Racialization of Postpartum Overdoses: A New Consideration for the Maternal Mortality Crisis

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Abstract

Maternal mortality is an increasing phenomenon in the US, particularly for Black mothers. It is also an important indicator used for maternal health measures. Current data show that Black mothers are 243% more likely to die from pregnancy or birth-related causes, and are three to four times more likely than white women to die from the five common medical complications related to postpartum hospitalizations (Martin and Montagne, 2017; Tucker et al, 2007). Yet, there is a postpartum morbidity overlooked among Black women, postpartum opioid use overdoses. New data from a 2018 CDC report revealed that from 2015 to 2016, the rate of opioid overdoses increased by 20% for women and increased four times among pregnant women (CDC, 2018). In fact, from 2004 to 2015, for pregnant women with amphetamine use, the risk of severe maternal morbidity and mortality was almost two times the rate among mothers with opioid use, which increased the incidence of common medical complications including preventable postpartum overdoses (Admon et al., 2019; Texas Department of State Health Services, 2017). The demographic most impacted were white mothers. However, Black mothers are also impacted by this outcome at increasing rates due to a host of factors associated with postpartum depression (Schiff et al., 2018). While the literature fails to underscore this fact, postpartum overdoses are growing among pregnant women and exacerbate the overall mortality rate in the US that impact Black women. Therefore, this paper explores the racialization of opioid use disorders on women postpartum and what it means for policymakers looking to address the opioid crisis and maternal mortality.

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**Postpartum Overdoses: A New Consideration for the Maternal Mortality Crisis**

The United States is one of 13 countries where the maternal death rates are worse than it was 25 years ago and the disparity disproportionately affects Black mothers across all class and educational attainment categories (Villarosa, 2018). Currently, there is a unique trend developing among Black women that the maternal mortality literature has just begun to recognize: opioid overdoses among mothers who are postpartum. While white men and women experience higher percentages of opioid overdoses, the number of Black Americans experiencing overdoses have increased over the last 8 years. In fact, deaths increased in Black communities by 41% in 2016. Rates among Black women have also spiked in recent years (James and Jordan, 2018).

As the narrative of women who use drugs has shifted from *Black crack-addicted mothers* to *women who struggle with opioid use disorder*, more attention has been paid to this overlooked issue. Reason being, white women are at the forefront of this new narrative. Opioid use disorder, like the opioid epidemic, no longer has a pejorative consequence due to an increase in white women and mothers who are increasingly impacted by drug use (James and Jordan, 2018). This reframing is inspired by racialized undertones facilitated through policy and public health. The result has been an increase in reporting of postpartum hospitalizations and recognition that Black women, like white women, have increasing rates of postpartum overdoses resulting in hospitalizations (Lyapustina, 2015). Postpartum hospitalizations are an indicator of the quality of maternal health care received and are often referenced as a complement to maternal death (Gray et al., 2012; Chhabra, 2014). They are also a way to capture overdoses that occur among mothers because pregnancy and childbirth are motivations for women to enter treatment for substance use (Schiff et al., 2018).
A NEW CONSIDERATION FOR THE MATERNAL MORTALITY CRISIS

Approximately 22 percent of pregnant women in the United States are prescribed opioids during pregnancy (BMJ, 2016). A national survey from the Substance Abuse and Mental Health Services Administration revealed that from 2007 to 2012, nearly 21,000 pregnant women between 15 to 44 years of age misused opioids in the past month (Smith and Lipari, 2017). Black new mothers are at greater risk of drug use due to their increased incidence of postpartum depression. Intervention strategies for Black mothers are limited, as 13 percent of outpatient-only substance use treatment facilities and residential treatment facilities provide special rehabilitation programs for pregnant and postpartum women in the U.S. Approximately 7 percent of special rehabilitation programs are offered within inpatient hospitals (Smith and Lipari, 2017; SAMHSA, 2012). Moreover, Black mothers are reluctant to report substance use due to stigma and fear of criminalization. Currently, Texas and Massachusetts are two states that thoroughly study opioids among postpartum women because of its detrimental effects on its population of women, many of whom are white. Dependence on opioids has devastating impacts on the health of mothers postpartum, but so did the crack epidemic which went underattended. With limited research that underscores how race has invigorated attention surrounding postpartum opioid overdoses and also hid aspects surrounding it, this research aims to fill a significant gap in the literature by asking, how has race shaped the narrative of opioid use disorders on women postpartum and what are the policy implications for opioid use among postpartum women?

