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Micaela Cadena

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This thesis is approved, and it is acceptable in quality and form for publication:

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**DELIVERING ACCESS: HOME BIRTH FOR WOMEN  
AND FAMILIES OF COLOR IN NEW MEXICO**

**BY**

**MICAELA LARA CADENA**

B.A., International Studies: Comparative Development,  
Minor in Human Rights,  
Trinity College, 2005

THESIS

Submitted in Partial Fulfillment of the  
Requirements for the Degree of

Master of Community and Regional Planning

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# **Delivering Access: Home Birth for Women and Families of Color in New Mexico**

**By**

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## **ABSTRACT**

This thesis examines the access that low-income women of color have to home birth in New Mexico through qualitative research with home birth providers, New Mexico Licensed Midwives. New Mexican women and families have been birthing their children in homes and community settings for generations. In contemporary New Mexico, pregnant women can birth at home, in a free-standing birth center, or in a hospital setting.

This thesis seeks to explore: 1) The central tenets of home birth, as explained by Licensed Midwives; 2) The factors that impact access to home birth in New Mexico as perceived by Licensed Midwives; 3) The framing language used by Licensed Midwives to describe potential clients in relationship to the outreach strategies used by Licensed Midwives to build their practices; and 4) Why or why not Licensed Midwives choose to accept Medicaid as a form of payment for home birth services and Licensed Midwife feedback on the Medicaid Birthing Options Program. Through exploration of these themes, this thesis includes recommended strategic directions for positively impacting access to home birth for low-income women of color in New Mexico.

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## CHAPTER I. Introduction

### 1.1 The Issue

This thesis examines the access that low-income women of color have to home birth in New Mexico through qualitative research with home birth providers, New Mexico Licensed Midwives.

New Mexican women and families have been birthing their children in homes and community settings for generations. As original inhabitants of this land, indigenous communities have provided their own ways and systems of maternity care to pregnant women for centuries. As the New Mexico Territory was colonized and settled beginning in 1540, the complicated history of settlements included women caring for each other through pregnancy, labor, and delivery. As urban areas developed alongside the railroad during the 1800's, New Mexico's pregnant women continued to receive pregnancy-related care and labor/delivery support from trusted women in their families and communities. Over the last century, hospitals have become the primary system for accessing maternity care.

Working from evidence-based research that shows home birth to be a safe and healthy option for low to normal risk pregnancies<sup>1</sup>, a pregnant person's access to a full range of birth options is a fundamental issue of reproductive justice<sup>2</sup>. In New Mexico, pregnant people can birth at home, in a free-standing birth center, or in a hospital.

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<sup>1</sup>Outcomes of planned home births with certified professional midwives: large prospective study in North America

<sup>2</sup>The author is using a working definition of Reproductive Justice to mean that at the intersections of their identities all people have access to the education, information and resources to make real decisions about their own bodies and lives.

New Mexico is considered to be a homebirth friendly state with a midwife designed licensure process that includes direct entry or accredited educational pathways to licensure, as well as Medicaid payment for births at home or in a birth center. Today, many whom would most benefit from the midwifery model of care are often uninformed about birth options in our state and do not know birth at home or a birth center to be a safe, affordable, and legal option for our communities. As an act of love, this body of work is intended to improve access that women of color have to home birth in New Mexico.

This thesis begins by illuminating the rich tradition of midwifery in New Mexico as well as demographic trends in women accessing home birth over the last two decades. Participating New Mexico midwives articulated why access to home birth is important for pregnant women and families; they explained their understanding of factors that impact the access a pregnant woman has to midwifery care. Moving from the way participating midwives talked about home birth, the author explores the concrete practices of midwives-- how they find home birth clients and whether they accept Medicaid for midwifery services. The thesis is designed to capture the voices of midwives expressing why home birth matters, and in turn provide thoughtful analysis on whether their practices as midwives are conducive to expanding access to home birth to more communities, and specifically to women of color.

This introduction includes the methodology used for the research project and thesis as well as the subject position and demographic information of participants. Chapter 2 provides a useful background and context for the question addressed by this thesis, beginning with a brief history of home birth midwifery in New Mexico from the

twentieth century forward, an explanation of the facilities and attendants available to pregnant women in New Mexico, and lastly, data on homebirth rates in New Mexico and the country. Chapter 3 utilizes qualitative data from Licensed Midwife participants to explore the central tenets of home birth; this chapter illustrates the value of home birth to New Mexico families as described by New Mexico midwives. Chapter 4 addresses factors that shape access to home birth in New Mexico from the perspective of Midwife participants. Chapter 5 presents data and trends on whom the Midwife participants consider to be potential clients, plus outreach efforts used by participants to connect with potential clients. Chapter 6 reviews data on midwife participants' attitudes about the Birthing Option Program and whether or not they accept Medicaid reimbursement as payment for home birth services. Chapter 7 presents opportunities to improve access to home birth for women of color in New Mexico.

## **1.2 Research Question and Analytical Method**

Built on the perspectives of New Mexico Licensed Midwives, this thesis is a study of the access that low-income women of color have to home birth in New Mexico.

This research seeks to explore:

- 1) The central tenets of home birth, as explained by Licensed Midwives;
  
- 2) The factors that impact access to home birth in New Mexico as perceived by Licensed Midwives;

3) The framing language used by Licensed Midwives to describe potential clients in relationship to the outreach strategies used by Licensed Midwives to build their practices;

4) Why or why not Licensed Midwives choose to accept Medicaid as a form of payment for home birth services and Licensed Midwife feedback on the Medicaid Birthing Options Program.

Through exploration of these themes, this thesis includes recommended strategic directions for positively impacting access to home birth for low-income women of color in New Mexico.

### **1.3 Methodology**

This thesis documents a qualitative research project designed by the author in the spring of 2009. The author was responsible for research design, development of survey instruments, field data collection, and data analysis. Data were collected through 2010. Research methods used included written surveys, individual interviews, and a focus group. This research was approved by the UNM Institutional Review Board on June 6<sup>th</sup>, 2009 and informed consent was obtained from each participant prior to their participation. Participants were promised confidentiality. Identifying information has been removed and names were changed for the purpose of this thesis.

All methods were used to study the access that low-income women of color have to home birth in New Mexico from the perspective of homebirth providers in the state. The author collected primary data from New Mexico Licensed Midwives, homebirth service providers, whose ongoing and extensive interaction with pregnant women in NM gives them a base of knowledge about birthing issues in the state and shapes the access that women in New Mexico have to birthing options.

Research participants were New Mexico Licensed Midwives (LMs), licensed through the NM Department of Health.<sup>3</sup> Participants were identified through use of the 2009 New Mexico Department of Health Licensed Midwife Roster. The author used the Midwife Roster to invite participation by LMs in the research project and used internet searches to find NM Licensed Midwives with published addresses and/or contact information. The LMs were mailed a summary of the intent and scope of the project, as well as a formal invitation outlining the different possibilities for participation. Contact information for the author was included, and the author was available to answer any questions and/or schedule participation of individuals in the study.

After mailing the introductory letter, the author waited two weeks and then mailed a survey packet to potential participants. The packet included a letter summarizing the research, the research survey, two copies of the survey consent form (one to be kept by participant) and a return envelope. By mailing back a completed survey and signed survey consent form, the participant agreed to participate in the initial stage of research. At this stage, survey participants also indicated whether they would like to be contacted

---

<sup>3</sup> One participant was a student apprentice midwife, studying to take the Licensure Exam. She was invited and accepted participation in the focus group. She has since become a NM Licensed Midwife.

for participation in an individual interview or focus group. The author repeated the consent process with individual interviews and focus groups.

### **Written Surveys**

The author collected 13 completed survey responses (out of 24 invitations to participate). The survey was designed to collect qualitative data on the perceived level of access to home birth for women in New Mexico: which outreach methods participant LMs utilized to recruit clients, whether or not participant LMs accept Medicaid, and their own knowledge and perception of the Birthing Options Program. Participants also shared core principles and philosophies that guide their own midwifery practice.

The survey also asked respondents to provide quantitative and qualitative information on their own (LM) familiarity with the New Mexico Birthing Options Program, their perception of the level of familiarity pregnant women in NM have with the Birthing Options Program, and opinions of how well the NM Birthing Options Program meets its purpose.

### **Individual Interviews**

Ten in-depth, face-to-face interviews were conducted by the author during the course of the research. Interview scripts were designed to collect data on perceived factors impacting access to home birth, barriers and challenges to accessing home birth, description of potential clients, outreach methods to potential clients, and potential tools for improving access to home birth for women of color in New Mexico.



## **Focus Groups**

The research included one focus group with five participants. The facilitation instrument for the focus group was designed with two areas of emphasis. First, the focus group was used to collect information from NM Licensed Midwives about the value of their service (home birth) to New Mexico families. Secondly, the focus group collected LM observations on the Birthing Options Program, administered through NM Medicaid.

### **1.4 Subject Position of Participants**

The 13 written surveys provided demographic information about respondents. The remaining 4 participants participated in an individual interview and/or focus group. Full demographic information was not collected for these 4 participants.

**TABLE 1: Participant Demographics 1**

	<b>urban/ semi/ rural</b>	<b>Accept Medicaid</b>	<b>race/ethnicity (as self-identified)</b>	<b>age</b>	<b>raised in NM</b>
Ana	Urban	Yes	White	35-50	No
Bella	Semi	Yes	Caucasian	under 35	No
Cathy	Rural	Yes	White	35-50	No
Dora	Urban	Yes	Mutt- woman of color, no	35-50	No
Ellen	Semi	Yes		over 50	No
Faith	Urban	Yes	Mixed Race	35-50	No
Gabby	Urban	Yes	White	35-50	No
Helen	Urban	Yes	White	over 50	No
Iris	Urban	Yes		35-50	No
Jo	Urban	No	Caucasian	35-50	No
Kaya	Semi	Yes	Caucasian	over 50	No
Liv	Urban	Yes	Anglo	over 50	No
Mona	Urban	Yes	Mutt - woc: not really... sort of	35-50	No
Nora	Urban	Yes	White	35-50	No
Olga	Urban	Yes	White	35-50	No
Pam	Urban	Yes	White	35-50	No
Rae	Urban	No	White	35-50	No

**TABLE 2: Participant Demographics 2**

	<b>childhood class (as self-identified)</b>	<b>adult class (as self-identified)</b>
Ana	Lower	Middle by lifestyle, less by income
Bella	Middle	Middle
Cathy	Middle	Lower Middle
Dora	Middle	Middle
Ellen		
Faith		
Gabby	Working	Middle
Helen	Middle	Initially downwardly mobile, now middle
Iris	Middle	Working
Jo	Middle	Middle
Kaya	Middle	Middle
Liv	Low-Income	Low Middle
Mona	Poverty	Working Poor
Nora		
Olga		
Pam	Working	Middle
Rae	Middle	Middle

Thirteen participants lived and practiced in urban areas (defined as over 50,000 residents and including Albuquerque, Las Cruces, and Santa Fe). Three participants self-identified as living and practicing in semi-rural areas (defined as 5,000-50,000 residents). One participant self-identified as living and practicing in rural New Mexico (defined as less than 5,000 residents).

Fifteen of the 17 participants accept Medicaid reimbursements for home birth care. Two of the 17 participants do not accept Medicaid reimbursements for home birth care.

Fourteen of the 17 participants self-identified as white/anglo/Caucasian, while 2 of the 17 participants self-identified as a mutt. Of these two participants one does not identify as a woman of color, the other responded “not really...sort of”.

One of the seventeen participants was under 35 years of age, twelve of the 17 participants were aged 35-50, and four of seventeen participants were older than 50. None of the participants were raised in New Mexico, they all self-identified as having moved to New Mexico as adults.

### **Data Analysis**

The author used a qualitative research design that combines grounded theory and critical inquiry to accomplish the goals of this study. A grounded theory approach allowed the author flexibility to follow empirical leads and emergent questions while building analysis and theoretical concepts. A critical theory approach allowed the author to center the subject position of research participants as important to the research question. The author made systematic comparisons between observations in data, and categories built from the data. Using 'access to homebirth' as a primary concept, the author studied the social, cultural, and logistical context provided by New Mexico Licensed Midwives.

By participating in this research project, Licensed Midwives had an opportunity to express insights and concerns central to the success of their profession. Participation was also an outlet for sharing opinions and ideas about the current access that low-income

women of color have to home births in NM, and provided an avenue for improving that access.

## CHAPTER II. Background and Context for Research

### 2.1 20th Century Midwifery in New Mexico

It is widely understood that 60 years ago, midwives provided the great majority of maternity care to pregnant women in our state, “Long before modern medicine and scientifically trained practitioners became a factor in New Mexico health care, traditionally trained midwives, particularly in the numerous Spanish communities of the state, had claimed for themselves a central place in the region’s medical culture.” (Spidle, 1986, 257) It wasn’t until 1877 that Catholic Sisters of Charity arrived in New Mexico and began the development of the first hospital, St. Vincent’s, located in Santa Fe. Even with the introduction of hospitals and the increasing presence of medical doctors in the territory, an overwhelming majority of New Mexicans still relied on community based healthcare for the needs of their families through the turn of the 19th century.

Vital statistics were first collected by the state of New Mexico in 1929, and in that year “midwives delivered 29% of all *reported* [emphasis Spidle’s] babies, figures which undoubtedly underestimate their activity” (Spidle, 1986, 257). Among Spanish speaking women of rural New Mexican counties, the percentage of live births delivered by midwives was even higher. In Rio Arriba County 48% of births in 1934 were by midwives, and another 23% by neither physician nor midwife, presumably by relatives or friends”, comparable figures from 1934 for Taos County were “71% and 9% respectively” (Spidle, 1986, 258 & Greenfield, 1962, 211).

