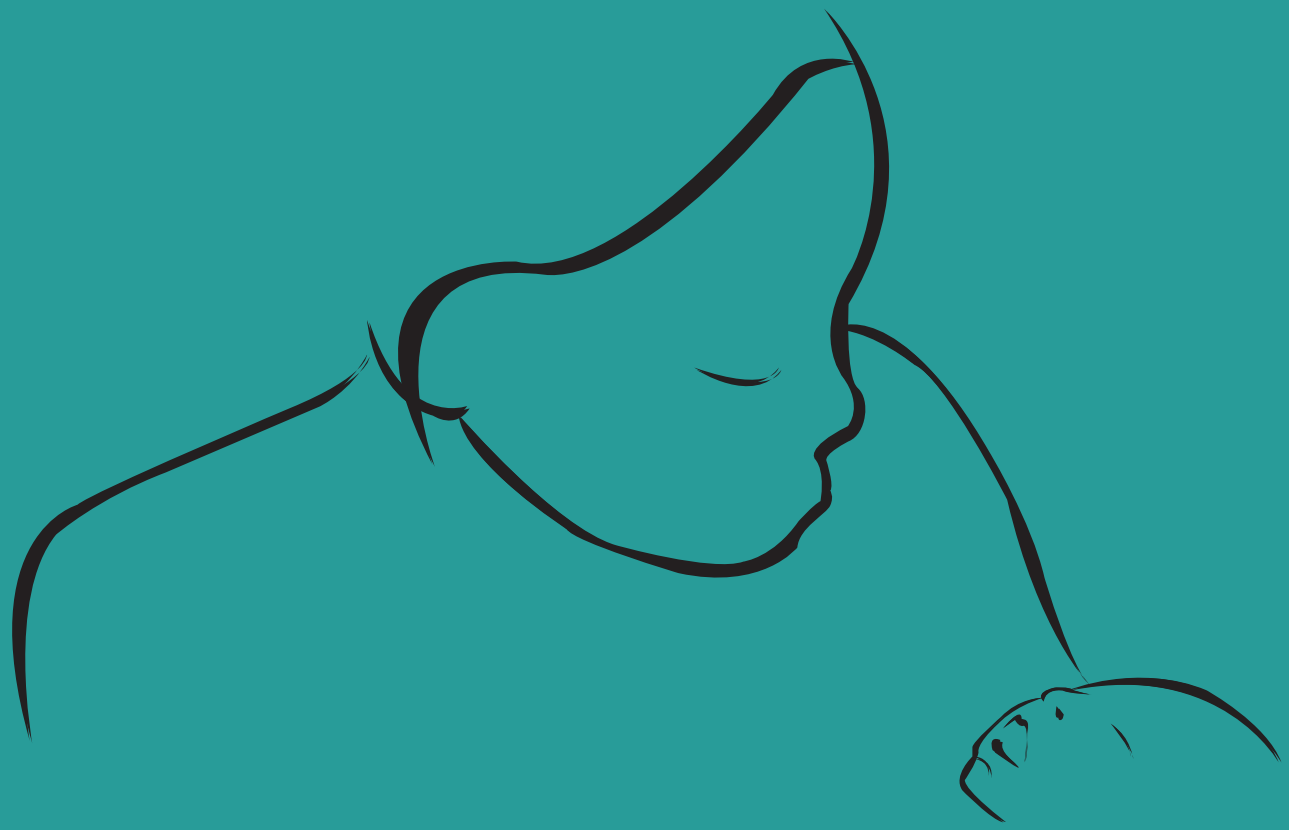
2016 - 2018

New Mexico PRAMS

PREGNANCY RISK ASSESSMENT MONITORING SYSTEM



PRAMS
- NEW MEXICO -

NMDOH
NEW MEXICO DEPARTMENT OF HEALTH

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The NM PRAMS team wishes to thank the New Mexico mothers who answered our survey. Because of their generosity, this report is possible.

We also thank the PRAMS Steering Committee members for their input on survey design and PRAMS data to improve maternal and infant health in New Mexico.

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What Is PRAMS?

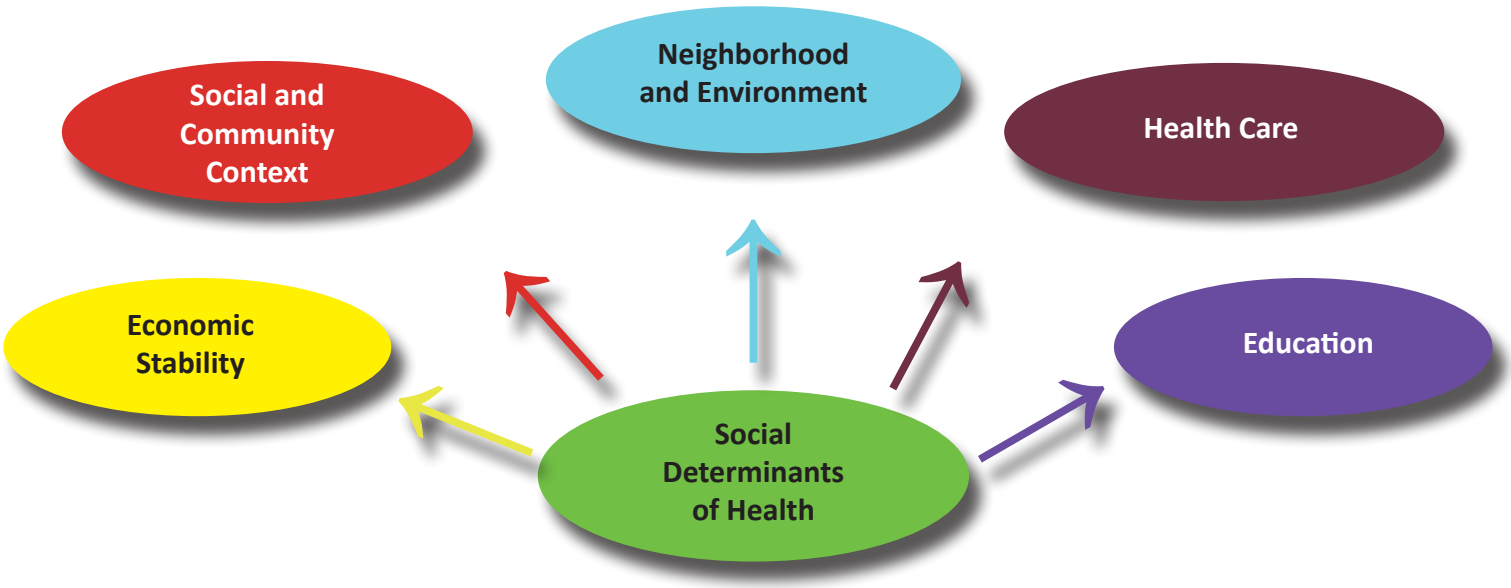
The New Mexico Pregnancy Risk Assessment Monitoring System (NM PRAMS) is a public health surveillance system of women giving live birth in New Mexico. Its purpose is to measure maternal attitudes, behaviors, and experiences before, during, and after pregnancy. The resulting data assesses the health of mothers and infants in New Mexico.

The New Mexico Department of Health (NMDOH) and the U.S. Centers for Disease Control and Prevention (CDC) sponsors PRAMS. PRAMS is conducted to improve the health of mothers, infants, and families, by providing the state's only population-based maternal and infant information. Each month New Mexico mails PRAMS surveys to a sample of women with a recent live birth, 2-6 months after delivery. After data collection ends for a birth year, New Mexico submits a complete birth file to the CDC for statistical weighting of the survey data to represent the N.M. birth population.

This report consists of the survey responses from N.M. resident mothers with a live birth in 2016- 2018. The state combined three years of data to increase the sample size of subgroups. In addition, the report includes trend data for specific indicators for several recent years.

About This Report

This report covers selected topics from many of the 80 survey questions. Each section contains bullet points highlighting NM PRAMS findings, referencing tables and graphs. In addition, multiyear line charts are included for selected topics to illustrate changes over time. This report's findings are associated with the social determinants of health (SDOH). According to the Office of Disease Prevention and Health Promotion, the SDOH has a significant impact on people's health and well-being and their quality of life. The SDOH includes five domains: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context (ODPHP, 2021). These domains can impact the health outcomes for pregnant persons and their infants.



METHODOLOGY

Population and Sampling

The study "population" is all New Mexican resident births to people with a registered live birth occurring in New Mexico from 2016-2018. The report includes only live births and has only one twin or triplet for the survey (excludes higher-order births). Other exclusions include births for infants adopted before birth registration and those who have an out-of-state delivery. For the years 2016-2018, the in-state resident birth population was estimated at 65,949 women. In 2016, New Mexico had 22,838 in-state births to N.M. residents; 1/12 were sampled. In 2017, 21,903 in-state births were to N.M. residents, and 1/13 were sampled. In 2018, 21,208 births were to N.M. residents, and 1/11 were sampled.

Because PRAMS sample data are statistically weighted, the information is estimated for the resident, in-state birth population. The sample selection for 2016-2018 was based on the mother's educational attainment and included the following strata: 1) less than high school, 2) high school, 3) some college, 4) Bachelors degree or graduate degree.

Data Limitations - Low response rates can limit the reliability of prevalence estimates and representativeness or comparisons among populations. Estimates were not reported for groups with fewer than 50 respondents, and data were not presented. We included error bars in the charts to show 95% confidence intervals (CI, upper and lower bounds). A conservative method of comparing responses among subpopulations is to asses statistical significant disparities by observing the overlap of CIs, but additional statistical tests are required to make that determination. For unstable estimates we used strike-through bars over estimates in the tables. Our strike-through criteria were a confidence interval spanning more than 15 percentage points or a relative error (standard error divided by point estimate) greater than 0.30.

Cleaning and Editing

This is done in three stages: 1) NM Vital Records before the sample is drawn; 2) CDC PRAMS after birth certificate and survey data are submitted; and 3) NM PRAMS. In the last stage, coded survey responses may be revised based on write-in responses and comments. This may produce estimates that differ slightly from the CDC weighted estimates for each state.

Analysis of Data - Data for this report were prepared with SAS 9.4 using complex survey procedures.

Variable Definitions

Unless otherwise stated, all variables below are derived from the PRAMS survey questionnaire.

Maternal Age – Collected from the birth certificate. Mother's age at the time of the baby's birth.

Ethnicity – Collected from the birth certificate and on the survey. Ethnicities included were non-Hispanic White, American Indian (A.I.), Hispanic, Black, Asian/Pacific Islander (API); Excluded 1.8%

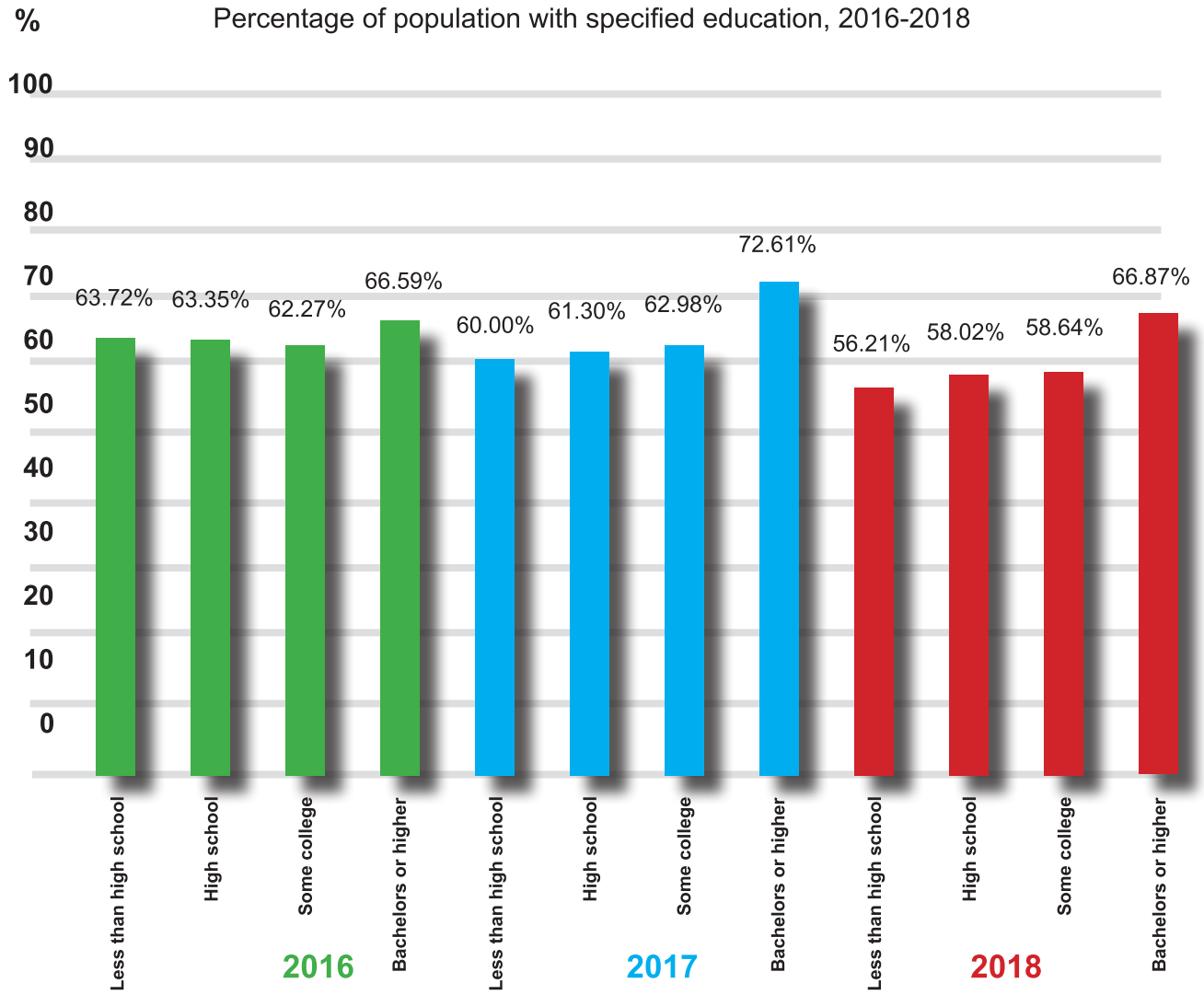
Education – Collected from the birth certificate. Those with missing data were excluded (0.3%).

