²⁷⁾ studying

access to health means looking at not only the formal care system but also the self-care strategies that people and communities implement to care for health. These practices include the range of representations and actions that a population uses autonomously to diagnose, explain and attend to processes that affect health without the direct and intentional intervention of professional healers.⁽²⁷⁾ Accessibility has been defined as the most desirable end of the spectrum of entering into and accessing health services, while barriers represent the least desirable end of the spectrum.⁽²⁸⁾ Some of the diverse dimensions considered in the discussion of the accessibility of health systems include: organizational dimensions, related to bureaucratic-administrative aspects; geographic dimensions, related to the distance that must be traveled to reach the institution; economic dimensions, related to the costs of the services themselves; and cultural dimensions, related to the habits, practices, attitudes and beliefs of health workers and the users of health services.⁽²⁹⁾

Therefore, when the material possibility of women to access and sustain treatment is analyzed, various dimensions must be considered. Traditionally, women have been assigned responsibility for domestic tasks and care of dependent others and at the same time have less social support. This makes starting and continuing treatment difficult, given that doing so means delaying responsibilities assigned to their gender role.⁽³⁰⁾ Furthermore, constructions such as romantic love undermine treatment continuity, given that when threatened with the possibility of their partners leaving them during the process, they prefer not to consult.^(31,32) It is evident that the use of psychoactive substances in women has particular social and family costs different from those faced by men.⁽¹⁶⁾

In using the aforementioned dimensions to examine the issue, two extremes become apparent, that seem opposed but the results of which are the same for the population under study. Both statistical studies and those that propose therapeutic strategies regarding the use of psychoactive substances in pregnant and postpartum women oscillate

between two possibilities: rendering such women invisible, excluding them from data and treatments; or approaching them without recognizing the specificities that their subordinate social role places on the forms of consumption of women who are pregnant and/or mothers, and the prejudices and stigmas that fall upon them.

From this perspective, the general aim of the study upon which this article is based was to describe the patterns of consumption of psychoactive substances, the access to care, and the social determinants of health in pregnant and postpartum women. The work of this article is structured around the following questions: What particularities are there in the use of alcohol, tobacco, cannabis and cocaine among pregnant and postpartum women? What are the social representations regarding substance use and the care strategies of women who consume psychoactive substances during pregnancy, childbirth and postpartum?

METHODOLOGY

This study is exploratory-descriptive, multi-center, qualitative-quantitative and cross-sectional. It was carried out between May 2018 and June 2019, with funding from the grants *Salud Investiga* of the Research Area of the Argentina's National Ministry of Health and Social Development. The hospitals included in the study were Hospital Zonal Dr. Ramón Carrillo, in San Carlos de Bariloche, Río Negro; Hospital Felipe Heras, in Concordia, Entre Ríos; and Hospital Dr. Alberto Balestrini, in La Matanza, Buenos Aires.

The choice of institutions was subject to criteria of accessibility and feasibility. However, to ensure a richer set of data, the sample was homogenous in terms of the type of health care provider (general provincial hospitals) and yet heterogeneous in including different regions of the country.

The research team was made up of the study coordinator and seven psychology and social work professionals with experience in the subject at a clinical and research level.

The sample was non-probabilistic, intentional and homogenous, made up of 62 women over the age of 18 who had consumed any psychoactive substance during pregnancy and/or postpartum, who had received care at the participating hospitals and who agreed to sign the informed consent. The fieldwork took place between July 2018 and January 2019, as established by the timetable approved by the funder.

Semi-structured interviews were carried out, during which the same instrument was applied in all three institutions. The instrument contained both open- and closed-ended questions taken from modules of previously validated instruments. Although consolidating modules from a number of other instruments resulted in a rather lengthy instrument for our study, using tools validated by international organizations such as the Pan American Health Organization (PAHO) or by national government agencies offered the advantage of providing us with interpretational parameters based on studies showing the distribution of these same indicators at different scales.

The interviews were organized into the following sections:

- a. *Socio-demographic data*: Closed-ended questions regarding the interviewee's age, place of residence, educational level, living situation with respect to cohabitants, and drug use practices.
- b. *Current and prior pregnancies*: questions regarding the planned or unplanned nature of the pregnancy, the existence of obstetric check-ups, and the establishments where care for the pregnancy was received.
- c. *Postpartum and infant feeding*: questions regarding infant feeding practices, including both exclusive breastfeeding and mixed feeding, as well as other food sources.
- d. *Health problems*: questions regarding the existence of any of the following diseases: syphilis, congenital syphilis, HIV-AIDS, tuberculosis and STDs, and the care practices implemented in relation to the interviewee's own health. Both this category and the prior one used as reference the questions from the national Perinatal Information System.
- e. *Substance consumption*: the World Health Organization's ASSIST (alcohol, smoking, substance involvement screening test)^(33,34) was applied.
- f. *Gender violence*: the questions were based in the National Study on Violence Against Women of the National Ministry of Justice and Human Rights,⁽³⁵⁾ which looks into gender violence experienced throughout the lifespan and in the last year, as well as the perpetrator of the violence.
- g. *Social support*: questions regarding the number of close friends or other people with whom the interviewee is able to talk about her problems, using an adapted version of the questionnaire from the Medical Outcomes Study Social Support Survey (MOS-SSS).⁽³⁶⁾ The indexes used came from Revilla *et al.*⁽³⁷⁾ and were validated in Argentina by Rodríguez Espínola and Enrique.⁽³⁸⁾
- h. *Representations regarding substance use*: a series of statements created by the research team reflecting beliefs regarding the dangerousness of different drugs and their possible health consequences, to which interviewees expressed their degree of agreement.
- i. *Accessibility*: a list of possible barriers and difficulties in accessing health services was created, with fixed ordinal responses defined based on the results of a study regarding accessibility of public health services for drug users in Buenos Aires and Rosario.⁽²⁹⁾
- j. *Employment situation*: the questions of this section were based on the third National Survey on Risk Factors for Non-Communicable Diseases.⁽³⁹⁾

The main variables were selected based on a process of operationalization of the study dimensions and a critical analysis of the advantages and disadvantages of using certain empirical definitions, stemming from a review of the indicators utilized in validated instruments for which there was also epidemiological data for Argentina available for comparison. Therefore, the primary variables studied for the unit of analysis "pregnant and postpartum women" were: age; gestational age of child; consumption of legal or illegal

psychoactive substances; representations, information and experiences of pregnancy, birth and the postpartum period; family configuration; educational level; employment situation; social support networks; access to health care; and strategies of self-care.