According to records of the time, the state was reasonably concerned with high infant and maternal death rates. In 1930, the infant death rate was 138.3 per 1,000 live

births, in the same year the maternal death rate was 8.9 per 1,000 live births, these were among the highest rates in the nation. (Greenfield, 1962, 188-189)

Edith Rackley was a Public Health Nurse in San Miguel County. By Edith's account, midwives were catching 95% of the babies in the 1930's. Edith shared that despite the outreach and availability of medical doctors and their resources, "many people in the rural areas of San Miguel County did not get needed help...transportation problems, economics and cultural differences all contributed to this lack of care." (Buss, 1980, 114) Edith explained that it was "in spite of the midwives efforts that the country had one of the highest infant mortality rates in the country" (Buss, 1980, 115). Edith did not blame midwives for high infant and maternal death rates, and understood that one of the factors was malnutrition:

"There were a lot of sad things for everybody to deal with. There were many babies and mothers lost where malnutrition was a factor. It often happened because they just couldn't get food because of the droughts and general poverty and because the diet had been changed so that many just weren't getting the nutrition they needed. The mothers were overworked and underfed." (Buss, 1980, 115)

A description that captures the negative view of midwives held by the medical establishment of the twentieth century is provided in *Doctors of New Mexico, a History of Health and Medicinal Practice*:

"The range of skills and information among the midwives working in the state, and hence the caliber of their service, unfortunately varied across a broad spectrum. Many of them were solidly seasoned by years of practice and a great score of experience, but many others were not. Almost none of them had any formal education or training in the birthing experience, and there existed no formal supervision over them and their work. The consequences were predictable: Those areas with largest number of babies delivered by midwives were the same areas with the highest infant and maternal death rates. Midwife practice was certainly not the sole explanation for the higher rates of those areas, but it was a factor

in them. Too many of the traditional midwives were inattentive to the basics of prenatal care and the importance of cleanliness, and too few of them were competent to handle abnormal births and emergency situations.” (Spidle, 1986, 258)

The public health community, including state, county, and district agencies, had done what they considered to be within their powers to impact death rates, “They recognized the problems and were conscious of the untrained midwife.” (Greenfield, 1962, 211) Concerned with the high number of maternal and infant deaths, the public health community focused on:

“the major number of deliveries made by untrained midwives, and the fact that the mothers had little medical help in the care of their babies....If the care of mother and child were to be more effective than they were a generation ago, it would depend not upon what grandmothers taught but upon the teaching and practice of scientific medicine relative to child and maternal care and protection from disease.” (Greenfield, 1962, 211)

While many in the medical community seemed to regard midwives in a negative light, on occasion they recognized the value of services provided by the partera community, “All of the traditional midwives should not be indicted with one, undifferentiating brush, for many of them performed a valuable service to their communities.” (Spidle, 1986, 258) For some in public health, it became clear that to impact New Mexico’s high infant and maternal mortality rates their strategies to improve health outcomes would have to include midwives:

“To their credit, New Mexico’s health department officials, from the very inception of their work, recognized the realities of the situation and made the pragmatic decision to work with and not against the state’s midwives, accepting them as indispensable partners in the region’s medical culture. That decision



required professional and political courage, for not all the state's physicians were happy with a commitment of that sort."(Spidle, 1986, 258)

Some in New Mexico's influential medical community spoke out against the acceptance of midwifery, "complaining that no educational or remedial programs supervised by state authorities could ever raise the midwives as a group to acceptable standards." (Spidle, 1986, 259) Nevertheless, officials in the Health Department moved forward with their plans, beginning in the 1920's:

"The work began in 1922 with instructional programs started by a midwife consultant loaned (to) the state by the U.S. Childrens' Bureau. That solitary professional devised the basic procedures and programs for working with the state's midwives, a regimen which remained in place till the 1940's. Since the health department's initial estimates suggested that there were around 800 midwives practicing around the state, a figure consistently accepted all the way up to World War Two, the work of the midwife instructor began with a kind of pilot program focused on the five northern counties (San Miguel, Mora, Taos, Rio Arriba, and Santa Fe) where midwifery was most common." (Spidle, 1986, 259)

In one example of activities in the Midwife Program, Mrs. Agnes B. Courtney, RN, reported that between February of 1925 and February of 1926:

"...she had located 198 midwives not previously identified, had made 367 visits to homes of midwives, and held 301 formal classes for groups of midwives, ranging from two or three or up to a dozen ....the pupils were taught standard obstetrical techniques, procedures for dealing with the most common complications encountered in delivery of babies, and the fundamentals of care for the newborn, with the emphasis always placed on the importance of cleanliness and on calling the doctor at the first real sign of difficulty." (Greenfield, 1962, 259)

This program was staffed primarily by public health nurses, and extended from northern New Mexico to the rest of the state by the 1930s. Nurse Midwife Jean Egbert made a comprehensive survey of midwives from 1934-1935, counting 760 midwives who were reporting deliveries to the Bureau of Public Health. Before leaving the Child

Hygiene Program, Jean Egbert drafted directives for a Manual of Midwives serving in the state. (Greenfield, 1962, 212)

Throughout the Public Health efforts to improve infant and maternal outcomes, “It was recognized that the midwives were customarily outstanding in their communities and that they had the confidence of the people. They were thus ideal individuals to help spread the education programs designed for mothers and children.” (Greenfield, 1962, 212)

In 1935, the New Mexico legislature passed the Health District Act, “the state law made possible the rapid and efficient development of public health work, which was the aim of federal law; and as a direct result New Mexico was one of a small group states that could claim the full subsidy for public health work” (Greenfield, 1962, 209). In doing so they were able to use Federal Children’s Bureau Title V funding to improve programs for mothers, infants and children. This legislation created health districts and these resources provided for full-time health officers for the entire state. In 1936 the State Maternal and Child Health Division was created. (Greenfield, 1962, 209)

From 1920 to 1930, New Mexico’s rural population dropped from 81.98% to 74.77%. Despite the drop in rural populations, there were still only 3.5 New Mexicans per square mile (average population), but the majority of counties had even fewer residents. In explaining access to care in the overwhelmingly rural state, “Family incomes were low, too low to make possible the services of a physician even at childbirth, and physicians in the rural areas were too few to give the services needed even had families financially been able to call them.” (Greenfield, 1962, 211) Using perceived culture to rationalize these trends, Greenfield writes, “The natural modesty of the

Spanish-speaking woman led her to seek aid at the time of her delivery from another woman—a relative, neighbor, or midwife.” (Greenfield, 1962, 211)

In 1937, Nurse Midwife Francis Fell was supervising the Midwife Program. Fell made visits for midwife supervision, taught lessons, and set up permanent clubs for midwifery meetings. She also set up systems of referral for midwife prenatal cases to the prenatal clinics for medical maternity care. Ms. Fell was “instrumental in revising the midwife pledge” (Greenfield, 1962, 213), an initiative quite comprehensive in nature. Signing the pledge meant midwives were committed to using recommended best practices (list of materials for delivery, cleanliness, a promise to call for doctor if needed, etc.) , as well as annual examinations by a District Health Officer. Under the Fell program, “Midwives who completed a course of instruction, who were cooperative with local health units, passed a physical test, and signed the midwife pledge were issued a certificate and received a regulation bag and equipment.” (Greenfield, 1962, 213)

Also in 1937, additional resources were provided by the Children’s Bureau and 25 additional nurses were hired. In turn, there were additional study groups for midwives. Besides midwifery, midwives were taught the basics of nutrition and care of infants and children. Meeting in each other’s homes over potlucks of “well-balanced” meals, the midwives were asked to bring their patients to these learning sessions. Jesusita Aragon describes being a participant in the midwifery program:

“Once a nurse came to Trujillo to teach a class for mothers. That nurse’s name is Edith Rackley, and I still know that lady. We are friends. I go to the class, and she says ‘Can anyone here read these papers to the other mothers?’ And I say, ‘Sure, I can read them for us.’ And she says, ‘Thanks’ and is glad to have my help.”

“Sometime later I go to her and tell her I’m a midwife, and I want to take a special class they have for midwives, a class in Las Vegas the nurses have. Then we come here to town in Las Vegas, and we stay about fifteen days and the government pays everything. The trip, the board and room, everything. There are about 30-45 women from different places, from Los Lunas, Santa Rosa, Wagonmound and only me from Trujillo.” (Buss, 1980, 52)

Jesusita reflected on the knowledge she carried from elders in her family as well as the Public Health instructional programming, “My grandmother teach me to wear my apron years ago, but the nurses talk more about how to use it. Now my neighbors know when my patient is going to have her baby because I get ready to put my white apron, and they see it and say, ‘oh pretty soon the baby is coming.’ They know it is near to come because of my apron.” (Buss, 1980, 52)

Jesusita and other community midwives already carried basic principles of cleanliness that were reinforced through the public health programs, “They teach us many things, one of the nurses, Mrs. Ordonias, she was about 50 or 52 years, and she told me that I should have my nails short, clean, because we have to show our nails, but I never use my nails; I never let them grow. I can’t use them if I do.” (Buss, 1980, 52) As Jesusita expressed, the classes had interesting and useful topics:

“I didn’t like to miss the meetings, nor the movies, because they teach us with good movies, movies of natural birth and other kinds of birth. And D’s and C’s and bad diseases like gonorrhea. They taught us that’s why the patients have to go the clinic and have blood tests, so that way they know if they have something wrong, and if they have something wrong it hurts the baby. But some of the patients don’t believe on those things, but I do, I do believe. If they don’t have their blood tests before, they are supposed to go to the hospital as soon as they get out so they can get checked.” (Buss, 1980, 52)

New Mexico midwives and the NM Health Department continued to build collaborations and began to lower the infant and maternal mortality rates through the 1930s (infant: down from 138.3 in 1930 to 100/1000 in 1940, maternal: down from 8.9/1000 to 5.1). In *Partera*, the oral history of New Mexico midwife Jesusita Aragon, readers are presented with a reminder, “it must be remembered that important changes have occurred that had little to do with the traditional midwives’ skills or lack of skills” (Buss, 1980, 121). Anne Fox was a Nurse Midwife in Northern New Mexico. From 1945-1964 she taught local midwives and stated that “nutritional education, economic aids, and eventually the introduction of food stamps remarkably improved the general health of many people in the area.” (Buss, 1980, 121) Along the same thought, Fox shared that “when she first arrived in 1945 the impoverished people in this area considered a five to five and a half pound newborn to be good sized, and, by the time she left in 1965, the same group of people considered a seven and a half or an eight pound baby to be normal, healthy weight” (Buss, 1980, 121).

In an interesting historical turn, World War II had a direct impact on the maternity care accessed by women in the state. Greenfield writes that “World War II brought many problems to health officials in every state...It was soon realized that special provision must be made for dependents of men in the armed services.” (Greenfield, 1962, 215) Funds were provided by the Children’s Bureau to pay for maternity care of pregnant women whose husbands were enrolled in armed services. The program was designed to bring “a large measure of security to the pregnant women and their husbands, who frequently were on the firing line” (Greenfield, 1962, 215). Beyond the programmatic benefits to the women receiving care:

“(T)here were fringe benefits to the health programs. The program assisted in raising the standards of maternity service throughout the state. The young mothers learned about adequate maternity care and realized that such care saved the lives of both mothers and children. They were able to accept and understand this care for they were in a receptive state, not only because of approaching motherhood but also because of the tension and unrest of war. The days of delivery by relative or neighbor were past. This program tended gradually to change the midwife program. The nurse-midwives conducted the clinics, instructed the patients, and advised on nutrition problems, but the patient was examined by a physician and usually delivered in a hospital.” (Greenfield, 1962, 216)

Mary P. Simons, a public health nurse-midwife, submitted a 1955 report writing that “more of the patients chose to be delivered in hospitals either in Embudo, Espanola, or Santa Fe. This change from home delivery to hospital delivery was partly because of their understanding of the need for hospital care and partly because of the emergency program for the care of wives and children of men in the armed services.” (Greenfield, 1962, 218)

As public health professionals oversaw the transition from home to hospital births, “Parteras remained of basic importance across much of the state during the first half of the twentieth century, and indeed, they have not been entirely displaced in some areas of the state to this day [1986]. Their prominence in the state’s health care delivery system is not hard to understand, given that complex of factors mentioned earlier—distance, economics, and cultural differences—which so distinctly colored the interaction between patients and doctors in New Mexico.” (Spidle, 1986, 257)

The New Mexico Midwife Association, incorporated in 1977, was created by a group of midwives, many of whom had come to the state to learn and practice midwifery. In 1979, “New Mexico promulgated regulations that required all practicing curandera-parteras to obtain formal education and pass the licensing examination.” (Ortiz, 2005,

416) In the early 1980's with leadership from New Mexico newly licensed midwives, the New Mexico Medicaid program began paying for out-of-hospital births.

In the late 1990's Medicaid payment for home births was suspended because Licensed Midwives had limited capacity to purchase malpractice insurance. New Mexico Managed Care Organizations (MCO's) that contracted with state to implement Medicaid would not reimburse any provider without malpractice coverage.