Understanding Maternal Mortality

In the United States, the estimated maternal mortality rate (per 100,000 live births) for 48 states and Washington D.C. (excluding California and Texas, analyzed separately) increased by 26.6%, from 18.8 in 2000 to 23.8 in 2014 (MacDorman et al, 2016). According to the IHME Index, the most recent data reveals that maternal deaths are at about a rate of about 34 per
A NEW CONSIDERATION FOR THE MATERNAL MORTALITY CRISIS

100,000 live births and will only continue to rise through 2030 (CDC, 2018). The most recent data tracking trends by race was conducted by the CDC through the Pregnancy Mortality Surveillance System. It shows that from 2011 to 2013, white women had mortality rates of 12.7 per 100,000 live births as compared to 44 per 100,000 live births for Black women. Women of other ethnicities combined had mortality rates of 14.4 per 100,000 live births (CDC, 2018). The data show that maternal mortality greatly impacts Black women who have the worst maternal outcomes when compared to white women. New data by the CDC (2018) reveals that the trend continues as Black women are approximately 4 times more at risk of pregnancy-related deaths than white women.

Maternal mortality or pregnancy-related deaths¹ in the United States is an important indicator of unaddressed determinants and the quality of health care. Since 1987, the U.S. mortality ratio has increased nearly three-fold in 2013 (CDC, 2014). While reasons for maternal deaths remain unclear, maternal mortality trends reveal that it is not solely income inequality behind this disparity, but racial inequality as well. Even though the rate of mortality is highest among poor Black women, Black women with advanced degrees and of upper-middle-class status are rising in mortality numbers as well (Martin and Montagne, 2017). Despite all we know regarding the growing maternal mortality disparity, there is still more to uncover, including how it can be prevented.

Since 2007, the United States has been unable to provide maternal mortality rates to OECD data repositories (MacDorman et al, 2016). Continuous CDC underfunding has led to lack of accurately reported US maternal mortality data, chronic underreporting of the disparity, and less quality control of the data. For example, the National Vital Statistics System, a significant data source for collecting maternal death data, is riddled with underreporting of

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¹ As defined by the CDC’s Pregnancy Mortality Surveillance System. This surveillance system is one of the only surveillance systems to capture maternal deaths since 1986 in hopes of filling in gaps in clinical data.
maternal deaths (MacDorman et al, 2016). The Pregnancy Mortality Surveillance System, a supplemental data system that focuses on pregnancy related maternal deaths is influenced by the National Vital Statistics System. The CDC definition of maternal mortality\(^2\) does not weigh in on the development of the pregnancy question that attempts to fully capture pregnancy related deaths on US Death Certificates. As a result, there is also severe under-reporting and inaccurate recording of deaths. Even though data sources lack validity, what we do know is that 1) Black women bear the brunt of the maternal mortality disparity, 2) there is a racialized component embedded in the data regarding opioid use among women, which is understudied and underreported, and 3) one of the best ways to reduce maternal mortality is to investigate postpartum hospitalizations that happen, which is a more common event as compared to maternal deaths. If research is able to identify the events associated with postpartum hospitalizations there would be more informed providers who could prevent the outcome of death by intercepting prior to the exacerbation of morbidity.

**The Narrative Surrounding the Black and White Opioid Disparity**

While the data show that white Americans maintain a slightly higher prevalence of opioid overdose, Black Americans are rising in death tolls related to opioids. The national outrage surrounding the opioid crises remains for “white, middle-class, suburban and rural users”, highlighting that “90% of the 33,091 people who died from opioids in 2015 were white” (James and Jordan, 2018). However, in 2014, Black opioid related deaths began to rise similarly to white opioid related deaths. Currently, Illinois and Washington D.C. have some of the highest incidence for opioid overdose related deaths (Murray, 2018; James and Jordan, 2018). Indiana is also on the rise for high fentanyl overdoses impacting their Black population. There are

\(^2\)The CDC defines maternal mortality as death that occurs from the start of pregnancy to one year after delivery (CDC, 2014). However, the pregnancy question uses the WHO definition of maternal mortality to capture maternal death perhaps due to the severity of this disparity. WHO defines maternal death as death that occurs by way of “[potentially treatable] complications during and following pregnancy and [42 days after] childbirth” (WHO, 2014).
additional states where the Black-white opioid disparity gap is highest, with Black Americans leading in opioid-related overdoses. These states include West Virginia, Washington D.C., Wisconsin, Ohio, Maryland, Missouri, Massachusetts, Michigan, Illinois, and Minnesota.

Between 2015 and 2016, there was approximately a 56% increase in opioid overdoses in Black communities across the U.S. By 2017, 61% of Black overdoses were related to fentanyl. Rates of Black women have also begun to increase considering this trend (Murray, 2018).