Marital Status – Collected from the birth certificate. Marital status of the mother is reported at the time of the baby's birth.

Income – Those with missing data were excluded (8.9%). Household income and the number of household members were converted to Percentage of the U.S. Health and Human Services Federal Poverty Level (FPL). See guidelines: http://aspe.hhs.gov/poverty/.

Payer of preconception care – Asked on the survey. The respondent could choose several options for the source of insurance coverage before pregnancy. The variable in this report combined these options hierarchically into three categories: Medicaid, Private Insurance, or Other. Missing insurance before pregnancy = 1.8%

RESPONDENT PARTICIPATION BY EDUCATION, 2016 - 2018



There were a total of 3,571 survey respondents in PRAMS for birth years 2016-2018. The statistically weighted responses represent 65,035 births.

Payer of prenatal care – Respondents could choose several options for payer of prenatal care. This variable was created by categorizing the payers hierarchically as Medicaid, Private Insurance, or Other payers. Missing insurance for prenatal care = 3.5%

Payer at time of survey – This variable was coded in the same manner as the payer of prenatal care. Missing insurance at the time of survey= 2.4%

Alcohol use – Drinking before pregnancy (preconception alcohol use) means that the mother reported drinking at least one alcoholic beverage in the past two years and in the three months before pregnancy.

Breastfeeding – Initiation: the respondent reported breastfeeding or pumping milk for their infant at least once. Continuation over two months: for respondents saying they were still breastfeeding at the time of the survey, a variable was constructed to measure breastfeeding at least nine weeks. This cut-off was chosen to ensure that the majority of respondents could be included in the answer. Breastfeeding exclusively: among moms who initiated breastfeeding, they had had not introduced any liquids or solids when they answered the survey.

Cigarette (tobacco) smoking – Respondents were asked how many cigarettes they smoked (ranging from 41 or more cigarettes to not smoking) in the three months before pregnancy, in the last three months of pregnancy, and if they were smoking at the time of the survey.

Diabetes – Pre-existing diabetes and gestational diabetes diagnosis are asked on the survey. These conditions are self-reported about what a health provider said and may not indicate a valid medical diagnosis.

Postpartum depressive symptoms – Postpartum depression was defined as responses of "often" or "always" to two questions: "Since your baby was born, how often have you felt down, depressed, or hopeless?" and "Since your new baby was born, how often have you had little interest or little pleasure in doing things?".

Pregnancy intention – The PRAMS survey asked mothers how they felt about being pregnant at the time of conception with the following response options: 1) they wanted to be pregnant later, 2) they wanted to be pregnant sooner, 3) they wanted to be pregnant then, or 4) they did not want to be pregnant then or at any time in the future, 5) they were not sure what they wanted. Unintended pregnancy includes both mistimed, unwanted, and unknown pregnancies.

Preconception multivitamin - Respondents were asked how frequently they took a multivitamin, a prenatal vitamin, or a folic acid vitamin during the month before they became pregnant.

Prenatal care entry and delayed entry – Prenatal care visits are collected on the birth certificate, and respondents are asked how many weeks or months pregnant they were when they first had a prenatal care visit. A variable is created from the birth certificate information to calculate the trimester of prenatal care entry.

Respondents were asked if they had prenatal care later than they wanted and why care was inaccessible at that time. The reasons on the questionnaire include: 1) could not get an appointment when they wanted, 2) did not have enough money or insurance for a visit, 3) did not have transportation, 4) could not take time off from work or school, 5) did not have Medicaid or Centennial Care Card, 6) did not have child care, 7) did not know they were pregnant, 8) did not want anyone to know they were pregnant, 9) clinic or doctor's office was too far away, 10) did not believe prenatal care was essential or would help, 11) did not feel prenatal care was culturally appropriate, 12) mother did not want prenatal care.

PRAMS Data Collection

The New Mexico PRAMS data collection is conducted through surveys of a stratified, random systematic selection of new mothers as early as two and up to six months after delivery. The survey participation is voluntary. The data collection is conducted for each monthly sample by mailing and phone, using a mixed mode methodology. A pre-letter notifies new mothers about the program, followed by a survey mailing including the survey booklet, a small gift incentive, a cover letter, a return postage envelope, and a list of community resources. For non-responders, a reminder postcard to complete the survey is sent, and a second mailing packet is sent to anyone not replying to the first. Follow-up mailings occur for mothers that no longer reside at the address on file. For people who do not return the survey, phone interviews are attempted. Further, mothers can schedule appointments to complete the survey at their convenience and are provided a toll-free number to contact the PRAMS program. Respondents receive a $20 gift card after participating in the survey.

The entire data collection period for each monthly sample spans 90 days. After the data are collected for a birth year, the response data are reviewed by the Centers for Disease Control and Prevention for initial cleaning and statistical weighting. The CDC returns the weighted data to the New Mexico program where data are cleaned, recoded for state use, analyzed, and published in reports.

PRAMS Questionnaire

The PRAMS questionnaire consists of two portions: core and state-specific. The core portion, created by the CDC, is the same for all participating states. There are also standard question options available for selection by all states, and there are state-specific questions tailored to the state's needs. Topics of the core and standard options include (Centers for Disease Control and Prevention, 2021):

- Attitudes and feelings about the most recent pregnancy
- Preconception health care
- Access and utilization of preconception health care and prenatal care
- Breastfeeding and breastfeeding support
- Cigarette smoking, marijuana, and alcohol use
- Health insurance coverage
- Depression
- Physical abuse
- Infant wellness
- Infant sleep environment
- Postpartum contraceptive use and methods
- PRAMS data collection

Survey Phases and Changes

The CDC and states conduct evaluations of PRAMS survey content every three to five years to assure that any necessary additions or changes are made to reflect evolving surveillance needs. During the survey revision process, states may make changes for the next phase of the survey to reflect the needs of their states' maternal and infant populations. From 2016-2018, PRAMS was in its 8th questionnaire phase, and more information can be found on Phase 8 at the New Mexico Department of Health website: https://www.nmhealth.org/about/phd/fhb/prams/

How to Read Tables/Graphs

Data tables show estimates by maternal characteristics such as age, race/ethnicity, marital status, education, income level, and source of insurance. The line at the end of each bar shows the margin of error (95% Confidence Interval). A strike-through over an estimate cautions the reader about a wide confidence interval, indicating the data may be unstable for that subgroup. Multiyear line chart figures contain rounded percentages to give a general overview of the trend for select indicators. Overlapping Confidence Intervals did not always detect lack of statistical significance so statistical tests were performed.

More Information about PRAMS

To contact NM PRAMS, email nm.prams@doh.nm.us. This report was prepared by Eirian Coronado, MA, Jennifer Schusterman, MPH, Glenda Hubbard, MPH, and Dorin Sisneros, AA. The publication is supported by grant U01-DP006594 from the Centers for Disease Control and Prevention. The report does not reflect official opinions or views of the CDC unless expressly stated and cited. Learn more about NM PRAMS at http://www.health.state.nm.us/phd/prams/home.html and visit us at https://ibis.health.state.nm.us/query/selection/prams/_PRAMSSelection.html for data

PRAMS surveys in English and Spanish can be found at the following links:

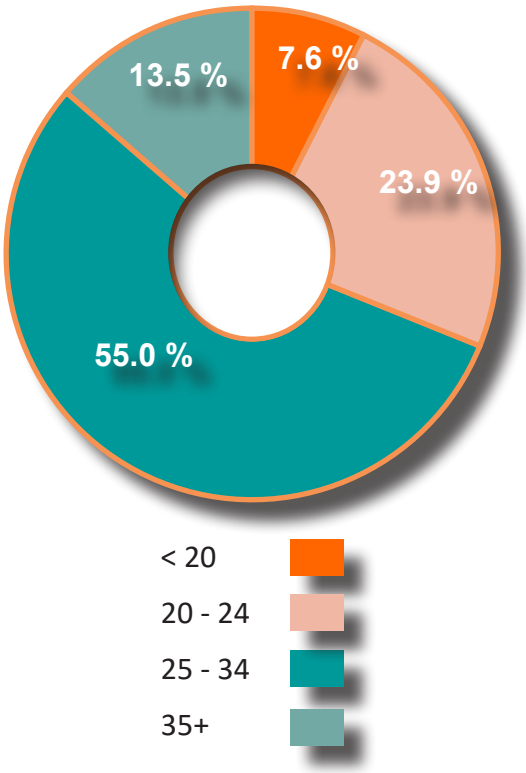
English: https://www.nmhealth.org/publication/view/survey/6685/

Spanish: https://www.nmhealth.org/publication/view/survey/6686/

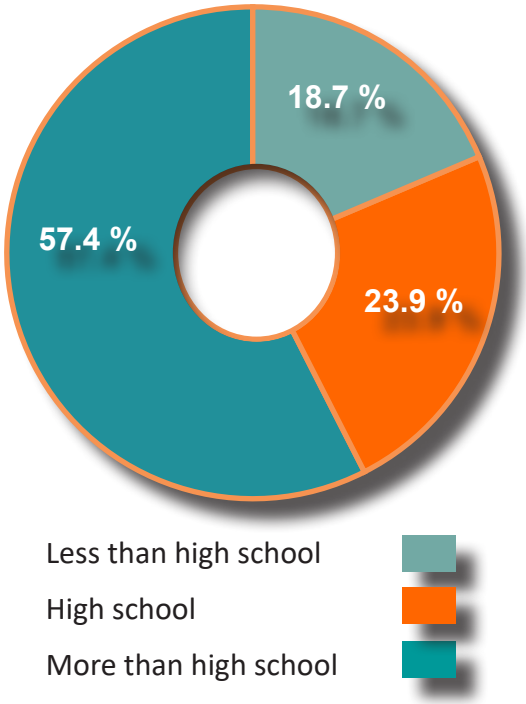
From 2016-2018, New Mexico PRAMS responses included the following demographic information from the birth certificate: maternal age, maternal education, marital status, and maternal ethnicity. The survey also collected information on household federal poverty level and maternal insurance coverage before and during pregnancy and at the time of the survey. The pie charts show that most respondents were between 20 and 34 years of age and had more than a high school education. Marital status was nearly equal between married and not married respondents. Most respondents (67%) had a household income equal or less than 185% of the Federal Poverty Level. Fewer than half (40%) were at or below 100% of the Federal Poverty Level. The majority of respondents identified as Hispanic/ Latina. And most respondents had Medicaid as their primary insurance provider regardless of the perinatal period (before, during or after pregnancy/ postpartum).

There were a total of 3,571 survey respondents in PRAMS for birth years 2016-2018. The statistically weighted responses represent 65,035 births.