In 2006, with the support of Governor Bill Richardson, (who grew up in Mexico City with a personal friend that later became a Licensed Midwife in New Mexico), the state established the New Mexico Birthing Options Program. From a New Mexico Human Services Department press release announcing the Birthing Options Program in May of 2006, "the Birthing Options Program addresses this issue through agreements with the midwives, the MCOs and the mothers-to-be". As explained in HSD press release:

"The Birthing Options Program was developed by the state with input and support from the New Mexico Midwives Association, the New Mexico Chapter of the American College of Nurse Midwives and the SALUD! Managed Care Organizations (MCOs). Women in New Mexico have choices when it comes to giving birth through this program, including a birth center, a hospital or at home with the assistance of a midwife." (HSD press release)

## **2.2 Facilities and Attendants in Contemporary New Mexico**

Over the century, maternity care has shifted to pre-natal clinic settings and hospitals for labor and delivery. The New Mexico Selected Health Statistics Annual Report, 2011, states that "Except in rare cases, newborns in New Mexico are delivered by

the following birth attendants: Medical Doctor or Doctor of Osteopathy, Licensed Midwife, Certified Nurse Midwife, or Registered Nurse.” (NMDOH Report, 2011)

The New Mexico Selected Health Statistics Annual Report states:

“Of all the births to New Mexico resident mothers in 2011, 98.2% occurred in hospitals. Medical doctors attended 66.1 % of the births, and certified nurse midwives (CNMs) attended 23.9 % of the births. The percent of births delivered by medical doctors decreased from 88.0% in 1990 to 66.1% in 2011. With this decrease, the number of births delivered by other types of attendants increased during this time period. Specifically, the percent of deliveries by CNMs increased from 10.6% in 1990 to 23.9% in 2011.” (NMDOH Report, 2011)

Descriptions of LMs and CNMs in New Mexico:

“Licensed Midwife (LM). A Licensed Midwife is a person who has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.

Certified Nurse Midwife (CNM). A Certified Nurse-Midwife (CNM) is an individual educated in the two disciplines of nursing and midwifery and who possesses evidence of certification according to the requirements of the American College of Nurse-Midwives. A certified nurse-midwife must be licensed in New Mexico as a registered nurse.” (NMDOH Report, 2011)

In New Mexico, the Certified Nurse Midwife scope of practice allows Nurse Midwives to function as primary maternity care providers in a hospital setting, in a birth center, or in a homebirth practice. CNMs are the only midwives whose scope of practice allows them to practice in a hospital setting. A large majority of CNMs in New Mexico practice in hospital settings; CNMs provide maternity care alongside Ob-Gyns and family practice doctors.

Both Certified Nurse Midwives and NM Licensed Midwives are allowed to provide well woman care, pre-natal care, labor/delivery services and post-partum care (6weeks). Only CNMs have prescription privileges. Like CNMs, LMs are allowed to test



blood and other biological specimens in the course of maternity care. LMs are required to carry oxygen and Pitocin (to stop a hemorrhage) in case of emergency.

In New Mexico, Licensed Midwives have the option of maintaining a Certified Professional Midwife (CPM) license. The CPM is a national licensure and standards system that some states use to regulate or legalize home birth midwifery within their jurisdiction.

In New Mexico, Licensed Midwives are the overwhelming majority of home birth providers and are the focus of this study. Under their scope of practice, Licensed Midwives may only provide services in a free-standing birth center or a home. For purposes of this research, home birth refers to a planned delivery attended by a Licensed Midwife that occurs at an out-of-hospital setting, primarily a client's home or a free standing birth center.

### **2.3 Research on Safety of Home Birth, Results Compared to Hospital Outcomes for Year 2000**

In a prospective cohort study designed to evaluate the safety of planned home births in North America, researchers examined outcomes of all Certified Professional Midwife attended home births in the United States (98%) and Canada (Johnson and Davis, 2005, 1)

With 5,418 women planning deliveries with CPMs, the study measured “intrapartum and neonatal mortality, perinatal transfer to hospital care, medical intervention during labour, breastfeeding, and maternal satisfaction” (Johnson and Davis, 2005, 1). As explained by Johnson and Davis, “planned home birth for low risk women in

North America using certified professional midwives was associated with lower rates of medical intervention but similar intrapartum and neonatal mortality to that of low risk hospital births in the United States” (Johnson and Davis, 2005, 1).

## **2.4 Home Birth in the Country and Contemporary New Mexico**

To be a legally practicing homebirth midwife in New Mexico, one must hold a Midwifery License issued by the New Mexico Department of Health. The legal status of midwifery differs across the country. There are 28 states in which homebirth midwifery is regulated or legalized; New Mexico was the third state to do so by law in 1978. In the remaining states, home birth is either illegal or without legal status. Midwives where home birth is illegal or without legal status, consider themselves to be in similar situations. Practicing underground in a state where home birth is illegal or practicing underground in a state where home birth has no legal status, midwives could be criminally charged for practicing medicine without a license.

The Big Push is a national campaign advocating for regulation or legalization of home birth in all 50 states, and for Medicaid coverage for home birth in all 50 states. What follows is an image created by the Big Push Campaign that has state-by-state information on Certified Professional Midwifery Licensure or other processes for legalization of home birth.

**Table 3: The Big Push Midwives State Regulation PushChart**

26 States that Regulate CPMs (Year Law Enacted/Rules in Some States)	2 States that Legalized CPMs by Statute (Year Law Enacted)	14 States that have an Active CPM Bill in Legislative Process	3 States that are Planning for CPM Legislation	5 States that are Legislatively Inactive at Present	#	28 States and Years of CPM Regulation or Legalization (in Chronological Order)
AK (1999)	ME (2008)	AL	CT	GA	1	SC (1976)
AZ (1978)	MO (2007)	IL	DC	GU	2	AZ (1978)
AR (1983)		IA	ND	HI	3	NM (1978)
CA <sup>1</sup> (1993)		MA	WV	KS	4	DE (1978)
CO (1993)		KY		NV	5	NH (1979)
DE (1978)		MD		OK	6	AR (1983)
FL (1995)		MI		VI	7	TX (1983)
ID (2009)		MS			8	LA (1985)
IN (2013)		NE			9	WA (1991)
LA <sup>2</sup> (1985)		NC			10	MT (1991)
MN (1999)		OH			11	NY (1992)
MT (1991)		PA <sup>3</sup>			12	CO (1993)
NH (1979)		PR			13	CA (1993)
NJ (2002)		RI <sup>4</sup>			14	OR (1993)
NM (1978)		SD			15	FL (1995)
NY (1992)					16	AK (1999)
OR (1993)					17	MN (1999)
SC (1976)					18	VT (2000)
TN (2000)					19	TN (2000)
TX (1983)					20	NJ (2002)
UT (2005)					21	UT (2005)
VT (2000)					22	VA (2005)
VA (2005)					23	WI (2006)
WA (1991)					24	MO (2007)
WI (2006)					25	ME (2008)
WY (2010)					26	ID (2009)
					27	WY (2010)
					28	IN (2013)



NOTE: this Big Push for Midwives State Regulation PushChart also contains the District of Columbia (DC), Puerto Rico (PR), the Virgin Islands (VI), and Guam (GU). Groups of midwifery supporters in DC, PR, and GU are members of the Big Push Coalition of state midwifery supporters and midwife orgs.

<sup>1</sup> Midwifery supporters in CA are working on amendment of their state midwifery practice rules.

<sup>2</sup> Midwifery supporters in LA are working on amendment of the state midwifery practice statute.

<sup>3</sup> PA law already requires the state Board of Medicine to issue licenses to all types of midwives, but the BOM has not done so yet for CPMs.

Following a court order, the BOM is now working with midwifery supporters and CPMs to develop CPM licensure & practice rules.

<sup>4</sup> RI law already requires the state Department of Health to issue licenses to all types of midwives, but the DOH. has not done so yet for CPMs. The DOH is now working with midwifery supporters and CPMs to develop CPM licensure and practice rules.

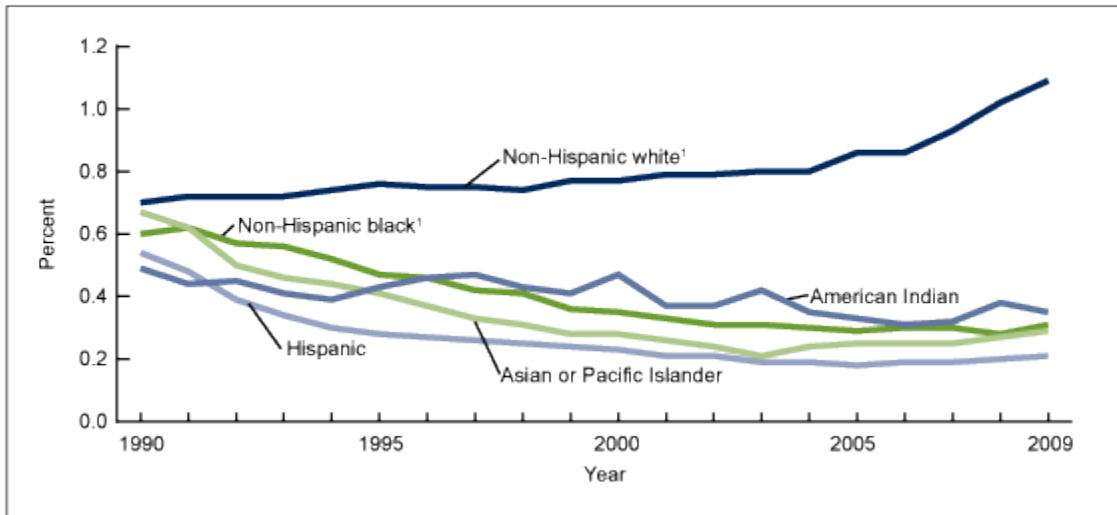


New Mexico's longstanding licensure of homebirth midwives and history of recognizing midwives (Parteras and LMs), along with NM Medicaid reimbursement for home birth, has contributed to a strong perception of New Mexico as a homebirth friendly state. Perceiving New Mexico as a place that respects home birth is shared among communities of women who want a home birth and for those seeking to learn or practice midwifery. In such a context, many are grateful for the access women in New Mexico have to home birth, compared to many states. Unfortunately this appreciation and recognition of New Mexico as a homebirth friendly state can limit critical dialog about the nuanced ways women of color and other underrepresented communities in homebirth rates access midwifery care.

National homebirth rates provide a useful context for a study of access to home birth in New Mexico. Data from the Center for Disease Control demonstrates a 29% rise in home births across the country, from .56% of births in 2004 to .72% in 2009 (NCHS Data Brief). According to the CDC, "For non-Hispanic white women, home births increased by 36%, from 0.80% in 2004 to 1.09% in 2009. About 1 in every 90 births for non-Hispanic white women is now a home birth. Home births are less common among women of other racial or ethnic groups." (NCHS Data Brief). Since 1990, there has been an increase in percentage of home births to non-Hispanic white women. It is important to note that for all Hispanic and non-white women (women of color), home births have been on a steady decline for same time period. In summary, for the last 20 years more white non-hispanic women are having home births, while simultaneously less women of color are using homebirth maternity care.

**Table 4: Percentage of Births Occurring at Home, by Race and Hispanic Origin of Mother: United States, 1990-2009**

Figure 2. Percentage of births occurring at home, by race and Hispanic origin of mother: United States, 1990–2009



(NCHS Data Brief Number 84, January 2012 Home Births in the United States, 1990–2009  
Marian F. MacDorman, Ph.D.; T.J. Mathews, M.S.; and Eugene Declercq, Ph.D.)

New Mexico Vital Statistics Records from 1990-2012 indicate that despite being a homebirth friendly state, New Mexico follows national homebirth trends. In this 22 year span, White non-Hispanic women were 71% of those who had home births; in the same period white non-Hispanic women only made up 33% of overall births. Conversely, women of color made up only 29% of home births and 68% of overall births for same period (Table 5, Birth Query Module).

**Table 5: Home Births by Race and Ethnicity: New Mexico, 1990-2012**

<b>1990-2012 Home Births by Race and Ethnicity</b>		
<b>Type of Birth Attendant: Licensed Midwife; Facility Type: Freestanding Birthing Center, Mother's Residence</b>		
African American Women	#0.009 (1%)	
Asian or Pacific Islander	#0.018 (2%)	
American Indian or Alaska Native	#0.023 (2%)	
Hispanic	#0.235 (24%)	
White	#0.712 (71%)	
<b>All Types of Birth Attendants: All Facility Type:</b>		
African American Women	#0.017 (2%)	
Asian or Pacific Islander	#0.015 (2%)	
American Indian or Alaska Native	#0.126 (13%)	
Hispanic	#0.513 (51%)	
White	#0.327 (33%)	
<b>All live births v. Licensed Midwife Attendant</b>		
	<b>All births</b>	<b>LM</b>
African American Women	2%	1%
Asian or Pacific Islander	2%	2%
American Indian or Alaska Native	13%	2%
Hispanic	51%	24%
White	33%	71%

NM data also shows interesting homebirth trends in other demographic areas. From the same time period, 1990-2012, 74% of the women who had home births in New Mexico were married. In the overall birth population, only 54% of women were married at time of delivery. Data also shows that those who have home births have comparatively high levels of educational attainment, with 43% having a college degree and 28% having some college. In the overall birth numbers for same time, only 15% of women have a college degree and 22% have some college (Table 6, Birth Query Module).

**Table 6: Home Births by Marriage and Education: New Mexico, 1990-2012**

<b>Married v Not Married,</b>	<b>Care of All Providers</b>	<b>Care of LM</b>
Married	#0.54 (54%)	#0.74 (74%)
Not Married	#0.46 (46%)	#0.26 (26%)
<b>Education</b>	<b>Care of All Providers</b>	<b>Care of LM</b>
Less than high school	#0.263 (26%)	#0.097 (10%)
High school	#0.344 (34%)	#0.184 (18%)
Some college	#0.217 (22%)	#0.275 (28%)
College grad	#0.149 (15%)	#0.434 (43%)
Unknown	#0.027 (3%)	#0.009 (1%)

### **CHAPTER III. Central Tenets to Home Birth**

Chapters III, IV, V, and VI present the primary findings of this qualitative study. Chapter topics are as follows: Central Tenets to Home Birth as Articulated by Licensed Midwives, Access to Home Birth as Perceived by Licensed Midwives, Licensed Midwife Description of Potential Clients and Outreach, and Licensed Midwife Observations on NM Birthing Options Program.

