Advancing Racial Equity in Maternal-Child Health and Addressing Disparities through a Reproductive and Birth Justice Lens

Prepared for the W.K. Kellogg Foundation by the New Mexico Research Evaluation and Learning (REAL) Team Members: Rebecca Rae, Erica Surova, Beverly Gorman, Sara Twiss, Marisa Wagner, Felicia Otto, Maria Livaudais and Ruth Juarez
The W.K. Kellogg Foundation (WKKF) supports access to quality, affordable and culturally relevant maternal-child health care. WKKF has long invested in organizations focused on improving health care across the spectrum of parenthood, from pregnancy and childbirth to breastfeeding and improving health outcomes for mothers, birthing parents and babies.

Grantees are leading community efforts to drive a broad range of maternal-child health strategies that improve access to care for women, families of color and more – all with the goal of creating the conditions to propel children towards high health and well-being outcomes. Their work is funded from a variety of sources, not exclusive to WKKF.

Still, despite progress in maternal and infant health care, led in part by the organizations WKKF and other funders support, significant challenges remain for families in the United States. For women from low-income backgrounds, birthing parents and for people of color in particular, disparities in areas like access to prenatal care, infant and maternal deaths and breastfeeding rates reveal persistent barriers. These disparities expose the longstanding effects of systems and practices that fall short of supporting all mothers, birthing parents and children.

Through grantee interviews, the report critically examines how New Mexico community-based organizations are addressing the full ecosystem of maternal-child health-racial inequities and disparities. The report explores how grantees are addressing, advocating for, and implementing actions, to advance racial equity to improve maternal-child health outcomes in New Mexico. The historical data and content in this report reflect the grantees’ comprehensive work, supported by multiple partners and funders. Their testimonials represent their work and the communities they serve.
Introduction
Purpose of Study

From 2014 to 2015, W.K. Kellogg Foundation (WKKF) partnered with the University of New Mexico evaluation team to conduct a study to examine if and how the Foundation’s investments in the strategies of folic acid initiative, home visiting, doulas, breastfeeding peer counselors and baby-friendly hospitals were improving maternal-child health in WKKF’s priority places in New Mexico. One key finding in the Healthy Birth & Early Development in New Mexico evaluation report was that these strategies supported a continuum-of-care that is essential for strengthening the health and wellbeing of babies, mothers, and families from preconception through a child’s third year. A continuum of care framework was developed by the evaluators to capture achievable short-term outcomes such as healthy family behaviors, policy change and systems change that over time could be linked to improvement in the long-term outcomes of full-term births, healthy birth weights, exclusive access to mother’s milk, decreased adverse childhood experiences, increased social support, improved parental well-being, and healthy developmental milestones.

The purpose of this report summary is to critically examine how local community-based organizations are influencing reproductive and birth justice, especially based on racial disparities, to influence the full-spectrum of a woman’s reproductive life and the
direct impact of that justice on maternal-child health and child well-being. Reproductive justice and health care is often seen in isolation from the care a person receives during pregnancy and delivery, however, they are part of an ecosystem of care throughout a person’s reproductive years that influences their autonomy and health and their ability to have a health pregnancy and delivery for them and their babies. This is particularly true in communities of color where racial equity issues often create barriers for women and girls to access the reproductive health care that they need. Women’s health care, and the reproductive justice that assures its access, is maternal and child health care, and must be examined holistically to truly address barriers to healthy pregnancies, deliveries, and babies. While home visiting, breastfeeding, doulas and baby-friendly hospitals are essential strategies for improving maternal-child health, a health gap still exists for women and families of color, as evidenced by high infant and maternal mortality rates and low infant birth weight rates in New Mexico, particularly for women of color. While the maternal-child health strategies may improve access to care for women and families of color, they do not necessarily translate to quality of care. “Evidence-based” practices will not lead to changed outcomes for WKKF target populations if racial equity is not addressed and foundational in the work. The aim of the deep dive was to learn how the grantees are addressing, advocating for, and implementing actions to advance equity to improve maternal-child health outcomes.

The deep dive was framed to address the following evaluation questions:

1. How are local, national, and international grassroots/community-based organizations advancing reproductive justice and birth justice work to address the racial inequities in maternal-child health for families of color? What emerging evidence is available to support reproductive justice and birth justice work?

2. What value do reproductive justice and birth justice investments bring to the WKKF Maternal-Child Health (MCH) portfolio? How do investments in grassroots, women of color–led organizations improve access as well as quality of care that is culturally responsive, linguistically relevant, integrated, and normalized into the broader body of maternal-child health-racial equity work?

2.2. What approaches, strategies, or teachings are laying the foundation for movement toward equity? And, how do these efforts contribute to improving the health and well-being of babies, mothers, and families?

3. What are the current maternal-child health data for WKKF’s priority places in New Mexico? What story is the maternal-child health data telling when disaggregated by race?

The report is divided into three sections to address these evaluation questions. The first establishes a foundation from the field for reproductive justice and birth justice as defined from sources in the literature review and from the grantees. The second section discusses insights drawn from grantee interviews that show where and how WKKF-funded efforts have begun building a pathway toward increased racial equity in maternal-child health in the state. The final section provides supportive data that tells the maternal-child health story in New Mexico at present.
SECTION 1: Laying the Foundation for Reproductive Justice and Birth Justice

This section provides historical context and the foundation for reproductive justice and birth justice from the literature review and from the grantees. The literature review on reproductive justice and birth justice (RJ/BJ) examined what current definitions, models, frameworks and policies were implemented locally, nationally and internationally to address social and racial inequities in maternal-child health for families of color. As described in the literature, reproductive justice is rooted in the advocacy for reproductive health, reproductive rights and social justice that addresses maternal and infant health disparities at the social, economic, political, environmental and structural levels. Birth justice aims to dismantle inequities of race, class, gender and sexuality that lead to negative birth experiences, especially for women of color, low-income women, immigrant women and LQBTQ+ individuals.

There was agreement among grantees that reproductive justice centers on individuals and families having the autonomy to make decisions about their own bodies and what’s best for them. This includes individuals’ rights to prevent pregnancies, end pregnancies and pursue gender nonbinary conceptions and “nontraditional” forms of pregnancies without judgement and limitations to healthcare services. Birth Justice ensures that individuals and families have access to quality and non-biased care regardless of their social, economic, cultural and environmental background. Several grantees also expressed that reproductive justice is about healing and acknowledging the historical trauma of individuals and communities and its impact on their birthing experience. It is also about (re)connecting to the land and connecting people’s history to the land and environment.
SECTION 2:
Pathway Toward Equity in Maternal-Child Health

This section is divided into four main findings that also serve as recommendations to improve equity in the maternal-child health field. The findings are a reflection of the dedication and committed work that the grantees have undertaken to impact services, systems and policies that would improve the health and wellness of birthing families and babies in New Mexico.

FINDING ONE
Equity Practices Improve Maternal-Child Health Access and Care

This finding provides an analysis of five practice areas that could improve access and quality of equitable care for birthing families in New Mexico. The six practice areas for finding one include:

1. Truth telling: Historical context of birthing for communities of color
2. Reclaiming traditional birthing practices
3. Culturally and linguistically appropriate practices
4. Gender equity
5. Payer systems
6. Meaningful data representation
FINDING TWO

Diverse and Inclusive Birth Workers, Home Visitors and Healthcare Providers Have Equitable Pay

This finding discusses the importance of having a diverse and inclusive maternal-child health workforce within hospitals and community-driven organizations. It also highlights the need for equitable pay for doulas, midwives, home visitors and other birth workers of color. This finding is outlined by:

1. Why representation matters
2. Pay equity

FINDING THREE

Collective Actions Drive Racially Equitable Change

This section provides context for how the grantees are creating policy and systems change through their individual and collective efforts. This finding includes:

1. Navigating institutional systems change
2. Collaborative community-driven efforts
3. Policy

FINDING FOUR

Essential Reproductive, Birth, Family and Infant Systems of Care Model Improves Spectrum of Care

The reproductive, birth, family and infant systems of care model was developed to conceptualize the various findings that emerged from the study. The holistic model is comprehensive of the racial equity work that grantees expressed were essential to improving the spectrum of care (from preconception to infant/family services) for birthing families and infants in New Mexico.
This section provides an analysis of data collected from various New Mexico state databases. Data includes maternal and child indicators for preconception, prenatal, perinatal, and breastfeeding. The analysis is primarily descriptive and aims to tell the story of maternal and child health in New Mexico through data.

The need for accessible and high-quality data across the spectrum of maternal and child health outcomes continues to be a concerted struggle for state agencies, Tribal communities and WKKF-funded initiatives. Comprehensive and reliable data can be essential for leveraging funds or informing policy and systems change efforts to improve accessible equitable prenatal, postpartum, breastfeeding and early childhood family social support systems.
Laying the Foundation for Reproductive Justice and Birth Justice

How are local, national and international grassroots/community-based organizations advancing birth and reproductive justice work to address the racial inequities in maternal-child health for families of color?

What emerging evidence is available to support birth and reproductive justice work?
In a recent national survey of lived experience of care during pregnancy and childbirth, women of color (African American, Asian, Indigenous and Latinx) reported inequitable perinatal care more often than White women (23.8% vs 14.1%, respectively) (Vedam et al., 2019). Survey items were included to measure experiences with health care providers in the domains of physical, verbal and sexual abuse; abandonment and neglect; poor rapport; forfeiture of confidentiality; and inadequate support. For example, twice as many Hispanic and Indigenous women as compared to White women reported that healthcare providers shouted at or scolded them.

Likewise, Black women, Hispanic women, Asian and Indigenous women were twice as likely as White women to report that a healthcare provider ignored them, refused their request for help, or failed to respond to requests for help in a reasonable amount of time. There were also higher rates of mistreatment when preferences for care did not align between women and providers. Women who gave birth at the hospital were 7 times as likely to report any mistreatment compared to women who gave birth in the community.

A large body of research is dedicated to identifying and understanding the complex factors that influence and sustain racial disparities in maternal and infant health in the United States. While studies consistently find lower socioeconomic status is linked to higher risk of adverse birth outcomes for both mothers and infants (Blumenshine et al., 2010), socioeconomic status may not fully account for why Black and American Indian or Alaska Native mothers and babies experience a higher rate of adverse health outcomes during birth. Researchers are increasingly interested in the role of interpersonal and institutional racism in determining
maternal and child health outcomes (Dominguez, 2011; Heck et al., 2021).

Historically, African American, Indigenous, and Latinx Women have been denied access to care and have received segregated substandard health care, leading to significantly poorer health outcomes (Robinson et al., 2019). This generational trauma continues to exist within a system that was not built with their unique experiences and systemic disadvantages in mind. The current healthcare model continues to replicate, in contemporary forms, barriers that adversely affect not only healthy births and breastfeeding by Black, Indigenous, women of color and LGBTQ+ individuals, but also the ability of healthcare providers to be self-aware of the personal biases and discrimination that contribute to these inequitable outcomes.

Reproductive justice and birth justice emerged to address the maternal and child health inequities that communities of color have experienced and continue to experience. Recently, community groups, public health agencies, medical providers and researchers have focused on understanding the impact of life course and social determinants of health in which race and structural racism play strong roles (Cole et al., 2018; Okolo & Molina, 2020; Wallace et al., 2017). This has coalesced into an identifiable Reproductive Justice Movement and Birth Justice Movement, as documented by Sister Song (n.d.) and Black Women Birthing Justice (n.d.). These movements have asserted that all persons have the right to experience healthcare that is free of discrimination and bias based on race, ethnicity, gender, culture, religion, age, income, insurance status, sexual orientation, marital status or any other individual characteristic (Robinson et al., 2019).

Reproductive justice and birth justice advocates and community led organizations are not only advocating for equitable healthcare, they are challenging the Western model of medical care and uplifting traditional birthing practices that include midwifery, doulas and community birth settings (home births or birth centers) (Parry, 2008; Sakala, et al., 2020). Historically, in institutional hospitals or facilities where Western medical care is centered and “gynecological and obstetric medicine emerged as male-dominated, professionalized specialties, traditional women-centered knowledge and experience could be sidelined and then officially outlawed” (Ross & Solinger, 2017, p.17).