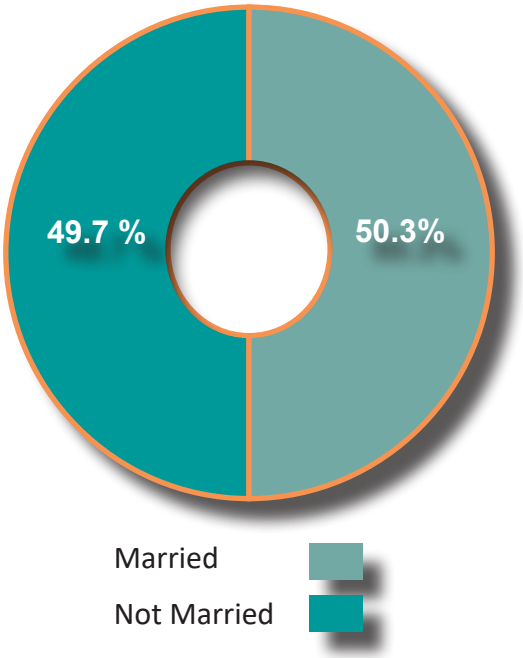
Maternal Age



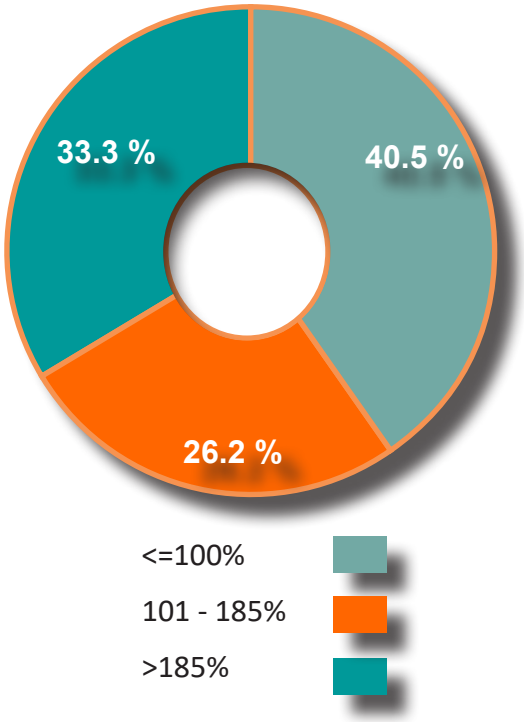
Maternal Education



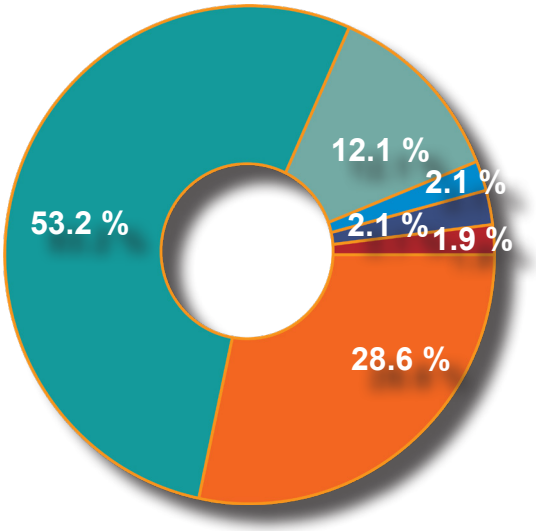
Marital Status



Federal Poverty Level

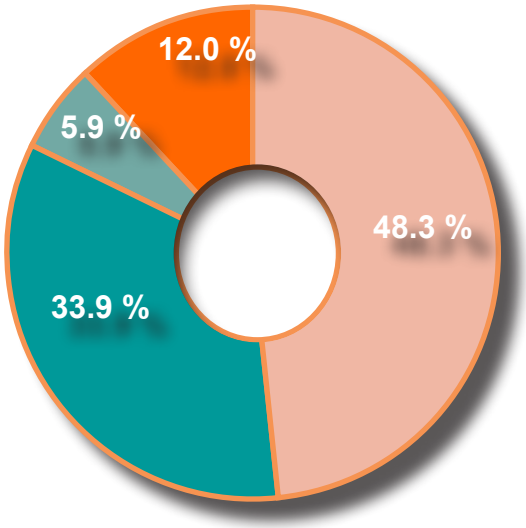


Maternal Ethnicity



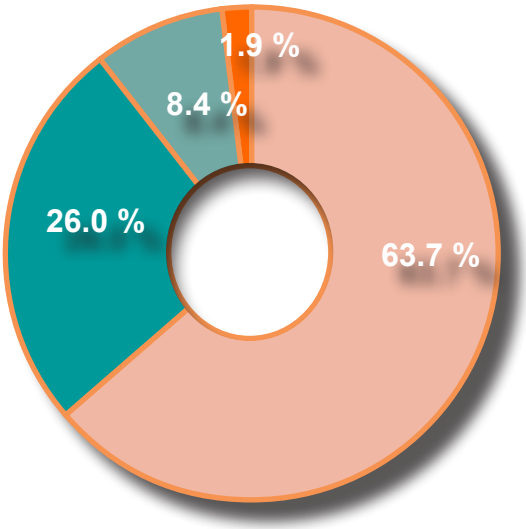
Non-Hispanic White
Hispanic
AI/Native American
Black-African American
Asian/Pacific Islander
Other/Unknown

Insurance Before Pregnancy



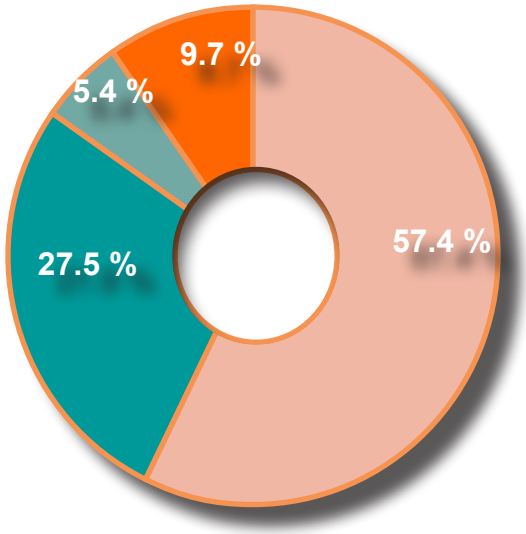
Medicaid
Private
Other
None

Insurance for Prenatal Care



Medicaid
Private
Other
None

Insurance at time of survey



Medicaid
Private
Other
None

Preconception health is the health of a woman before pregnancy. Preconception health status and health conditions or behaviors can impact the pregnancy and neonatal outcomes for birthing people (Office of Women's Health, 2021). People able to become pregnant should receive individualized medical care during their reproductive years, increasing their opportunities to identify and address health conditions before a pregnancy occurs.

- Multivitamin Use Before Pregnancy
- Pregnancy Intention
- Drinking Alcohol Before Pregnancy
- Marijuana Use Before Pregnancy

PRECONCEPTION MULTIVITAMIN

BACKGROUND

A daily regimen of vitamins is essential to a healthy pregnancy. Prenatal vitamins taken before and during pregnancy, are vital for proper fetal growth and development. Multivitamins with calcium, beta carotene and iron may also include folic acid. Folic acid vitamins taken before pregnancy are recommended to prevent neural tube defects and support healthy cell division (Mayo Clinic, 2019). Historically, New Mexico mothers have not had the necessary nutrients provided by daily multivitamins, with fewer than 30% of women taking a prenatal vitamin every day in the month before pregnancy (NMDOH, 2012).

NM PRAMS FINDINGS

Daily vitamin use before pregnancy increased by about nine percentage points between 2012 and 2018. Daily vitamin consumption was statistically more likely among married women than unmarried (40% v. 26%), and among those with household incomes exceeding 185% of federal poverty compared to those with lower incomes. Asian and non-Hispanic white women were most likely to take a preconception vitamin every day, and those 35 years or older were significantly more likely to take a vitamin each day compared to younger women.

Over half (53%) of resident women giving birth in NM did not take any multivitamin or prenatal vitamin with folic acid in the month before pregnancy. Just 40% of women thirty-five years and older reported no vitamin use compared to 65% of those under the age of 20. Not taking any preconception vitamin was greatest among Native American women (60%) and least among non-Hispanic white women (44%). Not shown are responses for taking a vitamin 3-5 or 4-6 days per week.

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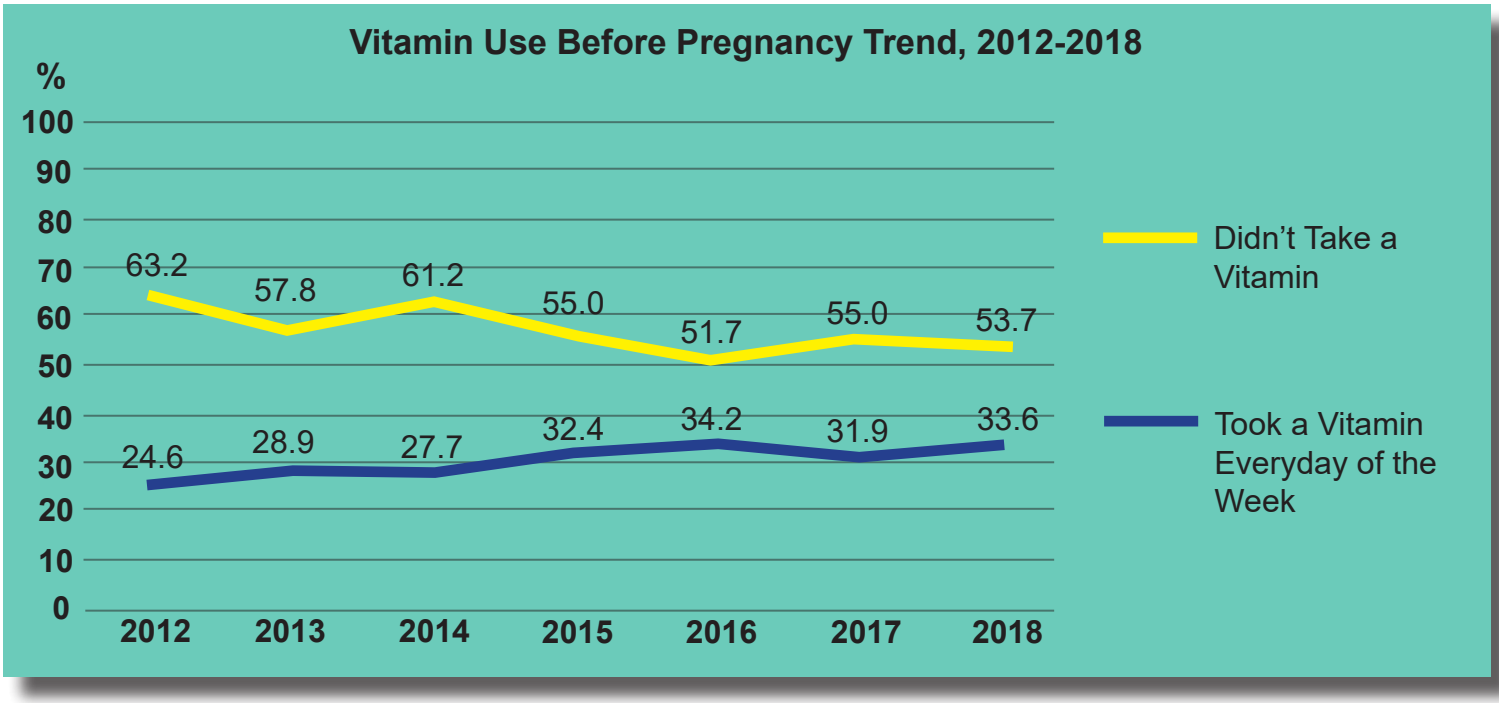
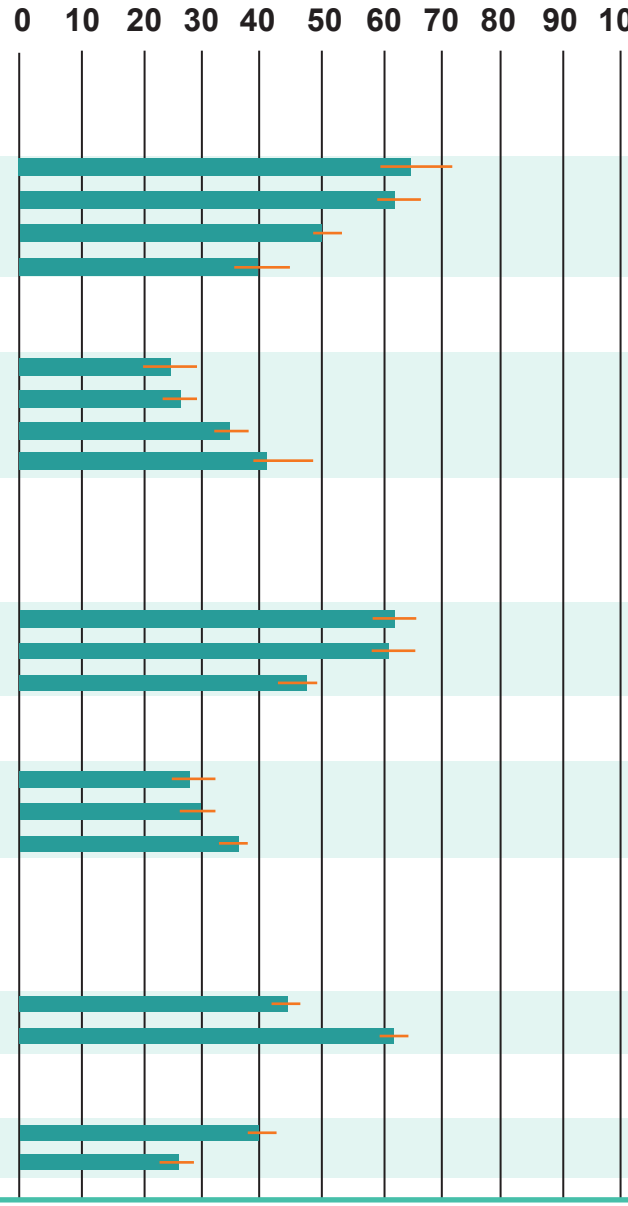