The New Mexico Licensed Midwives who participated in this research project spanned many identities, self-defined by the communities in which they practice (urban/rural/semi-rural), the communities in which they were raised, and the economic class in which they have functioned as children and adults. In the author's professional experience<sup>4</sup>, each individual has a unique set of lived experiences and identities (both born into, chosen, and labeled) that inform their subject position. As midwife participants express elements of home birth that resonate for themselves, they do so at the intersections of their own experiences and identities. Acknowledging this dynamic allows for a more nuanced reflection on the questions at hand.

This study acknowledges qualitative responses outlining the core principles and philosophies that guide the practice of midwife participants as well as their articulation of the reasons why home birth is valuable to women and families. As midwife participants expressed elements of home birth that resonate for them, four elements central to home birth emerged: belief that birth is normal, respect for freedom/choice in the birthing process, an appreciation of home birth as empowering for women, and an articulation of a set of midwifery skills that are central to positive experiences and benefits for women and

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<sup>4</sup> Micaela Cadena, the author, is the Policy Director at Young Women United. Young Women United is a Reproductive Justice Organizing and Policy project. Micaela guides change making strategies from the intersectional identities of those most impacted by an issue.



families. Of note, throughout responses garnered in surveys and the focus group, the overwhelming majority of participants positioned themselves and the care they provide in comparison to services provided in a hospital maternity setting<sup>5</sup>.

### **3.1 Birth is Normal**

In response to these questions framing central tenets of home birth, and in supportive evidence from overall participant responses, “Birth is normal” arose as an emergent theme. Participants explained that “birth is a normal physiological experience, not a medical emergency” (Dora) and that it is “important to understand that pregnancy and birth are natural and very normal processes in healthy low risk women” (Liv). Given this, participants argued that “healthy normal pregnancies are not medical events and women with healthy pregnancies should not be managed medically in birth” (Pam).

Throughout this “birth is normal” theme were also intersecting messages framing women as powerful, and natural birth as a right. Key to the “birth is normal” argument is that women and their bodies are powerful, and carry innate wisdom to naturally be pregnant and labor to a healthy outcome. Participants recognized the power of bodies in pregnancy, sharing that “women have physical strength and ability to birth their babies.” (Dora) Another participant recognized the intellectual capacity of women in pregnancy and labor, writing that “women are intelligent and know how to give birth”. (Jo)

Explained simply by a participant, “Birth works. Our bodies work.” (Iris) For some, the trust in bodies relies on references to evolution and reproduction in humans:

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<sup>5</sup> Beyond BMJ study of safety of home birth in North America, with results that planned home birth with CPMs for low risk women was associated with lower rates of medical intervention, particular assertions about hospital births are not checked by research independent of participants

“Can we give birth back to the women and let their instincts and their DNA work— I mean, our bodies are designed to give birth. They know exactly what to do, and unless you, yourself, are the product of a C-section, you are the cutting edge, leading edge of birthing excellence, female in your family. Why would we downplay that? Why would we forget that part of this process?” (Rae)

Participants also expressed that “natural birth is a right”. This right-based frame included the “right to choose where we give birth” (Kaya) and that “natural, non-interventive birth is a right which should be afforded to all women.” (Dora)

Throughout this theme, midwives used strong language in expressing their value of birth as normal. In their framing of birth as normal, they do not offer exceptions to this concept or state that birth is only normal for some. From these responses, a reader would garner that birth can be normal for all women and that ideally, home birth should be accessible to all women.

### **3.2 Home Birth as Empowering**

A frequently mentioned theme is that of ‘homebirth as an empowering experience’. While participants use ‘empowerment’ without defining the term, participants share a positive view of homebirth care as “such a special empowering time in a woman's life and her family” (Liv). Woven through the ‘homebirth as empowering’ theme were values and philosophies that articulated the spiritual/experiential value of homebirth. In a focus group conversation, participants explained the experience of home birth for themselves:

[Home birth is]"total love, total heart, total connection, empowerment is the spiritual connect that happens at a certain point for me, every time. It's like --

[mama and baby] they've connected up, oh my god--that feeling of relief, it's so beautiful." (Focus Group)

Empowerment statements were closely connected to self and spiritual growth for women through this process. Among the participants with many years of midwifery practice, there was a shared language and sentiment following this theme and a concern for what may be lost when one does not birth outside of a hospital, "Birth is a profound rite of passage that carries the potential for extreme empowerment for women...I believe that the continued hospitalization of natural birth is fundamentally disempowering to women" (Pam). Another regrets that in the Western world we have "totally disempowered these precious values and in turn, women are further from their knowledge of self and this sacred mother path" (Liv).

While participants state that "birth is an opportunity to grow, change, and realize your true self" (Anna) and that women gain "autonomy, independence and empowerment through healthy pregnancy, birth, and postpartum" (Helen), there were unstated assumptions about how one reaches these positive outcomes.

In this theme, most language was framed around birth as an opportunity for empowering pregnant and laboring women. Key to empowerment discussion is the implied "opportunity"; participants positioned home birth and midwifery care as an important link to the empowered experience in pregnancy and birth. Participants view themselves as "helping women to have a conscious, informed and enriching birthing experience" (Cathy); this self-perception seems to be supported by several participants. From the focus group conversations, empowerment emerged as something that women, midwives and babies can "get" in a home birth:

"Empowerment. I think that we all know how we've seen women and ourselves be empowered...Every birth we get it. The woman gets it from the obvious places. The baby, hopefully, will be taught that, and just innately having a peaceful birth, hopefully that will happen. .... But empowerment just goes so far, and really, literally, of all the births that I've seen, I've only seen a couple of women not be empowered. I've only heard of a couple of women being empowered in the hospital, so it's so reverse, if you ask that particular word about empowerment. And it's sad to see the women not empowered, and I've noticed that it's not the ones that struggle that aren't." (Focus Group)

Another subtext argued that alongside "helping babies to have a supported entry into this world" (Cathy), women who were empowered by home birth would be healthier and more committed mothers, which is good for their children and the world:

"I believe one's birth and infancy can set up the groundwork for the future. If a mother is empowered by giving birth, she may also work for a better world for her children fueled by the intensive bond formed through birth and breastfeeding. Peace and Environment and mental health and relief for the suffering" (Mona)

A focus group participant echoed this sentiment in regards to home birth, "It seems like, to all of us, it is healthier. It is healthier for whole family. It is healthier for woman, for the baby, for other children, for the planet..."

In common usage, 'empower' implies the actions or behaviors of a body with agency to empower an individual or community with less agency. As midwives talk about 'birth as empowering' they are distinguishing birth outside of a hospital as a different experience than within a hospital setting. As participating midwives support the theme of 'home birth as empowering', they are positioning themselves and the care they provide as the link to such experiences for women.

The term ‘empower’ as used by participating midwives does not indicate critical reflection about privilege and the opportunity to empower another individual. Neither do they consider that every woman has a distinct capacity to ‘experience’ birth as more than a physiological event. From the author’s personal<sup>6</sup> and professional experience, the opportunity for birth as an emotive and/or transformative experience correlates with the resources and respect one has within their parenting situation.

The ‘home birth as empowering’ theme carries an unsaid implication that women who have not achieved such greatness in birth are in some way faulty or deserving of pity. As New Mexico data shows, 71% of women who’ve had home births over the last two decades are white (compared to 33% of general birthing population), and that 43% percent have a college degree (compared to 15% of general birthing population). While one might assess that white, well-educated women are more receptive to empowerment, arguing from another angle supposes that a homebirth culture that is built on emotive experiences instead of outcomes or practical explanations of homebirth benefits may be inaccessible to women of color who have less economic and educational privilege.

### **3.3 Respecting Freedom and Choice in the Birthing Process**

Throughout research responses, there was a strong element of respecting freedom and choice in the birthing process, which included a context of comfort. Midwives articulated how home birth by design allows for women and families to have freedom and choice throughout pregnancy, labor and postpartum time. Through many examples, midwives shared how respecting freedom and choice of clients allowed them to be a

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<sup>6</sup> The author has had two home births in New Mexico, the first with health care coverage through New Mexico Medicaid and the second through Lovelace State Coverage Insurance.

better provider, while making the experience more comfortable for the client. This value of freedom and choice is central to home birth practice and key to a commitment that majority of midwives expect from home birth clients. These sentiments were expressed in the focus group:

“Eat your placenta, do whatever you need to do to have this experience. Freedom to be able to laugh, to bring humor into it, spirituality. I mean, we’ve all been at a home birth, gone to the hospital, and we just can’t connect anymore. There’s just too many buttons to get through, the spirits, the helpers, all that, if you believe in that. You’re looking for it and it’s hard. It’s like this thick thing, and it’s just radiating off the hospital. It’s just really hard to penetrate, I think. I would think you’d have to work in the hospital quite a bit to get through that.”(Focus Group)

Valuing freedom and choice was about women and families having the liberty to decide on the maternity care they have deemed best for their bodies and lives. This was not expressed as a right, but instead as elements of freedom and choice that come with home birth. The examples shared acknowledge that aspects of homebirth care allow for clients to do as they please. The crucial elements of freedom and choice expressed by participants were primarily about clients feeling good and being in control of their own birth experience.

While many women may aspire to feel good and be in control of their own births, not all women will be in a situation that allows them to make these choices. Many women of color carry the weight of personal and historical trauma that stems from colonialism, systematic racism and gender based violence, among other oppressions. Many women of color consistently face criminalization of their bodies and reproductive decisions. The frame of ‘choice’ in birth, to feel good and be in control, may feel

unrealistic and out of touch for some women of color when faced with addressing needs for basic safety in maternity care.

For women on Medicaid and other state programs, there is often no-to-little choice presented in any aspect of being pregnant or raising a family. Women are routinely treated as if they must be grateful for support they are receiving, without any rights or decision making power. If midwives are not articulating a narrative beyond a frame of choice, in a way with resonates with women that exist in different realms of privilege, many low-income women of color may assume they are not part of the community deserving of home birth care.

### **3.4 Midwifery Model of Care and Unique Skills**

The fourth important theme addresses the midwifery model of care and the particular skills midwives carry and practice in their homebirth profession, specifically around their clinical outcomes, their capacity to provide emotional care, and their low-cost services. Participants are confident in their capacity “to provide a midwifery model of care” (Helen). Dora explains that the “role of midwife is to support a woman through preconception, normal pregnancy, birth and postpartum and recognize and respond to complications and emergencies.” Iris explains this theme in more depth:

“Midwives’ role is primarily to offer education and support. Support includes motivating the mother to make good choices for the healthiest possible pregnancy. My role at birth is to surround the mother with confident, loving support so that she is comfortable enough to do what she needs to do, and to keep affirming that everything is normal. I tell parents my role is a lot like the lifeguards at the beach in California...it doesn't mean if you go surfing you're gonna drown. And mostly they are not needed. But it's probably a good idea to have them there.” (Iris)

Participants were proud to share that they offer “evidence-based, women-centered care” (Bella) and that their home birth practices are based on “personalized care, client centered, informed consent and education” (Kaya). As was explained in the focus group, the training and exam process to become a Licensed Midwife is built on high standards, “NARM<sup>7</sup> laid out skills and competencies, exactly ones needed to reduce maternal and infant death” (Focus Group). In positioning outcomes of home birth against those through hospital care, Rae explains that dangers are present in hospital, where “intervention creates risk and need for more skilled intervention.”

Besides their training and Midwifery model of care, midwives trust their intuition to ensure healthy outcomes:

"If you listen intermittently [to baby's hear tones], then that's good enough. We have all proved that that's good enough, but when we take our time to go in there, because our intuition has told us, even if we don't acknowledge that, we're going to listen to those decels [heart decelerations]. We're not going to dismiss them. We're not going to say, "Oh, decels are normal." Well, they're not normal to us, because we don't listen constantly."....And also I think midwives, uniquely, are able to either be very relaxed and sit back and do nothing, or then the moment something goes wrong, they're in there and they're fixing it, which does not happen in the hospital, and it's so scary. It's so scary to go and watch them not handle it." (Focus Groups)

Through the focus group and surveys, participants highlighted that their caring communication and midwifery model allow for them to work “through emotional stuff in a pregnancy” (Focus Group). Bella shares that midwives provide “warm and compassionate care”, which they feel is a stark difference to the hospital setting from

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<sup>7</sup> National American Registry of Midwives, NARM is nationally accredited and sets the standards for the competency-based CPM credential



which they distinguish themselves. As an additional distinction, Helen, “believe[s] strongly in networking pregnant women and new moms. This means the design of an LM practice that supports clients in building community with each other, regardless of their relationship to her.

The participating midwives were proud of and confident in their model of care, and used common language to describe this model of care. In its design, this model is seen to promise a way to provide care for all pregnant women, an assertion that is a marker of community identity for homebirth midwives in New Mexico.

Across themes, midwives shared positive, open, and welcoming tenets of home birth that guide their midwifery practices. It is evident that as a community, these New Mexico homebirth midwives believe deeply in their model of care and are well-intentioned in providing care to those who also value birth as normal, birth as empowering, and elements of freedom and choice in birth. The following chapters seek to explore the access women of color and other pregnant women have when they don't already hold shared values articulated by the midwifery community these participants belong to.

## **CHAPTER IV. Access to Home Birth for Women in New Mexico**

As New Mexico Licensed Midwives, this study's participants are in a clear position to provide observations on the access that women have to home birth in New Mexico. This research illuminated five prominent factors that shape access to home birth: 1) Most New Mexico women do not know about home birth as an option in our state; 2) Women are frightened about pregnancy and birth and therefore make decisions about maternity care based on fear; 3) Women and families without a deep commitment to home birth make decisions on birthing options based on cost of care; 4) A small group of women with strong commitment and determination to have a home birth will find access to care, despite logistical challenges; and 5) Practices of the Licensed Midwifery community and external misperceptions of the midwifery community impact access to home birth.