We conducted a literature review on reproductive justice and birth justice (RJ/BJ) to examine what current definitions, models, frameworks and policies were implemented locally, nationally and internationally.
to address social and racial inequities in maternal-child health for families of color. As described in the literature, reproductive justice is rooted in the advocacy for reproductive health, reproductive rights and social justice that addresses maternal and infant health disparities at the social, economic, political, environmental and structural levels. Reproductive justice, a term developed by Black women activists in 1994, was defined by Monica Simpson of Sister Song in a 2019 *Washington Post* article as “the human right to have a child, to not have a child, to parent the children that we have in healthy and safe environments, to make sure there aren’t food deserts or contaminated water or police bullets, conditions that do not make communities safe for the children we bring into the world...Ultimately RJ is about the human right to bodily autonomy and self-determination.” According to a recent publication by a team of Black women physicians (Julian et al., 2020), reproductive justice is grounded in the following principles:

1. Every person has the right to decide if and when to become pregnant and to determine the optimal conditions under which they will birth with equitable access and utilization of culturally relevant options and opportunities for pregnancy, labor, birth and postpartum.

2. Every person has the right to prevent or end a pregnancy and can do so via options that are accessible, approachable, acceptable, available, accommodating, affordable and appropriate.

3. Individuals have the right to parent children they already have with dignity and with the necessary social supports in safe, affordable and sustainable environments and healthy, thriving communities without fear or threat of violence, intimidation, coercion or control from individuals or the government.

4. Individuals have the right to dissociate sex from reproduction, and that healthy sexuality and pleasure are essential components to whole and full human life.

The Birth Justice Movement acknowledges the impacts of racism and stress, which have disproportionate effects on the health outcomes of mothers and infants of color. It seeks to go beyond providing access to care to families of color, empowering them and addressing the systems of power and oppression that perpetuate high maternal and infant mortality rates for them. Brief definitions for reproductive justice and birth justice are outlined in Figure 1.

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**Figure 1.** *Sister Song (n.d.); Black Women Birthing Justice (n.d.)*
The maternal-child health landscape also includes lesbian, gay, bisexual, transgender, queer, intersex, asexual, and two-spirit (LGBTQ+) families. Birth justice includes the right of LGBTQ+ families to birth and parent children. In general, the navigation of healthcare systems can be stressful for LGBTQ+ individuals due to the health care providers’ lack of training and lack of knowledge of LGBTQ+ healthcare needs, further impacting parents’ considering birthing a child (Kano et al., 2016). LGBTQ+ parents have to navigate healthcare systems, especially childbirth services, cautiously due to the ideal “natural birth,” or “male-female conceived birth,” “only” being experienced by female-identifying or cisgender mothers (Malmquist et al., 2021). Birth justice also includes “gender inclusive” care for fertility and infertility; prenatal and postnatal care; and breast/chestfeeding support. Gender inclusivity includes access to maternal-child health practitioners or other services, the right not to be turned away due to sexual orientation, gender identity, or social gender identity, and the right for nonbinary-identifying individuals to have children without gender discrimination or unfair treatment in medical facilities.

Reproductive justice also includes the right and autonomy to breast/chestfeed babies at home and in public without judgment. There is a stigma that breast/chestfeeding babies should not occur in public spaces and that birthing parents should cover up when feeding their baby. Birthing parents have the right to breast/chestfeed their babies in public as freely as when babies are fed with a bottle. Scientific studies show that breastfed babies have increased immune function, reduced risk for various infections, and reduced likelihood of developing asthma, obesity, and diabetes. One practice that promotes breast/chestfeeding is human milk donation—one of the more practiced, yet publicly unrecognized, supports for breast/chestfeeding in human societies. Human milk donors engage in what is sometimes termed

“There is a lot of trust and relationship building that must happen with families and communities that have previously had very negative experiences with medical providers, organizations and the government.”
“bodily gifting,” drawing attention to the uniqueness of this form of giving (Oreg & Appe, 2020). It is rooted in the sharing of milk, as women have always shared milk and it has taken many forms throughout history, including both formal and informal modes.

Our broad literature review grounded our development of interview questions (See Appendix A) in the historical context for the Reproductive Justice and Birth Justice (RJ/BJ) Movement and its impact on improved health equity for women, the LGBTQ+ community, birthing families and children. We also noted in the literature review some complexity in how reproductive justice and birth justice is understood and implemented, as the movement has been driven by the needs and complexities of diverse communities. Therefore, we wanted to hear from WKKF grantees how they define and/or implement RJ/BJ. We asked, “How would you define reproductive justice or birth justice, or what does it mean to you?” (While we intended to ask each grantee this question, several grantees were not asked the question either because they started sharing their work immediately or there was a time constraint. We tried to be flexible during the interview and not force any questions, therefore this question was not asked during a few interviews.)

Each grantee that answered the question shared rich meaningful perspectives about what reproductive justice and/or birth justice means to them and their work. Instead of trying to merge each perspective into one blended definition, we have chosen to honor and uplift what each grantee expressed. Some grantee descriptions were lengthy or included contributions from two or three individuals that were in the interview, so text has been slightly modified (sentences or parts of sentences omitted or merged) to create a condensed, meaningful description that still authentically represents what was shared. Grantees, perspectives on reproductive justice and birth justice are:

Reproductive justice means everyone. All people having the resources and information they need to be able to make real decisions about their own bodies and lives. That intersects with not only birth justice but also criminal justice reform, health care reform, reproductive health care in general, environmental justice and all the ways that we’re able to interact with our environments, with our communities, all the ways that we’re able to parent, whether we choose to or not, not only in ways that keep us alive, but in ways that get us to a thriving place where we can find joy.

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“Liberation, decolonization, freedom, having the autonomy and the ability to freely make choices for yourself and having all the resources that you need to make the decisions that you need to make for yourself in your family and your community...Birth justice or reproductive justice is healing for our communities. We think about all of the factors that have impacted Indigenous people on these lands and about how many things have been affected and about how birth is the first thing that we all experience in our lives and how that has been impacted and how it has affected us. What makes more sense to me rather than justice is really birth sovereignty. And thinking about sovereignty in terms of, not just like in a political legal concept, but sovereignty that we get to choose...We are very land-based people so it’s really connecting back with the land in a holistic way, therefore, understanding your body more holistically too.”

“Reproductive justice says women, trans, queer and people of color lead. We protect the full spectrum of reproductive health and its impact on our lives and bodies. Reproductive justice is when people as a social, economic, and political power make decisions about their bodies. So, that includes environmental justice, workers’ rights, healthcare access, every single part of our reproductive health, specifically medical reproductive health needs, which is the core of our reproductive health. But it includes where we can raise our kids, that we live in an environment where we feel it is safe, and away from gun violence or environmental pollution. That’s what birth justice is.”
The Navajo Nation Breastfeeding Coalition

“I’m a breastfeeding advocate and a doula - birth to me is sacred. It is our hope, it is our future, and that is one of the avenues our coalition is really working on, protecting the sacredness of birth, promoting sacredness and promoting birth of ceremony. The female body is the vessel of bringing in a new life and when the baby is in the womb the baby’s still in the spiritual realm, as a spiritual being. Once they birth, they come into this new world like another hope and hope for our people, hope for our future. Birth is sacred and we are trying to make sure that the baby is protected. Part of reproductive justice is … one of the things that we learned doing doula work from one of our Medicine people … whoever touches the baby first … are actually passing on their promise to the baby. When we heard … that’s what really put us in gear to really do what we can do to protect our children because in hospitals and tribally owned hospitals, you have doctors and OBGYN midwives that they just come in and then they go. We don’t know what kind of trauma or intentions they’re bringing in with them, and yet they’re getting our babies, the first ones to touch our babies. A form of reproductive justice first for us is to help by supporting families when they choose to do home births, but also educate them about this. If they plan to do a hospital birth with our doulas and the midwives that we work with. When we do the home birth, we are taught how to not pass on our trauma by little practices that we do before and during the birth … That’s part of our movement with reproductive justice is to bring our tradition and our culture back.”
Having the autonomy and ability to make decisions about reproductive health, so whether to have a child or not to have a child and then the first process which sometimes, unfortunately, very much gets taken out of people’s hands. Empowering families to have choices in that area and to not just have the system take over and force them in certain directions … it also speaks to the imbalance that exists in society when it comes to someone’s gender and the way reproductive justice could be met is to ensure that that imbalance is addressed because just providing access to things does not mean that everyone actually can access it because of different experiences that people have … There is a long history of trauma in the US around reproductive health and huge inequities in terms of birth outcomes. Identifying and acknowledging all of that and figuring out how it is currently affecting people’s experience with that whole process and making sure that the way things are being done is trauma-informed and just acknowledging that whole history.

The Home Visiting Referral Quality Improvement Initiative (THRIVE)

Ensuring that all families have access to birth the way they want to birth, in the cultural aspects as well. They have the support they need, and they have access to medical care that they choose. They also have the information to make those choices, without any judgment or without any bias around it or without any fear. I think that is a big part of it. They do feel supported that their birth experience, regardless of the outcome, they feel they have all the access, care, and support, they still knew that they were in the best hands. In my version I believe that all families are able to birth this way. We recognize the impacts that communities have on that access to equitable care … On the impacts that we have for generational families that are growing up in our communities. When I talk about birth equity, I like to talk preconception, what are our families’ experiences and knowledge about conceiving babies, conception options/alternatives, what are their cultural roots that come from those experiences? What is the education they are receiving in these households, related to these major decisions when it comes to giving birth?“
These grantees expressed deep insights into what RJ/BJ means to them, and these insights are reflective of the work that they do. There was agreement that reproductive justice centers on individuals and families having the autonomy to make decisions about their own bodies and what’s best for them. This includes individuals’ rights to prevent pregnancies, end pregnancies and pursue gender-nonbinary conceptions and “nontraditional” forms of pregnancies without judgment and limitations to healthcare services. Birth justice ensures that individuals and families have access to quality care regardless of their social, economic and environmental background. Several grantees also expressed that reproductive justice is about healing and acknowledging the historical trauma of individuals and communities and its impact on their birthing experience. It is also about (re)connecting to the land and connecting people’s history to the land and environment.
Pathway Toward Equity in Maternal-Child Health

What value do reproductive justice and birth justice investments bring to the WKKF Maternal-Child Health (MCH) portfolio?

How do investments in grassroots, women of color–led organizations improve access and quality of care that is culturally appropriate, linguistically relevant, integrated and normalized into the broader body of maternal-child health-racial equity work?

What approaches, strategies or teachings are laying the foundation toward equity? And, how do these efforts contribute to improving the health and well-being of babies, mothers and families?
To address this set of questions, evaluators interviewed grantees currently funded in the WKKF MCH portfolio. Building from the literature review, we developed a set of questions tailored toward learning what maternal-child health services, structural/institutional systems and policies were in place or in progress to help address inequities for rural, low-income, immigrant/undocumented and gender-inclusive families and families of color.

We interviewed 11 of 13 identified grantees to gain an understanding of how they were advocating and/or addressing maternal-child health equity. While we were unable to schedule an interview with the Tribal PRAMS Project and Santa Fe Community College First Born Program, we did incorporate their learnings from the document review of their evaluation/narrative reports.

Below is a list of grantees and a short description of each organization that was included in our study. Of the 13 grantees, 5(*) provide direct maternal-child health services. The majority of grantees provide advocacy, organizing, education, research and data efforts to make systematic changes to improve maternal-child health services.

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**Black Health New Mexico (BHMN)** is a nonprofit that supports improving maternal-child health outcomes, diabetes, heart disease prevention and management and health equity for African American families in New Mexico. BHMN has been a W.K. Kellogg Foundation grantee recipient since 2020. They are the only New Mexico nonprofit that addresses health disparities for Black New Mexicans. Their project, New Mexico Birth Equity Collaborative (NMBEC), led by Black women, is an inter-ethnic, interdisciplinary coalition of community members, birth advocates, clinical and public health workers. They seek to improve the promotion and inclusion of Black leadership as representatives on the State Maternal Mortality Review Committee (MMRC). BHMN works to develop strategies, policy and system changes that explain how to create equity within the hospital systems of New Mexico, leveraging community knowledge, tools and leadership.