The open-ended questions that sought to collect the interviewees' account of the age and mode of their initiation into consumption, the effects sought and/or their concerns regarding their experiences of consumption were entirely formulated by the research team. The criteria used in choosing these questions were their relevance for the stated research aims, the recommendations offered by the five intervening ethics committees and the overall duration of the interview.

The way in which the semi-structured interviews were carried out showed particularities in each location according to the form of access. In Bariloche, meetings in which the project was presented were carried out for different key actors who then provided contact with the women. In Concordia, given that the Hospital Dr. Felipe Heras did not have a maternity and obstetrics ward, women seen at the Hospital General de Agudos Masvemat were also included. In La Matanza, contact was established with different areas of the hospital as well as with shelters and group homes and a program of the Rights Protection System [*Sistema de Protección de Derechos*] of La Matanza. The interviews were scheduled at days and times that generated a space of confidentiality. Notes were taken of everything the women expressed, although the only interviews recorded were those carried out in La Matanza, as per the decision of the interviewers and with the express oral and written consent of the women. The study was approved by the authorities of each hospital and the research project was evaluated and approved by all the hospital and provincial Ethics Committees. Intercambios Asociación Civil was the coordinating institution.

For the analysis of quantitative data the program Statistical Package for the Social Sciences (SPSS) was used. Data was triangulated with qualitative analysis, using the corpus of textual material that was segmented and

coded in order to perform content analysis based on the recognition of regularities and identified patterns. The process then combined the criteria deriving in the central categories of the study, included in the specific aims, and the criteria for constructing emerging codes of meaning that unfolded from the qualitative empirical material.

RESULTS

The research results are organized into four parts: the first is a brief description of the women who participated in the study; the second refers to consumption practices; the third examines social representations regarding substance use and maternity, as well as the women's experiences of discrimination; and the fourth presents the results related to health services accessibility and strategies of self-care.

Characteristics of the sample: Who were the women interviewed?

Sixty-two women from La Matanza, Concordia and Bariloche were interviewed, of which 24 were pregnant and 38 were postpartum, 48 were aged 18-29 years and 14 aged 30-39 years. In relation to educational level, 6 women had started or completed primary school, while 42 had started or completed secondary school and 4 had started or completed tertiary or university education (Table 1).

Regarding their living situation, 57 of the women interviewed lived with others (family members or friends), of which 32 lived in nuclear families and 25 in extended or blended families. Only 3 lived alone and another 2 were homeless.

Regarding their employment situation, 12 women were economically inactive (they did not have nor were they seeking employment), 24 were unemployed (they did not have formal nor informal work but were seeking employment), 24 had worked the week

prior to the interview, and 2 women did not explain their employment situation (Table 1).

Of the 24 women who had worked the week prior to the interview, only 3 were formally employed, while the rest had informal jobs: 10 worked odd jobs (primarily in jobs associated with care provision), 8 were self-employed in their own businesses without other employees and 3 were sex workers (Table 1).

Of the women interviewed, 33 were within the 90-day period stipulated for legal maternity leave: 4 were in the last four weeks of pregnancy and 29 were in the postpartum period with children up to two months of age. However, of these 33 women, only 6 were actually able to access maternity leave: 3 legally as workers with formal employment and 3 others as part of an agreement in their informal employment. It is worth highlighting that of the 41 women who received State subsidies, 35 received the Universal Allocation per Child [*Asignación Universal por Hijo*], 4 received "other plans" and only one was receiving unemployment insurance (Table 1).

The networks of belonging and social support the women have could be a protection factor, understood as the set of contextual resources that favor well-being and protect people from the adversities of the environment.⁽³⁹⁾ Table 2 shows the values obtained for different dimensions of social support; it can be observed that the greater levels of social support are found in the affective sphere ("someone who shows you love and affection," "someone to love and make you feel wanted"). Nevertheless, the interviewees received less material support in activities that require active assistance: 12 women a little or none of the time had someone to help them with daily chores if they were sick and 10 did not have someone who could take them to the doctor if they needed it. Emotional support ("someone to share your most private worries and fears with") had the lowest level of all. For example, 12 women stated having someone like that "a little or none of the time." Some interviewees, although stating that they had support all or most of the time, then mentioned that they did not actually

Table 1. Number and percentage distribution of interviewed pregnant and postpartum women (N=62), according to socioeconomic variables. Cities of Bariloche, Concordia and La Matanza, Argentina, 2018-2019.

Variables	n	%
<i>Condition</i>		
Pregnant	24	38.7
Postpartum	38	61.3
<i>Age range</i>		
18 to 29 years	48	77.4
30 to 39 years	14	22.6
<i>Educational level</i>		
Incomplete/complete primary	16	25.8
Incomplete/complete secondary	42	67.7
Incomplete/complete tertiary or university	4	6.5
<i>Type of living situation</i>		
Nuclear family	32	51.6
Extended or blended family	25	40.3
Living alone	3	4.9
Homeless	2	3.2
<i>Employment situation</i>		
Inactive	12	19.4
Unemployed	24	38.7
Formally employed	3	4.8
Informally employed (odd jobs)	10	16.2
Informally employed (self-employed)	8	12.9
Informally employed (sex work)	3	4.8
No information	2	3.2
<i>Condition of maternity leave</i>		
<i>Within mandated leave period¹</i>		
Formally employed	3	9.1
Agreement in informal employment	3	9.1
No leave	27	81.8
Not within mandated leave period	29	46.7
<i>Receipt of government subsidies</i>		
No subsidies	21	33.9
Universal Allocation per Child	35	56.5
Unemployment insurance	1	1.6
Others	5	8.0

Source: Own elaboration.

¹Of the 33 women within the period of legally mandated maternity leave, 4 were in the last four weeks of pregnancy and 29 had children up to two months of age.

go to these people to share their fears or personal problems. Therefore, although there appears to be a high level of social support, when the support is disaggregated into particular dimensions imbalances can be seen, and the answers seem to highlight that support in domestic and care activities is less than emotional, affective or recreational support. With respect to the index of social support among the women interviewed, 43 had a high overall

level of social support, 9 had a medium level of support and 10 had a low level.

Patterns of consumption: diversity in the use of psychoactive substances

Data regarding the women’s of use of alcohol, tobacco, cannabis and cocaine is organized according to the state of the women at the time of the interview: pregnant, breastfeeding postpartum, and postpartum without breastfeeding (Table 3).