### **4.1 Most New Mexico Women Do Not Know Home Birth is an Option**

Several participants agreed that most New Mexico women do not know about home birth option as an option in our state. Following this conclusion, participants were also concerned that women don't know about the benefits or value of home birth. According to participants, it seems that for many in New Mexico, it is assumed that the hospital is safest place to give birth, and that every birth will take place in a hospital. It is also of concern to participants that the option of home birth is not advertised or promoted effectively, particularly by the NM Medicaid Birthing Options Program.

When Gabby was asked about access for women she responded, “I’d say one of the first things is whether people even know that home birth is an option. It seems like a lot of women will say, ‘Oh, I didn’t even know you could have a home birth. I didn’t know that was available’.... I would say the bulk of people in New Mexico don’t even know that they have an option for home birth.” Cathy shared an example of rural New Mexicans being surprised and shocked to hear about home births:

“Instead of, ‘When’s your induction?’ which is more of the common thing that people ask each other nowadays, it should be, ‘Are you having your baby at home or in the hospital?’ Or ‘Where are you having your baby?’ Things like that. That’s never even brought up. There was one woman. She was a second-time mom, and I [had] helped her with the first. Her husband was a tile guy and he had his whole crew there. I remember when she was getting down to the last bit, and she was just big and round, and somebody asked her that question, ‘When is your induction date?’ and she’s like, ‘What? I’m having my baby at home,’ and they’re like, ‘What? What do you mean? We’ve never even heard of that. Is that possible in this day and age?’ It’s like, yes. People actually ask that sometimes. ‘Does that still happen?’ Yeah, it does, and it’s actually happening quite a bit, all over, and people are starting to look at it a little bit more, with having more financial aspects that are covering it, and that helps.” (Cathy)

Ellen, who has a practice in a semi-rural community, noted, “Interestingly, even though the birth center has been here for over 30 years, there are still people that don’t know about it. There are still access issues around, I guess, advertising or notification of its existence.”

Equally important, participants agreed that because most women and families don’t know about the benefits and value of home birth, there are implications for the care these women receive. As Gabby sees it, there are negative consequences when families don’t know about benefits to home birth:

“I’m not sure I’m going to use the right words here – but even one generation ago, most local Latinas in New Mexico gave birth at home with a partera, and in one or two generations that is gone, and part of it is gone because of the parteras don’t exist anymore, but part of it is gone because there is access to hospital births, there is access to epidurals for all, and people think somehow they’re getting better care in the hospital. So even if a woman has birthed at home, she doesn’t necessarily want that for her child, because she thinks her child will get better care, or that she somehow will get worse care by birthing at home.”

Helen offers a similar perspective that women should know about birth options, “I think getting the word out, and getting the information out – you know, there’s a lot of research that supports that a planned home birth with a trained attendant is as safe, if not safer, than a low-risk hospital birth, and most birth is low-risk.” Considering that most New Mexican women don’t know about home birth, an important part of this theme is that the hospital is assumed to be the safest and best place to access maternity care. As Helen explains:

“Bottom line it’s where women feel safe is where they should birth, but I think our culture perpetuates the hospital [as] the only safe place, and there’s nothing safe about a 30 to 50 percent Cesarean rate. And fortunately, in New Mexico, we do have lower rates than the national level, the Cesarean rate, but still, 5 to 10 percent is a more normal rate for Cesarean.”

Cathy was excited to be a Medicaid provider thinking that Medicaid reimbursement would make home birth “accessible to a wider population here. And it did. It opened it up for a lot of people, I’d say, a variety of people. But there’s still a gap there. There are still people that I’ve met that are like, ‘Home birth? What?’ Like they don’t know about it.” As Ellen explained, “Even women on Medicaid aren’t aware of their payment options.” Helen expressed:

“Well, women just need to hear it on so many levels, number one - that the hospital isn't the only option, and I think Medicaid has helped. I know that in the three-and-a-half years that I've been practicing in New Mexico, I have a lot of people, probably half my practice is Medicaid, and a lot of them come saying, 'I had no idea I could do this.' ”

As Cathy understands the situation, staff in Medicaid-related offices are not presenting families with birthing options, “It's never even been put in there. None of the Medicaid people say, 'So, are you having your baby at home or in the hospital?' Everyone assumes you're having the baby in the hospital.” Cathy further explains her disappointment in the limited information about home birth in the New Mexico Medicaid Birthing Options Program:

“Birthing options, when that came out, was like, 'OH, birthing', and I thought, get that out. It will get out, even at the Medicaid offices. It should be there, presented. It's not. People aren't really told, 'You have options,' and even just to put the idea in there. It might not even happen at that birth, but it might happen [at] the next one. They realize, 'What about those options? I should have options. What was that? I want to see what those are. Okay, there are birth centers. There's home birth. There's this sort of model of care and there's that sort of model of care. What works for me and my family?' Those aren't presented, and it's really not publicized to the level that it should be.”

As Pam offers in a succinct statement, “Most NM women are unaware that home birth is a viable option. Most women on Medicaid don't know that Medicaid will pay for home birth.”

An important observation made by participants is that when women are in a position to consider home birth this is often because of their social circle. As Iris shares, “People are informed and make decisions within a social circle; usually through word of mouth... this perpetuates a home birth crowd.” Gabby agrees, “There is definitely the home birther crowd, where people know home birth is available because all their friends have had home births. They come from a community where home birth is sort of the

norm”. Considering these observations alongside New Mexico data, it may be inferred that these social circles function to allow access for white, educated and married women. Without women of color accessing home birth and sharing information and experiences, these conversations will remain within circles of those currently accessing home birth.

Ellen makes a connected but distinct point that in her semi-rural setting most of their moms come from word of mouth. Gabby’s clients explain: ‘My sister had her baby with you, so I came,’ and ‘My friend told me that you guys were nice, so I came.’ Iris thinks critically about which circles have shared homebirth experiences in urban settings:

“I think that people in certain social circles are much more likely to know about home birth and be interested in having a home birth. If their family had home births, if they were born at home, if their friends had home births – and I would say the majority of our clients, not all, there is some diversity but the majority of our clients come from a certain social circle in Albuquerque, and honestly, I think of it like the granola munchie, more alternative or hippie type, or people who perceive themselves as progressive type of people. I think that home birth is really pretty well established in that community, in Albuquerque, so it would be nice to spread it out a little bit more.”

In considering access for women of color in New Mexico, Licensed Midwives, as homebirth providers, are explaining a structural problem in that pregnant women do not know about their birth options. Also worth noting, several participants blame hospitals, the medical establishment and Medicaid for not doing more outreach on home births and the Birthing Options Program. The majority of participants in this study did not express any responsibility for increasing knowledge about home birth in the state.

## 4.2 Fear--Most Women are Frightened about Pregnancy and Birth

Women are frightened about pregnancy and birth, and make decisions based on fear, according to the qualitative responses expressed by the majority of participants. Helen noted that “Our culture perpetuates a culture of fear around birth, and that’s so big that it’s sometimes mind-boggling how to approach it. I think education from early on about the normalcy and health and environment of birth are important.” Mona explains the power of media in dictating perceptions of birth:

“I think women will seek out home birth for different reasons, but I feel like the media presentation of birth to us, either local media, advertising, billboards for hospitals and births, or on a grander scale, imagery that we get in TV and movies will probably dictate what people think is a good birth and a safe birth, and then make it a little bit harder for them to think of accessing different types of care than the hospital birth.”

The widespread culture of fear creates pressure on those who have decided to birth at home. Rae shares the kind of reaction her clients often receive: ‘You’re going to do what? You should be at the hospital, because what if something happens?’—“ ‘What if something happens’ is the most frightful sentence visited upon pregnant women.”  
(Rae)

The inaccurate media image in which the majority of births are portrayed as scary emergency situations, leave women as incompetent actors in need of being saved and their bodies managed. As Gabby explains:

“I think, sadly, one of the biggest barriers to home birth doesn’t even have to do with whether or not there are midwives around, but our broader understanding of what birth is and how women should birth. There is so much internalized fear of birth, and ways in which women don’t even know they’re

being controlled about birth. That is probably the hugest barrier. This barrier is a pervasive cultural, sociological, political issue that women across the boards have internalized about out-of-hospital births, in terms of ‘it’s unsafe’, and in terms of women’s inability or fear of their inability to give birth naturally, that the pain will be too much.”

As Olga explained, this fear-based climate strips away women’s confidence, the “medical establishment has done very well in the last 100 years to convince women that they can’t do it. I think after knowing it, most women don’t choose to do it because they’re not confident that they can, and we’ve been taught that. That’s not innate to us.”

As Gabby explained, though there are many reasons women and families make decisions about maternity care, doubts of home birth being safe are often critical, “Money, insurance, family pressure. I have a lot of people who they might have wanted a home birth but their partners or their parents or their extended family don’t feel like it’s safe.”

Many of the participants see this fear of birth as permeated by today’s media, “the fear and doubt, it’s promoted on every television show, every cable network, the music [makes musical “da-da-dum” sound]. Her water broke. Oh, it’s green, it’s brown. Nobody talks about all the stuff that goes right [in birth], because you can’t sell television shows, and you certainly can’t support your NICU unit or all the OBs that now work at your hospital.” (Rae)

Following the conversation about fear raises the question of whether the participants are presupposing that women will make the ‘best’ choice by birthing at home if they are aware of the midwifery model of care. If participants respect the choice of home birth over other options, this may subvert the discussion of freedom and choice as central tenets to home birth. This may reflect a limited understanding of the structural



forces faced by low-income women of color that may be making decisions about what is best for themselves in circumstances not reflected in a homebirth narrative.

It is important to note one divergence from this narrative. Multiple midwives talked about the positive implications of a film documentary on birth in this country, the *Business of Being Born*. According to Mona:

“I’ve actually felt impact of that the movie, *The Business of Being Born*, people are talking about it to me, that I wouldn’t have thought would be interested in that at all... People are like, ‘Oh, I just watched this movie, *The Business of Being Born*.’ I’m like, ‘You did?’ So I feel like the media is really, really powerful, and what’s on Netflix, which that is, can really alter people’s perceptions of what is a good birth, what is a safe birth, and where they want to go to access birth service.”

Iris further articulated, “Like a crazy lot of people have seen Ricki Lake’s documentary, and that’s awesome. That’s a wonderful thing, because, in some ways, if it’s on Netflix, it’s a little more widely accessible to people to check this out, or to have heard of this.”

Study participants feel that fear around birth is all encompassing and impacts all pregnant women. When considering access to home birth, midwives pointed to the inaccurate and sensationalized culture of fear constructed around birth as keeping women from trusting in themselves or trusting out-of-hospital care settings. Participants talked about how fear is created by media (and supported by the medical establishment) then fueled by families and communities who add their own bad birth stories. While recognizing the power of bad birth stories to keep women from home birth, midwives also point out that while saved by a hospital facility, many of these bad experiences were initially caused by poor medical management of birth.

Missing from this discussion is an acknowledgement of the stressful or emergency situations and occasional negative outcomes associated with pregnancy, regardless of where someone receives maternity care. By dismissing bad birth stories as causing harm to home birth, midwives are not using such opportunities to highlight their skill and expertise in caring for women, assessing risk of a situation, and making sure a woman is in the optimal place to receive the care she needs. This may have the unintended effect of keeping women with concerns about safety away from home birth.

By responding to sensational media about the dangers of birth, without providing communities with accurate and straightforward information, midwife participants may be positioning themselves and CNMs/MDs as a dual authority on pregnancy and childbirth, without building capacity of women to make reasoned decisions for themselves. Important throughout this theme, midwives see themselves as helpless actors fighting a big media fear machine. Without taking responsibility for shifting the culture of fear, midwives may perpetuate a harmful shaming of those with negative birth experiences and the communities that hear their stories.

#### **4.3 Money--Women and Families who are Considering but Not Committed to Home**

##### **Birth Make Decisions on Birth Options Based on Cost of Care**

For a substantial number of participants, there was a shared sense that the financial situation of a family is an important factor in determining their access to home birth. Gabby shared what matters in a family's decision about birth options:

“Obviously, money, whether people have insurance. ...Now with Medicaid covering birth in New Mexico, that’s an option for women, but for many years it wasn’t an option. Many private insurances don’t pay for home birth, and for a lot of women they might not see that paying for their homebirth experience is worth it, and not maybe see what the difference is or the value.”

For Rae, one of the two participants who do not take Medicaid, it is clear that without a deep commitment to home birth for insurance and cash clients, the final decision will be based on price:

“I would say the overwhelming, defining factor is money. The financial aspect of it often becomes the deciding factor. I do get a lot of questions, ‘Do I take Medicaid? Do I have a sliding scale?’ And then the overwhelming desire to use their insurance, if they have insurance – and usually that comes from the father – that if we use our insurance, it’s only going to cost us whatever, fill in that blank, \$100 or \$500 or whatever. So it seems cheaper to go to the hospital, from the financial standpoint.”

“My typical answer to that is, you can pay for the birth of your child with your wallet or you can pay with your wife or partner’s body and your relationship’, because going to the hospital changes how you birth in ways that often aren’t even anticipated by the couple themselves, or certainly a single mother, as well, who is feeling little or no support, and might think the hospital is going to become support.”

For a midwife participant that has made the choice not to take Medicaid, they may not have witnessed the capacity of poor women to develop social capital in the face of structural constraints. Without understanding this mechanism of everyday resistance, participants may not be fully utilizing their power to subvert some of the constraints faced by low-income women of color in accessing home birth.