**Bold Futures (BF)** uses place-based delivery of services, policy work, cultural/change shifts and research to address racial equity at the local, state and national level. Bold Futures has been a W.K. Kellogg Foundation grantee since 2014. The organization staff, leadership and board membership include individuals who have done birth justice work in New Mexico over the last 20 years. The organization has been central to birth justice work through community-based advocacy and policy to address the racial inequities experienced by birthing families in New Mexico. The grantee’s model of care is grounded in organizing and advocacy that supports place-based birthing services that strengthen and support families’ physical health and strengthens social supports and quality of care for families.
Strong Families New Mexico/Forward Together (SFNMFT) is an advocacy organization with a mission to advance health equity for New Mexico families and children. SFNMFT has been a W.K. Kellogg Foundation grantee recipient since 2020. They are a women-led organization serving women, gender-nonbinary individuals, Indigenous people and people of color. They are a policy and culture-shift organization that partners with rural communities, using the grassroots organizing model to bring attention to healthcare and reproductive health laws that affect Black Indigenous people and people of color. Their advocacy work exists by working to improve equitable access for birthing families through the “full spectrum” of birth justice. Utilizing an organizing model as the framework for social and health equity movements, they have been successful at uplifting communities to advocate for policies that support equitable reproductive health care and access for families.

The Navajo Nation Breastfeeding Coalition (NNBC) supports the well-being of infants, mothers, and families through their pregnancies, labor, postpartum and breastfeeding journeys. The NNBC has been a W.K. Kellogg Foundation grantee recipient since 2020. The Coalition’s programs and services include access to midwives/doulas, prenatal/postnatal care, and lactation support. They support Indigenous birth keepers on their midwifery and/or doula journey through childbirth preparation and skills and development workshops, as well as by educating hospital facilities and communities about Indigenous-based values and teachings of community, kinship (K’é) and knowledge sharing. The NNBC initiatives work beyond the state of New Mexico to provide more programmatic activities to families across the Navajo Nation.

Changing Woman Initiative (CWI) is an Indigenous nonprofit whose mission is to revive cultural birth knowledge that empowers and reclaims Indigenous sovereignty of women’s medicine through holistic approaches in New Mexico. CWI has been a W.K. Kellogg Foundation grantee recipient since 2016. CWI’s focuses on reproductive wellness by offering homebirth services, easy access clinics, doula support, midwifery, and lactation support for parents and families in a way that integrates traditions. This organization advocates for policy change that will create greater access to birth support, inform and educate Indigenous women, leverage funds, and improve maternal/infant outcomes. CWI collaborates with other Native-led and birthing organizations for the purpose of health equity, spiritual/emotional health, and improved overall health outcomes for birthing families. CWI has built international partnerships in coordination with Birthplace Lab, an Indigenous-owned research, data, and mapping company based in Canada.
Human Milk Repository of New Mexico (HMRNM) builds awareness of the need of human donor milk and offers access to its benefits by advocating for and supporting donor milk-friendly policies within our state, and dispensing pasteurized donor milk to families in need and medically fragile infants. The HMRNM has been a W.K. Kellogg grantee recipient since 2020. The Human Milk Repository of New Mexico is the first and only organization to earn accreditation through the Human Milk Banking Association of North America for families in New Mexico. The HMRNM educates hospital facilities, clinics and communities about human donor milk, how and where to donate human milk and how to receive human milk. They provide services through outreach, communications, advocacy efforts and building strong staff/volunteer development.

Los Alamos National Laboratories Early Childhood Pueblo Outreach Project (LANL ECPOP) is a partnership with the Eight Northern Indian Pueblos Council (ENIPC) aimed to assess and develop early childhood education programs in the eight northern Pueblo communities. LANL ECPOP has been a W.K. Kellogg grantee recipient since 2015. LANL developed authentic relationships with the eight Northern Pueblos to assess the facilitators and barriers for establishing home visiting services in the Pueblo communities and similar collaborative efforts. Multiple health and early childhood sectors were assembled to facilitate the expansion of the First Born Home Visiting Program. Each of the eight northern Pueblos developed their own early childhood education plans with strategies for strengthening and implementing their own early childhood systems.

New Mexico Breastfeeding Task Force (NMBTF) is a large network of advocates that aim to normalize breast/chestfeeding in New Mexico by providing access to resources, offering trainings and building partnerships through established chapters in various communities. The New Mexico Breastfeeding Task Force has been a grantee for W.K. Kellogg Foundation since 2012. Through their advocacy, the NMBTF supports breast/chestfeeding families and individuals by educating on laws that support work environments for breast/chestfeeding employees. They have worked to increase the number of baby-friendly hospitals (BFH) in New Mexico. The NMBTF has been able to progress the baby-friendly hospitals initiative by reaching 17 facilities, which is nearly half of the maternity care units across the state. The BFH initiative has close to 80% of babies being born at these facilities throughout the state. The majority of these facilities are located in rural communities.
The Home Visiting Referral Quality Improvement Initiative

THRIVE’s focus is to create a Quality Improvement (QI) Change Package for hospitals and clinics serving rural and underserved communities that would increase referral rates from hospitals and outpatient clinics to home visiting programs. To identify changes that hospitals and clinics can make to improve home visiting referrals, the THRIVE project is working with clinics and hospitals to conduct QI projects focused on home visiting referral. Successful strategies will then be packaged into a toolkit that can be widely distributed to NM clinics and hospitals. The THRIVE project is currently housed under the Regents of the University of New Mexico Health Sciences Center, who has been a grantee recipient of the W.K. Kellogg Foundation since 2013.

Northwest First Born Program (NWFBP) provides a variety of birthing and family support through home visiting, which includes prenatal, pregnancy, childbirth, breastfeeding and child development support, as well as parenting education/support. The NWFBP has been a W.K. Kellogg Foundation grantee recipient since 2016. The NWFBP provides home visiting services to McKinley and San Juan Counties. The two rural counties have a high Hispanic and American Indian population, which includes the Navajo Nation and Zuni Pueblo. The NWFBP is one of very few organizations that provide home visiting services in rural and Tribal communities. One of the fundamental elements of the First Born Program is including the child’s family, extended family and community in their service. The NWFBP also uses a multidisciplinary approach by connecting families to additional services that the families may need.

Tewa Women United (TWU) is an Indigenous women–founded and led organization located in Northern New Mexico that holds safe spaces for Indigenous women and empowers women to be positive forces for social change in their families and communities. Tewa Women United has been a W.K. Kellogg grantee recipient since 2013. They provide doula services and trainings, support for pregnant and parenting families, breastfeeding support and advocacy and education on reproductive health and environmental justice. TWU strengthens partnerships, community networks and policies that improve access to healthcare for low-income families, women, and people of color in our rural and underserved areas. TWU also incorporates educational, social and benevolent practices, specifically for ending all forms of violence against Native Women and girls, and to promote peace in New Mexico.
The Santa Fe Community College First Born Program (SFCC FBP) provides a variety of birthing and family support through home visiting which includes: prenatal, pregnancy, childbirth, breastfeeding and child development support, as well as parenting education/support. The SFCC FBP has been a W.K. Kellogg Foundation grantee recipient since 2018. The SFCC FBP provides home visiting services to McKinley and San Juan Counties. The two rural counties have a high Hispanic and American Indian population, which includes the Navajo Nation and Zuni Pueblo. The SFCC FBP is one of very few organizations that provide home visiting services in rural and Tribal communities. One of the fundamental elements of the First Born Program is including the child's family, extended family, and community in their service. The SFCC FBP also uses a multidisciplinary approach by connecting families to additional services that the families may need.

The Albuquerque Area Southwest Tribal Epidemiology Center (AASTEC) project seeks to collect culturally appropriate metrics (data) from American Indian perinatal women and their infants in each of New Mexico’s 23 Tribes and use the information to apply data-driven strategies to promote health equity, determine the impacts from the social determinants of health and implement interventions. The AASTEC has been a grantee recipient of the W.K. Kellogg Foundation since 2017. The project seeks to organize, implement, and produce maternal health data for all Tribal partners. AASTEC strives to partner with Tribes to implement community health assessments and provide training and technical support for Tribal partners for data collection, management, analysis and reporting. These metrics will provide information for future program planning, provide health status data, identify areas of need, and develop interventions.
We acknowledge and thank the grantees for taking the time to share their knowledge, wisdom, challenges and successes towards advancing equity for birthing families in New Mexico. The results are a reflection of the dedication and committed work that the grantees have undertaken to influence services, systems and policies that would improve the health and wellness of birthing families and babies in New Mexico.

Across the board, we heard similar challenges and barriers that the grantees have witnessed and experienced while providing services or advocating for systems change to improve maternal-child health practices. Many of these barriers and challenges were intensified by the COVID-19 pandemic. The pandemic further strained an already strained system, heightening the equity gaps in access to and quality of care for underserved communities. The grantees pointed to barriers within hospital and rural clinical systems to include:

**BARRIERS**

- Hiring and recruiting a healthcare workforce representative of the community;
- Lack of ongoing coordinated services between hospitals and community birthing and home visiting organizations;
- Inequities that continue to result in unnecessarily high infant and maternal mortality rates in communities of color;
- Inclusion issues such as unequal access to services for the LGBTQ+ community;
- Lack of information and access to services for immigrant/undocumented status;
- Language barriers due to shortage of interpretation and translation resources;
- Clinics' and hospitals' need for improved assessment and referral processes and continuity of care between agencies;
- Barriers to broadband access to telehealth services in certain rural areas;
- Lack of coordinated services for homeless, substance-using and nonbinary families;
- Omission of post-discharge lactation services from medical billing;
- Lack of policies supporting health promotion/healthy communities;
- Limited community-driven research and evaluation that could support community-specific solutions; and
- Inadequate scale and speed in implementation of effective trauma-informed practices in reproductive health.

While the list of challenges and barriers is daunting, grantees are navigating solutions to influence the system to improve quality of care for birthing families in New Mexico, as indicated in our findings.
We heard from numerous grantees that one of the first steps to addressing equity in the maternal-child health field is to have critical conversations on the history of colonization and its impact on communities of color. Colonization displaced communities of color from their original homelands and disrupted generational ways of being, knowing and doing. The overwhelming infliction of violence and genocidal losses have had generational impact in ways that have contributed to current social and health challenges in communities of color. Research on historical trauma indicates that trauma can be genetically passed on through generations. With this understanding, it is clear that birthing families of color enter into care from a starting place of inequity, exacerbated when healthcare providers do not understand or acknowledge the historical context for the families they are serving.

**FINDING 1:**

**Equity Practices Improve Maternal-Child Health Access and Care**

**A. Truth Telling: Historical Context of Birthing for Communities of Color**

“When history is missing, equity is hard to reach. What needs to be learned or recognized is New Mexico’s history of birthing for BIPOC communities.”
Although childbirth itself has not changed, the way babies are brought into the world has evolved significantly over the last century. The shift away from traditional birthing practices and care from doulas and midwives from the community to hospitalized care using Western medical practices and systems has dramatically changed the natural birthing process. In discussing reproductive justice and birth justice, it is also important to acknowledge the violence and trauma that has been and continues to be inflicted on women, especially among women of color and LGBTQ+ individuals. Reproductive justice and birth justice requires having these difficult but important conversations because they challenge the systems that contribute to health inequities for birthing families.