In the group of 24 pregnant women it can be seen that, throughout their lives, 22 had at one time consumed alcohol and 21 tobacco; additionally, 10 had used cannabis and 9 cocaine. In this same group, in the three months prior to the interview, 19 continued to smoke and 16 to drink alcohol. Regarding the use of illegal substances, 7 had used cannabis and 8 cocaine. Therefore, the primary substances consumed in this group were alcohol and tobacco.

Among the 33 women breastfeeding postpartum, it was observed that all had had alcohol at least once in their lives and 30 had

smoked tobacco; in addition, 24 had used cannabis and 16 cocaine. On the other hand, in the last three months, among these same women, 17 had consumed tobacco, another 17 alcohol, 7 cannabis and 6 cocaine. Among these same women, 31 had used a substance during pregnancy, 24 had smoked tobacco daily throughout the pregnancy, and 24 had consumed alcohol. Regarding the use of illegal substances, 15 had smoked marijuana and 11 had used cocaine (Table 3).

Lastly, among the 5 postpartum women who were not breastfeeding (Table 3), all reported having drunk alcohol at least once, while 3 had used cocaine and 2 cannabis. In the past three months all had consumed tobacco and 2 alcohol. All 5 had smoked tobacco during the pregnancy while 2 had drunk alcohol and 2 had taken cocaine.

Based on this data, in the groups of pregnant and postpartum women (both breastfeeding and not), for lifetime use as well as use in the last three months and during pregnancy, the largest consumption was of tobacco and alcohol, which coincides with the National Study on the Consumption of Psychoactive Substances.⁽³⁾

Table 2. Number and percentage distribution of responses of interviewed pregnant and postpartum women according to dimensions of social support (N=62). Cities of Bariloche, Concordia and La Matanza, Argentina, 2018-2019.

Dimensions of social support	All or most of the time		Some of the time		A little or none of the time		No response	
	n	%	n	%	n	%	n	%
Someone who shows you love and affection	52	83.9	6	9.6	4	6.5	0	0.0
Someone to love and make you feel wanted	51	82.3	3	4.8	7	11.3	1	1.6
Someone to take you to the doctor if you needed it	50	80.7	2	3.2	10	16.1	0	0.0
Someone you can count on to listen to you when you need to talk	48	77.4	5	8.1	9	14.5	0	0.0
Someone to help you if you were confined to bed	46	74.2	7	11.3	9	14.5	0	0.0
Someone to turn to for suggestions about how to deal with a personal problem	46	74.2	9	14.5	7	11.3	0	0.0
Someone to do things with to help you get your mind off things	46	74.2	8	12.9	8	12.9	0	0.0
Someone to give you information to help you understand a situation	44	71.0	11	17.7	6	9.7	1	1.6
Someone to have a good time with	44	71.0	6	9.7	12	19.3	0	0.0
Someone to share your most private worries and fears with	40	64.5	12	19.4	10	16.1	0	0.0
Someone to help with daily chores if you were sick	39	62.9	11	17.7	12	19.4	0	0.0

Source: Own elaboration based on the validation of the MOS social support survey by Revilla et al.⁽³⁷⁾ validated for Argentina by Rodríguez Espínola and Enrique.⁽³⁸⁾

Table 3. Number and percentage distribution of interviewed women pregnant, breastfeeding postpartum and postpartum without breastfeeding (N=62), according to period of use and type of substance. Cities of Bariloche, Concordia and La Matanza, Argentina, 2018-2019.

Substance use	Pregnant (n=24)		Breastfeeding postpartum (n=33)		Postpartum without breastfeeding (n=5)		Total (n=62)	
	n	%	n	%	n	%	n	%
<i>Used at least once in their lifetime</i>								
Tobacco	22	35.5	30	48.4	5	8.1	57	91.9
Alcohol	21	33.9	33	53.2	3	4.8	57	91.9
Cannabis	10	16.1	24	38.7	2	3.2	36	58.1
Cocaine	9	14.5	16	25.8	3	4.8	28	45.2
<i>Used in the past three months</i>								
Tobacco	19	30.6	17	27.4	5	8.1	41	66.1
Alcohol	16	25.8	17	27.4	2	3.2	35	56.5
Cannabis	7	11.3	7	11.3	0	0.0	14	22.6
Cocaine	8	12.9	6	9.7	2	3.2	16	25.8
<i>Used during pregnancy</i>								
Tobacco	19	30.6	24	38.7	5	8.1	48	77.4
Alcohol	16	25.8	24	38.7	2	3.2	42	67.7
Cannabis	7	11.3	15	24.2	1	1.6	23	37.1
Cocaine	8	12.9	11	17.7	3	4.8	22	35.5

Fuente: Elaboración propia con base en la prueba ASSIST (alcohol, smoking, substance involvement screening test)^(33,34)

One known factor associated with consumption patterns is living on a day to day basis with other people who use drugs. Of the 44 women who provided information regarding the substance use of the other people with whom they lived, the substances were distributed in the following way (categories are not mutually exclusive): 36 alcohol, 29 tobacco, 9 cannabis, 5 cocaine base paste and 4 cocaine. Additionally, of the 13 women who had a partner at the time of the interview but did not live with them, 8 reported that their partner was a substance user (Table 4).

With relation to the meanings that the women attribute to substance use – and in particular to their first experiences – the large majority of the women reported having used them in the company of friends, in recreational situations. Some of the contexts of initiation mentioned were nighttime outings, concerts and parties. Some women also reported that drugs helped them disconnect from problematic situations.

Among the concerns the women experienced due to substance use during pregnancy,

many mentioned the consequences their consumption could have on the physical health of their unborn children and, to a lesser degree, the fear that the consumption could cause their children to be born prematurely.

It should be highlighted that the interviewees discussed the pleasure of consumption, mentioning the feeling of calm and relaxation the substances offered and the attention they receive from those around them when consuming. Only one of the interviewees reported that nothing about consumption provided them with pleasure.

I like to smoke tobacco because it takes the stress away, marijuana relaxes me. (29 years of age, postpartum, La Matanza)

When I'd go out, everyone would drink... It's fun. (19 years of age, postpartum, Concordia)

Cigarettes calm me down. Alcohol makes things fun. (24 years of age, pregnant, Bariloche)

Table 4. Number and percentage distribution of interviewed pregnant and postpartum women (N=62) according to cohabitants' use and type of substance and partner situation. Cities of Bariloche, Concordia and La Matanza, Argentina, 2018-2019.