For a larger number of participants, Medicaid reimbursement for home birth is crucial to the financial capacity of New Mexican women to access care of Licensed Midwives. As Helen states, “Medicaid payment for birth options opens access to care for low-income women.” In Anna’s stand-alone example, she indicated that midwives may

hold responsibility to the financial aspect of creating access to home birth through their own billing practices. Anna explains that, “Midwives make decisions on whether they accept insurance, Medicaid or use a sliding scale for payment.”

The responses around this theme were more direct than in other thematic areas. Either you can afford a home birth or not. Different than other themes, midwives centered themselves in this issue through their stance on this theme. Midwives can choose what insurance and/or Medicaid to accept, and in turn a small number of participants recognized that they have an active role in shaping affordability of home birth. Two participants held the view that cost was only a factor for those without a deep commitment to home birth. One participant explained that families with a strong commitment to homebirth care would find a way to pay for services, as detailed in the next section. This thread seems to contradict the small group of participants who have acknowledged the structural economic barriers for some women and families.

#### **4.4 A Small Group of Women with Strong Commitment/Determination to have a Home Birth Will Find Access to Midwifery Care**

A small but determined group of participants expressed that women with a strong commitment/determination to have a home birth will find a way to do so. Participants talked about trends in where the strong commitment/determination comes from, including family tradition and bad hospital experiences. “When a woman is determined to have a home birth, she’s usually going to have one.” (Mona) In more detail, Cathy’s words:

“Mostly, more than their own interpersonal reasonings of why they would want to do a home birth, beyond, I’d say, even distances – I have people from very far distances that want to do home birth, so it has nothing to do with availability of distance or space that way – it’s more about their upbringing, their teachings, what they’re familiar with. Yeah, sometimes it has to come more from such a deep place within them, they’re just not ready for it.”

While some may travel long distances for a home birth because their commitment comes from a “deep place”, the capacity to travel depends on viable resources to cover real costs. This may imply a level of privilege that low income women of color don’t often have.

Mona talks about how some people in natural health circles know they want a home birth so they seek out care. There are also women who have family traditions they are following:

“I’ve just seen a lot of different, interesting ways that people come to it. They know they want a home birth, for example, and they seek out home birth. They look in the phonebook, they ask around, they come to the co-op a lot, because that’s like the community center. And then there are women who aren’t in any of those natural health circles but there is a tradition in their family. Coming from Illinois, where home birth was kind of new again, here, I think, for some women, it’s continued as tradition in their family, and the women that came to the clinic in El Paso, as well. It’s not like, ooh, I’m doing this radical thing. It’s like, this is what you do.” (Mona)

Cathy offers an interesting perspective on the idea of people coming back to home birth as a traditional practice. She also considers some of the tensions in conflating home birth with poverty or 2nd tier care:

“And even though we have mostly second-generation people from all over, but a lot from Mexico, there’s been a cut-off place there that really, I feel like they can’t access it anymore. Either somehow it became a stigmatism about

lower class, or something, so people are moving forward in this place of not just really wanting that.”

“Then you see the next generation, after that, moving into where they’re not even questioning, and it mostly comes a bit from fear. I’m not 100 percent sure of that, but it feels like, well, if your mother was cut off from breastfeeding or told that you really can’t breastfeed – and I’ve seen this, directly, in working with a breastfeeding organization here. The grandmothers or whatever were really like, ‘You can’t do that. That baby needs formula.’ ”

“It’s like, wait a second. This is so cut-off. What happened in that gap? I don’t really know what actually happened in that gap, but these are just theories in my own mind. It’s like somehow there was a gap created. Actually, I think the more educated that people get, then they start realizing to go back, but it’s going to take some time to get people to really understand that this isn’t a lower-class or higher-class thing.”

Taking a different stance, Rae emphasized negative experiences either with a previous birth in a hospital setting or a hospital tour that shaped the commitment/determination to have a home birth. Other participants expressed similar ideas. Rae elaborates:

“Once they’ve had a hospital experience, they do. Their body language is completely different when they walk into my office. They may not be able to articulate what they want, but they’re very clear about what they don’t want. And then, there is a lot of reframing that has to take place, because once they have this nice home water birth, and they were in the driver’s seat, and I didn’t have to do anything except set up and clean up – my perfect birth scenario – they kind of get angry all over again [about the previous hospital birth], because it could’ve been like that if I had only known.”

Rae also shares interesting insight into the process many of her clients go through when choosing a home birth. When she gets a frantic call it’s:

“ ‘How late can I switch over to a home birth?’ And I can just say, ‘Did you just do the hospital tour?’ ‘Yeah. How did you know.’ It’s like, ‘Well, there’s just a little note of panic in your voice, that it’s become perfectly clear to you that even if it’s only going to be \$500 and your insurance is going to pay, you can’t do it.’ ”

“The tour does send me probably five or six clients a year, and then there’s the whole thing around that-- that we haven’t had an opportunity to work together and get bonded. ...Of course I’m going to interview this woman. How courageous of her, at this late stage, and probably under lots of pressure and, ‘Oh, honey, don’t. It’ll be okay. We’ll just do this. We’ll just do that to make it better,’ that she says no and stands up for herself and her baby, and says, ‘I cannot do it in this room, under these circumstances. I have to follow my instincts and my intuition, which says we need to stay at home, we need a different care provider, we need a completely different model of care, and this is what we’re doing.’ ”

The midwives who talked extensively about this deep commitment to home birth span rural and urban New Mexico, some of them take Medicaid, others do not. While they have nuanced explanations on the reason for a strong commitment or determination to have a home birth, they have a shared understanding that once a woman has this determination within her, she will find a way to have a home birth. The responses from participants did not include any information on the ethnicity or income of those who had a deep commitment to home birth.

#### **4.5 Practices of the Licensed Midwifery Community are Factors that Impact Access to Home Birth**

There is a small but firm group of participants who see their Licensed Midwifery community as having a responsibility to shape the access the women have to home birth. According to Ellen, barriers to home birth are very “self-caused, in a sense, or at least it’s up to us to address them, but you can’t blame it on somebody else. You have to take down barriers yourself.”

Two participants shared a narrative that expresses the agency and responsibility of midwives to remove barriers to home birth for women in New Mexico, without shifting the blame on someone else. These narratives reflect the basic goal of improving access

for women of color, by acknowledging the midwifery community can build opportunities to make a difference.

As a shared point, Ellen and Gabby both framed midwives as responsible for the position they hold in community. “Access isn’t just the presence of something and the location. So much of it is attitudes and reputation.” (Ellen) Ellen talks about the attitudes with which they treat clients and how that shapes access in her semi-rural community:

“A lot of access has to do with the mom’s perception of how she’s going to be treated. If she thinks that people are going to be nice to her and not yell at her, then she feels like she has more access. She feels more at ease to go to wherever that is. The hospital there has, in the past, a lot of reputation for yelling, forcing, you know, force your legs back, and force them open, force you to have your IV, and force the monitoring equipment. These are the rules, and no, you can only have one person with you. Then some people think that the birth center is luxurious, because it has these special deep tubs right in the room that you can deliver in. I ask people, ‘Why are you coming to the midwives?’ and they say, ‘The midwives are pretty.’ I say, ‘What does that mean?’ and they say, ‘Well, they’re always smiling and they never yell at you.’ ”

Gabby talked about how women have limited knowledge about home birth and safety and whether they personally know any midwives. Gabby asked about whether midwives have an active role in their communities as a means of impacting access, outside their homebirth practice:

“Women don’t know they can have a natural birth. They don’t know that it’s safe. They don’t know midwives. Midwives themselves haven’t integrated themselves into communities. Many midwives are very mono-centric in terms of their politics, that they fight, whether it’s locally, state, or nationally, or even internationally, on an issue. It’s all about birth and access to home birth, or access to midwifery care. They don’t see midwifery care in the bigger realm of reproductive health, or even reproductive justice. Midwives tend to see midwifery as the only thing that they’re working on, their only issue, so they don’t get involved in other community activities. I think midwives being public and being



out in public, doing things other than just talking about home births affects whether people know home birth is available in their community.”

For Ellen, a clear step in improving access to home birth in her community was:

“creating opportunities for meeting with the local medical family, and taking them out to lunch, talking to them, and telling them what you do, and how you’re licensed, what sort of emergencies you’ll be bringing in, and all that stuff. I did that a lot, and I think that really helped me. And I thought it was really honest, and I gave them the rules from the state, as to what I could and couldn’t do. And I think that always continues to be a barrier, is our willingness to connect with the medical community and the rest of the community.”

In an observational approach, multiple participants shared that the physical location of midwives in New Mexico would have a clear and direct impact on access to home birth. For Gabby, “the presence of midwives, obviously, whether it’s accessible or not, whether there are any midwives in the community, and as we’ve talked about before, there are not a lot of midwives. Even though there’s a lot in New Mexico on paper, there’s not a lot of midwives working and living in a lot of communities around the state.”

Gabby went on to express that New Mexico is lacking in a diversity of midwives who would be reflective of New Mexico’s population and particular community needs. In Gabby’s words, “There is not a lot of variety of midwives. You come to a town and you want to meet all the midwives, and I’ve definitely had people say, oh, they can’t find a midwife that they either like, feel like they are connected to, feel like they’re going to be well cared for.”

While only two midwives contributed data on this theme, their narrative is an important divergence. In stating that midwives have a role and responsibility in shaping

access to home birth, they are creating opportunities for more intentional strategic direction in doing so.

#### **4.6 Collective Vision of Home Birth in New Mexico**

While New Mexico has real reasons to be considered a homebirth friendly state, Gabby offered a nuanced read of this positive environment for midwifery in New Mexico:

“In New Mexico, it’s a state that people would say midwifery is accessible, and as a midwife, it is one of the best states to practice in because it’s easy to get licensed, there are good laws around midwifery, Medicaid covers it, there are good relationships, in general, with the medical system in New Mexico. But, at the same time, there are so many other factors that go into it; there are so many different elements that go into access that we don’t always think about. We talked about access in terms of whether somebody can get something, and whether they know it exists, but there are also those aspects that are like, ‘Is it appropriate? Is it affordable? Is it, I guess, appropriate in lots of different ways? Do people feel comfortable with it, safe with it? Do they feel good about it?’ ”

In a clear example of a focused but important access issue not presented by any other participants, Dot expressed that the undocumented Latina communities she serves in a pre-natal clinic capacity have no access to home birth. She explains:

“If there were Spanish speaking women [midwives] available, the women I serve, for the most part, are ineligible for Medicaid due to document status. There is also the lack of information available and fear about the safety of home birth. Many of the women I speak to feel that home birth is old-fashioned, some feel it is associated with poverty and not safe. Many women feel they are not physically capable of giving birth without medication. One of the frustrating aspects of my work at the clinic is identifying this great need for information and education about the safety and benefits of home birth and yet not feeling I can

back it up with referrals and resources. This community needs Spanish speaking midwives.”

From a divergent perspective, these two participants asked critical questions about New Mexico’s position as a homebirth friendly state. While valuing the pieces of New Mexico’s system that work, they presented opportunities to move forward in more realistic and nuanced efforts. They recognized a need for multi-lingual homebirth midwives as well as a need for midwives that can respectfully provide care for undocumented women and families in New Mexico. While these participants are NM Licensed Midwives, they both provide services in a medical establishment as well, one as a nurse in a labor and delivery unit, and the other provides well-women and pre-natal care in a community health clinic for those with no insurance coverage. Their routine interaction with women who are outside of the demographics of those most accessing home birth care likely shapes their understanding of the realities of low-income women of color. By engaging with broader communities in thoughtful and respectful ways midwives may be better prepared to build practices that are accessible for a wider range of New Mexican women.

#### **4.7 Spectrum of Participant Perception of Access to Home Birth**

The following diagram displays participants’ perceptions of access.

**Table 7: Spectrum of Perceived Access to Home Birth**



In expressing a general sense of the access women have to home birth in New Mexico, the table illustrates evenly distributed opinions, from excellent access to no access to home birth in NM. This fairly even distribution across a range of access levels is particularly interesting when given that midwife participants had many shared perceptions of what factors shape access to home birth. While midwives did identify external themes, (knowing about home birth, fear of birth, cost of home birth, and care provided by midwives) there was an overall sense of blame and responsibility on outside, often uncontrollable forces. There was also some blame on individual women for not

being sufficiently informed or committed to home birth so as to navigate structural forces that may pose as barriers to access. There was only a small divergent group who characterized midwives as being accountable to the access women have to home birth in the state.

## **CHAPTER V. Trends in Description of Potential Client and Outreach**

### **Efforts by Participants**

#### **5.1 Trends in Description of Potential Clients**

All participants provided clear and concise responses when asked to describe potential clients and their outreach strategies for building their midwifery practices. Participants' language when describing clients ranged from very open and encompassing- - covering a wide group of women (just about anybody/anyone), to a narrowed description of clients as any pregnant woman wanting a natural birth or home birth. In response to this question a few participants included descriptions of who they do not serve.

#### **5.2 Outreach Efforts by Participants**

These queries were crucial in identifying the potential pool of homebirth clients as perceived by NM Midwives, as well as participants' concrete outreach efforts in building clientele. Most of the participants had congruency and alliance between their own defined clients and their subsequent activities and actions to connect with such clients. Of note, several of the midwife participants who had congruence between identified clients and their outreach strategies were those with a narrow description of client-- any pregnant wanting a natural birth or home birth. Describing a client as one who is already aware or committed to the home birth option leaves out significant New Mexico women who don't know about home birth, as described in the access chapter.

This may mean that the outreach strategies used by these participating midwives, while congruent to their description of clientele, likely works to find clients within the demographics of those already accessing home birth (white/married/educated).

The remaining participants had a clear idea of their potential clients, but their actions/inactions as outreach strategies may not be sufficient in creating access to their universe of defined clients. These participants were largely those that described potential clients in general and encompassing terms-- all pregnant women. This presents an opportunity for these particular midwives to use more strategic outreach strategies so that more women realize access to home birth. The following tables (Tables 8 and Table 9) include a summarized compilation of all responses detailing description of clients and outreach by midwives.