It is important to give space and recognize the disproportionate violence inflicted on nonconsenting Black bodies, families, and communities with the intent of advancing medical sciences (Black Women Scholars & Black Mamas Matter Alliance, 2020; Washington, 2006). Experimentation on Black bodies of Black women included, but was not limited to, experimentations by Dr. J. Marion Sims, the “father of modern gynecology,” on Anarcha Westcott, Betsey Harris and Lucy Zimmerman without anesthesia; the dissection, study and display of Sarah Baartman’s body; and the unauthorized use of Henrietta Lack’s cervical cells for biomedical research (Bailey et al., 2017; Washington, 2006). These atrocious examples are necessary to highlight the unethical foundation that perpetuates high levels of maternal and infant mortality today.

The history of violence also includes the historical nonconsenting sterilization of Black, Indigenous, and Latinx women, which was still allegedly happening in 2020 with immigrant/undocumented women in ICE detention centers in Georgia (Manian, 2020). It is likewise essential to give space and recognize the overwhelming violence against Indigenous women with the ongoing epidemic crisis of missing and murdered Indigenous women and girls (MMIWG). According to 2016 data from the National Crime Information Center, there were over 5,700 reports of MMIWG. Indigenous women

“Traditional peoples lost their healers because of colonization and slavery and how that has devastated the health of our communities and the reality of midwives and traditional healers.”

“Because of the high rates of sexual violence that Native women experience, what we know about boarding schools, what we know about trauma exposure, and all of those things we’re looking at, how do we prevent child sexual abuse, how do we prevent sexual assault? The levels of child sexual abuse are epidemic levels, and it’s not just in Indigenous communities, or Native communities, it’s across all communities. How did we become a society, you know the United States, as a place where women and children are so devalued and really seen as that property? A lot of that is connected to the white supremacy, the structural state national violence that’s been directed at our community since colonization, so really that colonial experience.”
Making sure that we use trauma-informed approach to these families, because of historical trauma and you know trauma that’s passed down from generation to generation so there’s definitely a lot of ways that we have to approach families. Our concepts about health and what we need to do in terms of taking care of our health has been so heavily impacted by all the systems, by colonization, by this heavily medicalized industry that dictates these health systems ... confronting colonization and having to do some of that educating and helping people to remember, you know when people who come for care is considerably traumatized by a lot of those things.

also face 2.5 times the risk of sexual assault or rape compared to non-Indigenous women (Urban Indian Health Institute, 2019). It is important for birth workers, home visitors and healthcare providers to know and understand the root causes of these traumas from inflicted violence so they’re not perpetuating the traumas and so that they can address the internal system barriers that hinder the healing that women and birthing families need.

The LGBTQ+ community has also historically experienced, and continues to experience, higher instances of trauma, discrimination and violence (Searle et al., 2017). Maternity staff and obstetricians who practice heteronormativity, patriarchal and discriminatory maternal health services perpetuate pervasive structural and gender-specific inequities for birthing LGBTQ+ families. For queer birthing families this could mean further traumatizing individuals, resulting in LGBTQ+ individuals experiencing transphobic violence as well as being hesitant to have their baby in a healthcare facility (Echezona-Johnson, 2017).

We heard from several grantees about how they are addressing their own internal traumas and biases and enhancing their capacity through trainings and collaborative learnings, so they are mindful of how they are providing training, education and services to families. This highlights the importance of supporting local organizations, driven by communities of color, that have advocates, birth workers and providers from the community who understand the multifaceted needs of the families they serve. While it is necessary and crucial to uplift women-of-color-led organizations and have them leading MCH change efforts, the equity work cannot fall solely on them. The medical field can learn and benefit from the knowledge and wisdom of individuals of color and grantee organizations. Medical nurses, doctors and staff should be continuously engaging in conversations and establishing partnerships with organizations led by people of color while being active participants in training their birth workers, healthcare providers and staff in implementing actions that address the colonial, patriarchal, medical model of care that contributes to the inequities.

A couple of the grantees also talked about the importance of having resources available to help families through reproductive loss. This includes support for birthing families that experience miscarriages, infertility and/or abortions. There’s a need for increased resources to help families grieve and provide the mental health support they need. The grantees also shared that reproductive loss is connected to environmental justice and the land. The
destruction and contamination of land, water and air can have direct impact on birthing families that could contribute to high rates of infertility or miscarriages.

### B. Reclaiming Traditional Birthing Practices

“Birthing shouldn’t have to even be in a hospital, right, like we all know that [the hospital] is where you have sick people.”

A general theme expressed by a number of the grantees was that the medical model of care does not align with an ideal inclusive system of care for birthing services, especially if the goal is to meet the expressed preferences of clients. Midwife Nandi Hill shared that hospitals do not use doula and midwife terminology appropriately and what is needed is a system of care. Other grantees expressed similar insights: a system of care means that midwives, doulas, home visitors, lactation consultants and other birth workers are included in the healthcare medical system and not seen as separate. New Mexico is a state that has access to traditional birthing services and home visiting for diverse, Tribal, and immigrant/undocumented families. Pushing practices based in Western dominant culture norms based on “evidence” or for cultural standardization of birthing care can be an injustice, particularly if families are advocating for Indigenous or cultural birthing practices that are enduring and preferred by the birthing families.

Birth justice pushes for families to have access to and the option to choose how they prefer to birth their child. It also includes creating space within the healthcare system that is supportive of birth workers and advocates that are on the frontlines revitalizing, relearning and practicing traditional birth work.

Changing Woman Initiative is the only grantee funded to provide traditional birthing practices/services to birthing families. However, Black Health

“Part of the problem is that doulas and midwives are not part of the system. So, when people are using doulas and need to go to the hospital, hospitals are not taking care of them and saying it’s not their responsibility. Frustrations about how hospitals are treating people of color, there are too many gaps in the system of the birthing process for people of color.”

[Image: Tewa Women United]

**ADVANCING RACIAL EQUITY IN MATERNAL-CHILD HEALTH AND ADDRESSING DISPARITIES THROUGH A REPRODUCTIVE AND BIRTH JUSTICE LENS**
New Mexico, Bold Futures, Forward Together/Strong Families New Mexico, Navajo Nation Breastfeeding Coalition, New Mexico Breastfeeding Task Force, New Mexico Northwest First Born, Santa Fe Community College First Born Program and Tewa Women United have trained doulas, midwives, home visitors, and/or lactation consultants that are also honoring, supporting and practicing community traditional birthing practices. While a majority of the grantees listed do not provide direct services, their advocacy, support, and education on reclaiming traditional community birthing practices are vital to creating change to a system that validates practices that have been in communities for generations before the establishment of hospitals or medical facilities.

The collective work of grantees, across the activity spectrum of advocacy to practice, is essential for confronting the inequities that BIPOC birthing families and birth workers experience at medical facilities. The grantees expressed that birth workers, doulas, midwives, home visitors, and lactation consultants should receive the same respect and validation as nurses and doctors.

“Provide support for families in ways of providing traditional foods, we have some dried corn here, and some blue corn meal that we provide to the mothers for first foods, and we make teas. Our students and our midwives make teas here and they are prepared, you know in a holistic way before we meet, we make sure we come in with a good mindset, good intentions, and we smudge ourselves, and we make our medicine. It’s looking good for the families and you know their babies that are growing, so I feel like we definitely take a holistic way and making sure we know we prep medicines and foods, for the families and the mothers and the growing baby … we do offer some traditional healers to families for their Hizhonchee (Diné) because typically you get a blessing way ceremony, a month before mother is due, so, we do offer that.”
Doulas, midwives, home visitors and lactation consultants need to be part of the system and not seen as an add-on service for birthing families nor only for families that can financially afford the “additional” services.

Hospital and healthcare systems were not prepared for birthing and birth work during the pandemic. This lack of preparation, conversations and collaboration with outside reproductive organizations weakened hospital systems’ reputations. The need to support traditional birthing options, inside and outside of the hospital, was heightened during the pandemic. Particularly problematic were hospital restrictions that allowed one person in the birthing room, which kept doulas and midwives out of the birthing room during the time when birthing parents needed them the most. A well-known hospital in Albuquerque racially profiled Native American mothers during the pandemic by separating them from their babies upon giving birth without consent, further exemplifying the inequitable care that women of color were subjected to during the pandemic.

Bold Futures, Forward Together/Strong Families New Mexico, New Mexico Breastfeeding Task Force, Navajo Nation Breastfeeding Coalition, Tewa Women United and other perinatal partners organized to address this incident and other perinatal disparities that influenced families of color during the pandemic. Collectively they developed a report, “Perinatal Emergency Recommendations, Considering Disparities and Outcomes: COVID-19 and Beyond,” that emphasized the need for a midwifery model of care, doula support, and infant feeding as positive steps towards health equity. Much of the report centered on health justice and representing birth workers of color and including voices from communities most impacted by the major changes in the delivery of birthing services during the pandemic. This document reemphasized the importance of respecting a family’s option to have a home birth and other holistic practices.

The birthing community emphasized reconsideration of home births and “informed decision making” by healthcare providers when offering options to birthing families regarding how they will give birth. It is important that medical providers suggest and support home births as a viable and non-intrusive option for birthing mothers. Some grantees reported that medical providers reached out to home birthing providers during the pandemic, when most facilities were only providing basic and emergent services. They noted that these medical facilities were neither prioritizing nor taking into consideration how expectant mothers could navigate their health care needs during this time.

In order to deliver quality care to birthing families, federal and state funders and/or home visiting entities have to adjust and be flexible to meet the diverse needs of New Mexican families. This means advocating, supporting and validating home births; supporting birthing parents to practice their birthing traditions or customs; supporting

“During COVID we had many lactation consultants in the facilities furloughed. Lactation care was not seen as an essential thing which hurts my brain to even think about, but that’s one of the issues we ran into. Entities not seeing lactation consultants as an essential thing to support and because of that we’ve seen a lot of calls being routed to the task force looking for lactation care beyond the hospitals.”
doulas and midwives to provide birthing support; supporting immigrant/undocumented birthing parents to have full medical birthing coverage despite their immigration status and creating a hospital/clinic protocol or practice that establishes a system of care where hospital/clinic staff work alongside doulas/midwives and allows the birthing parent to guide the birth practices.

C. Culturally & Linguistically Appropriate Practices

“We realized that there are multi-generations in different areas of our community that are grandparents raising grandchildren and this kind of brought up the conversation of, from our Pueblo upbringing, that how traditionally, in one household, you would have your mother, father, and grandparents living with you at some point, and aunts, and uncles, and vice-versa. So, on some level, there were multi-levels of family that were around and raising you.”

The grantees expressed striving to promote and implement more culturally and linguistically responsive care for birthing families through their practices, methods, advocacy and services. They emphasized the importance of tailoring their services to diverse cultural families, using culturally responsive content and allowing families to define what
family means to them, as well as understanding cultural roles in families to better fit the needs of birthing parents and babies. Whether the grantees were providing direct services, education or training they talked about approaching families and community partners in a way that focuses on their beliefs, family and community teachings, social and environmental norms.

The grantees have provided training for doulas, home visitors, midwives, and lactation specialists to increase culturally and linguistically appropriate care for birthing families. Some grantees have also worked to adapt curriculums to be more community-driven and inclusive of communities’ culture and language. Several grantees also provide education, spend time with families relearning traditional birthing practices, so families are knowledgeable, and can self-advocate for birthing options inside and outside of the hospital. Birthing families in turn become educators and advocates in creating spaces for additional families to have equitable holistic birthing options.

“Our next session they’re going to teach us how to sing a song when the babies are coming in and are getting ready to be born there. We will learn how to sing those songs so we can start learning how to sing it when the baby’s coming in. We’re hoping to get more of the partners like the father’s involved, because the singing portion is led by the partner, so we try to get a lot of partners involved.”

Building trust and relationships is part of honoring cultural practices. The grantees talked about the importance of listening to families and understanding their cultural backgrounds and upbringings and bringing those teachings into the collective learning space. In this space, grantees are building a collective learning space that honors the community’s cultural teachings along with the medical science.