Variables	n	%
<i>Substance use among cohabitants</i>		
Does not live with other people who use substances	14	22.6
Lives with other people who use substances	45	72.6
No information	3	4.8
<i>Substances used by cohabitants¹</i>		
Alcohol	36	81.8
Tobacco	29	65.9
Cannabis	9	20.5
Cocaine base paste	5	11.4
Cocaine	4	9.1
<i>Partner situation</i>		
No partner	22	35.5
Non-cohabiting partner	13	20.9
Cohabiting partner	27	43.6

Source: Own elaboration.

¹Responses to non-exclusive categories from 44 women.

Social representations and discrimination: the stigma of “mothers who use”

The women interviewed mostly subscribed to representations that imply negative value judgments of women who, as mothers, use psychoactive substances. The fact that the interviewees subscribe to such representations results in a negative valuing of themselves (expressed through guilt and self-reproach) and in the fears of being reported to the authorities, of not receiving health care and of being discriminated against (punishment). In relation to this last aspect, 32 interviewees reported having felt discriminated against at some point in their lives. The places most reported as sites of discrimination were: health establishments, in general society (on the street, in their neighborhood or at hang out spots), educational institutions, at the workplace and within the family (Table 5).

In the places mentioned, the women indicated that they had been treated differently and negatively due to their personal characteristics. ⁽⁴⁰⁾ Most reported was discrimination related to the socioeconomic category of poverty, ⁽⁴⁰⁾

which includes not only unemployed women but those who are underemployed.

[I felt discriminated against by] a *doctor that told me that he did not treat “negros”* [a term used derogatorily to denote poor people in general, only somewhat related to skin color] ... *I asked to be seen by someone else and then I was given good care.* (23 years of age, postpartum, Bariloche)

Because of my skin [scabies infection]... and because I work with the trash... (19 years of age, postpartum, Concordia)

Because of the drugs, because I'm a single mother, because I had to sell myself to feed my kids. (18 years of age, pregnant, Concordia)

Other characteristics for which the women mentioned having been discriminated against included age, features of their phenotype such as skin color, and immigration status.

[I was discriminated against] *because I was under age, I had to do more tests than other women when I had my first*

Table 5. Number and percentage distribution of interviewed pregnant and postpartum women (N=62), according to experiences of discrimination. Cities of Bariloche, Concordia and La Matanza, Argentina, 2018-2019.

Experiences of discrimination	n	%
<i>Has ever felt discriminated against</i>		
Yes	32	51.6
No	29	46.8
No information	1	1.6
<i>Place where discrimination was felt¹</i>		
In health establishments	11	34.4
“On the street. in the neighborhood or at hang out spots”	10	31.2
In educational institutions	7	21.9
In the workplace	3	9.4
In the family	3	9.4

Source: Own elaboration.

¹Responses to non-exclusive categories from 32 women.

kid in the Hospital Piñero. (26 years of age, postpartum, La Matanza)

Since I didn't have an Argentine identity number, during the birth they said to me "these immigrants." (39 years of age, postpartum, La Matanza)

I felt humiliated because of how I look, I'm treated badly because my skin is dark. (34 years of age, postpartum, Bariloche)

Gender discrimination was also highlighted by the women. This refers to all constructions that assign certain roles and sociocultural attributes based on biological sex and transform sexual difference into social inequality.⁽⁴⁰⁾

They always treat me badly for being young and having a lot of kids. (26 years of age, pregnant, La Matanza)

When the manager heard I was pregnant he said, "What, am I supposed to congratulate you?" And being 8 months pregnant they didn't take into account that I needed to be doing less stressful activities. (32 years of age, postpartum, Bariloche)

Because I take drugs, they called me a whore, a drug addict. (23 years of age, pregnant, Concordia)

Some women reported haven been victims of derogatory treatment on the part of health care staff for the double condition of being pregnant or postpartum and being a drug user.

They treated me badly for taking drugs and being the mother of a premature baby. (26 years of age, postpartum, La Matanza)

Because I didn't get (prenatal) check-ups, in the hospital all the doctors treat me badly. (18 years old, postpartum, Concordia)

Nevertheless, it should be highlighted that although 50 women responded that they "agree/totally agree" with the statement "pregnant women often hide their substance use out of fear of being judged and discriminated against," 31 said they "agree/totally agree" with the statement "pregnant women often hide their substance use out of fear of not receiving health care" (Table 6). In this way, it can be inferred that often the situation of discrimination is obscured by the concealing of drug use.

In relation to way the women were treated by the health agents upon receiving care for the pregnancy, birth and postpartum periods, some women reported haven been victims not only of discrimination but also of obstetric violence. Their accounts include a certain naturalization of the situation, especially lack of access to and comprehension of relevant information, insufficient accompaniment, little consideration of the unique life experience they were going through, and unnecessary prolongation of pain, among others. Some women expressed "waiting until the last moment," that is, the birth, to go to the hospital in order avoid mistreatment, and several women had not had prenatal check-ups. Other women spoke of a certain degree of insensitivity on the part of the health agents regarding their pain. They gave accounts of a variety of different situations of distress and disorientation in which they did not understand what was happening in procedures such as a miscarriage or stillbirth, or in situations in which they considered that they had been unable to make decisions about the type of birth, in violation of their rights.

Health care strategies

In this same vein of the women's relationship to health services, this section presents the results regarding accessibility, the details of which can be seen in Table 7. It can be highlighted that 43 women stated that they always or almost always had to "wait a long time to be seen," which is one of the largest organizational barriers to access. In this same

Table 6. Number and percentage distribution of the responses of interviewed pregnant and postpartum women (N=62), regarding representations of substance use. Cities of Bariloche, Concordia and La Matanza, Argentina, 2018-2019.

Representations regarding substance use	Totally agree/Agree		Somewhat agree		Disagree/Totally disagree		No response	
	n	%	n	%	n	%	n	%
It is often more looked down upon that a mother use drugs than that a father do so	54	87.1	4	6.5	4	6.4	0	0.0
Pregnant women often hide their substance use out of fear of being judged and discriminated against	50	80.7	1	1.6	9	14.5	2	3.2
Pregnant women often hide their substance use out of fear of being reported to the authorities	49	79.1	5	8.1	8	12.8	0	0.0
People often think that you are a bad mother if you use drugs when you are pregnant. breastfeeding or have a baby	48	77.4	10	16.1	4	6.5	0	0.0
Pregnant women often hide their substance use out of fear of losing their children	47	75.8	4	6.5	11	17.7	0	0.0
Pregnant women often hide their substance use due to feelings of shame and guilt	43	69.3	8	12.9	11	17.8	0	0.0
A woman who uses drugs is often seen as a bad mother	41	66.1	9	14.6	11	17.7	1	1.6
People often believe that pregnant women who consume base paste are harming their health more than those who consume cocaine	40	64.5	4	6.5	16	25.8	2	3.2
Drinking alcohol in small quantities does not affect the pregnancy	32	51.6	10	16.1	19	30.7	1	1.6
Pregnant women often hide their substance use out of fear of not receiving care in the health system	31	50.0	6	9.7	24	38.7	1	1.6
When you're high you forget to use a condom	31	50.0	8	12.9	19	30.6	4	6.5
People often think that smoking tobacco during pregnancy is less harmful than smoking marijuana	26	41.9	12	19.4	24	38.7	0	0.0
Smoking does not affect the pregnancy	22	35.5	4	6.5	34	54.8	2	3.2
Consuming psychopharmacological drugs isn't as bad as consuming other drugs	14	22.6	16	25.8	32	51.6	0	0.0