**Table 8: Potential Clients as Described by Midwife Participants**

**Any normal pregnancy:**

- Just about anybody/anyone is potential client
- Any pregnant woman
- Have to have uterus and breasts
- Few restrictions, most women are excellent home birth candidates
- 90% can birth at home, 10% extreme fear or health problems won't allow
- LMs are trained for normal pregnancy, births, postpartum, well woman care....90% of births are Normal
- Others are strict (smoking/brown rice)--she will talk about dangers but still help

**Anyone committed to natural birth:**

- Anyone ready for birth as natural
- Any pregnant woman that wants natural birth
- Someone who really wants home birth
- Anyone able to take responsibility for own health, not expecting someone to do that for them
- Anyone with deep spiritual/emotional or other desire to do it

**Those who don't usually access care:**

- Wants to provide midwifery care to those who don't usually have access

**Who we will not take:**

- NO SMOKERS
- Not those beyond scope of practice
- JOKE: white hippies. no. (but yes in practice)

**Who was considered client in my training:**

- From apprenticeship/training: Spanish speaking, economically/racially/culturally representative from family background (and in practice now, serving a lot of these women): right wing Christian types



**Table 9: Outreach Strategies Used by Midwife Participants**

\* Indicates the number of participants that employed given strategy

**Word of mouth:**

- Word of mouth\*\*\*\*\*
- Recommendations/Reference\*\*\*\*
- Repeat clients\*\*
- Usually by family/friends\*
- Passionate about networking clients as pregnant women and new moms (Network of Clients)\*\*
- Referrals from other practitioners
- Referrals from other clients
- Referrals from other midwives, including CNMs at hospitals

**Internet/Website:**

- Website\*\*\*
- Only midwife in area with website
- Internet
- Internet article about me
- Phone bank\*More and more initial contact through email

**Flyers and other media/materials:**

- Flyers---but honestly those are to same coffee/health food/coop crowd\*
- Flyers
- Occasional TV/radio
- Fundraisers
- Yellow pages/phone book\*\*
- Business cards
- Brochures
- Have advertised births in local paper

**Community Involvement:**

- Getting involved in community organizations
- Engaged in community issues
- Community events
- Health fairs
- When I help one woman, 4 or 5 show up to meet me
- Wants to improve Spanish and serve more Spanish speaking
- Have done free pregnancy tests

**Classes and educational opportunities:**

- Used to do free classes at BabiesRus, through Alb Birth Network, reached whole different crowd, taught on natural birth, etc
- High school classes, health fairs
- Building practice: beating bushes/public education
- classes on normal birth, herbs for pregnancy/parenting, etc
- Many classes on childbirth
- Holding classes

**Why I don't outreach:**

- Been limited\*
- Haven't worked hard on outreach to good slice of population
- Not a lot of advertising, busier than I want to be
- Not big on publicizing- size of practice is good
- I do no advertising. I like that people have to look or seek me out as HB provider
- We don't have any really, clients outreach to us
- The rare HB clients I've accepted as primary midwife found me through low cost clinic where I offer prenatal care

As seen in Table 9, the majority of midwives use some form of word of mouth and personal reference to build their clientele. While that may prove effective within demographic communities where home birth is being accessed, it may fall short of reaching low-income women of color that may not know home birth is an option, or may not know people who have had home births. The primary outreach strategy being used is word of mouth, midwives have begun to use the internet to advertise. One participant that did so rightfully pointed out that low-income families and often families of color have less access to internet, and even for those that do, you have to be aware of home birth as an option to search for midwives online. Midwives continue to use traditional media, like flyers and brochures; they are primarily leaving materials in places where home birth is seen as an option.

Some participants shared outreach strategies of community involvement like teaching classes and conducting educational workshops for pregnant women. These strategies present a positive opportunity to reach more women of color. Participants indicated they currently used these strategies in limited ways and wanted more tools to do so effectively.

Other midwife participants did limited or no outreach at all. Their reasons varied, some could not expand services and were at capacity with clientele they had built through word of mouth or personal references. One participant, who previously expressed that women determined to have a home birth would find access to a midwife, said she did not outreach because she felt a woman needed to seek her out as a homebirth provider.

## CHAPTER VI. Medicaid and New Mexico Midwives

As outlined in Table 3, New Mexico is one of only a handful of states that provides Medicaid reimbursement for out-of-hospital maternity care, free-standing birth centers and home birth. A Health and Human Services 2012 report, *Improving Outcomes for Pregnant Women and Infants through Medicaid*, explains that the “New Mexico’s Medicaid program covers pregnant women with incomes of up to 185 percent of the Federal Poverty Level (\$3,554 monthly income for a family of four). In 2010, this placed NM in the top ten states for this benefit level.” The same report stated that in Fiscal Year 2011 Medicaid paid for 71% of all births in the state.

As clarified in previous chapters, the New Mexico Medicaid Birthing Options Program is an important resource for providing access to home birth for low-income families, given that the majority of the births in the state are paid for by the Medicaid program. As part of the written survey, participants were asked if they accepted Medicaid, and were asked to provide information on why they did or did not take Medicaid payment. Of the 13 written survey respondents, eleven accepted Medicaid while two did not.

Those who accept Medicaid explained their reasons for doing so along three clear dimensions. Some respondents noted that accepting Medicaid allowed for them to provide care to *more women or a larger population* of women. As one participant expressed, “It has made home birth more accessible to middle and low-income women.”

(Iris)

Some respondents described their client base as “*all or everyone*” and expressed that everyone should have access to birthing options and that Medicaid enables all women to access home birth. Along this theme, a midwife shared, “It’s an honor to serve all women.” (Kaya)

Lastly, some respondents cited the *high number of births to women on Medicaid (75-83%) in New Mexico*, arguing that the great majority of women in the state would not have basic access to home birth without midwives willing to accept Medicaid reimbursements. One midwife asked a compelling question, “If it’s true that 75% of New Mexico women qualify, how can I not accept?” (Anna)

Only two participants do not take Medicaid, citing low/poor payment. They made no mention of the nature of their client base, the conditions faced by women on Medicaid, or percentage of Medicaid births in the state. Though these participants embrace the benefits of home birth for all families, their decision to not accept Medicaid clients (unless they are willing to pay out of pocket) results in their services not being available to most women in the state.

### **6.1 Observations about the Birthing Options Program (BOP)**

Participants in the focus group shared observations on the negative and positive attributes of the NM Medicaid Birthing Options Program. As a program that provides reimbursements to Licensed Midwives for home births, the focus group was useful in gauging participant usage of the program, as well as illuminating serious concerns midwives have about the function of BOP. These concerns have substantial policy implications; it is crucial that the BOP program work well for New Mexico midwives since a great majority of New Mexico births are being covered by the Medicaid program.

In speaking positively about the program, a focus group participant expressed that the Birthing Options Program makes home birth “accessible for those truly in need”. Another participant expressed that this program means “NM is trying to let women know that they have a choice of birthing care and that more woman are choosing a birth center or home birth.” For another participant a positive impact of the BOP is that there will be “safer birth for women at home.”

As for the negative responses about the Birthing Options Program, focus group participants expressed concerns that most women do not know about birthing options and that the program does not do an effective job at advertising. They also pointed out that other maternity providers like CNMs and MDs are not discussing home birth options with women of color. Other negative observations are that reimbursement levels for services to Medicaid providers are low, and receiving payment is a difficult process. One focus group participant noted that in her area there was a large undocumented immigrant population that cannot receive support from the Birthing Options Program.

A different focus group participant expressed at length that some individuals enrolled in Medicaid/BOP could pay out-of-pocket and are not carrying their responsibilities to pay for their own care. This particular participant blamed families for making her judge our system, and gave many examples of families who had nicer homes, vehicles, or more entertainment options than she had.

In the written survey, participants were asked to share what they thought the purpose of the Birthing Options Program was. The majority of responses were accurate and straightforward—BOP provides out of hospital birth options to women who have Medicaid. For those who didn’t know about its purpose, they had a basic idea that it was

about getting more people access to home birth. A majority of the participating midwives identified themselves as somewhat to very familiar with the BOP. From their own perspective, a number of midwives found that women in New Mexico have no to limited knowledge of the BOP. A majority of midwives surveyed felt that the BOP fell short of meeting its intended purpose, while others did not know if the BOP was effective in its efforts.

Participant observations of the Birthing Options Program reflect evidence presented in other chapters, namely that pregnant women in New Mexico don't know about birthing options or the Birthing Options program itself. Midwives articulated that those using the program already wanted a home birth, and then found out about BOP. From their observations, women are not learning about birth options through BOP materials. Participants also express noteworthy concerns that midwives have in navigating payment through Medicaid (BOP) billing.

Overall, most participating midwives decided without hesitation to accept Medicaid through the Birthing Options Program. These decisions follow a philosophy reflected in their core tenets of homebirth practice, and their descriptions of potential clients. It seems that currently Medicaid payment is used by pregnant women and midwives who already know of and want a home birth. There is a sizeable group of participants who want to expand their own outreach and advocate for a more effective promotion of the program so women on Medicaid in New Mexico (the majority of births in state) are making real and informed decisions about where to seek maternity care.

As written in a 2012 Health and Human Services Report, "More than half of pregnant women enrolled in Medicaid managed care enter prenatal care after the thirteenth week of pregnancy. Previous LFC reports have highlighted New Mexico and

the Medicaid program's persistently low rates of women who receive full prenatal care.” The report further explains that, “Late and infrequent access to prenatal care undermines efforts to improve birth outcomes and lower Medicaid costs for deliveries. Prenatal care is one of the most effective interventions to improve birth outcomes.” The Report recommended identifying barriers to late pre-natal care and implementing corrective measures to address this issue. By strategically building outreach efforts to include information about home birth as well as the importance of receiving prenatal care in first trimester, Licensed Midwives may find stronger alliances in the Medicaid program. This would serve as useful in addressing their concerns with the Birthing Options Program and positively impact access for low-income women of color to home birth.



## **CHAPTER VII. Tools to Improve Access to Home Birth for Women of Color in New Mexico**

As part of the individual interviews, respondents were asked to suggest tools that would improve access of low-income women of color to home birth in New Mexico. This research question was designed to 1) identify tools for improving access 2) discern whether distinct problems surfaced when including women of color in the question.

One participant offered concrete, affordable and easy to implement tools (she serves a semi-urban community and accepts Medicaid). These tools included celebrating babies born at home through small ads in area newspapers, appearing on community radio stations to answer questions about birth, and recognizing local businesses for being baby friendly. Another participant offered no tools to improve access for women of color (she serves an urban population and does not accept Medicaid). A substantial number of participants offered some less concrete tools, but in lengthy conversations explained why outreach to these communities has been difficult for them, or for the midwifery community. These suggestions included broad ideas like talking to families about home birth, and raising community awareness of birthing options.

Overall, the sentiment behind the tools suggested indicated that individual midwives and some members of the midwifery community were willing to make concrete efforts to positively impact access for low-income women of color. When asked to provide tools for improving access to home birth for women of color, participants responded in a pro-active frame. This differed from responses to other questions in which the participating midwives had expressed concerns about access to birthing options, without taking any responsibility for impacting the barriers to home birth that currently exist.

When asked about tools for improving access, some responses reflected barriers to accessing home birth care presented in earlier chapters. Throughout the chapters participants expressed concern that many women do not know about birthing options in the state, and several participants expressed a need for increased awareness of midwifery and homebirth care. Throughout preceding chapters a sizeable group of participants expressed concerns that the state and Medicaid office were not doing effective advertisement and promotion of the Birthing Options Program; participants offered advocacy ideas to shift this dynamic.

A small group of participating midwives had identified the responsibility of their own communities in addressing barriers to home birth. In response to the question asking for tools to improve access for women of color, participants shared potential ideas for midwives to be more active in reaching “community” (community seemed to be a replacement for women of color), as well as the political nature of designing outreach to expand accessibility for more families.

The conversation about improving access to home birth for women of color evoked an important outlier not previously addressed. Noteworthy was the suggestion that midwives may not currently understand the benefits that midwifery care could provide to a wider scope of communities. A tool suggested to impact this barrier was additional opportunities for Midwifery education, including curriculum on social determinants of health. One participant suggested that there is an opportunity for women of color to educate each other about benefits of midwifery and home birth.

Overall responses with tools to improve access to home birth for women of color solidified the positive intentions of a majority of participants to ensure their midwifery practices match the core values of their homebirth practices.