Several grantees also talked about the need and importance of having more bilingual birth workers and health care providers available. With Spanish being the second most spoken language in New Mexico, it is pertinent that families are able to receive services and get materials in their native tongue. Language barriers contribute to the health equity gap, particularly for immigrant and undocumented and Spanish speaking

“We know in the past, mothers or grandmothers would breastfeed their grandchildren, or their nieces, or other people would do that if they were expressing milk. I like how communal that was, again, that support that surrounds you. Then with colonization, with economic disparities, and with patriarchy, that’s a challenge, and so, how do we do that, and encourage, not necessarily discouraging, or shaming, or causing stigmatization around breastfeeding.”
families. A grantee shared that the language equity gap resonated when they witnessed a Spanish speaking family receiving information from a doctor through an interpreter, but not having any of the materials provided in Spanish. Therefore, the family was trying to take notes while understanding the complex information that was being shared about their child. That moment triggered the grantee to start working on translating their materials into Spanish.

Gender Equity

Birthing families that require essential maternal-child health care in New Mexico include lesbian, gay, bisexual, transgender, and LGBTQ+ identifying individuals who can conceive a baby biologically. Due to discrimination and heteronormativity, often LGBTQ+ families are unacknowledged in the maternal and child healthcare systems, which already impose structural racism, furthering early childhood disparities. These individuals could also be people of color, immigrant/undocumented, and people with disabilities and/or come from low economic backgrounds. These are multifaceted health disparities and intersectional maternal-child health issues need to be addressed by health systems, including infant/toddler programs who serve the LGBTQ+ communities in New Mexico. The majority of grantees consulted in this study are in the space of learning and building partnerships with LGBTQ+ organizations to strengthen their internal advocacy and service to LGBTQ+ birthing families.

Religious refusal rules or laws allow healthcare providers to deny services or refuse treatments to patients because of religion. Patients can be denied services and/or discriminated against based on their cultural, language, and/or gender identities. Religious refusal laws or policies can deny birthing families birth control, abortions, hormone therapy and/or vaccines (Planned Parenthood, n.d.). A

“ When we’re talking about the culturally competent care and work that we do and also the language piece, all of the work moving forward, we’re always triple checking and making sure we are putting this information out in English and in Spanish, and do we have it accessible to people whose first language is not English. We’re working on improving that process, and in our clinic piece, all of our steps are going to be in English/ Spanish. When we are trying to get applications for our Certified Lactation Consultant project to get people trained, we are putting it out there on the forefront that first applications are going to go to underserved populations who maybe don’t speak English. We want to make sure that the people we are opening up doors for, we’re tapping into communities who don’t often get any support.”
grantee shared that many immigrant/undocumented and LGBTQ+ families they work with have to navigate religious refusal, particularly if they are receiving services from a Catholic or other religious charity.

LGBTQ+ birthing parents often experience structural marginalization due to standardized healthcare models that associate childbirth with the female gender and a feminine body type. Hospital child delivery providers can discriminate against LGBTQ+ parents, specifically those parents presenting masculine identities (Malmquist et al., 2021). According to research (Echezona-Johnson, 2017; Searle et al., 2017), most healthcare models are based on heteronormative and patriarchal service delivery models, which in turn creates resistance by LGBTQ+ individuals to utilize Western birthing facilities and to disclose their sexual orientations and gender identities to healthcare providers. Structural marginalization is most experienced by transgender patients who identify as male (Hoffkling et al., 2017), where maternity doctors have refused services and declined continued care for these patients. For this reason, perinatal maternal-child healthcare facilities are encouraged to engage in further staff training regarding the transitional assessment and parental, birthing, and chestfeeding needs.

“We are doing a lot of work around religious refusals and just informing folks about what that means. It’s difficult, one of the things that we’ve learned over a few years about religious exemptions or refusals is that many times, because they carry so many identities, they may be discriminated against but don’t know if it’s because someone disagreed based on their moral or religious beliefs with the decisions that the person was making. Or if it was because they were not an English speaker or because they were presenting as queer or because they were undocumented…. So just really informing and connecting the dots between reproductive healthcare and LGBTQ+ right; they go together.”

In Indigenous communities, historically there are traditional narratives that celebrate two-spirit individuals, who are treated with respect. Two-spirit terminology represents an individual that identifies with having both a feminine and masculine spirit. According to some tribal elders, two-spirit individuals were accepted as part of the family and community. They were considered healers or medicine people and were included in the societal structures. In some tribal
communities, transgender individuals served as foster mothers or fathers, and lesbian women had a place in warrior or hunting groups, often fighting or hunting with the men. In less than 500 years, most likely after the Pueblo Revolts of the 1600s and the Navajo Long Walk and Bosque Redondo encampment of Apache and Navajo people of the 1800s, settlers practicing Christianity had inflicted violence and trauma in tribal communities that disrupted traditional cultural norms, which included imposing gender binary views.

In New Mexico, according to a New Mexico Department of Health report (Greene, 2017), the state has about 47,439 (3%) adults who currently identify as lesbian, gay or bisexual (data did not include transgender). A majority of adults (more than 25%) were in the age range of 18-24 years, which means a large proportion of LGBTQ+ individuals in New Mexico are in their childbearing years and may be seeking birthing, perinatal and postnatal and child health services in the coming years. A majority of the grantees interviewed expressed that birthing services for LGBTQ+ families does need support and is an area in the field that needs to be strengthened.

The LGBTQ+ community continually seeks equal birthing rights in New Mexico, most urgently for transgender parents. According to research (Levitt et al., 2020), current maternal healthcare facilities could be places where 100% gender inclusion can be fulfilled through training and education of healthcare workers on the needs of transgender birthing families. Specific gender inclusive strategies for immediate consideration are the use of gender inclusive pronouns and respecting the gender identities of male-identifying transgender patients, who often are ridiculed or neglected, based on their gender identification as a “man” conceiving or having a baby. Health care facilities and service programs who provide care to transgender parents and engage in structural inequities further traumatize LGBTQ+ patients, causing poorer health conditions for these individuals (Haseen et al., 2020).

“Everybody gets treated badly as soon as they walk in [to a hospital], you just don’t want to go in there at all. The first thing they [hospital staff] ask you when you walk in is if you have insurance. You get bombarded with these questions, so a lot of the moms that are not legal, that are immigrants… they are close to delivering before they go into the hospitals because they know they’re going to get bombarded with questions. A pregnancy or the delivery is considered an emergency, so they [hospital] have to treat you. They [immigrant/undocumented] don’t get prenatal care because first of all they can’t afford it, and if they can afford it then they’re not treated nicely.”

E. Payer Systems

Immigrant and undocumented families face many birthing and health care barriers in New Mexico because they either lack health insurance or have limited health access to prenatal care by nonprofit organizations that provide direct maternal-child health services. One grantee stated that many healthcare workers assume a person of color does not have the means to qualify for health insurance or the means to pay for services if they are provided care.

Unfortunately, even when organizations can provide prenatal care to immigrants or undocumented families, they are unaware of the services available. Profiling and services rendered based on someone’s
“legal” status, ethnicity, linguistics, or gender is an unfortunate practice by healthcare workers that continues today (Sakala et al., 2020).

Numerous grantees talked about the challenges that families experience with hospital billing, being overcharged and navigating what their insurance will cover. One grantee shared that they hired a third-party legal group to investigate and assist families that have been overcharged for hospital services. Many of these families have low socio-economic status with Medicaid being their primary insurance, so hiring outside legal support groups are out of reach for these families. This is not only overwhelming for the patients and families, but for the organizations who have to navigate the system and expend additional costs with their limited budgets to help remedy the situations.

Several grantees discussed the challenges of Medicaid reimbursement for lactation consultants, doulas and other birth work services. The majority of the families that the grantees serve have Medicaid as their primary insurance. One grantee discussed addressing this challenge by working with the superintendent and the Public Relations Coordinator of Medicaid and building traction before bringing it to the forefront of the state’s legislation.

The insurance issue is one of the key structural ways that we can cause change and really increase access, that is critical. 70% of our births are on Medicaid, and it’s just the fact that we can’t get reimbursement through Medicaid, I think it’s just almost criminal. That’s one of our key issues for structural change.

New Mexico passed a law that International Board-Certified Lactation Consultants and Certified Lactation Counselors could become licensed in New Mexico as a provider, but it’s not embedded in the Medicaid system. So, unless they have another credential that they can bill under like a nurse or a physician or a midwife, they cannot be reimbursed for their services.

This barrier continues to keep doulas, midwives and lactation consultants from being embedded into the maternal-child healthcare system. It also prevents birthing families from receiving these services. This presents a hardship and major challenge within low-income rural communities.

Meaningful Data Representation

“The data issue is significant. I think we need this, the thing with data sovereignty and like how messed up this pilfering of statistics, the numbers are not real, the numbers are misleading, and they are harmful. There are so many things about those numbers, so I think that is another thing that we think about too is like we do not even really know, and it would be lovely to know.”
Numerous grantees talked about the need for more consistent and inclusive maternal-child health data. There were concerns that the maternal-health data from the state is not always reflective of the communities and can be racially diminished and outdated. Grantees expressed that having accurate data is crucial for advocating for policy and systems change, particularly for legislative sessions, but also for leveraging funding to support community birthing and home visiting efforts.

A couple of grantees also talked about pushing back on collecting “mandatory” assessment data that funders require but are not culturally or linguistically appropriate for the families they serve. There were concerns about “standardized assessments” that were not sensitive to cultural, family or community norms because they were developed outside of New Mexico. One grantee expressed that these types of assessments often cause families to shy away from receiving services because they don’t feel inclined to answer questions that feel invasive.

Several grantees talked about the importance of building relationships, listening, and establishing thoughtful partnerships with community partners on the ground for improving data collection efforts with families and communities. A couple of grantees mentioned that collecting data from families and communities without sharing the findings back is another extractive practice that further amplifies mistrust from families and community-based organizations. One grantee shared that their years of advocacy efforts and trainings in communities have helped establish trust and understanding for the collective mutual work.

“We did over 1700 surveys across the state, in rural communities and so anyone that identified they live in a city was removed from [the survey]. We talked to people and asked them questions about abortion access, sexual assault, and those things. I felt like I knew we would have positive outcomes from those areas, but to see 70% participation speaks to how we work with our community and how we ask the questions... We are careful how we ask the questions and aware of who we’re talking to... when engaging communities, we promised we would bring the report back and of course, we did.”

New Mexico Breastfeeding Task Force

ADVANCING RACIAL EQUITY IN MATERNAL-CHILD HEALTH AND ADDRESSING DISPARITIES THROUGH A REPRODUCTIVE AND BIRTH JUSTICE LENS
The grantees expressed that hospital systems have improved very little in terms of accessibility of culturally- and linguistically-relevant perinatal services for the communities of color. Though doulas, midwives and home visitors are prepared to provide such services, their role in medical settings continues to be structurally limited. The distinction of medical roles and responsibilities between doulas/midwives and hospital staff remains unclear, and, as mentioned by several grantees, equitable pay for doulas and midwives of color is a significantly large barrier. Their limited access means that family accessibility to prenatal, postpartum, cultural practices and linguistic services continues to be limited. There are not enough advocates serving bilingual families; and there is an imbalance in how the LGBTQ+ community accesses healthcare. To help advance equitable services, healthcare systems need to recruit and retain a healthcare workforce that represents the linguistic and cultural aspects of each unique community.

Finding 2:
Ensuring Diverse and Inclusive Birth Workers, Home Visitors and Healthcare Providers Have Equitable Pay

Representation Matters

The grantees expressed that hospital systems have improved very little in terms of accessibility of culturally- and linguistically-relevant perinatal services for the communities of color. Though doulas, midwives and home visitors are prepared to provide such services, their role in medical settings continues to be structurally limited. The distinction of medical roles and responsibilities between doulas/midwives and hospital staff remains unclear, and, as mentioned by several grantees, equitable pay for doulas and midwives of color is a significantly large barrier. Their limited access means that family accessibility to prenatal, postpartum, cultural practices and linguistic services continues to be limited. There are not enough advocates serving bilingual families; and there is an imbalance in how the LGBTQ+ community accesses healthcare. To help advance equitable services, healthcare systems need to recruit and retain a healthcare workforce that represents the linguistic and cultural aspects of each unique community.