MULTIVITAMIN USE BEFORE PREGNANCY

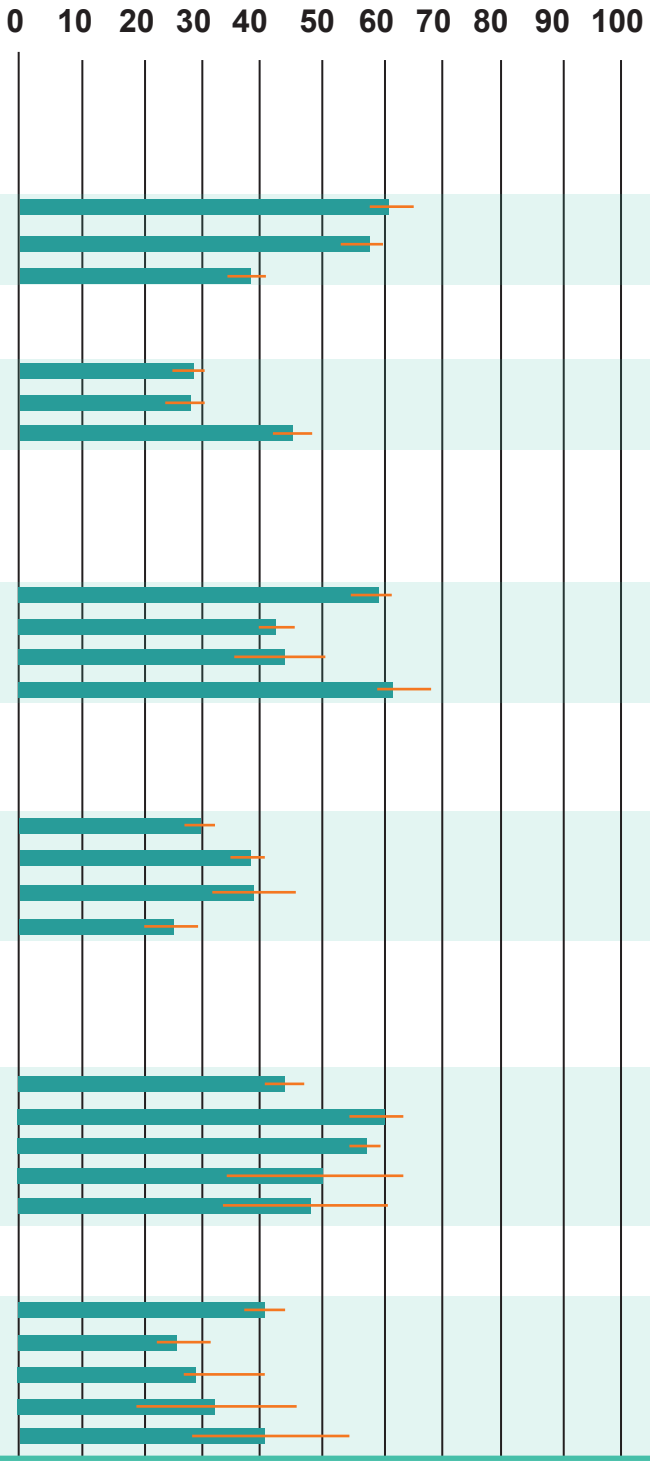
Percent of population who took daily vitamin or no vitamin before pregnancy, 2016-2018



	%	LOWER	UPPER
Maternal Age			
Didn't take Vitamin			
<20 years	65.5	59.8	71.0
20-24 years	63.0	59.4	66.4
25-34 years	50.7	48.4	53.0
35 or more years	40.7	36.2	45.0
Every day/ Week			
<20 years	24.2	19.2	29.2
20-24 years	26.2	23.0	29.3
25-34 years	35.2	32.9	37.4
35 or more years	42.9	38.4	47.2
Level of Education			
Didn't take Vitamin			
Less than high school	62.1	58.7	65.5
High school graduate	61.8	58.5	65.0
More than high school	47.3	44.9	49.5
Every day/ Week			
Less than high school	28.9	25.6	32.0
High school graduate	29.1	26.0	32.2
More than high school	36.4	34.1	38.5
Marital Status			
Didn't take Vitamin			
Married	44.6	42.2	46.9
Not married	62.3	59.9	64.6
Every day/week			
Married	40.4	38.0	42.7
Not married	26.0	23.9	28.1

MULTIVITAMIN USE BEFORE PREGNANCY

Percent of population who took daily vitamin or no vitamin before pregnancy, 2016-2018



	%	LOWER	UPPER
Federal Poverty Level Didn't take Vitamin			
<=100	61.7	58.9	64.4
101-185%	57.4	53.8	60.9
>185%	38.2	35.2	41.1
Every day/ Week			
<=100	28.1	25.6	30.6
101-185%	27.8	24.5	30.9
>185%	45.2	42.1	48.2
Insurance Before Pregnancy Didn't take Vitamin			
Medicaid	59.2	56.7	61.6
Private	43.7	40.8	46.6
Other	44.2	36.7	51.5
None	63.9	59.1	68.7
Every day/ Week			
Medicaid	30.3	27.9	32.5
Private	38.9	36.1	41.7
Other	39.6	32.4	46.7
None	25.2	20.8	29.4
Race/Ethnicity Didn't take Vitamin			
White	44.4	41.1	47.5
American Indian	60.0	55.2	64.8
Hispanic	57.3	55.0	59.6
Black	~~50.3~~	35.7	64.8
Asian/ Pacific	~~48.0~~	34.9	61.0
Every day/ Week			
White	41.7	38.5	44.7
American Indian	27.8	23.5	32.1
Hispanic	29.5	27.4	31.6
Black	~~33.4~~	19.8	46.8
Asian/ Pacific	~~41.3~~	28.5	54.1

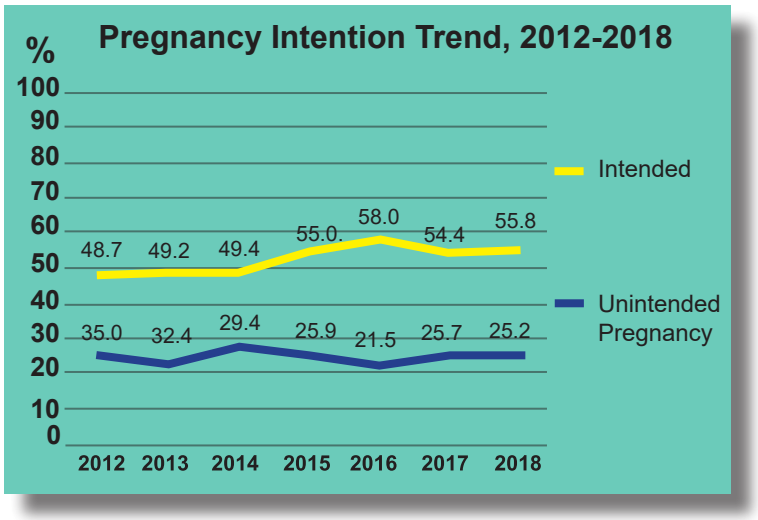
BACKGROUND

Pregnancy intention is an expression of someone's desire to become pregnant. The PRAMS survey includes a question on pregnancy intention to report feelings about the timing of their recent pregnancy (Lindberg et al., 2015). According to the CDC, unintended pregnancy is either mistimed (happened earlier than desired) or unwanted. Unintended pregnancy is a reproductive public health concern because it impacts many different outcomes for both mother and child. These outcomes include breastfeeding, prenatal care utilization, substance use, depression, and many other experiences. Women with an unintended pregnancy are less likely to take vitamins as recommended and are less likely to receive adequate medical care (Dott et al., 2009; Dye et al.,1997; Finer et al., 2011). Historically, just over half of women in New Mexico said their pregnancy was intended. This was associated with various characteristics and experiences, including maternal age, ethnicity, marital status, and family income relative to federal poverty levels (NMDOH, 2012).

NM PRAMS FINDINGS

More than half of NM women giving live birth intended their pregnancy when (or before) it occurred, while an estimated 24% would have wanted their pregnancy later or not at all. An additional 20% were not sure what they wanted or how they felt about the timing of their pregnancy. Populations with higher than state average proportions of intended pregnancy were over the age of 25, had higher educational attainment (more than high school), were married, earned greater than 185% of the FPL, had private health insurance. About 70% of married women reported an intended pregnancy compared to 43% of unmarried people. Poverty level and ethnicity were both strongly associated with pregnancy intention with about 75% of higher income and Asian people reporting intended pregnancy compared to lower income and those of non-Hispanic white, American Indian, Hispanic or Black ethnicity.

SOURCES



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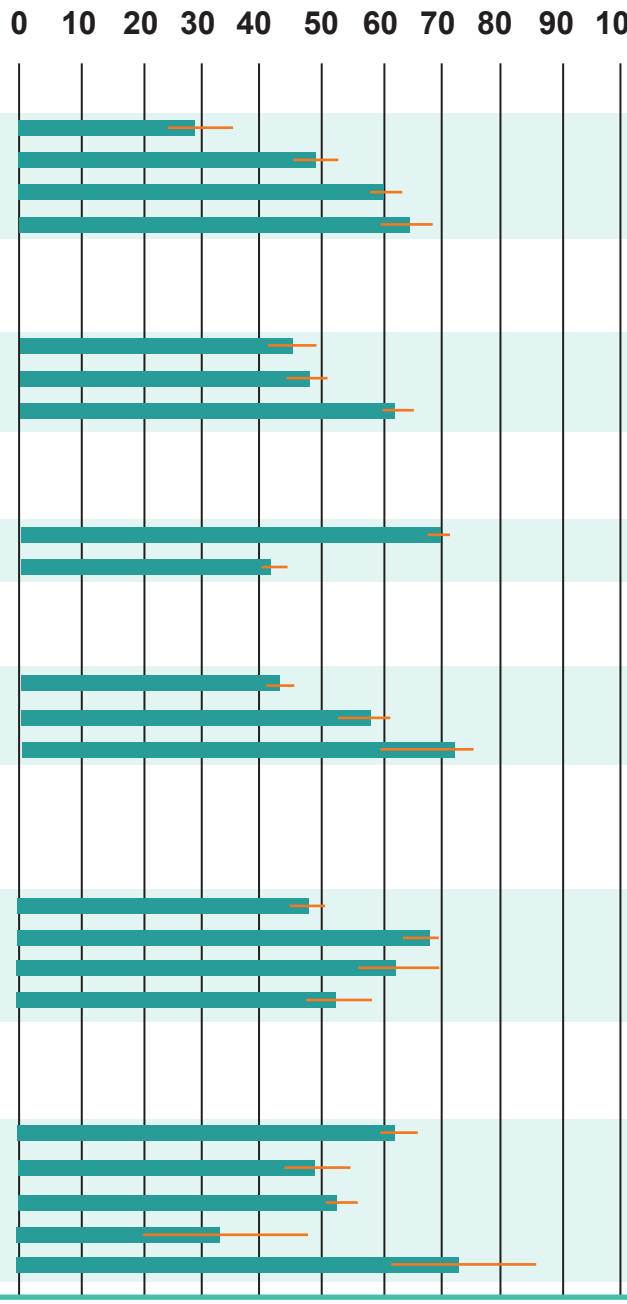
PREGNANCY INTENTION

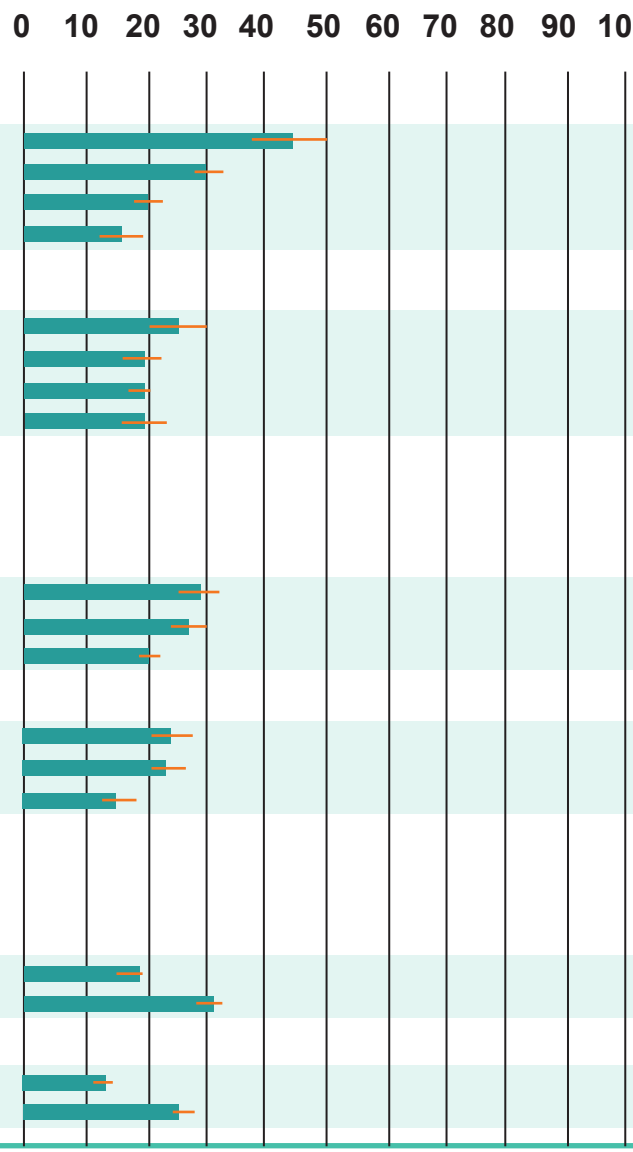
Percentage of population with an intended pregnancy, 2016-2018



	%	LOWER	UPPER
Maternal Age Intended			
<20 years	29.8	24.3	35.3
20-24 years	49.9	46.2	53.5
25-34 years	60.8	58.4	63.0
35 or more years	64.0	59.5	68.4
Maternal Education Intended			
Less than high school	45.8	42.2	49.3
High school	48.4	45.0	51.8
More than high school	62.8	60.5	65.1
Marital Status Intended			
Married	69.7	67.4	71.9
Not Married	42.5	40.0	44.9
Federal Poverty Level Intended			
<=100%	44.1	41.2	46.8
101-185%	57.5	53.8	61.0
>185%	72.6	69.7	75.3
Insurance Before Pregnancy Intended			
Medicaid	48.1	45.6	50.6
Private	67.2	64.4	70.0
Other	63.3	56.1	70.4
None	53.3	48.3	58.2
Mother's Race/Ethnicity Intended			
White	63.5	60.4	66.7
American Indian	50.0	45.0	54.8
Hispanic	53.8	51.4	56.0
Black	~~34.2~~	20.2	48.2
Asian/ Pacific	~~74.4~~	62.7	85.9