Interventions led by the medical and public health community have ignored these data, considering white American opioid-related deaths have dramatically increased. Heroin overdoses in the Black community have more than doubled since 2000 and these deaths have been overlooked and remain absent in media (James and Jordan, 2018). This inattention mimics that of the crack epidemic that ran rampant in urban Black communities in the 80s and 90s and the opioid epidemic that occurred in the 60s and 70s in Black communities surrounding heroin addiction and overdose (James and Jordan, 2018). The marginalization and lack of compassion for Black people is related to the framing of addiction surrounding people of color—labeling...
them as criminals who do not need treatment, but intervention via militarized policing and interaction with the criminal justice system (James and Jordan, 2018).

Source: Kaiser Family Foundation

Opioid Overdose Deaths by Race/Ethnicity: White, Non-Hispanic, 2017

Opioid Overdose Deaths by Race/Ethnicity: Black, Non-Hispanic, 2017

Source: Kaiser Family Foundation
Over the years, pain treatment has shifted from specialty care area to primary care and the pharmaceutical industry, who have contributed to the current growth in opioid prescriptions. Globally, the U.S. has led in opioid consumption rates. In 2009, “the United States consumed 99% of the world’s hydrocodone, 60% of the world’s hydromorphone, and 81% of the world’s oxycodone” (Lyapustina, 2015). This increase was partly driven by what the CDC considers the “First Wave” of the opioid crises that happened in the late 1990s (CDC, 2018). During this time, overdoses caused by natural and semi-synthetic prescription opioids increased. Since then, approximately 33,000 Americans have died from opioid-related overdoses, which succeeds the 7,1000 overdose deaths from any drugs during the 1975 heroin epidemic. Overall, overdose drug use overall has increased faster among whites, yet death rates between Blacks and whites have been comparable for the past five years (James and Jordan, 2018).

Source: CDC, 2018
Opioid Use Among Postpartum Mothers: The Black and White Disparity Continued

Opioids are a class of pain-relieving drugs that include prescription opioids, synthetic opioids, and illicit opioids designed to target opioid receptors to block pain and reduce fatigue, which are immediate concerns for postpartum mothers. Untreated pain is associated with postpartum depression, consistent pain, and the potential for illicit opioid use (Vestal, 2018). Postpartum pain in particular interferes with a woman’s ability to provide optimal care for her infant and herself, leading to postpartum depression. Much of the pain that occurs postpartum varies with intensity, which may inform the amount of opioid exposure a mother can potentially have. Prescription opioids usually prescribed to mothers include both semisynthetic opioids, like hydrocodone (i.e. Vicodin) and oxycodone (i.e. OxyContin), and those that are naturally-occurring and derived from the opium poppy plant, like morphine.

The postpartum period after pregnancy is a dangerous period for women, especially already vulnerable Black women. Opioid use overdose deaths are more likely to decline during pregnancy and peak seven to twelve months postpartum (Schiff et al. 2018), during the time where resources are less prevalent for the mother, and medical protocols and maternal health programs shift attention towards infants. In fact, Medicaid, which covers half of all U.S. births, only support mothers up to two months past delivery. As a result, pre-existing conditions may go unseen or untreated until the next pregnancy (Ellison and Martin, 2017; Admon et al, 2017). Since 1999, nearly 400,000 people in the U.S. died from opioid use, including prescription and illicit opioids (CDC, 2018). The number of pregnant women with an opioid addiction has quadrupled since then.

Postpartum depression (PPD) is one of the most common reasons that women seek prescription opioids. Women who experience PPD are at greater risk for drug addiction than those without (Chapman and Wu, 2013). While little research explores the connection between
A NEW CONSIDERATION FOR THE MATERNAL MORTALITY CRISIS

PPD and opioid misuse and overdoses, what is known is that maternal alcohol and drug use contributes to increased rates of children in foster care, child neglect, and potential abuse (Chapman and Wu, 2013). Because the postpartum period is transitional, it is the optimal time for intervention; however, proper intervention is nearly non-existent. The reason for lack of interventions partly lies with the medical community which upholds racial biases that influence their practice. Hoffman et. al (2016) assessed in their study that physicians have a tendency to uphold false beliefs and stereotypes towards Black patients who seek medical care. This informs an undertreatment of Black patients who seek proper pain management. This undertreatment may extend to the illicit use of opioids by Black women who suffer from postpartum depression.