“It’s really clear that we need more midwives, we need more direct care providers that are from Tribal communities and we need to also be very thoughtful around all of our ancillary care, which is what I’ve been calling that but it’s not a good word but it’s like all of the other folks that are filling in all the gaps.”
As stated earlier, the grantees have been intentional in diversifying their organizations and board members to be more reflective of the communities they serve. The grantees also talked about training more community members and birthing families of color, so they feel empowered to advocate for themselves and other families. Advocates for families and communities of color are key partners that have pushed for policy and practice changes.

**B. Pay Equity**

“Political and social, where people having a living wage is part of reproductive justice.”

Several of the grantees talked about structural racism and barriers to providing equitable pay for birth workers and getting more individuals of color trained to become doulas, midwives or lactation consultants. Each profession has its own lengthy training requirement, practitioner or clinical hours that need to be fulfilled and training program costs. These are expensive certifications that many people of color cannot afford unless paid for by an employer or scholarship. Community-based organizations also cannot afford to pay their employees to be trained, unless they have funded grants to support the trainings. WKKF has been instrumental in funding organizations to train more doulas and lactation consultants or specialists.

“...the only obstacle that we’re coming up against is the clinical hours that are required, depending on pathway. It could require anywhere from 300 to 1000 clinical hours to become an International Board-Certified Lactation Consultant (IBCLC), and right now the only mentorship program that is happening... in Phoenix ...and that’s Valley Wise Hospital. Although there are several IBCLC’s but with the red tape with Indian Health Service and also the privately owned hospitals on those IBCLC’s in that setting will not take on community members to mentor.”

The first part is working from within the organization itself. You can’t lead the work if you don’t have the voices at the table who are experiencing the work/barriers. We really focused on these past two years, look at our Board, it’s more diverse, with respected voices and they feel heard. Our staff is also diverse and comes from different communities, with levels of expertise and specialism. “
Doulas, midwives and lactation consultants of color often are serving communities that are on Medicaid, have no insurance, or depend on the Indian Health Service for their medical care. Individuals and community-based organizations invest time and money to increase the number of doulas, midwives, or lactation consultants and struggle to sustain their living wage. The insurance reimbursement process is daunting and tedious and does not reimburse at the same pay grade that it would for a nurse or a doctor at a hospital.

“"There are so many folks that can’t afford to become a doula or birth worker. Even in New Mexico, we see affluent, white women paying thousands (of dollars) to run a practice. A person of color who is learning about the field of birth work and training doesn’t have that same access ... but I do see an amazing next generation of doulas and birth workers."”

“"We often get shortchanged as rural communities, it takes us twice as much to run a program than it would, and oftentimes we’re underfunded because we’re rural communities and we don’t have the population. We also have the challenges of not having transportation, public transportation and all of these other things. So really making it accessible for our low-income communities and also looking at the pay equity, paying our doulas and other birth workers what they should be paid. When we look at Medicaid reimbursement, it’s a great thing but often times people aren’t getting reimbursed at the rate that they should be. We’ve seen that with mental health providers as well, and so we’re always talking and thinking about how we can address this, how we can talk about it, how we can bring that to people’s attention. I think our rural and tribal communities get shortchanged a lot, because we don’t have the numbers, and that’s always going to be a challenge for us, so being able to talk about it is important. ”"
The grantees’ collective efforts of all the “little things” are contributing to policy, system, and environmental changes within the maternal-child health field. Some of the grantees expressed that they have diversified their workforce and boards to be more inclusive of individuals of color that are representative of the communities they work with. These environmental programmatic changes help to amplify people of color voices in the MCH field and can help build trust with families and communities when they feel represented.

**FINDING 3:**

Collective Actions Drive Racially Equitable Change

**Navigating Institutional Systems Change**

“Talking about how structural change happens with little things, like you know, our families are birthing in hogans and how beautiful is that. It’s not this big, massive building that needs to happen, it’s these little spaces on people’s own land or in their territories where the change will happen. You know, for us home birthing midwives, we are already a little bit outside of the system and it’s wonderful.”
A number of the grantees have organized to successfully influence policy changes in recent state legislative sessions (further discussed in policy section below). During the pandemic, several grantees were instrumental in providing PPE, food, water, diapers and other essentials to families in need. They have also brought to the forefront, for instance, the importance of access to basic internet and/or telehealth services and maternal and family access to birthing services. While the systemic changes needed are vast and not easy to address, the grantees’ consistent passionate efforts are nurturing seeds that are gradually creating change. Other organizations such as the Navajo Nation Breastfeeding Coalition have become involved in the mapping session and provided feedback to write out and create the legislation in both New Mexico and Arizona.

Grantees are advocating for birthing families by keeping birthing health facilities or hospitals accountable for the quality of care for birthing mothers. Grantees are continually addressing health care access and health coverage, specifically making sure that birth service providers are included in discussions regarding revision of laws that will allow doulas, midwives, lactation consultants and home birth champions benefits or reimbursement for their services.
Among the challenges expressed by some grantees is providing comprehensive and quality birthing services to rural communities. The rural communities that grantees work with often have limited options for birthing services. The closest hospital could be 1-2 hours away and be the only facility that’s providing medical care for the region, which can contribute to an overstrained system that leads to lower standards of care. Grantees reported that they often hear from families they work with that they are not trusting of the hospitals or clinics based on their personal experiences. However, with limited options, families have no choice but to receive birthing and family care from the medical facility that’s available to them. A few grantees mentioned that this hesitancy and trust contributes to the marginal prenatal care, particularly for Native and immigrant/undocumented birthing parents.

The IHS was established in the mid-1950s as part of the Federal Government’s treaty trust obligations to provide healthcare for sovereign, federally recognized Tribes. It is the primary healthcare provider for Tribal communities and the urban Native population. However, there is a long-standing history of Tribal communities’ complaints of inadequate care and overall mistrust of the IHS. The federal IHS budget has also decreased over the years, which has eliminated some services including birthing and maternal-child healthcare from many facilities. This amplifies the importance of revitalizing traditional birthing practices, so Tribal communities have access to birthing options beyond IHS.

**Acknowledging that one of the structures that we must deal with is the Indian Health Service. And how we can purposefully engage in conversations about what that looks like for our communities. What are they doing? What are they not doing? And how can Tribes really come to that conversation in a way that can be transformative for healthcare systems that are wrapped up in the Indian Health Service (IHS).**

**B. Collaborative Community-Driven Efforts**

Improving the maternal-child health field requires creating a robust, comprehensive system of care that works to eliminate the barriers, challenges and negative racial impacts that families of color face in the hospital.
systems that should support all families no matter their race, gender identity or ethnicity. The grantees funded by WKKF are at the forefront of creating this system of care through their collaborative community-driven work. The grantees have organized and come together to address different institutional barriers, push policy changes, and provide consistent education to advance equitable opportunities for birthing families in New Mexico.

The “Perinatal Emergency Recommendations, Considering Disparities and Outcomes: COVID-19 and Beyond” report is a prime example of grantee collaboration to promote inclusion during a time of major shifts in how birthing services are delivered. The development of the recommendations brought New Mexico people of color perinatal voices together to address the need for preparedness (creating crisis plans) around perinatal services when emergent situations like COVID-19 arise. The document provides healthcare birthing service providers with preparedness recommendations that support inclusive and responsive service provision appropriate to diverse communities of color.

“There are midwives, OBGYNs, and doulas, and so being able to create that cross-discipline, cross-racial, cross-cultural understanding and communication is important. We can only speak from the perspective of a doula, because that’s the service that we provide, but the midwives are an internal key to this work as well, and so again, the system complicates things and we create these silos. So how do we continue to have those intercultural, intra/interrelationships within those disciplines? I think that is an important piece for us to really understand. Our strength in this work of birth justice and reproductive justice in the State of New Mexico, is that we work hard to create those relationships, so if there’s people that are meeting, and they’re not talking about doulas we try to bring ourselves to that meeting. The doulas are bringing all of the other agencies, programs, entities, and we want to continue to strengthen and build on that, and I think that’s an important place for the state and others to really understand and support community-based programming and access all of those different levels in our communities, and for us we always bring to the table the rural communities.”
C. Policy

Community-based organizations also engaged in education, relationship building and advocacy addressing issues they found critical to racial equity, reproductive and birth justice, and consequently, maternal child health.

Black Health New Mexico, Tewa Women United, the Navajo Nation Breastfeeding Coalition and Changing Woman Initiative, along with other Black and Indigenous birth workers and birth advocates, combined advocacy and education during the 2021 Legislative Session to reform the statewide Maternal Mortality Review Committee (MMRC). The result, Senate Bill 96, ensures that all MMRC members are trained in trauma-informed care and thinking, including the trauma of racism. SB 96 also ensures that lived experience and professional diversity are taken into consideration and Black and Indigenous community members are given the opportunity to serve on the MMRC and designated as essential members. As a direct result, more than four Black and Indigenous community members have been newly appointed to its membership. Prior to it, no Black people had ever served on the New Mexico MMRC.

Simultaneously, Bold Futures, Tewa Women United, Forward Together/Strong Families and Changing Woman Initiative worked collaboratively in the 2021 Legislative Session on Senate Bill 10, Repeal of the Abortion Ban, repealing the longstanding (1969) state abortion ban and upholding a woman’s right to make decisions about her own body. Together, these policy efforts address the intersecting issues of racial equity, reproductive and birth justice.

Bold Futures has also worked to help certify the Birth Center Licensure program, which was a huge step that helped provide reimbursement for individuals to give birth at the centers. This primarily aids those especially living in rural areas. Part of this initiative was to also pass rural tax credit, which provides credit to healthcare workers in rural areas for providing their services, and includes doulas and licensed midwives. Bold Futures also works collaboratively with the Center for Applied Research and Analysis (CARA) Work Group of New Mexico, which consists of approximately 160 public and private sector stakeholders working to bring the State of New Mexico into compliance with federal law regarding substance-exposed newborns and their families.

Forward Together/Stronger Families, in collaboration with other partners’ collective leadership, was instrumental in enacting policies that will expand healthcare access for uninsured New Mexicans. In partnership with New Mexico Together for Healthcare, they successfully advocated for passage of the following healthcare policies: SB 317 Healthcare Affordability Fund, HB 112 Health Benefits for Certain Non-Citizens, and SB 71 The Patients’ Debt Collection Protection Act.
FINDING 4:

Essential Reproductive, Birth, Family and Infant Systems of Care Model Improves Spectrum of Care

Created by Beverly Gorman, Diné/Navajo LMSW, MSW/MBA
NMREAL Team Program Specialist

Full-Term Births
0-1 YEARS INFANT CARE
BREAST/CHESTFEEDING
Improve Parental Well-Being
POSTPARTUM
BIRTHING SUPPORT
Healthy Developmental Milestones
Healthy Birth Weight
Access to & Duration of Breast Milk
1-3 YEARS TODDLER CARE
BIRTHING FAMILY WELLNESS & CARE
Decrease ACEs
REPRODUCTIVE CHOICES

Spiritual/Policy/Enviro.
Self-Determination & Sovereignty
Leverage People of Color Voices
Restoring Birthing Cultural/Spiritual Practices

Health/Well-Being
Reproductive & Birth Justice Values
Systems of Care
Healthcare Accessibility & Quality of Care

Mental/Behavior/Social
Truth Telling/Building Trust
Gender Neutrality
Decolonizing & Healing Cultural Traumas

Birth Service/Econ.
Compassionate Care
Trauma-Informed Care
Pay Equity

Improve Parental Well-Being

ADVANCING RACIAL EQUITY IN MATERNAL-CHILD HEALTH AND ADDRESSING DISPARITIES THROUGH A REPRODUCTIVE AND BIRTH JUSTICE LENS

PATHWAY TOWARD EQUITY IN MATERNAL-CHILD HEALTH
The reproductive, birth, family and infant systems of care model was developed to conceptualize the various findings that emerged from the study. We aimed to develop a holistic model that was comprehensive of the racial equity work that the grantees expressed was essential to improving the spectrum of care (from preconception to infant/family services) for birthing families and infants in New Mexico. The model is inclusive of reproductive justice and birth justice values and processes that the grantees are advocating for and implementing. At the center of the model is a loving healthy birthing family which is the core work that the grantees are aiming to achieve. Surrounding the healthy birthing family are holistic factors and social determinants of health that include physical health and well-being, mental and behavioral health, social, economic and spiritual considerations and policy and the environment. These are factors that help assess the needs of families and can be indicators of success or stress depending on where a family is positioned within the various areas. These factors also help grantees understand the type of care birthing families need and can also be indicators of racial-health inequities.