PREGNANCY INTENTION

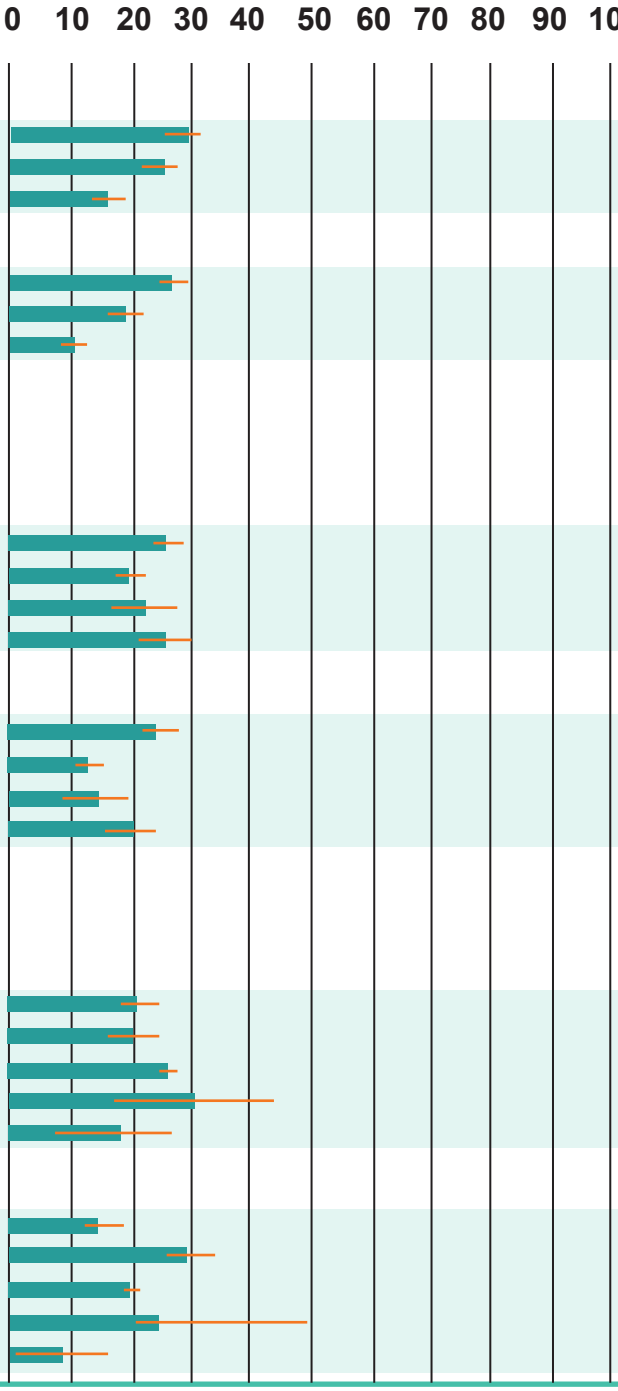
Percentage of population with unintended pregnancy or was not sure about intention, 2016-2018



	%	LOWER	UPPER
Maternal Age Unintended			
<20 years	44.5	38.6	50.4
20-24 years	30.5	27.1	33.8
25-34 years	20.2	18.2	22.0
35 or more years	16.5	13.0	19.9
Unsure			
<20 years	25.6	20.4	30.7
20-24 years	19.6	16.7	22.5
25-34 years	19.1	17.2	20.9
35 or more years	19.5	15.7	23.1
Maternal Education Unintended			
Less than high school	29.8	26.5	33.0
High school	27.6	24.5	30.6
More than high school	20.7	18.7	22.6
Unsure			
Less than high school	24.4	21.2	27.4
High school	24.0	21.0	26.8
More than high school	16.5	14.6	18.3
Marital Status Unintended			
Married	17.1	15.2	18.9
Not Married	31.1	28.7	33.3
Unsure			
Married	13.2	11.5	14.8
Not Married	26.4	24.2	28.6

PREGNANCY INTENTION

Percentage of population with unintended pregnancy or was not sure about intention, 2016-2018



	%	LOWER	UPPER
Federal Poverty Level Unintended			
<=100%	29.2	26.6	31.7
101-185%	24.1	21.0	27.1
>185%	16.5	14.0	18.8
Unsure			
<=100%	26.7	24.2	29.2
101-185%	18.4	15.5	21.2
>185%	11.0	8.9	12.9
Insurance Before Pregnancy Unintended			
Medicaid	27.0	24.7	29.2
Private	19.6	17.2	22.0
Other	22.3	16.0	28.6
None	26.1	21.8	30.4
Unsure			
Medicaid	24.9	22.6	27.0
Private	13.2	11.1	15.2
Other	14.4	9.1	19.5
None	20.6	16.5	24.5
Mother's Race/ Ethnicity Unintended			
White	21.5	18.7	24.2
American Indian	20.2	16.2	24.2
Hispanic	26.3	24.2	28.3
Black	~~31.2~~	17.7	44.5
Asian/ Pacific	~~17.2~~	7.0	27.2
Unsure			
White	14.9	12.5	17.3
American Indian	29.8	25.3	34.2
Hispanic	19.9	18.0	21.7
Black	~~34.6~~	20.0	49.0
Asian/ Pacific	~~8.4~~	1.0	15.7

BACKGROUND

Smoking during pregnancy, whether it be cigarettes, pipes, cigars, or e-cigarettes, can adversely affect a woman's pregnancy, including fetal health. Adverse effects on the pregnancy include miscarriage, an ectopic pregnancy which can lead to miscarriage, placental abruption, which can cause bleeding and loss of oxygen and nutrients to the fetus; placenta previa, which can cause severe bleeding during pregnancy and delivery, preeclampsia which can cause placental abruption and premature births, and premature births which can impact the overall health of the newborn. Adverse effects to the baby include congenital disabilities and an increased risk of Sudden Infant Death Syndrome or SIDS (CDC, 2020; March of Dimes, 2019). SIDS is the sudden death of a seemingly healthy infant less than a year old whose cause of death is unclear after autopsy and death scene examination. Congenital disabilities related to smoking during pregnancy include damaged lungs and brain, cleft lip, cleft palate (or both). In previous years, a higher propotion of non-Hispanic White, unmarried, or poor people reported smoking during pregnancy compared to the state average (NMDOH, 2012).

NM PRAMS FINDINGS

PRAMS surveys women about cigarette smoking before and during pregnancy. The majority of women surveyed did not smoke before or during pregnancy, and there was a 50% cessation rate during pregnancy.

Those more likely to smoke before pregnancy were under age 35, were non-Hispanic White, had earned less than a high school education or had Medicaid during pregnancy.

SOURCES

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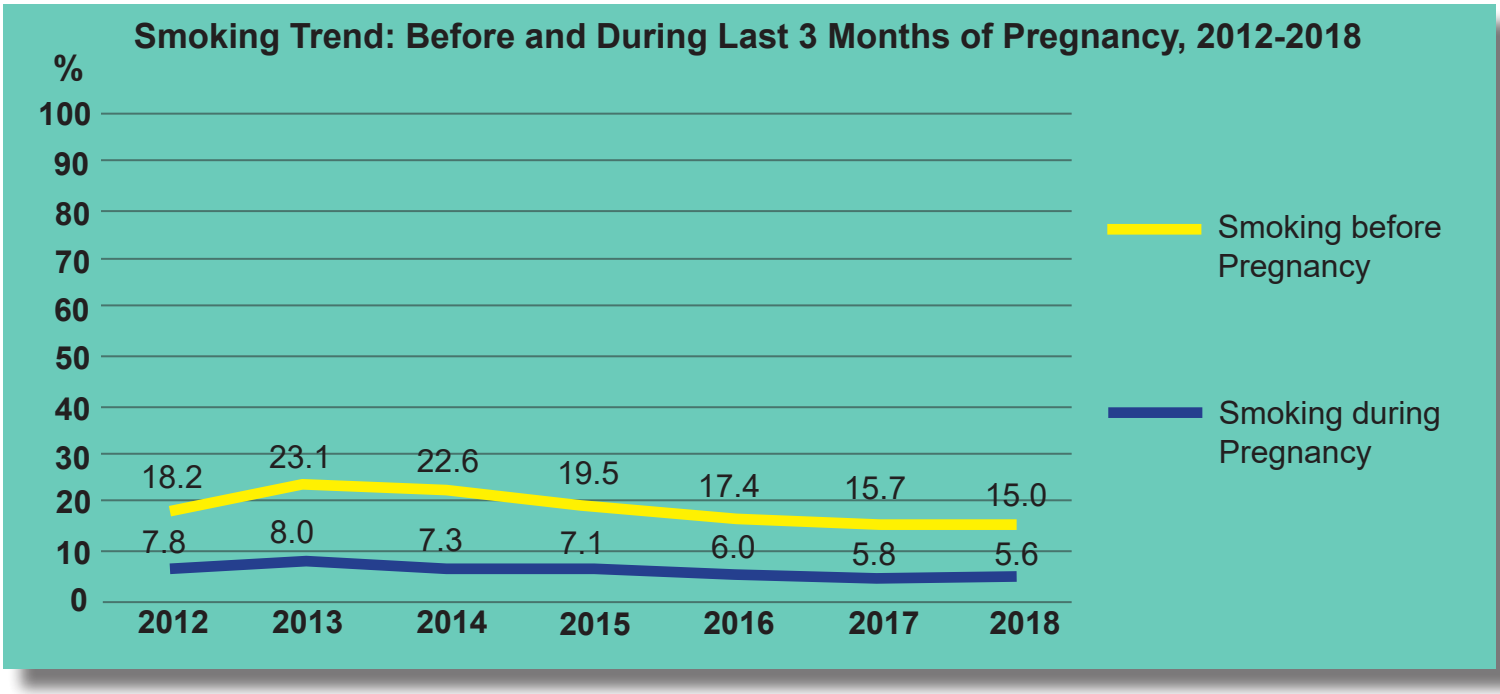
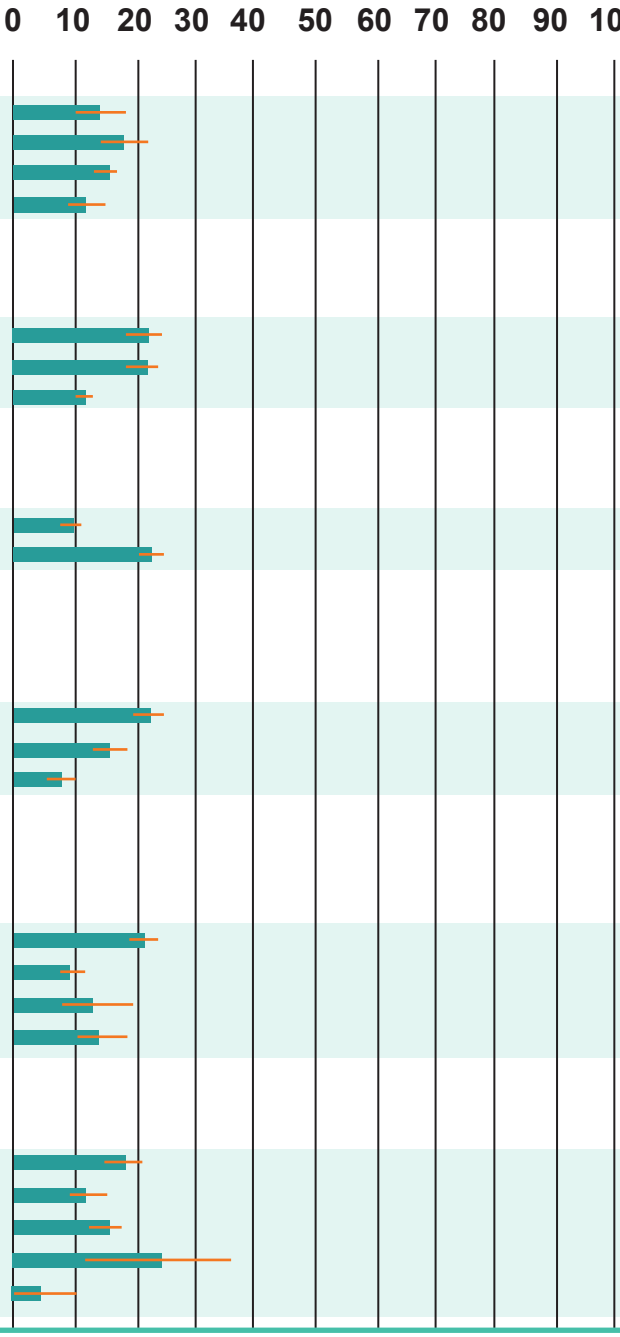


CIGARETTE SMOKING BEFORE PREGNANCY

Percentage of population who smoked in the three months before pregnancy, 2016-2018



	%	LOWER	UPPER
Maternal Age			
<20 years	14.6	10.4	18.7
20-24 years	18.4	15.6	21.0
25-34 years	16.2	14.4	17.9
35 or more years	12.4	9.3	15.4
Level of Education			
Less than high school	21.4	18.4	24.3
High school graduate	21.0	18.2	23.7
More than high school	12.3	10.6	13.8
Marital Status			
Married	10.0	8.5	11.4
Not married	22.2	20.1	24.2
Federal Poverty Level			
<=100	22.1	19.7	24.4
101-185%	16.2	13.5	18.8
>185%	8.7	6.9	10.4
Insurance Before Pregnancy			
Medicaid	21.4	19.3	23.4
Private	9.8	7.9	11.5
Other	13.9	8.5	19.2
None	14.6	10.9	18.1
Mother's Race/Ethnicity			
White	18.5	15.9	20.9
American Indian	12.7	9.4	15.9
Hispanic	15.3	13.6	17.0
Black	~~24.3~~	12.1	36.3
Asian/ Pacific	~~4.3~~	0.0	10.1

BACKGROUND

Alcohol use during pregnancy is unsafe, regardless of the type of alcohol, the amount consumed, or when it is taken. Any amount of alcohol is risky for fetal development. Alcohol consumption is a public health concern as it results in a host of adverse effects, from miscarriage and stillbirth, to lifelong disabilities known as fetal alcohol spectrum disorder (CDC, 2020). All these outcomes are preventable, and the goal of Healthy People is to increase alcohol abstinence (ODPHP, 2020). Historically, almost a quarter of New Mexico women had reported binge drinking in the three months before pregnancy which was associated with education, marital status, and race/ethnicity (NMDOH, 2012).