Source: Own elaboration.

category the women mentioned a lack of available appointments, that *"the next available appointment is a long time from now,"* and the *"few options available for appointment times."* Among the cultural or symbolic barriers to access, the primary difficulty for these women was that the health professional did not sufficiently explain things to them.

In accordance with this, when asking the women what they did to quit using (whether or not the attempt was successful), accessing more professional resources from the formal health system was infrequent. Out of the 61 women, only 5 mentioned having started psychiatric or psychological treatment.

Table 8 shows the other care strategies the pregnant and postpartum women mentioned, related mainly with self-care. Among

the women interviewed, 59 responded that they took on one or more individual practices to regulate use: *"I decided to quit," "I stopped buying," "I tried to cut back on the amount," "I left the group I consumed with," "I tried to quit but wasn't able to," "I hung out with friends," "I looked to my partner for support," "I didn't see a problem with my substance use."* To a lesser degree, 21 women (not excluding those who had also tried other strategies) mentioned at least one of the following strategies of self-care involved in substitution of consumption: *"I ate something when I felt like using," "I took medication," "I used an electronic cigarette."*

There were 8 women who related quitting with a life event such as pregnancy and the concerns of others (*"I quit because*

Table 7. Number and percentage distribution of the responses of interviewed pregnant and postpartum women (N=62), regarding dimensions of health services accessibility. Cities of Bariloche, Concordia and La Matanza, Argentina, 2018-2019.

Accessibility of health services	Always or almost always		Half of the time		Never or almost never		No response	
	n	%	n	%	n	%	n	%
You must wait a long time to be seen	43	69.4	10	16.1	8	12.9	1	1.6
There are no appointments available	33	53.2	17	27.4	11	17.8	1	1.6
The next available appointment is a long time from now	33	53.2	17	27.4	11	17.8	1	1.6
The health professional spends little time with you	30	48.4	18	29.0	13	21.0	1	1.6
There are few options available for appointment times	29	46.8	11	17.7	21	33.9	1	1.6
The professional does not sufficiently explain what is going on	27	43.6	19	30.6	15	24.2	1	1.6
The hours of the establishment are during times that you cannot go because you have other things to do	18	29.0	13	21.0	30	48.4	1	1.6
The establishment where you receive care is far away	16	25.8	8	12.9	36	58.1	2	3.2
You don't have the money to get there	9	14.5	21	33.9	31	50.0	1	1.6

Source: Own elaboration based on Rossi et al.⁽²⁹⁾

Table 8. Number and percentage distribution of the responses of interviewed pregnant and postpartum women (N=62), regarding the strategies adopted to stop consumption. Cities of Bariloche, Concordia and La Matanza, Argentina, 2018-2019.

Strategies to quit using	n	%
<i>Strategies to regulate consumption</i>		
I decided to quit	48	78.7
I stopped buying	38	62.3
I tried to cut back on the amount	34	55.7
I left the group I consumed with	15	24.6
I tried to quit but wasn't able to	15	24.6
I hung out with friends to distract myself	5	8.2
I looked to my partner for support	5	8.2
I didn't see a problem with my substance use	5	8.2
<i>Strategies of consumption substitution</i>		
I used an electronic cigarette	3	4.9
I took medication	3	4.9
I ate something when I felt like using	20	32.8
<i>Related to a life event or the concerns of others</i>		
I quit for health reasons	11	18.0
I quit because a family member asked me to	7	11.5
<i>Consulting a "specialist"</i>		
I went to the Church	10	16.4
I starting psychiatric or psychological treatment	5	8.2
Others	1	1.6

Source: Own elaboration.

a family member asked me to," "I quit for health reasons"):

I know that smoking during pregnancy is bad. The cigarette packs even say it. When it's for yourself it's harder, but when you are in charge of another life it's different. (26 years of age, pregnant, Bariloche)

I thought that using could kill my baby ... It's an ugly drug. (18 years of age, postpartum, Concordia)

My mom asked me to and I felt like if I didn't quit, she was going to die from seeing me like that. (20 years of age, pregnant, La Matanza)

With this information it can be inferred that, sometimes the largest motivating factors for quitting are becoming responsible for the care of children or at the request of loved ones.

DISCUSSION

In the study that informs this article, it was possible to see, in a small sample of 62

women from three cities, the transformation in the consumption patterns mentioned in the introduction.

The data on substance use showed that in all use categories – at least once in their lifetime, in the last three months and during pregnancy – the most frequently consumed substances were tobacco and alcohol. It was also shown that quitting or cutting back on substance use during pregnancy is a way for women to care for their unborn children or family members, situating themselves more as caregivers than subjects with a right to care.

Another notable aspect was the existence of a strong connection between the substance use of the women and that of those they lived with, showing that when these women had a sexual-affective relationship with a man, their use adjusted to that of their partners. This finding is similar to another study of 150 cocaine users⁽⁴¹⁾ which demonstrated how substance use becomes a form of communication or identification in the partner relationship.

With respect to the level of social support, it was seen that some of the interviewees, despite reporting that they had support all or most of the time, did not go to those people to share their most private fears and problems, and the support diminished in relation to the distribution of household chores and care work. It is worth examining from the perspective of the care economy⁽⁴²⁾ the real extent of the support and networks these women have and how much a certain social ideal regarding gender roles leads them to respond that they have someone who shows them love or someone to love and that makes them feel wanted but don't have the same level of support in terms of someone to help them with their household chores if they are sick or someone to take them to the doctor if they need it, without themselves problematizing the possible contradiction between these two types of responses.