The racial equity strategies that the grantees are advocating for or implementing are positioned within the four sections of the star. The grantees are advocating for reproductive justice and birth justice so that families have the right, plus access and support, to birthing healthy babies and raising families in safe sustainable communities. This includes having a system of care where traditional birthing practices, midwifery, doulas, lactation consultants and home visiting are inclusive of the maternal healthcare systems. This would help improve access and quality of care for more birthing families, especially for rural or low-income families. Grantees expressed that truth telling about the history of colonization and its impact on communities of color and birthing practices are foundational to addressing the racial inequities. Understanding and having trainings on generational impacts of colonization could help healthcare providers provide better care for families. Grantees talked about how implementing compassionate or trauma-informed care for birthing families would help them build trust in the healthcare system.

The grantees’ racial equity work positioned within the star sections is metaphorically represented in the model as the sun’s heat source. The grantees are strengthening this heat source to advance racial and health equity through policy, environmental and systems change from a holistic health perspective that will radiate toward outcomes across the spectrum of care for birthing families and infants. The outer moon cycle represents the spectrum of care that birthing families need to support birthing healthy babies and healthy parents. The spectrum of care begins with reproductive choices at the east, representative of the sun rising. Reproductive choices are inclusive of birth control, preconception care, abortion, fertility support or other choices that families can make to prevent or start a family. The spectrum of care that birthing families need continues with each moon cycle from prenatal to birthing support, to postpartum, to breast/chestfeeding, to 0-1 years infant care, to 1-3 toddler care, and to birthing family wellness care. The grantees are leveraging the racial equity work and providing services throughout the spectrum of care with the goal of birthing babies at full-term with healthy birth weight that have access to breast milk; and ensuring that birthing parents have healthy support systems and overall healthy well-being.
The Data Story of Maternal-Child Health Equity in New Mexico

What are the current maternal-child health data for WWKF priority places in New Mexico?

What story is the maternal-child health data telling when disaggregated by race?
The United States is known for its monumental healthcare spending that consistently outpaces other nations of similar economic prosperity. Yet the maternal and infant health outcomes that are key indicators for gauging the overall health and well-being of the nation are consistently lower than that of similarly prosperous nations (Tikkanon et al., 2020). The following is an analysis of data collected from various New Mexico state databases. Data includes prenatal and perinatal maternal and child indicators. This analysis is primarily descriptive and aims to highlight the story of maternal and child health in New Mexico through data.

### Data Highlights

#### Reproductive Care

- The fertility rate is decreasing for all racial and ethnic groups. Although white non-Hispanic women have the lowest fertility rates of all women, Native American women have experienced the sharpest decline in fertility rates over the past ten years.

#### Prenatal

- First-trimester prenatal care has increased steadily statewide and among racial and ethnic groups except for Black/African American women who experienced a 7.9 percentage point decrease between 2011 and 2017.
- More women reported getting prenatal care as early as they wanted (10 percentage points higher than in 2009). However, nearly a quarter (22%) of Native American women cannot get it as early as they want, indicating a need to identify barriers and increase access.
- Native American women are nearly two times as likely as Asian and white non-Hispanic women to receive late/no-prenatal care.

#### Birthing Care

- Black/African American women are two times as likely as white non-Hispanic women and Native American women to have a low-birth-weight baby.
• Infant Mortality rates (overall) show trends that remain flat. However, Black or African Americans are roughly twice (10.3, 2019) as likely as their Asian or white counterparts (4.5 and 4.8, 2019) to experience an infant death.

• The relative risk of severe maternal morbidity for Black women in 2018 was 25% higher than white non-Hispanic women. For Native American women, the rate was 60% higher than for Black women and twice as high as white non-Hispanic women.

Breast/Chestfeeding

• The overall percentage of women who breastfeed has remained flat, although the percentage of Native American women breastfeeding is declining.

• Native American women initiate breastfeeding during the first hour of birth at a higher rate than white non-Hispanic or Hispanic/LatinX women.

• Native American women breastfeed for longer than all other groups of women.

• Data may indicate that education initiatives through hospitals (or other organizations) are broadening perceptions of breastfeeding, as evidenced by the decrease in formula distribution and mothers reporting hospitals providing an increase in breastfeeding resources.

Postpartum through Toddler Care

• Home visiting funding and services have increased dramatically.

Please consider that the data is volatile in many instances due to small population samples and/or missing data. Some data are suppressed. In the graphs that follow, many axes do not start at zero and are exaggerated to show differences. In addition, the charts are intended to highlight data points that stand out. In some cases, we removed the overall “all race/ethnicity” trends and/or unstable subgroups from graphs for visual clarity. PRAMS data rarely includes data for Asians and Black/African Americans in New Mexico. Nor does it have any of the county-level data. The W.K. Kellogg Foundation has funded the Albuquerque Area Southwest Tribal Epidemiology Center (AASTEC) Tribal PRAMS to improve the collection and analysis of data for Native American women. However, AASTEC has not yet publicly released the data as they are still reporting the data back to Tribal partners and need Tribal approval to share publicly. Therefore, the following data does not include Tribal PRAMS data, only state PRAMS data.

The need for accessible and high-quality data across the spectrum of maternal and child health outcomes continues to be a concerted struggle for state agencies, Tribal communities and WKKF-funded initiatives. Comprehensive and reliable data can be essential for leveraging funds or informing policy and systems change efforts to improve accessible, equitable prenatal, postpartum, breastfeeding and early childhood family social support systems.
Births and Fertility Trends

The number of live births in New Mexico has seen a steady decline since 2009. In 2019 22,966 babies were born compared to 28,873 in 2009. Most deliveries occur in hospitals, which has changed very little over the past ten years (99% hospital births in 2009 and 98% in 2019).

Differences exist between racial and ethnic groups. LatinX women accounted for the largest proportion of live births in 2019 compared to other groups. Black/African American and Asian women have the lowest percentage of live births at 2%.

Consistent with national trends, New Mexico has seen a decline in fertility rates. In 2008 Native American women had the highest fertility rate of all racial and ethnic groups in New Mexico, with 41.5 babies per 1,000 women. By 2019 the rate dropped to 27.8. From 2008-2019, white non-Hispanic women had lower fertility rates than other groups, with 15.6 babies born per 1,000 women in 2019.

Health Insurance and Health Supports

Insurance Before Pregnancy (Medicaid, Private, No Insurance) PRAMS

In 2018, 49% of women reported having Medicaid before pregnancy, 36% reported private insurance, and 12% had no insurance. Hispanic/LatinX and Native American mothers reported having Medicaid before pregnancy at higher rates (52% and 75%, respectively) than white non-Hispanic women (35%). Since 2009, the percentage of women with no health insurance before pregnancy has dropped considerably. Approximately 1 out of every 4 women in 2009 (26%) had no insurance; in 2018, 15%. Native American and Hispanic women both saw the most significant drops, although data for Native American women is considered unstable due to small samples. In 2009, 30% of both groups had no insurance compared to 17% (n=118) of Hispanic women and 4% (n=6) of Native American women in 2019.

Insurance for Mothers and Babies After Delivery

According to PRAMS data, the percentage of women and babies with insurance sometime after delivery has also steadily increased in New Mexico. (The PRAMS survey is given to mothers two to six months after they deliver.) Trends indicate this can primarily be attributed to the increase in mothers/babies receiving Medicaid, which spiked in 2014. When disaggregated by race, all groups show increasing levels of insurance.

Sources: New Mexico (NM IBIS, PRAMS)
Multi vitamins Before Pregnancy

The PRAMS survey indicates the percentage of women *not taking a multivitamin* the month before pregnancy has decreased. In 2009, 60% of women did not take a multivitamin before pregnancy compared to 54% in 2018.) When disaggregated by race, data suggest white non-Hispanic women take multivitamins before conception at a higher rate than Hispanic/LatinX and Native American mothers. The data also indicate that since 2009, Native American women and LatinX/Hispanic women have increased their preconception multivitamin use at a higher rate than white women. Data were not available for Asian or African American women.

WIC during Pregnancy

A little over half of the women (55%) in NM receive WIC during pregnancy, 15 percentage points higher than the national rate (40%). In 2015, LatinX and Native American mothers were nearly 2.4 times as likely as white non-Hispanic women to receive WIC during pregnancy, approximately 66% of women of color compared to 28% of white non-Hispanic mothers.
Prenatal Indicators

Access to 1st Trimester Prenatal Care

In 2019, 65% of women in New Mexico received 1st-trimester prenatal care, 7 percentage points higher than 2009 but still below the national rate of 77%. Differences in 1st-trimester care exist between the four counties. In Bernalillo, 69% of women accessed early prenatal care in 2019 compared to 64% in San Juan, 60% in Doña Ana, and 55% in McKinley.

Nearly all racial and ethnic groups follow similar upward trends with peaks in 2010 and 2015. Disparities exist between groups. In 2019, white non-Hispanic and Asian women accessed early care at the highest rates (70% and 68%, respectively), while just over half of Native American women (55%, n=1,516) accessed early prenatal care in 2019.
Received Prenatal Care as Early as Wanted

According to PRAMS surveys, in 2018, 86% of women reported receiving prenatal care as early as they wanted, compared to 77% in 2009. These rates increased for all racial and ethnic groups available. Disparities in access exist between groups. In 2018 only 78% of Native women reported receiving care as early as wanted compared to 87% of Latinx women and 89% of white non-Hispanic women.

PERCENTAGE OF MOTHERS WHO RECEIVED PRENATAL CARE AS EARLY AS WANTED IN NEW MEXICO BY RACE AND ETHNICITY, 2009-2018
Late Trimester or No Prenatal Care

Trends for women who received prenatal care late in their pregnancy or not at all remained relatively flat over ten years, with only a slight upward trend in women getting late/no prenatal care 8% statewide in 2009, and 12% in 2019, a four percentage point increase. Differences in trends between groups mirror 1st-trimester prenatal care data. Asian and white non-Hispanic women typically trend towards the lower end of the spectrum for women receiving late/no care (9% and 8% respectively, in 2019), and Native American women trend on the higher end (16% in 2019). Native women are nearly two times as likely as Asian and white women to receive late/no prenatal care.

Counties follow similar trends, seeing very little change in overall rates in either direction. However, Doña Ana and McKinley reveal slightly higher rates of women receiving late/no prenatal care (14% and 15% respectively) than Bernalillo and San Juan (10%). Overall, women in New Mexico are twice as likely to receive late/no prenatal care than women in the US (6%).

Source: New Mexico Birth Certificate Database, Bureau of Vital Records and Health Statistics, New Mexico Department of Health (NM), US-Kidscount
Perinatal Indicators

**Births by Method (Vaginal)**

Vaginal births have decreased steadily statewide. In 2020, 74% of births were vaginal compared to 77% in 2009. There is a similar trend by race. Vaginal births have decreased among all race/ethnic groups, and Latinx, Asian, and white women mirror overall trends. Black/African American women experience the lowest percentage of vaginal births and Native American women the most compared to other groups. This data is not available by county.