Approximately 20 percent of women develop a pregnancy-related mood disorder. Black women are 44 percent more likely to report depression two weeks after delivery compared to the 31 percent of white women, yet only 4 percent of Black women seek treatment (Karras, 2018; Kozhimannil et al, 2013). This disparity is fueled by much of the structural disadvantage, birthing trauma, and stress Black women face, as well as their experiences with medical racism resulting in unnecessary or unwanted maternal procedures (Owens, 2017; Karras, 2018). Because Black women are screened less for postpartum disorders and are less likely to receive quality, equitable treatment (Karras, 2018), it is easy for Black women to turn to opioids. According to Chapman and Wu (2013), marijuana was the drug used most often by postpartum women, however recent studies have found that illicit and nonmedical drug use is more prevalent and accounts for current drug use trends among postpartum Black mothers. It is not poor Black mothers who solely experience this disparity. In fact, Black mothers who have higher income levels and educational attainment are just as susceptible to negative maternal health outcomes as their low-income counterparts (Martin, 2017; Love, 2010). This issue spans across all income and educational levels. There is a huge disconnect between what these women need and the
service the medical community provides them. Fear of loss of child from a mental illness diagnosis or criminalization for drug (mis)use keeps Black women from coming forward to the medical community for help.

The narratives of Black Americans who struggle with opioid addiction is often overshadowed by the ongoing narratives of white individuals. The same is true for Black women who experience postpartum depression and the opioid misuse that follows. The narrative of the Black woman is lost when identity politics excludes advocacy based on race and gender. As a result, the varying forms of oppression (economic, social, and political) manifest itself in ways that promote poor health outcomes for Black women, and more specifically, poor maternal and reproductive outcomes. “Black women are systematically denied the resources, services, and information they need to make these important and personal health decisions. The consequences for Black women have been profound: they are disproportionately likely to become pregnant unintentionally, to experience pregnancy-related health complications, and to become gravely ill or die in childbirth” (Williamson et al., 2017). These factors inform the importance of prioritizing Black women in discussions of health, as well as the ways in which history lays the foundation of the way in which Black women are treated.

Theory and Hypotheses

In order to understand how race plays a role in narrative of opioid use disorders, this research uses the Levels of Racism theory (Jones, 2000) which builds off of the Fundamental Cause Theory and the Social determinants of Health (SDoH). The Fundamental Cause Theory (Link and Phelan et al., 1995) states that resources are at the bedrock of health outcomes. This is because a fundamental cause 1) influences multiple disease outcomes, 2) affects disease outcomes through multiple risk factors, 3) involves access to resources that can be used to avoid risks or consequences of disease, and 4) without resources, association between determinants and
health is reproduced overtime with intervening mechanisms. For example, a woman who has access to resources to combat drug addiction is more likely to seek help. However, seeking help also means that the person is guaranteed they will not be racialized and criminalized. This is key in operationalizing the SDoH framework. Optimal health outcomes are based on health behaviors, clinical care, social and economic factors, and the physical environment (the four categories of the SDoH framework) (ODPHP, 2018). The success of these categories is dependent on the reduction of barriers and biases within a system. Should a woman who is postpartum and in need of substance use treatment be met with barriers and biases, the fundamental cause for her drug use is not treated and her incidence for mortality increases.

The Levels of Racism theory follows up by identifying three ways or levels in which racism operates. The most common level is personally mediated. According to the literature, personally mediated racism or discriminatory practices that are facilitated systemically, drives much of the social determinants that impact the mobility, health, and well-being of Black Americans (Jones, 2000; Williams and Mohammed, 2009). This is because actions and assumptions are motivated by differential treatment towards one’s ability, intentions, and motives based on their race. This can be intentional or unintentional actions, or assumptions that manifest itself through biased actions (e.g. hate crimes, suspicion, devaluation, etc.) (Jones, 2000; Anderson, 2012). An additional level is institutionalized (systemic) racism, also known as a “historical insult” that imposes restrictions on access to material conditions and power (Jones, 2000). Institutionalized racism is normative and inherited legalized disadvantage that emphasizes differential access to quality resources, appropriate medical facilities, an organized and wealthy built environment, fair government representation, and a reduced (or nonexistent) socioeconomic wealth gap. The third level is internalized racism or the acceptance of messages regarding the intrinsic worth of stereotyped races. This level is where individuals of color embrace concepts of
“whiteness” as goal posts for achievement (Jones, 2000) because for example, they have been taught helplessness, hopelessness, rejection of ancestral culture, and particular standards of beauty that are not their own.