In accordance with the above, the low response regarding material support can be understood in light of the data from the third Survey of Risk Factors⁽⁴³⁾ on unpaid work and time use. The survey showed that certain conditions extended the amount of time that

women dedicated to unpaid care work, including: being of productive age (18-64 years), being spouses, having children under 6 years of age in the home and living in homes with a low income level, characteristics that abound among the women in our study.

Therefore, women's time use is conditioned by the mandate of performing care work, which impedes them from – among other things – visiting health institutions when they need care for themselves. In parallel, performing unpaid work is possible for them only when they reduce the time spent on their own care, rest and enjoyment, which has a negative impact on their quality of life and constitutes another indicator of gender inequity.

In relation to the representations that women attribute to their substance use, some women reported concern regarding the consequences of substance use during pregnancy, others signified substance use as a way to avoid their everyday problems, and a number of them mentioned fun and pleasure. The omission of the dimension of pleasure associated with drug use in both academic studies and the construction of statistics should be questioned. This could be interpreted as an operation of power, a disciplinary device to consolidate gender mandates that, at the same time, equate drugs with trouble. The study of psychoactive substance use in pregnant women and/or mothers⁽⁴⁴⁾ only perpetuates this invisibilized aspect, focusing on the children of these women and assuming that if a psychoactive substance user puts her own pleasure first she is unable to be responsible for the care of another person. From this perspective discourses of guilt and fear are installed, associating the use of drugs only with dependency.⁽⁴⁵⁾

Stigmatizing social representations are also reproduced regarding drug users, identified with social images connoting negative value judgments of women who, as mothers, use psychoactive substances and break with social mandates surrounding being a woman and mother. Therefore, the women in our study state having been discriminated against in different types of places for different reasons, not just due to their socioeconomic

situation, their age or their race, but also for specifically gender-related reasons – such as being pregnant or postpartum drug users – that have on occasion made them feel rejected and humiliated. This could reflect what is known as intersectional discrimination, magnified by multiple oppressions that exacerbate situations of vulnerability, in this case for as women, as indigenous and/or immigrants, as drug users and as poor.

On the other hand, discrimination in health services can stem from the symbolic position that health agents occupy in the microcosm of the medical field,⁽⁴⁶⁾ that is, the power asymmetries established within the health system between professionals and health system users. In particular, in this area, frequently invisibilized situations of obstetric violence were mentioned, that is, dehumanized treatment and abuse of medicalization exercised by health personnel upon the body and reproductive processes of the women.⁽⁴⁷⁾ There were numerous accounts of these types of issues, which are often naturalized even as they push the women out of the health system to forgo timely and informed care during their pregnancy and birth. A gap in the literature regarding the overlap of these types of violence and drug use from a gender perspective can be seen.

The difficulties these women had in accessing health services centered on the fact that they do not fit the androcentric model upon which the health system was designed. However, these barriers are traditionally interpreted by health providers as “little commitment to treatment” on the part of the women, as if the only factor at play were an individual decision. By not incorporating in the approach to the problem the specificities of this population, these women become dangerous and strange others and the subjective asymmetry in the professional-user relationship favors the reification and objectification of this population. They become “objects of care” and from this symbolic place strategies are implemented related to the “good or bad predisposition” of the intervening professionals.

The other side of this situation has to do with other health care strategies put into play

by the women, often ignored in the literature on this subject, related to self-care,⁽⁴⁷⁾ through modifications in both individual and collective regulation of consumption practices. In some cases, as we have shown in other studies,^(48,49) changes in the regulation of these practices are due to the emergence of certain life events.

CONCLUSIONS

Different results converge in one shared experience: how the expectations related to gender roles in some way situate and structure the particularities of the diverse situations that the interviewed women face.

In this way, the rejection towards women who take drugs during pregnancy, childbirth and postpartum can be considered an analyzer through which the idealization of and demands surrounding motherhood that fall upon women are expressed. If the subjectivity of women is socially constructed based on the idea that aspiring to motherhood is one’s life project, guilt and stigmatization is its flipside and appears to manifest itself as the women depart from these models.

The multiple types of violence – gender as well as racial and obstetric – that these women drug users are exposed to intersect with one another and multiply. As a result, the health inequities related to gender disproportionately affect poor, young women from ethnic minorities. In this sense, being a woman, mother and substance user implies multiple positions of social subordination based upon which cultural and symbolic barriers are exacerbated.

In this way, the expectations associated with gender roles and the lack of treatments that take into account their social position conditions these women to hide their consumption and to enact strategies of self-care. At the same time, stigmatization could generate little recognition of a series of individual and collective consumption regulation strategies put in place and of the concealment of consumption that, in turn, makes it difficult to visibilize discrimination processes.

With their practices, health care providers can deepen or revert the inequalities experienced by women when accessing care. In this regard, it is urgent for the programs dealing with problematic consumption to include the perspective of harm and risk reduction. It is necessary for health teams to recognize that there are numerous modes of consumption resulting from the situational interweaving of the subjects, contexts and substances at play.

Finally, it should be highlighted that this study seeks to contribute to the production of

evidence that permits health care providers to approach this issue from a complexity perspective, understanding that offering quality accompaniment for women-mothers-drug users requires understanding the specific problems they face. Only through this recognition will health teams be able to accompany women in the construction of alternatives that allow them to make decisions about their consumption without having to sacrifice their health or their children in the process.

ACKNOWLEDGEMENTS

In particular, we acknowledge the contributions of Diana Rossi, Yamila Abal, Gonzalo Ralón and Graciela Touzé. Our thanks to Gabriela Olivera for suggesting and offering materials related to the subject matter. To those who helped us access the women in the sample: Leonardo Gil, Germán Guaresti, Fernando Tortosa, Daniela Goye, Sara La Spina, Gastón Vera, Carmen Anguita, Felipe de Rosa, Víctor Parodi, Natalia Kertz, Marcos Clausen, Gabriela Letón, Juan Rendo, Susana López Anido, Patricia Franco, Oscar Di Marco, Paula Allan, Carla Padovani, Alejandra Schneebeil, Patricia Fernández, Susana Tomasini, Paula Barberis, Fernanda Ganuza, Victoria Sánchez, Sandra Blasquíz, Miriam Ávila, Lucía Suárez, Betina Biscayart, María Pía Flores, Alfonso Zuñiga, Juan Manuel Cristiani, Lorena Sagaut, Gabriela Roth, Fernanda Díaz, Paula Hofer, Abel Butto, Eugenia Castellano, Julieta Ovin, Melina Quevedo, Celeste Avancini, Javier González and Valeria Hafford. To the intervening ethics committees: *Comisión Municipal de Bioética de La Matanza* (COMUBI), *Comisión Conjunta de Investigaciones en Salud de la provincia de Buenos Aires* (CCIS), *Comité de Ética del Hospital Dr. Ramón Carrillo de Bariloche*, *Comisión Provincial de Evaluación de Proyectos de Investigación en Salud Humana de Río Negro* (CEEPIH) and *Comité de Bioética de Entre Ríos*. To the following departments of the Hospital Zonal Bariloche: Obstetrics, Gynecology, Clinical Medicine, Social Services, Pediatrics, Mental Health,