## **CHAPTER VIII. KEY FINDINGS, RECOMMENDATIONS & CONCLUSION**

### **8.1 Key Findings**

#### **Central Tenets to Home Birth, Key Findings**

As they articulated central tenets of their own New Mexico home birth practices the participating midwives were proud of and confident in their midwifery model of care, and used common language to describe this model of care. In its design, this model is seen to promise a way to provide care for all pregnant women, an assertion that is a marker of community identity for home birth midwives in New Mexico. Across themes, midwives shared positive, open, and welcoming tenets of home birth that guide their midwifery practices. As a community, these New Mexico home birth midwives believe deeply in their model of care and are well-intentioned in providing care to those who also value birth as normal, birth as empowering, and elements of freedom and choice in birth. Highlighted here are the central tenets of home birth as expressed by participating midwives:

- Birth is Normal
  - Women as powerful, natural birth as a right
- Home Birth as Empowering
  - Spiritual/experiential value of home birth, self and spiritual growth, opportunity to empower pregnant woman, empowered women are good for planet
- Respecting Freedom and Choice in the Birthing Process
  - Allows midwives to be better providers, experience is more comfortable for client
- Midwifery Model of Care and Unique Skills
  - Clinical outcomes, capacity to provide emotional care, and low-cost services

## Access to Home Birth, Key Findings

Participating midwives also provided substantial insight into the factors that shape access to home birth for women in New Mexico. In considering access for women of color in New Mexico, Licensed Midwives, as the majority of New Mexico home birth providers, explained that that pregnant women do not know about their birth options. Several participants blamed hospitals, the medical establishment and Medicaid for not doing more outreach on home births and the Birthing Options Program. The majority of participants in this study did not express any responsibility for increasing knowledge about home birth in the state. Articulated by participating midwives, these are the factors that most directly shape access to home birth in the state:

- Most NM women Do Not Know Home Birth is an Option
  - Most women do not know home birth is safe, legal, and for many families affordable
- Fear—Most Women are Frightened by Pregnancy and Birth
  - Fear is perpetuated by media and medical establishment
  - Fear is all encompassing and impacts every pregnant women
  - Participants may be presupposing that women will make ‘best’ choice by birthing at home, if they have such awareness—may reflect a limited understanding of structural forces faced by low-income women of color
  - Concerned with ‘bad birth stories’ and their impact on pregnant women, participants may fail to provide thoughtful and necessary conversations with families, and miss opportunities to highlight their skill and expertise in caring for woman
- Money—Women and Families who are Considering but not Committed to Home Birth Make Decisions on Birth Options Based on Cost of Care
  - Majority of participants shared that finances are key to access
- A Small Group of Women with Strong Commitment/Determination to have a Home Birth will Find Access to Midwifery Care
  - Small group of participants shared that if a woman is committed she will find a way to pay for home birth
  - As participants supposed that a deep commitment or determination to have a home birth will be enough to secure access, this implies a level of privilege that low-income women of color and other women may not have

- Practices of the Licensed Midwifery Community are Factors that Impact Access to Home Birth
  - There was an overall sense of blame and responsibility on outside, often uncontrollable forces
  - There was also some blame on individual women for not being sufficiently informed or committed to home birth so as to navigate structural forces that may pose as barriers to access
  - Small group of participants shared that see their LM community as having a responsibility to shape the access women have to home birth, they expressed their own agency and responsibility to remove barriers to home birth for women in New Mexico

### **Description of Potential Clients and Outreach Efforts by Participants, Key Findings**

Participants' language when describing clients ranged from very open and encompassing-- covering a wide group of women (just about anybody/anyone), to a narrowed description of clients as any pregnant woman wanting a natural birth or home birth. These queries were crucial in identifying the potential pool of home birth clients as perceived by NM Midwives, as well as participants' concrete outreach efforts in building clientele. Most of the participants had congruency and alliance between their own defined clients and their subsequent activities and actions to connect with such clients.

Several of the midwife participants who had congruence between identified clients and their outreach strategies were those with a narrow description of client-- any pregnant wanting a natural birth or home birth. Unfortunately describing a client as one who is already aware or committed to the home birth option leaves out significant New Mexico women who don't know about home birth, as described in the access chapter. This may mean that the outreach strategies used by these participating midwives, while congruent to their description of clientele, likely works to find clients within the demographics of those already accessing home birth (white/married/educated).

The remaining participants had a clear idea of their potential clients, but their actions/inactions as outreach strategies may not be sufficient in creating access to their universe of defined clients. These participants were largely those that described potential clients in general and encompassing terms-- all pregnant women. This presents an opportunity for these particular midwives to use more strategic outreach strategies so that more women realize access to home birth. At the time of data collection, participating midwives were relying heavily on word of mouth and personal references in building a sustaining a client base. In order of reported use, these are primary strategies employed by participating midwives to reach clients:

- Word Of Mouth
- Internet/Website
- Flyers and Other Media/Materials
- Community Involvement
- Classes and Educational Opportunities
- No Outreach

### **Medicaid and New Mexico Midwives, Key Findings**

The participating midwives all understood that the majority of pregnant women in New Mexico are Medicaid qualified, and that the Medicaid program provides coverage for home birth through the Birthing Options Program. The majority of the midwives accepted Medicaid reimbursement for home birth services because they wanted to serve all New Mexico women that wanted a home birth. While their principles are noble, participating midwives expressed some serious concerns with the Birthing Options

Program, namely that it is not advertised effectively, and that the Medicaid payment process for home birth is a slow and arduous process. These concerns have substantial policy implications; it is crucial that the BOP program work well for New Mexico midwives since a great majority of New Mexico births are being covered by the Medicaid program.

### **Tools for Improving Access to Home Birth for Women of Color, Key Findings**

In thoughtful responses, the majority of participating midwives communicated that their will to improve access to home birth was greater than their capacity to do so. This dynamic presented an incredible opportunity to provide strategic resources and support to midwives invested in improving access for women of color so that they may be better prepared to do so.

### **3.2 Recommendations**

Key to recommendations offered here and throughout this thesis is an investment in building trust and working relationships between those who are concerned with improving access to home birth for more of New Mexico's women and communities.

Since embarking on this research, and learning from the insights shared by participants, the author has since created opportunities for strategic conversations about building a movement for birthing justice in New Mexico. For the author, birthing justice is an ideal in which all pregnant people have what is needed to make their own decisions about the maternity care that will be healthiest for themselves and their families, whether that be a home or hospital birth.

These conversations among mamas, birthworkers (pre-natal, labor, post-partum, and breastfeeding support people), midwives, alongside community organizers and promotoras de salud have identified barriers to home birth for women of color that are the same as those identified in this thesis. To address these barriers the group has decided on four strategic directions that align with opportunities identified here and form the recommendations of this paper:

- **Creating a New Mexico Birth Justice Coalition**

With a self-identified group of New Mexicans committed to addressing disparities in maternal and infant health outcomes through a midwifery model of care, a Birth Justice Coalition is a way to name and carry the collective efforts of this community. Building trust and relationships around this issue means including those most impacted by the issue are valued for their expertise and included in these important conversations. Such a coalition also creates opportunities for community building, an important element missing in and limited efforts of individual midwives in their efforts to reach a broader range of New Mexican families.

- **Expanding knowledge of birth & birthing justice options by engaging families in creative and thoughtful ways**

As participating midwives and others agree that the majority of women and families do not know home birth to be an option in the state, there is a clear need to build awareness about the range of birth options available to New Mexican families. Considering that every pregnancy is different, and every family in a unique situation, these efforts will be designed as interesting and community



based approaches to respectful conversations about pregnancy, birth, and birth options in New Mexico.

- **Developing opportunities to support birth workers & midwives committed to birth justice**

With an understanding that today the majority of New Mexico Licensed midwives identify as White and come from communities outside of New Mexico, many agree that New Mexico's families may be also served well with midwives who come from our people of color New Mexican communities. Some participating midwives and the Birthing Justice group have a shared sense of urgency and are ready to identify and support the professional path of New Mexican women of color that may be called to this work. These efforts are intended to improve the ways culturally safe and respectful care is provided for our New Mexican families, through the midwifery model of care.

- **Creating a process for and pursuing policy change in line with birth justice**

Recognizing that any movement, including efforts towards birthing justice, require collaboration and partnership of those with different positions and contributions to the overall efforts, this group is prioritizing the creation of a process to pursue meaningful and strategic policy change initiatives in line with greater birthing justice vision.

The expertise of participating midwives who expressed concern about aspects of the Birthing Options Program will be centered in initial efforts. These policy efforts will begin with planning and implementation of strategies to ensure that more New Mexican women know about the Birthing Options Program and that

some of the concerns around billing and payment raised by participating midwives are addressed.

### **3.3 Conclusion**

Only sixty years ago, the majority of New Mexicans were born at home or in community based settings. Soon after World War II, rural families, especially those who made up working poor and working class communities began to hear different messages about birth options in New Mexico. For the majority of people of color in the state, home birth was presented as unsafe, uncivilized, second-class care provided by uneducated midwives. In comparison, maternity care under a doctor's supervision in a hospital was presented as the ideal option and families were encouraged to seek a doctor's care as soon as they had access.

Today, those communities who shifted from home birth to hospital settings most recently are accessing Licensed Midwifery care in very small numbers. These communities are often disconnected from the resources and social circles that present home birth as a safe and healthy option for their families.

This thesis is a step in bridging the gap between Midwives practicing in New Mexico and the communities who were historically born at home. By acknowledging the contemporary tenets of home birth in New Mexico and identifying points of discrepancy that support access for some communities, and not others, this work serves as a point of discussion for those interested in improving access to home birth for communities of color in New Mexico. This thesis carries a respectful argument useful in understanding the context in which women access home birth in the state. This thesis may be of interest

to midwives and policy makers concerned with health outcomes in the state, and those curious about New Mexico's nuanced position as a homebirth friendly state.

Participants invested in working through critical challenges to improve access to home birth have a new community in which to do so, and clear directions that allow them to contribute their particular strengths in a movement for birthing justice. Together, we can shift the midwifery landscape in New Mexico so that women of color have real access to a range of birth options where they will find safe, respectful and dignified care.

## APPENDIX A. WRITTEN SURVEY

### Written Survey:

Thank you for choosing to participate in this research project, your participation will help improve the access of low-income women of color to homebirth in New Mexico. Your input is valuable, please elaborate on any question using a separate sheet of paper.

Please describe the core principles or philosophies that guide your midwifery practice.

What is your impression of the level of access New Mexico women have to homebirth services?

How do your homebirth clients find you?

Why or why not do you accept Medicaid as payment for homebirth services in your practice?

Please describe, to the best of your knowledge, the purpose of the New Mexico Birthing Options Program.

What is your familiarity with the NM Birthing Options Program? (please circle one)

Not at all familiar  
1                      2                      3                      4                      5  
Very familiar

comments:

In your opinion, what level of familiarity do pregnant women on Medicaid have with the NM Birthing Options Program? (please circle one)

Not at all familiar  
1                      2                      3                      4                      5                      I don't know  
Very familiar                      \*

comments:

In your opinion, how well does the NM Birthing Options Program meet its purpose? (please circle one)

Not well at all  
1                      2                      3                      4                      5                      I don't know  
Very well                      \*

comments:

**Demographics:** This information is collected for statistical purposes only, no individual demographic data will be revealed.

What is your gender?

How do you identify racially?

How do you describe your class identity-  
in childhood?

in adulthood?

Please circle the age range that describes you.

18-24 25-30 31-35 36-40 41-45 46-50 51-55 56-60 61-65 65+

Do you self-identify as a woman of color?

**Would you be interested in further participating in this research?**

- yes, in an individual interview
- yes, in a focus group
- yes, in interview and focus group

What is the best way to contact you?

## **APPENDIX B. INDIVIDUAL INTERVIEW GUIDE**

### **Individual Interview Script:**

What seem to be important factors that determine access to homebirth for women in NM?

Given your response to the previous question, what do you think causes these barriers and/or opportunities for homebirth?

Whom do you consider to be a potential homebirth client in New Mexico?  
Please describe your outreach to potential clients.

What tools would you recommend for improving the access of low-income women of color to homebirth?

Do you have anything else you would like to share?  
Do you have any questions of me?

## APPENDIX C. FOCUS GROUP GUIDE

### **Focus Groups:**

*This project has two areas of focus; the focus group is designed to gather data for both areas. First, the focus group will assess how culture of New Mexico midwifery informs the access that low-income women of color have to homebirth services. Second, the focus group will generate analysis, by NM licensed midwives, of how the Birthing Options Program, facilitates or undermines their capacity to serve low-income women of color in homebirths.*

**Facilitator:** Read focus group script (asking to record, asking for confidentiality)

**Facilitator:** Take and respond to any questions, ask participants for verbal consent to record and for commitment to respect confidentiality of group

### **Facilitator: (Introductions)**

Introduce self, ask participants to share their name and where they practice.

Explain to participants that while they may know each other and hold a nuanced understanding of their varied reasons for practicing midwifery, Facilitator is attempting to learn about who they are, and why they do what they do, among other things.

Session will begin with participants taking 5 minutes to reflect on the reasons they came to the practice of midwifery. They will be asked to write their reasons on a sheet of paper.

The group will then split into pairs. Pairs will have 5 minutes to talk with each other about the reasons they each came to the practice of midwifery. They will then be given another five minutes to talk about the value of midwifery in New Mexico. Each pair will be given a pile of notecards and asked to write their ideas about the value of midwifery in NM. (one idea per card) The facilitator will explain that the cards will be collected and used as part of a group exercise. The pairs will be encouraged to come up with 6 cards- more or less is ok. As they wrap up, the pairs will come back to larger group. A member from each group will share some of the highlights of the conversations, focusing on similarities or differences in the reasons midwives have for practicing. The facilitator will then ask the pairs to pass up three of their notecards, choosing the ones that are the most clear, or that they feel the most strongly about. The facilitator will read each card, post it on a wall, and encourage participants to ask for clarification on the meaning of a card, should it be necessary. After the facilitator collects three cards from each group, she will guide the participants in grouping cards that are similar. The facilitator will collect additional cards and continue with the grouping process. When all the cards are grouped, the participants will title each group with something they feel reflect the meanings of



each cluster of cards. The participants will be thanked for their contributions to the exercise, and it will be explained that researcher now has an articulated expression of the value of midwifery in NM, directly from local midwives.

**The Facilitator will then guide a discussion about the Birthing Options Program.**

Participants will be given a sheet on which they will individually reflect on what they know/have experienced about the BOP or similar programs. The sheet will have a column for neutral, positive, and negative observations about the program. After a few minutes, the participants will be asked to share the highlights of their sheets. The Facilitator will have large flip charts where she will record input.

Reflecting on collective input, the group will be asked to prioritize a) program strengths; b) areas of concern; and c) needed program improvements.

Participants will be asked to discuss actions that might be helpful in addressing areas of concern and making needed improvements with the program.

Participants will be asked if there is anything else they would like to contribute. Participants will be asked if they have any questions of the facilitator.

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