Source: Janevic et. al, 2011

Given the increasing rate of Black opioid use and overdose deaths, we know that Black women are less likely than whites to be identified for substance use treatment and are more likely to be ignored for their postpartum symptoms that call for prescription medication. Each of these levels are evident in the Black woman’s experience regarding this issue—whether it be from her experience with medical racism, discriminatory experiences with frontline healthcare staff, an inability to access proper resources for drug treatment, or fear of criminalization that leads to hopelessness for this issue and issues collectively tied to maternal mortality. The literature
A NEW CONSIDERATION FOR THE MATERNAL MORTALITY CRISIS

however, is lacks in detailing the ways institutionalized and internalized levels of racism facilitate normative “white” ideas about motherhood that enable personally mediated racism towards Black mothers.

- It’s partly, I hypothesize, why Black women’s narratives of postpartum opioid use disorder and overdose is hidden in the larger stories of white women.
- It’s partly, I hypothesize, why postpartum Black women refrain from seeking outreach of fear of stigma and criminalization.
- It’s partly, I hypothesize, why Black women are less likely to express feelings of pain and depression at any time during stages of childbirth, especially postpartum (which is, according to data, why mothers are prescribed substances to begin with), why physicians don’t listen to them and when they do, they may be under-prescribed proper medical dose of prescription opioids (due to stereotypes of Black people and pain) leading them to seek illicit substances as options.

Discussion and Next Steps (2)

Opioid use disorder is more widespread ethnically and geographically than the media and public outrage attends to. The data show that Black Americans have overdose death rates that have more than doubled, with rates of Black mothers also on the rise (James and Jordan, 2018). However, because Black Americans are left out of the greater discussion regarding opioid overdoses, not only are they undertreated, but they also suffer in silence. This suffering only contributes to the increase in the maternal deaths that Black women experience.\(^3\) There are clear racial undertones that underscore the opioid epidemic. While white Americans typically overdose more, Black Americans have consistently been overlooked since the beginning of the

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\(^3\) Black women are approximately 4 times more at risk of pregnancy related deaths than white women. Current maternal trends only look at the disparity between Black and white women because the disparity is so large (44 out of 100,000 v. 13 out of 100,000) (Louis et al, 2015).
United States’ heroin epidemic. As a result, they lead in overdoses beyond the national average in several different states and exceed rates of any other racial group. Further, considering what is known about postpartum depression, Black women have less access to prescription opioids either because their communities are under-resourced, or because of physician biases towards Black patients that inspire the belief that they do not feel pain. This outcome can lead to high incidences of substance use of illicit drugs and underreporting of illicit drug use for fear of judgment or criminalization.

In the midst of the opioid epidemic, we must recognize that use of opioids may stem from a need to manage untreated pain. In the United States, prescription opioid consumption is relatively high compared to other nations, speaking to the fact that pain is poorly managed, especially for vulnerable populations. For Black women, pain may look like postpartum depression. One major solution for the existing disparity is to collect the narratives of Black women as they experience the healthcare system. Personal narratives serve as a supplementary contribution to empirical data, adding nuance and perspective that would not exist, without knowing the extent to which a disparity impacts an individual. Secondly, it would be important to address the knowledge gaps that exist in pain management. Doing so would require retraining physicians and institutions regarding racial bias, cultural sensitivity as well as proper screening and assessment techniques for trauma exposure, access, and insurance coverage. This is important because of complications that surround pain management and the misinformation that exists about patients. Overprescription and underprescription (for Black women) are some of the leading causes for opioid overdoses and correcting these trends would allow for healthier mothers postpartum. Thirdly, there need to be culturally sensitive interventions that are community based that supplement medical treatment. This would ensure security and safety for mothers who seek treatment for opioid use. These interventions are only possible through
A NEW CONSIDERATION FOR THE MATERNAL MORTALITY CRISIS

initiatives that 1) add the issue of postpartum opioid overdoses to Title V block grant⁴; 2) challenge current care delivery models in order to replace them with models that are unique to the needs of particular populations of women and their families; and 3) challenge Medicaid to extend coverage for new mothers beyond two months.

It seems that the opioid crisis among white women has not been enough to consider maternal health of Black women who also struggle with opioids. However, this reinforces just how much narratives matter in the fight for social equity. Public administration certainly has a role to play in this issue because the discipline is strongly connected to the Social Determinants of Health. Public administration is broadly about organizational structures, managerial practices, and institutionalized values that aid in policy implementation and government action. Public health and maternal health more specifically, can communicate with the discipline here, given how maternal health disparities work through all of these levels. If public administration hopes to address issues of social equity, it would do well to blend its knowledge with public and maternal health in order to inspire change that could be successful on varying policy levels.

References

⁴ Title V is key in the “support for promoting and improving the health and well-being of the nation’s mothers, children, including children with special needs, and their families.” (HRSA, 2019)
A NEW CONSIDERATION FOR THE MATERNAL MORTALITY CRISIS


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