DAPA (*Departamento de Actividades Programadas para el Área*), Nursing, Clinical Medicine Residencies and General Medicine. To the Municipality of San Carlos de Bariloche, especially the *Secretaría de Desarrollo Humano Integral*, the *Subsecretaría de Coordinación de Políticas Sociales*, the *Dirección de Instituciones* and the *Departamento de Género*. To the *Sistema de Abordaje Territorial del Consejo Provincial de la Mujer, Delegación Zona Andina* (Province of Río Negro).

REFERENCES

1. Oficina de las Naciones Unidas contra la Droga y el Delito. Informe mundial sobre las drogas: Resumen, conclusiones y consecuencias en materia de políticas [Internet]. 2018 [cited 10 Mar 2019]. Available from: <https://tinyurl.com/ya5nbr4b>.
2. Comisión Interamericana para el Control del Abuso de Drogas, Organización de los Estados Americanos. Informe sobre el consumo de drogas en las Américas [Internet]. 2019 [cited 10 Mar 2019]. Available from: <https://tinyurl.com/yywy9g7>.
3. Secretaría de Políticas Integrales sobre Drogas de la Nación Argentina. Estudio nacional en población de 12 a 65 años, sobre consumo de sustancias psicoactivas: Informe de resultados No. 1 [Internet]. 2017 [cited 10 Mar 2019]. Available from: <https://tinyurl.com/y42dfxjr>.

4. Althabe F, Colomar M, Gibbons L, Belizán J, Buekens P. Tabaquismo durante el embarazo en Argentina y Uruguay. *Medicina*. 2008;68(1):48-54.
5. Lichtenberger A, López M, Cremonte M. Intervención breve para promover la abstinencia de consumo de alcohol en mujeres gestantes: Una reflexión crítica. *PSIENCIA, Revista Latinoamericana de Ciencia Psicológica*. 2015;7:428-437. doi: 10.5872/psiencia/7.3.122.
6. López MB, Arán Filippetti V, Cremonte M. Consumo de alcohol antes y durante la gestación en Argentina: prevalencia y factores de riesgo. *Revista Panamericana de Salud Pública*. 2015;37(4/5):211-217.
7. Secretaría de Políticas Integrales sobre Drogas de la Nación Argentina. El uso indebido de drogas y la consulta de emergencia, quinto estudio nacional: Informe final de resultados Argentina 2012 [Internet]. Presidencia de la Nación; 2013 [cited 10 Mar 2019]. Available from: <https://tinyurl.com/y45lwl6n>.
8. Tajer D, Reid GB, Lo Russo A, Cuadra ME, Jeifetz V, Roitenburd F, Ceneri E, Solis M, Salvo I. Equidad de género en la calidad de atención en adolescencia. *Anuario de Investigaciones*. 2015;22:301-308.
9. Rengel D. La construcción social del otro: Estigma, prejuicio e identidad en drogodependientes y enfermos de sida. *Gazeta de Antropología*. 2005;21:1-14.
10. Touzé G, (org.). Saberes y prácticas sobre drogas: el caso de la pasta base de cocaína. Buenos Aires: Intercambios AC, FIUC; 2006.
11. Allport G. The nature of prejudice. Massachusetts: Wesley Publishing; 1979.
12. Quiles MN, Morera MD. El estigma social: la diferencia que nos hace inferiores. In: Morales JF, Huici C, Gómez A, Gaviria E, (coords.). *Método, teoría e investigación en psicología social*. Madrid: Pearson Prentice Hall; 2008. p. 377-399.
13. Romo-Avilés N, Camarotti AC. Haciendo género en un mundo de varones: el consumo de pasta base de cocaína entre las mujeres de la Ciudad de Buenos Aires. *La Aljaba segunda época*. 2015;(19):229-235.
14. Fernández AM. La mujer de la ilusión: Pactos y contratos entre hombres y mujeres. Buenos Aires: Paidós; 1993.
15. Zaldúa G, Sopransi MB, Longo R. Vulnerabilidad, género y prácticas de autonomía. In: Zaldúa G, Bottinelli M, (comps.). *Praxis psicosocial comunitaria en Salud: Campos epistémicos y prácticas participativas*. Buenos Aires: EUDEBA; 2010.
16. Parga J. "Etnografía sobre la equidad de género en la atención del uso problemático de sustancias: un análisis sobre la "adherencia" al tratamiento". [Tesis de Maestría]. La Plata: Facultad Latinoamericana de Ciencias Sociales; 2012.
17. Llorca Suárez A, Ferrando Esquerré S, Borrás Cabacés T, Purroy Aritzeta I. El doble estigma de la mujer consumidora de drogas: estudio cualitativo sobre un grupo de autoapoyo de mujeres con problemas de abuso de sustancias. *Alternativas: Cuadernos de Trabajo Social*. 2013;20:9-22.
18. Tortosa PI. Trayectorias de atención y cuidado en la salud de mujeres en situación de calle en la Ciudad Autónoma de Buenos Aires. [Tesis de Maestría]. Buenos Aires: Universidad Nacional de Lanús; 2015.
19. Romo Avilés N. La mirada del género en el abordaje de los usos y abusos de drogas. *Revista Española de Drogodependencias*. 2010;35(3):269-272.
20. Maffia D. El ocultamiento de las mujeres en el consumo de sustancias psicoactivas. Buenos Aires: Unidad de Seguimiento de Políticas Públicas en Adicciones, Legislatura de la Ciudad Autónoma de Buenos Aires; 2011.
21. Setién L, Parga J. Disciplinamientos y estrategias biopolíticas de control de los cuerpos de mujeres usuarias de sustancias psicoactivas. In: *Horizontes en intervenciones sociales* [Internet]. Buenos Aires: Teso; 2018 [cited 10 Mar 2020]. Available from: <https://tinyurl.com/y4onknuk>.
22. Chodorow N. El ejercicio de la maternidad. Barcelona: Gedisa; 1984.
23. Marcús J. Ser madre en los sectores populares: una aproximación al sentido que las mujeres le otorgan a la maternidad. *Revista Argentina de Sociología*. 2006;4(7):
24. Castilla V, Lorenzo G. Emociones en suspenso: maternidad y consumo de pasta base/paco en barrios marginales de Buenos Aires. *Cuadernos de Antropología Social*. 2012;(36):69-89.
25. Camarotti AC, Romo-Avilés N, Jiménez Bautista F. Vulnerabilidad y prácticas de cuidado en mujeres consumidoras de pasta base del área metropolitana de Buenos Aires. *Acta Psiquiátrica y Psicológica de América Latina*. 2016;62(2):96-107.
26. Touzé G. Prevención del consumo problemático de drogas: Un enfoque educativo. Buenos Aires: Ministerio de Educación, Troquel; 2016.
27. Menéndez E. De sujetos saberes y estructuras. Introducción al enfoque relacional en el estudio de la salud colectiva. Buenos Aires: Lugar Editorial; 2000.
28. Comes Y. Accesibilidad: Una revisión conceptual. Documento laboris del Proyecto de Investigación (UBACyT P077); 2004.
29. Rossi D, Pawlowicz MP, Zunino Singh D. Accesibilidad de los usuarios de drogas a los servicios públicos de salud en las ciudades de Bs. As. y Rosario: La perspectiva de los trabajadores de la salud. Buenos Aires: Intercambios AC, ONUDD; 2007.
30. Sanchez Pardo L, González B, Cid González P, Fernández Lamparte A, Morán Iglesias M, Platas Ferreiro J. Drogas y perspectiva de género: Documento marco. Galicia: Xunta de Galicia; 2011.