NM PRAMS FINDINGS

Drinking any alcohol before (in the three months before) pregnancy is reported by an estimated 49.5% of birthing people in NM. Drinking prior to pregnancy is associated with maternal age and education. The higher the education level and the more advanced maternal age, the more likely someone was to take alcohol in the preconception period. Ethnicity and poverty level are also each associated with drinking. American Indian and Asian women were least likely to drink alcohol (33%) compared to white (62%) and Black women (57.8%).

SOURCES

CDC. (2020, October 08). Alcohol Use in Pregnancy. Retrieved from https://www.cdc.gov/ncbddd/fasd/alcohol-use.html

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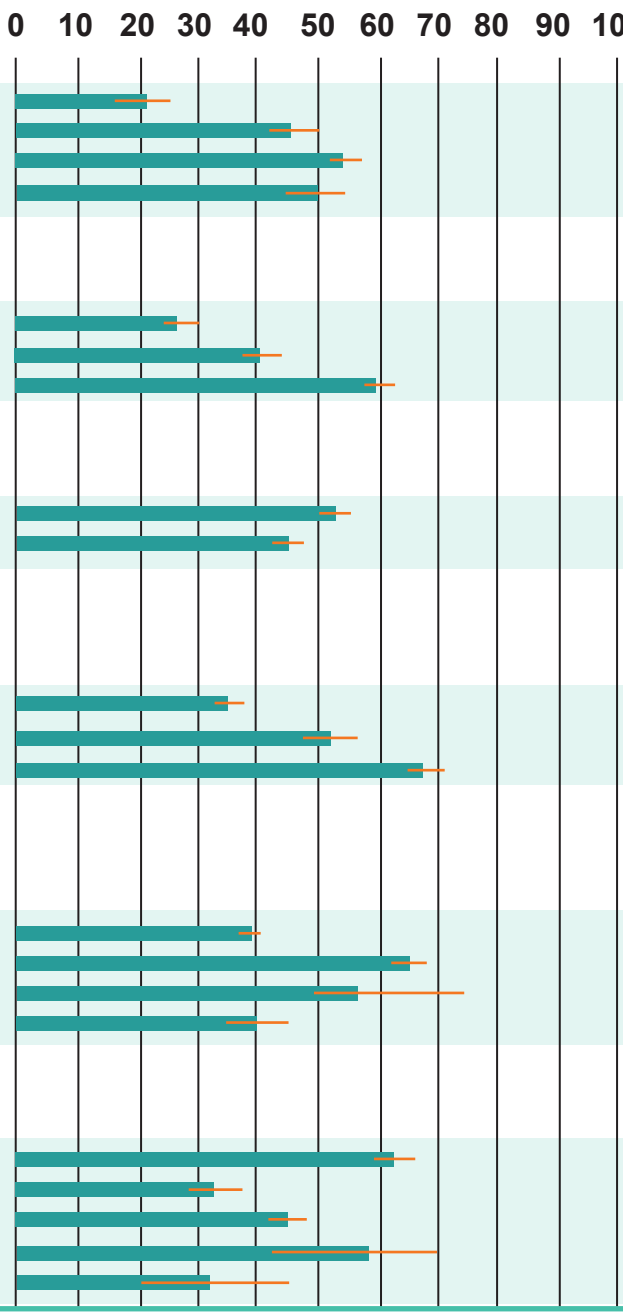
DRINKING ALCOHOL BEFORE PREGNANCY

Percentage of population who used alcohol before pregnancy, 2016-2018



	%	LOWER	UPPER
Maternal Age			
<20 years	21.0	16.1	25.8
20-24 years	46.4	42.7	50.0
25-34 years	54.6	52.2	56.8
35 or more years	50.4	45.8	54.8
Level of Education			
Less than high school	27.8	24.5	30.9
High school graduate	41.5	38.1	44.8
More than high school	59.7	57.3	62.0
Marital Status			
Married	53.3	50.8	55.6
Not married	45.5	43.0	47.9
Federal Poverty Level			
<=100	35.9	33.1	38.6
101-185%	52.6	48.9	56.2
>185%	67.9	65.0	70.8
Insurance Before Pregnancy			
Medicaid	39.0	36.5	41.4
Private	65.7	62.8	68.4
Other	56.8	49.4	64.1
None	40.7	35.7	45.6
Mother's Race/Ethnicity			
White	62.9	59.7	66.0
American Indian	33.5	28.8	38.1
Hispanic	45.9	43.6	48.2
Black	~~57.8~~	43.5	70.0
Asian/ Pacific	~~32.6~~	20.1	45.1

BACKGROUND

According to the Centers for Disease Control and Prevention, chemicals in marijuana, most notably tetrahydrocannabinol (THC), can harm the development of an infant. Marijuana use during pregnancy and breastfeeding may result in adverse outcomes for the infant, but very little is known to date. In a meta-analysis of 24 studies, the strongest association with marijuana use during pregnancy was with maternal anemia, and another slightly weaker association was found with low birthweight. The other outcomes studied showed no statistical pooled association: maternal outcomes include preeclampsia, eclampsia, postpartum depression, spontaneous delivery, retained placenta, placental abruption, placenta accrete, placenta previa, postpartum hemorrhage, anemia, uterine inversion, uterine rupture, vasa previa, oligohydramnios, polyhydramnios, maternal mortality, morning sickness, neonatal nursing, abnormal labor, and prenatal care. Fetal outcomes studied included: preterm birth (PTB), intrauterine growth restriction, head circumference, infant birth weight, low birth weight (LBW) (Gunn et al, 2016).

A major weakness in these studies is isolating marijuana as an independent predictor of low birth weight, and both tobacco and alcohol modify its effect (Gunn et al.). While antenatal marijuana use has been linked to low birthweight, few studies support an association with premature delivery or other adverse birth outcomes, and many more studies dispute the relationship (Klebanoff et al., 2020). Some research indicates that marijuana use during pregnancy has been linked to disabilities in learning and attention span (CDC, 2018).

NM PRAMS FINDINGS

An estimated 10% of NM birthing women report using marijuana in the three months before pregnancy. Just 5% of people over age 35 used marijuana before pregnancy compared to 12% and 14% of younger age groups.

Those with lower proportions of marijuana use included people over 35 years, those with college education, married people, and respondents with household incomes greater than 185% of the FPL. White or American Indian people were less likely to use marijuana in the preconception period compared to Hispanic and Black women.

SOURCES

Klebanoff, M. A., Wilkins, D. G., & Keim, S. A. (2020). Marijuana Use during Pregnancy and Preterm Birth: A Prospective Cohort Study. American Journal of Perinatology. doi:10.1055/s-0040-1708802

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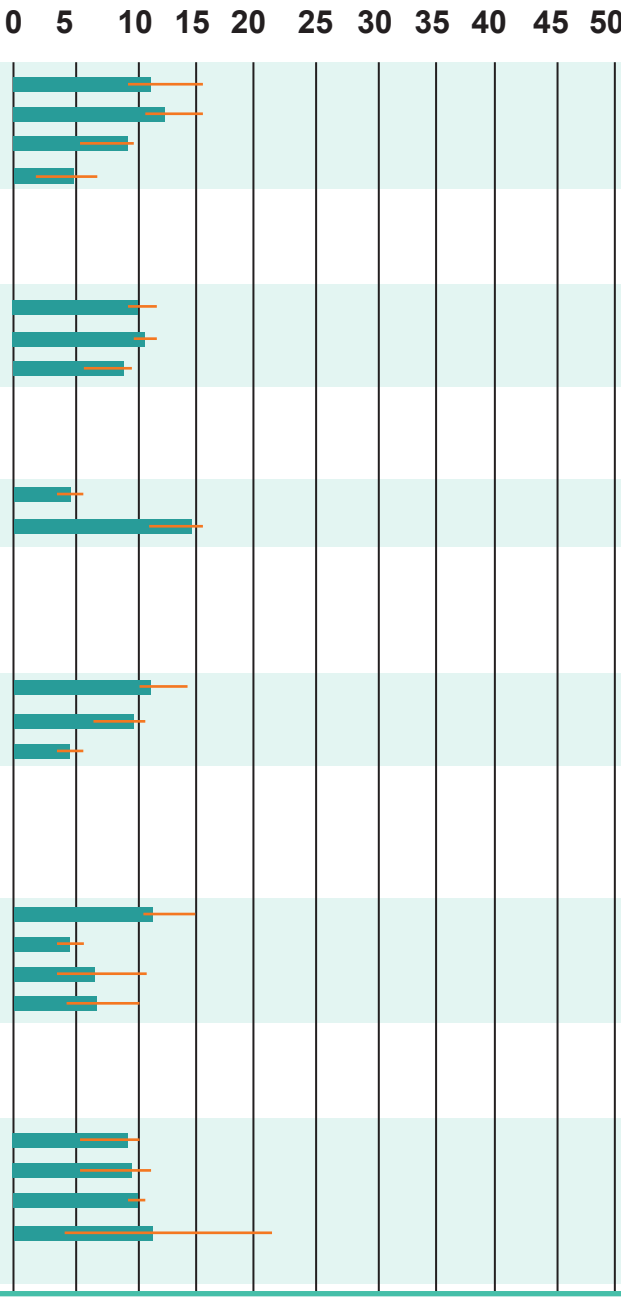
Gunn JKL, et al. BMJ Open 2016;6:e009986. doi:10.1136/bmjopen-2015-009986

MARIJUANA USE BEFORE PREGNANCY

Percentage of population who used marijuana before pregnancy, 2016-2018



	%	LOWER	UPPER
Maternal Age			
<20 years	12.3	8.2	16.2
20-24 years	14.2	11.6	16.7
25-34 years	8.1	6.8	9.3
35 or more years	5.1	3.0	7.1
Level of Education			
Less than high school	10.9	8.6	13.1
High school graduate	11.7	9.4	13.8
More than high school	8.0	6.6	9.3
Marital Status			
Married	4.6	3.5	5.5
Not married	14.4	12.6	16.1
Federal Poverty Level			
<=100	12.9	10.9	14.7
101-185%	9.4	7.3	11.5
>185%	4.2	3.0	5.5
Insurance Before Pregnancy			
Medicaid	13.5	11.7	15.2
Private	4.9	3.6	6.2
Other	7.1	3.2	10.9
None	7.5	4.7	10.2
Mother's Race/Ethnicity			
White	8.3	6.4	10.1
American Indian	9.7	6.8	12.6
Hispanic	10.1	8.6	11.5
Black	~~13.8~~	4.6	22.9
Asian/ Pacific			

Data points for Asian/Pacific Islander populations are not shown because values do not meet small number rules for NMDOH or CDC PRAMS.

Timely and adequate prenatal care permits evaluation of medical and psychosocial risks, treatment of problems, and referral for support services. It also gives families a chance to discuss maternal and infant health. Prenatal care is associated with decreased preterm birth rates, fetal death, and low birth weight (NM PRAMS, 2016). Preterm labor and low birth weight are costly; the March of Dimes estimated that preterm births cost $26.2 billion in the United States each year (March of Dimes, 2015).

- Prenatal Care
- Physical Abuse Before or During Pregnancy
- Smoked During Pregnancy
- Food Insecurity
- Flu Shot
- Dental Care

TRIMESTER OF PRENATAL CARE

BACKGROUND

Pregnancy consists of three trimesters. During each trimester of pregnancy, it is important that pregnant people receive consistent care to monitor their health and the health of the developing baby, whose health is closely linked to their mother's health status (WHO, 2013). The first trimester is especially crucial as the fetal anatomy and organs are developing, and this is the period when the most miscarriages and birth defects occur (UCSF, 2021).

First-trimester prenatal care should include a physical exam, lab tests, screenings for fetal abnormalities, and discussions on lifestyle behaviors (Mayo Clinic, 2020). Prenatal care is of public health importance because it reduces the chances of low birthweight, prematurity, and maternal and infant mortality. In addition, access to quality prenatal care allows for early identification as well as treatment of developmental delays and disabilities in children so they can live to their full potential (Healthy People 2020, 2020). Quality prenatal care is impactful as it is associated with whether patients continue regular scheduled prenatal care treatments (Novick, 2010).