**Births by Method (C-Section)**

Likewise, births by C-section have increased slightly statewide. In 2009, 23% of women gave birth by C-section compared to 26% in 2019. This increase is seen among all race/ethnic groups. Black/African American women experience the highest percentage of C-section births, and Native American women the lowest compared to other groups, which follow the overall trend. We should note that both Native American women and Black/African American women are experiencing steeper increases in C-sections than other racial and ethnic groups. This data is not available by county.
**Percentage of Infants Born at Low Birth Weight**

The overall percent of babies born at a low birth weight statewide (and in the 4 counties) has remained flat since 2009 (8% in 2009 and 9% in 2019) which is similar to rates nationwide (8% in 2018). However, between-group differences exist. Black/African American women and Asian women have the highest rates of low birth weight babies, 16% and 12%, respectively. Black/African American women are two times as likely as white non-Hispanic women and Native American women to have a low birth weight baby. (2019) African American n=75, Native American n=205, Asian n=61, Hispanic n=1283, White n=507

The data reveal a likely relationship between prenatal care access and infants born at a low birth rate. When viewed by the trimester prenatal care began, nearly 18% gave birth to low birth weight babies among women who had no prenatal care, compared to approximately 8-10% of women who received some type of prenatal care.
The data also reveal a likely relationship between mother’s age and infants born at a low birth rate. Nearly 15% of mothers 40 years-old and over gave birth to low birth weight babies compared to the lower rates among younger mothers. These trends hold when viewing the data over the past ten years.

### Percentage of Births that were Pre-term (less than 37 weeks)

The percentage of pre-term births remained steady statewide from 2008 (9%) and 2019 (10%). Rates by race/ethnicity cluster around the same trend as the statewide. However, pre-term births among Black/African American women remained higher than all other groups (17% in 2019). (2019) African American n=79, Native American n=277, Asian n=53, Hispanic n=1347, white n=564.

### Infant Mortality

Statewide trends remain flat. In 2010*, there were 5.2 deaths per 1,000 infants statewide, and in 2019, 5.8 deaths. When disaggregated by racial/ethnic categories statewide, Black or African Americans are roughly twice (10.3, 2019) as likely as their Asian or white counterparts (4.5 and 4.8, 2019) to experience an infant death. The top three causes of death in any racial/ethnic group are perinatal conditions followed by congenital malformations and sudden, unexpected infant death (SUID).

Data from the 2020 New Mexico Birth Equity Collaborative Legislative Brief, which focuses on Black maternal and infant health, found that statewide, Black infants are more likely to die in their first year of life than are white infants. Between 2012-2018, the rate for Black infants was 10.9 per 1,000 live births, a rate 88% higher than the state rate of 5.8 per 1,000 for all live births. Data was not available at sub-state geographies.

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**Note:** *Data were retrieved for 3-year moving time periods to account for data suppression due to small population sizes. “2010” corresponds to the 3-year period, 2008-2010. Sources: NMIBIS and New Mexico Birth Equity Collaborative Legislative Brief, [https://static1.squarespace.com/static/5a8b8090b0786697fd4ce4df0/1/5e42f6d50b92bb82c794cd02d/1581448686622/New+Mexico+Birth+Equity+Collaborative+Legislative+Brief+2020.pdf](https://static1.squarespace.com/static/5a8b8090b0786697fd4ce4df0/1/5e42f6d50b92bb82c794cd02d/1581448686622/New+Mexico+Birth+Equity+Collaborative+Legislative+Brief+2020.pdf)*
Maternal Mortality

New Mexico maternal mortality and severe maternal morbidity rates exceed national averages. Maternity Morbidity Rate (MMR) 23.7 vs. 18.0 per 100,000 live births. New Mexico’s Maternal Mortality Ratio is 28 deaths per 100,000 live births. Sub-population disparities are sharp.

- Relative risk of severe maternal morbidity (21 conditions, including transfusion) for Black women in 2018 was 25% higher compared to non-Hispanic white women.
- For Native American women, the rate was 60% higher than for Black women and twice as high as non-Hispanic white. Reference data are not available to measure stratum-specific trends or progress. Still, NM is taking concrete steps to address maternal morbidity and mortality through collaboration with medical providers, reproductive justice, and policy partners.
- Causes of death for pregnancy-associated cases and recommendations from the 2015-2017 review process indicate that motor vehicle accidents, overdose or substance use disorder, and mental health are the areas requiring the most attention and effort.
- Pregnancy-related deaths are highest among women of color, while pregnancy-associated deaths are more evenly distributed across ethnicity and may correlate to rural and poor residence (DOH-MMRC, 2015-2017).
Breastfeeding

**Ever Breastfed**

The percentage of mothers that have ever breastfed their babies had remained steady statewide from 89% in 2009 to 89% in 2018. When disaggregated by race, Latinx mothers follow the overall trend of little change. Native American and white non-Hispanic are showing downward trends, with Native Americans experiencing an 8% drop in breastfeeding between 2014 and 2015. (Data for Asians and Black/African Americans data was not available.)

Although the percentage of women breastfeeding has not changed dramatically over the years, the data indicate that initiation is happening earlier and breastfeeding duration is longer, particularly among Native American women.

**Breastfeeding in the first hour of birth**

The percent of mothers that breastfed in the first hour of birth increased by 11% between 2012 and 2018. When disaggregated by race, nearly all cluster around the overall trend except Native American women, who trended at a higher percentage than their peers for most years and showed the most significant breastfeeding initiation gains.

**Breastfed only milk at the hospital**

The percentage of babies fed only breast milk at the hospital increased since 2012, indicating an increase in awareness/education regarding breastfeeding benefits.
Breastfeeding Still (3 and 6 months)

According to data reported by the Centers for Disease Control (CDC), the percent of mothers still breastfeeding after 3 months has increased by approximately 10 percentage points statewide and nationwide between 2009 and 2018. The data also show that New Mexico was slightly higher at 3 months exclusively breastfeeding than the nation in recent years. We see similar upward trends in women breastfeeding exclusively at 6 months. New Mexico and national data follow nearly the same trends in percentages of women breastfeeding.

PRAMS survey data reported by the New Mexico Department of Health (NMDOH) show a slight upward trend since 2012. The survey is distributed 2-6 months after delivery; however, there is no indication of the period of duration this data reflects. It is unclear why the data does not match the CDC data (presumably they are both from the PRAMS survey.) It is possible the differences are the result of weighted data versus unweighted data.
Hospital Experiences and Support

In 2019, 93% of mothers reported being given information about breastfeeding at the hospital. This percent has not changed since 2009 (93%). However, other indicators may be contributing to the increase in breastfeeding initiation and duration. We see a sharp decrease in the percent of women given a gift pack with formula in the hospital (this data is evenly distributed among races). There are increases in women given numbers to call for help with breastfeeding. Hispanic/Latinx women follow the overall trend while Native American women show the most significant growth. Percent of women told to breastfeed on-demand in the hospital has increased slightly in recent years. The percent of mothers given a breast pump to use in the hospital has remained fairly flat over the years, except for Native American women. Notably, Native women showed the most significant gains in breastfeeding initiation and exclusively feeding breast milk in the hospital.
Paid Leave

**Took Paid Leave from Job after Delivery**

The percent of mothers statewide that took paid leave from their job after delivering their child slightly decreased from 40.8% in 2011 to 39.2% in 2018. Latinx and White non-Hispanic mothers followed a similar trend. However, Native American mothers went from 30.5% in 2012 to 42.7% in 2018, a 12.2 percentage point increase. Data from the New Mexico Department of Health Title V Needs Assessment suggest that if families have access to paid leave postpartum versus only unpaid leave, they are much more likely to sustain breastfeeding.

**Took Unpaid Leave from Job after Delivery**

The percentage of mothers statewide that took unpaid leave from their job after delivering their child slightly increased statewide from 66.6% in 2012 to 68.9% in 2018. Both Latinx and Native American mothers followed a similar upward trend.

Source: NMDOH Title V Needs Assessment
https://mchb.tvisdata.hrsa.gov/Narratives/IIFiveYearNeedsAssessmentSummary/05e64590-6512-4736-ab05-5b60ec124d89
Home Visiting

The Home Visiting Accountability Act was passed in 2013. Since its passage, New Mexico’s Children Youth and Families Department (CYFD) has worked to expand the Home Visiting System’s infrastructure.

Data shows that the state budget for Home Visiting has increased from $2.3M in 2012 to $23.2M in 2020.

State-funded slots have also trended upward since 2013, when there were 1,005 slots available to 2020 with 3,819 available home visiting slots available to families statewide.

All Home Visiting slots (federal, state, and privately funded) have also increased the available slots.

Source: New Mexico Legislative Finance Committee Legislating for Results: Post-Session Review
https://www.nmlegis.gov/Entity/LFC/Documents/Session_Publications/Post_Session_Fiscal_Reviews/April%202020.pdf
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Appendices
Appendix A: Grantee Interview Questions

Thank you for taking the time to meet with us. The main purpose of our conversation is to learn from your organization’s experiences about what’s working and not working to improve the overall health and wellness of babies and birthing parents in New Mexico. We’re hoping to highlight practices, policies or systemic changes that have been influential in increasing racial-equitable access to quality and community-driven, culturally responsive care for birthing parents and babies. We also want to know from your experiences, what are the gaps or barriers that are hindering vulnerable families from receiving the quality of care needed to ensure improved prenatal care, babies born at full-term with healthy weight, initiation and duration of breastfeeding, attachment and bonding, etc. This collective shared knowledge can help inform WKFF’s maternal child health investment strategies here in New Mexico.

To help guide our conversation, we’ll be asking questions tailored toward Maternal Child Health Services, Structural/Institutional Systems, and Policies that are in place or in progress to help address the inequities for vulnerable, rural, low-income and gender inclusive communities, and families of color. We understand that many organizations are advocating for birth and reproductive justice to address these inequities. Therefore, to start our conversation and as part of our learning in this field, we’d love to hear from your perspective what birth and reproductive justice means to you. Or, what comes to mind when you hear the term Birth and Reproductive Justice?
Services

1. In what ways is your organization working to improve racial-equitable access to quality healthcare for birthing parents and babies?
   a. What have been some of your successes?
   b. What are the challenges you’ve experienced in advancing the work?

2. Please share with us what factors positively influence breastfeeding initiation and duration to 6-12 months post-birth and how your organization has contributed to this work?
   a. How has your organization advocated or supported women who will return to work while breastfeeding?
   b. Do you keep track of breastfeeding duration for birthing/nursing families?

3. What types of practices does your organization implement to honor culturally and linguistically appropriate care for birthing parents and babies?
   a. From your perspective, how does culturally appropriate care improve racial health equity for birthing parents and babies?

4. Along the same lines of culturally appropriate care, does your organization support or provide services for LGBTQ+ families?
   a. If yes, what types of trainings or actions did your organization implement internally to ensure that LGBTQ+ families were receiving equitable care?
   b. What type of work needs to happen across the state to improve equitable care for LGBTQ+ families?

5. Do you provide services for immigrant families?

6. Can you share with us some key partners you’ve worked with to support the collective work?

Structural/Institutional Systems

7. Please share the type of work your organization has been doing to create change at the structural or institutional systems level. Structural or Institutional systems could include hospitals, work place, educational institutions, etc.
   a. From your perspective, what work needs to be done at the structural or institutional systems level to improve racial-equitable maternal child healthcare in NM?

8. From your experience in working with birthing parents, what have been their main challenges with accessing quality perinatal and postnatal care?

Policies

9. What type of policy work has your organization been involved with to support health equity for birthing parents and babies? This could be at either a program, institution, state or federal level.
   a. Has your organization engaged in additional work to ensure that the policies transfer to better practices and services for birthing families?

10. What policy changes are needed at the State level to improve racial equitable access to quality, community-driven, culturally appropriate care for birthing parents and babies?

Wrap-up

11. Do you have any recommendations for the WKKF?
Appendix B

Essential Reproductive, Birth, Family and Infant Systems of Care Model
The historical data and content in this report reflect the grantees’ comprehensive work supported by multiple partners and funders including the W.K. Kellogg Foundation.

The W.K. Kellogg Foundation acknowledges Indigenous, Native American, American Indian and Alaska Native (AI/AN), Black and African American, Asian and Asian American, Latino/a/x and Hispanic and People of Color people and communities have different preferences regarding terminology. Those preferences are honored, whenever possible, including acknowledgment of specific tribal affiliation(s) where appropriate.

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