31. Lagarde M. Los cautiverios de las mujeres: madresposas, monjas, putas, presas y locas. México: UNAM; 2005.
32. Aranja X, Germán I. Las personas usuarias de drogas especialmente vulnerables y los derechos humanos: personas usuarias con patología dual y mujeres usuarias de drogas. *Eguzkilore*. 2005;(19):169-215.
33. Organización Mundial de la Salud. La prueba de detección de consumo de alcohol, tabaco y sustancias (ASSIST): Manual para uso en la atención primaria [Internet]. 2011 [cited 10 Mar 2019]. Available from: <https://tinyurl.com/y43rq776>.
34. Organización Mundial de la Salud. Intervención breve vinculada a ASSIST para el consumo problemático de sustancias: Manual para uso en la atención primaria [Internet]. 2011 [cited 10 Mar 2019]. Available from: <https://tinyurl.com/y68vsmd4>.
35. D'Angelo J, Hubez G, De Cesare MD, Pedro D, Farace H. Estudio nacional sobre violencias contra la mujer: Basado en la International Violence Against Women Survey (IVAWS). Buenos Aires: Ministerio de Justicia y Derechos Humanos de la Nación; 2015.
36. Ware JE Jr, Sherbourne CD. The MOS 36-item short-form health survey (SF-36) (I): Conceptual framework and item selection. *Medical Care*. 1992;30(6):473-483.
37. Revilla L, Luna J, Bailón E, Medina I. Validación del cuestionario MOS de apoyo social en Atención Primaria. *Medicina de Familia (And)*. 2005;10(6):10-18.
38. Rodríguez Espínola S, Enrique HC. Validación Argentina del Cuestionario MOS de Apoyo Social Percibido. *Psicodebate*. 2007;7:155-168. <https://doi.org/10.18682/pd.v7i0.433>.
39. Instituto Nacional contra la Discriminación, la Xenofobia y el Racismo. Racismo. In: *Hacia un plan nacional contra la discriminación: La discriminación en Argentina, Diagnóstico y propuestas*. Buenos Aires: INADI; 2005. p 49-56.
40. Ministerio de Salud de la Nación, Instituto Nacional de Estadística y Censos. Tercera Encuesta Nacional de Factores de Riesgo para Enfermedades No Transmisibles. Buenos Aires: Ministerio de Salud; 2015.
41. Instituto Nacional de Estadística y Censos. Censo Nacional de Población, Hogares y Viviendas 2010. Buenos Aires: INDEC; 2010.
42. Rossi D, Pawlowicz MP, Cymerman P, Goltzman P, Touzé G. Evaluación rápida y desarrollo de respuestas en el uso de cocaína inhalable y la conducta de riesgo sexual en Buenos Aires 2002-2003: Informe Final. Buenos Aires: Intercambios AC; 2003.
43. Rodríguez Enríquez C. Economía feminista y economía del cuidado: Aportes conceptuales para el estudio de la desigualdad. *Nueva Sociedad*. 2015;256:30-44.
44. Medina-Mora ME, Rojas GE. Mujer, pobreza y adicciones. *Perinatología y Reproducción Humana*. 2003;17(4):230-244.
45. Goltzman P. Ideas poderosas: Producción de salud y cuidado en el uso de drogas con adolescentes. Buenos Aires: Intercambios AC; 2018.
46. Gutiérrez A. Las tareas y compromisos del investigador social. In: Gutiérrez A. *Política y poder*. Buenos Aires: Eudeba; 2000. p 83-115.
47. Argentina. Ley 25929 [Internet]. 2004 [cited 10 Mar 2019]. Available from: <https://tinyurl.com/vzrgsnf>.
48. Touzé G. Discursos, políticas y prácticas. In: Touzé G. *Saberes y prácticas sobre drogas: El caso de la pasta base de cocaína*. Buenos Aires: Intercambios AC, FIUC; 2006.
49. Rossi D, Rangugni V. Cambios en el uso inyectable de drogas en Buenos Aires (1998-2003). Buenos Aires: Intercambios AC, Ministerio de Salud y Ambiente de la Nación, ONUSIDA, ONUDD; 2004.

CITATION

Diez M, Pawlowicz MP, Vissicchio F, Amendolaro R, Barla JC, Muñoz A, Arrúa L. Between invisibility and stigma: consumption of psychoactive substances among pregnant and postpartum women at three Argentine general hospitals. *Salud Colectiva*. 2020;16:e2509. doi: 10.18294/sc.2020.2509.

Received: 30 Aug 2019 | Modified: 25 Jul 2020 | Accepted: 6 Aug 2020 | Publication online: 21 Sep 2020



Content is licensed under a Creative Commons Attribution — you must attribute the work in the manner specified by the author or licensor (but not in any way that suggests that they endorse you or your use of the work). Noncommercial — You may not use this work for commercial purposes.

<https://doi.org/10.18294/sc.2020.2509>.