SOURCES

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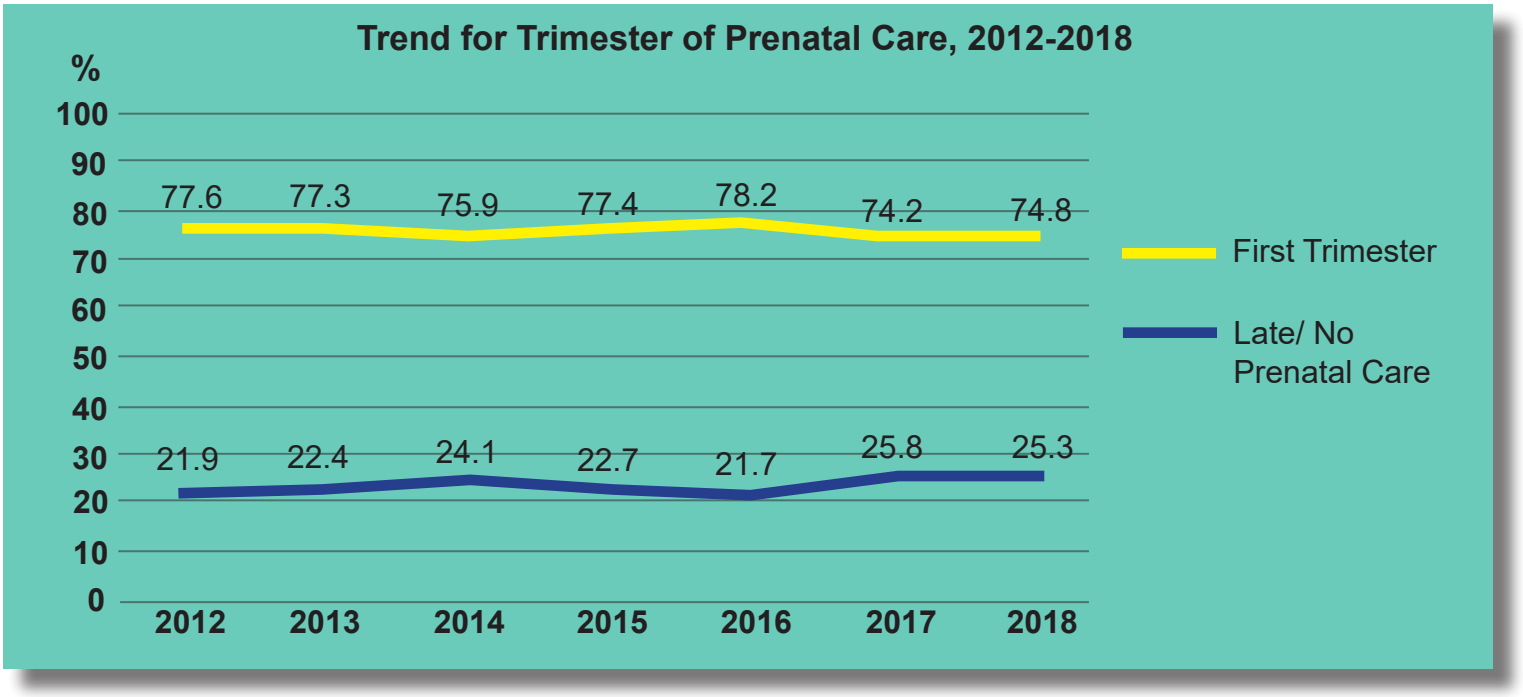
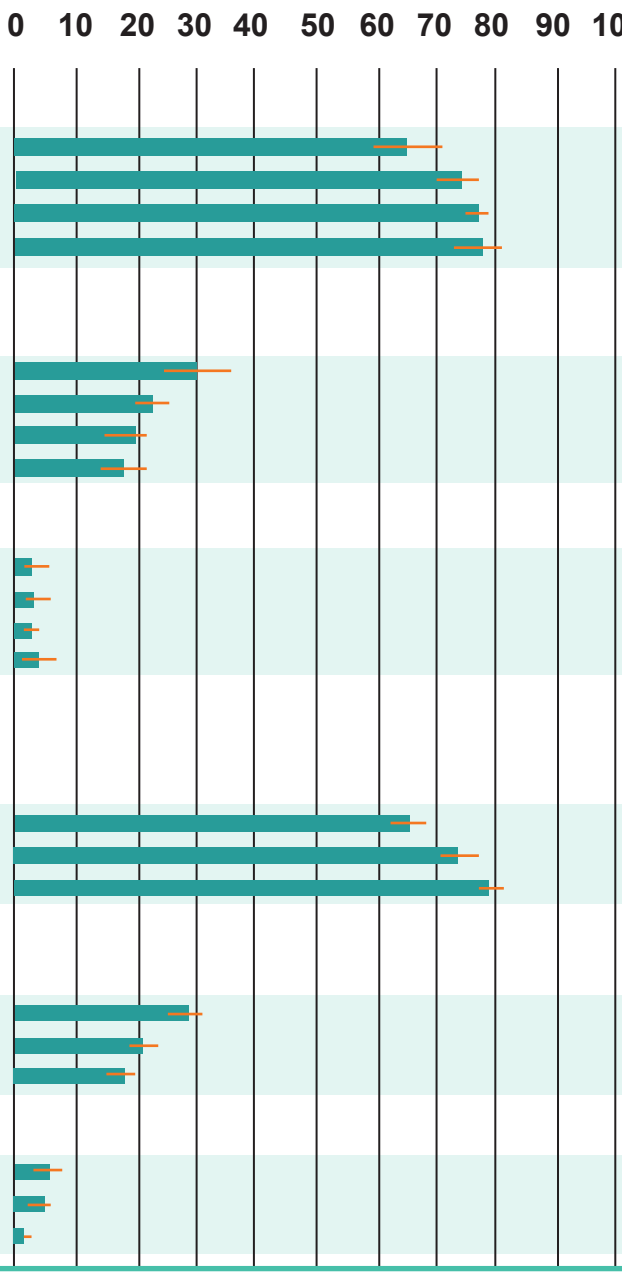


TRIMESTER OF PRENATAL CARE INITIATION

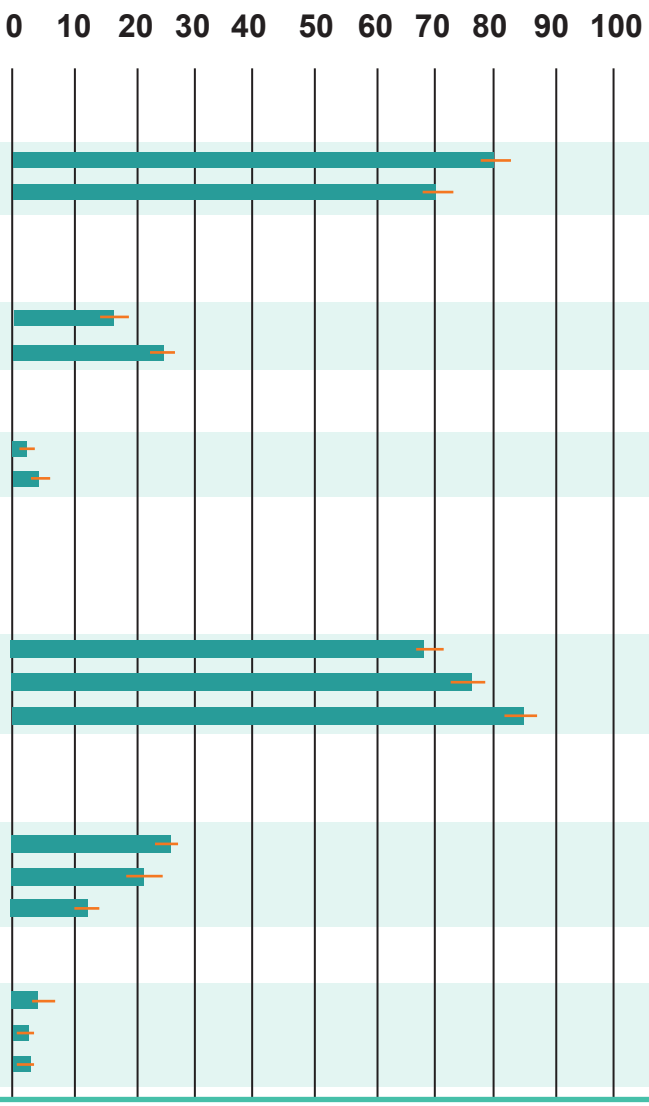
Percentage of population with no prenatal care or by trimester of entry, 2016-2018



	%	LOWER	UPPER
Age			
First Trimester			
<20 years	65.7	59.9	71.3
20-24 years	74.1	70.7	77.3
25-34 years	77.5	75.4	79.4
35 or more years	77.4	73.5	81.3
Second and Third Trimester			
<20 years	30.9	25.3	36.4
20-24 years	22.1	19.0	25.2
25-34 years	19.2	17.2	21.0
35 or more years	17.8	14.2	21.3
No Prenatal Care			
<20 years	3.4	1.3	5.5
20-24 years	3.8	2.2	5.3
25-34 years	3.4	2.4	4.2
35 or more years	4.8	2.7	6.8
Level of Education			
First Trimester			
Less than high school	66.0	62.4	69.4
High school graduate	74.7	71.6	77.7
More than high school	79.4	77.3	81.4
Second and Third Trimester			
Less than high school	28.4	25.0	31.7
High school graduate	21.3	18.4	24.1
More than high school	17.7	15.8	19.6
No Prenatal Care			
Less than high school	5.6	3.9	7.3
High school graduate	4.0	2.6	5.4
More than high school	2.9	2.0	3.7

TRIMESTER OF PRENATAL CARE INITIATION

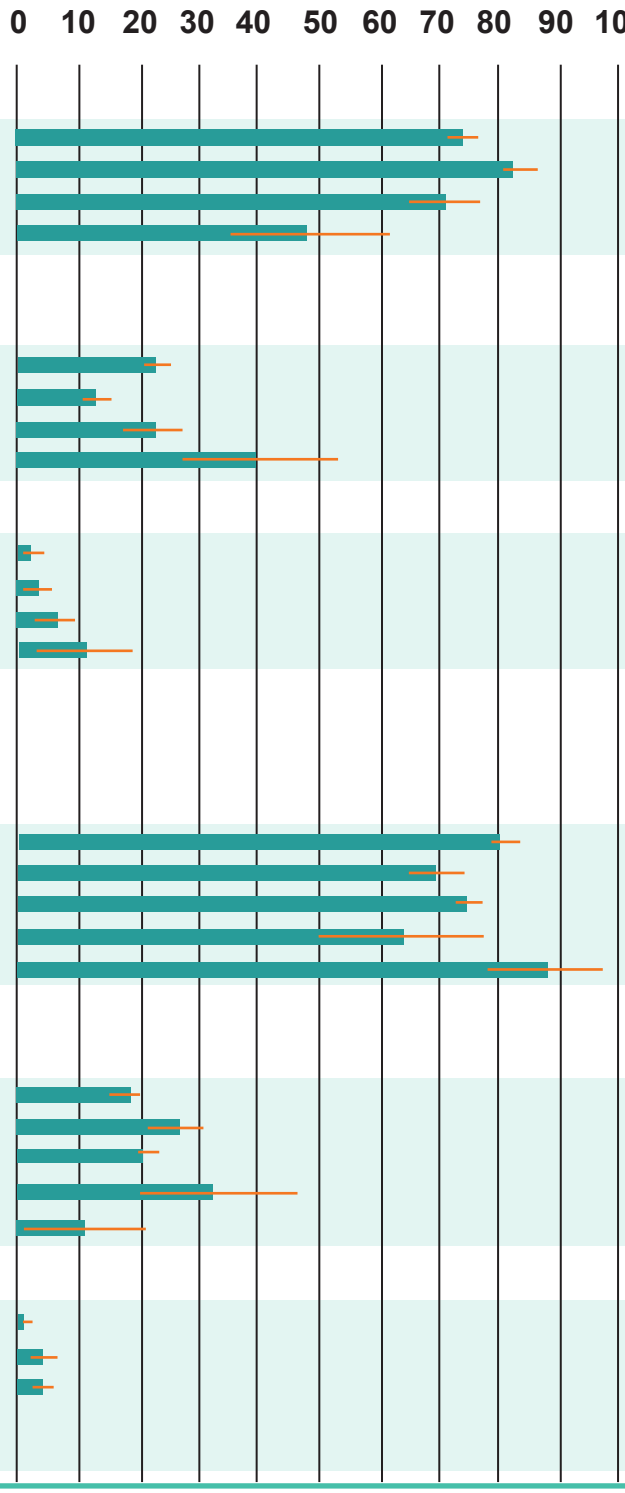
Percentage of population with no prenatal care or by trimester of entry, 2016-2018



	%	LOWER	UPPER
Marital Status First trimester			
Married	80.6	78.6	82.5
Not married	71.0	68.6	73.2
Second or Third Trimester			
Married	16.8	14.8	18.6
Not married	24.4	22.2	26.5
No Prenatal Care			
Married	2.7	1.8	3.4
Not Married	4.6	3.5	5.7
Federal Poverty Level First Trimester			
<=100	69.0	66.2	71.6
101-185%	76.4	73.1	79.6
>185%	85.2	82.9	87.4
Second or Third Trimester			
<=100	26.2	23.6	28.7
101-185%	21.1	17.9	24.1
>185%	12.3	10.2	14.2
No Prenatal Care			
<=100	4.8	3.5	6.1
101-185%	2.5	1.4	3.6
>185%	2.5	1.4	3.5

TRIMESTER OF PRENATAL CARE INITIATION

Percentage of population with no prenatal care or by trimester of entry, 2016-2018



	%	LOWER	UPPER
Insurance for Prenatal Care			
First Trimester			
Medicaid	74.5	72.5	76.5
Private	83.7	81.1	86.2
Other	71.5	65.8	77.1
None	~~48.3~~	35.4	61.2
Second or Third Trimester			
Medicaid	22.7	20.7	24.5
Private	13.2	10.7	15.5
Other	22.2	16.9	27.5
None	~~40.6~~	27.5	53.7
No Prenatal Care			
Medicaid	2.8	1.9	3.5
Private	3.1	1.8	4.3
Other	6.3	3.3	9.1
None	~~11.0~~	3.5	18.4
Mother's Race/Ethnicity			
First Trimester			
White	80.7	78.0	83.2
American Indian	69.3	64.7	73.8
Hispanic	74.5	72.3	76.5
Black	~~63.4~~	49.2	77.5
Asian/ Pacific	~~87.5~~	77.9	97.0
Second or Third Trimester			
White	17.4	14.8	19.9
American Indian	26.3	21.9	30.7
Hispanic	21.0	19.0	22.9
Black	~~33.0~~	19.3	46.5
Asian/ Pacific	~~11.1~~	1.8	20.3
No prenatal Care			
White	2.0	1.0	2.9
American Indian	4.4	2.3	6.4
Hispanic	4.5	3.5	5.5
Black			
Asian/ Pacific			

Data points for Black and Asian/Pacific Islander populations are not shown because values do not meet small number rules for NMDOH or CDC PRAMS.

NM PRAMS FINDINGS

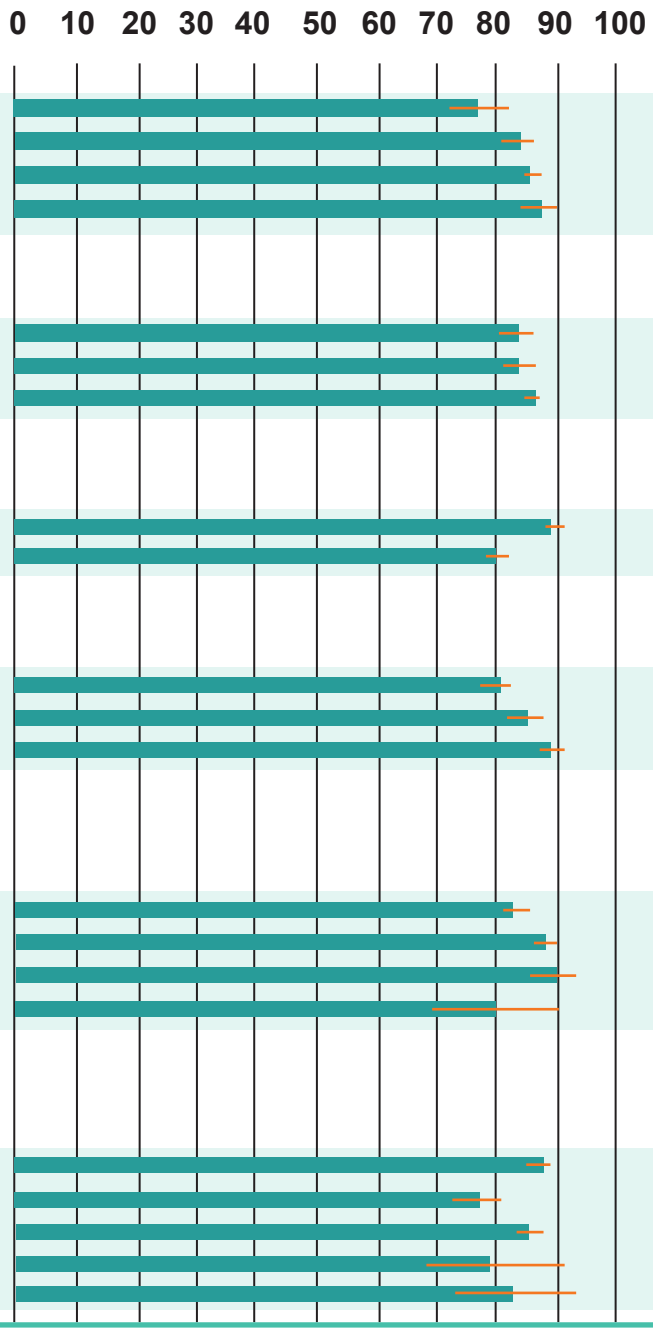
Prenatal care entry is measured on the standard US birth certificate in PRAMS surveillance. About three quarters (76%) of resident, instate births were to women receiving care in the first trimester (first thirteen weeks of pregnancy). First-trimester care prevalence was similar among all age groups except for the youngest. Historically, over sixty percent of New Mexican women reported adequate healthcare. Disparities in timely and adequate prenatal healthcare have persisted with suboptimal rates among American Indian women, women under the age of twenty, women earning less than 100% of the Federal Poverty Level, lower educational attainment, and unmarried women (NMDOH, 2012).

Only 66% of people under 20 years had prenatal care in the first trimester. Among those with some college education, among married people and for those with higher income people, first- trimester care was more likely than for their respective counterparts. Eighty-four percent (84%) of people with private insurance coverage had timely prenatal care compared to 75% of those with Medicaid and 48% of uninsured people.

Women ages 35 and older were more likely to have late (third trimester) prenatal care, compared to younger people, and uninsured people, as might be expected, were most likely to experience late care (11%). Despite having either Medicaid and private or Indian Health Services, only 69% of American Indian women had first-trimester care, and their late prenatal care rate, as well as for Hispanic women, was twice the prevalence as for white or Asian women.

PRENATAL CARE RECEIVED AS EARLY AS WANTED

Percentage of population who received prenatal care as early as they wanted, 2016-2018



	%	LOWER	UPPER
Age			
<20 years	77.6	72.5	82.7
20-24 years	84.1	81.3	86.7
25-34 years	85.9	84.2	87.5
35 or more years	87.8	84.7	90.8
Level of Education			
Less than high school	83.3	80.6	85.9
High school graduate	83.8	81.2	86.3
More than high school	86.2	84.5	87.9
Marital Status			
Married	89.8	88.2	91.2
Not married	80.4	78.3	82.3
Federal Poverty Level			
<=100	81.2	78.9	83.5
101-185%	85.1	82.4	87.6
>185%	89.5	87.6	91.4
Insurance Before Pregnancy			
Medicaid	83.4	81.6	85.0
Private	88.8	86.6	90.9
Other	90.5	86.9	93.9
None	~~80.2~~	69.6	90.6
Mother's Race/Ethnicity			
White	87.3	85.0	89.5
American Indian	77.8	73.6	81.8
Hispanic	85.7	84.0	87.4
Black	~~79.9~~	68.1	91.6
Asian/ Pacific	~~83.9~~	73.9	93.8

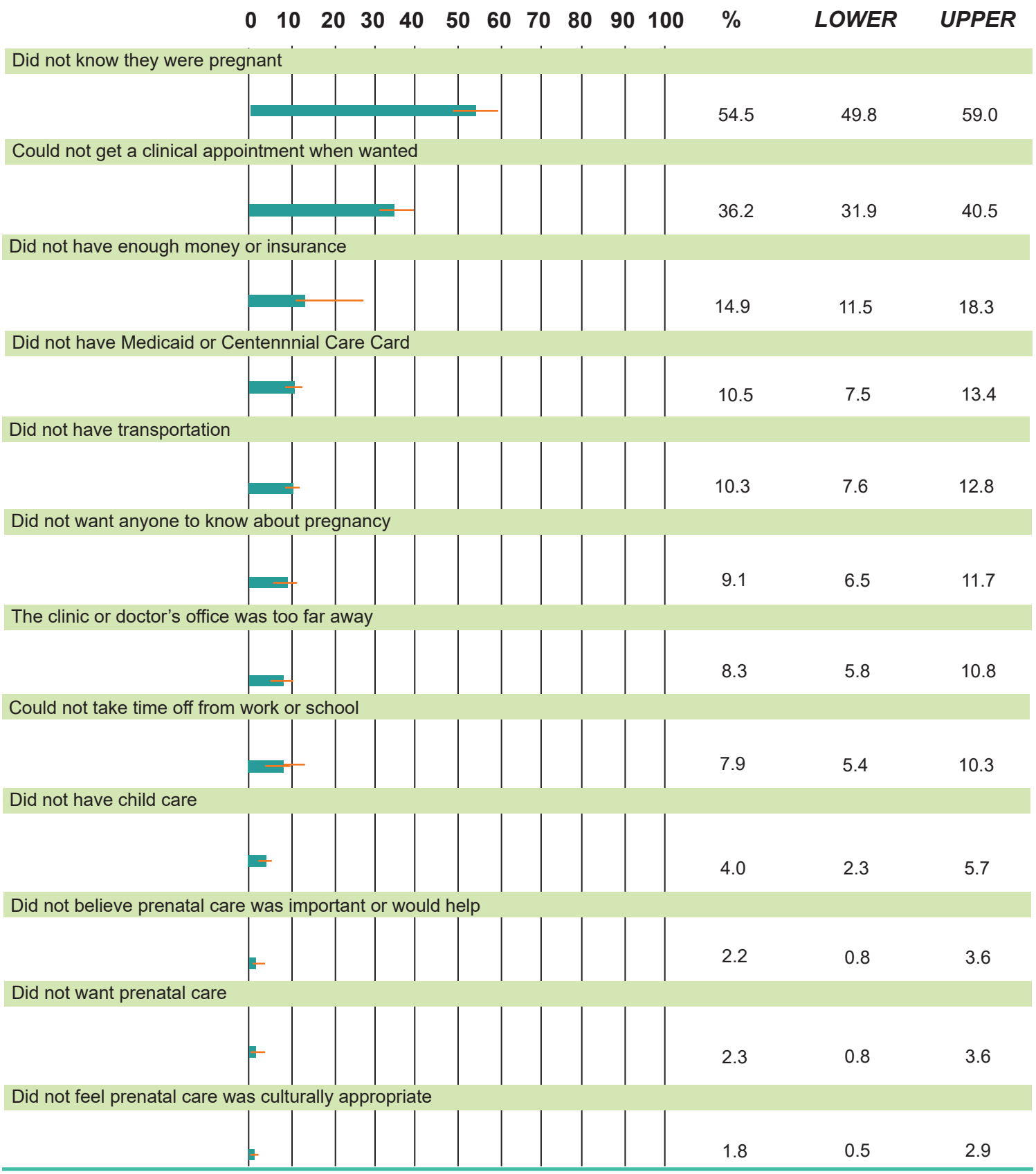
NM PRAMS FINDINGS

Approximately 85% of NM birthing people had prenatal care as early as they wanted (2016-2018). People most likely to have prenatal care as early as they wanted were older than age 34, married, privately insured, Hispanic or white. Those with an undisclosed insurance type also reported a higher proportion of desired care compared to those with Medicaid coverage (90.5% v. 80.4%).

Among people whose prenatal care started later than they wanted, over one-half said it was because they did not realize they were pregnant. Over one-third said it was because they could not get a clinical appointment, and about 15% did not have enough money or insurance to cover their care.

REASONS FOR DELAYED PRENATAL CARE

Prevalence of barriers to care for those who had prenatal care later than wanted, 2016-2018



SATISFACTION WITH PRENATAL CARE

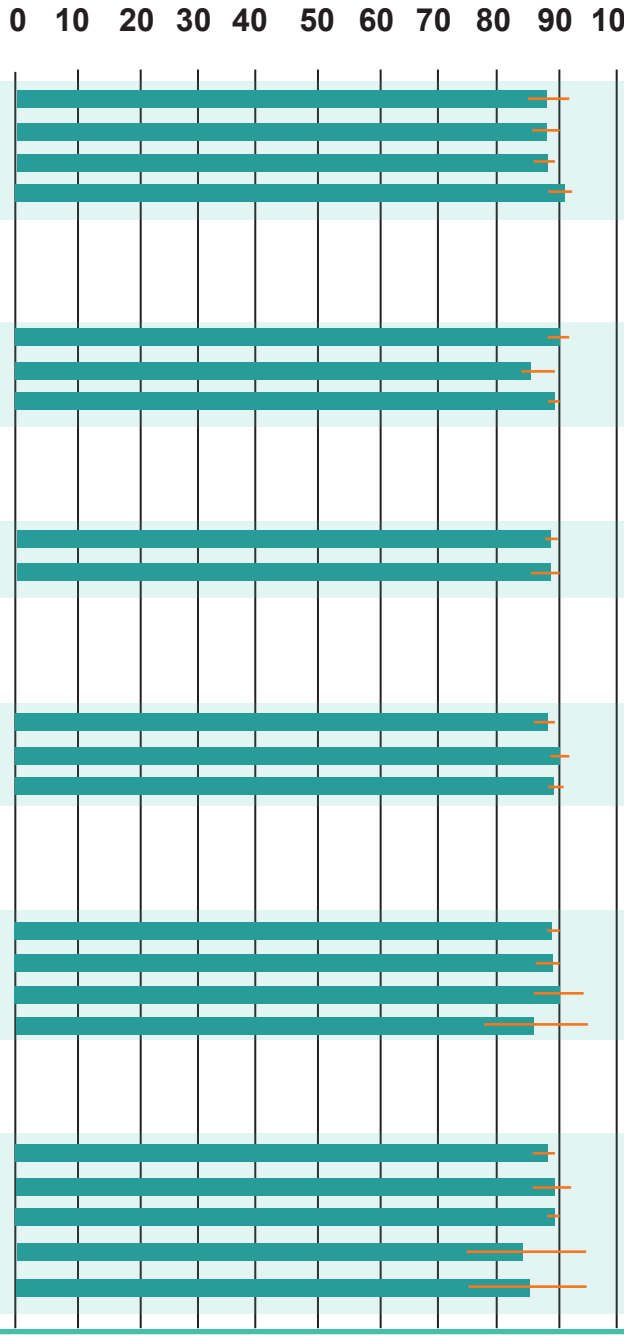
NM PRAMS FINDINGS

The PRAMS survey asks a range of questions regarding women's satisfaction with prenatal care services. These include satisfaction with wait time, time spent with a clinician, prenatal care advice, respect shown by prenatal care staff, and cultural awareness. Most women reported satisfaction with prenatal care services. Those reporting higher than average prevalence of dissatisfaction included people who earned less than 185% of the FPL, uninsured people, or those who were Black or American Indian.

More people reported dissatisfaction with the time they had to wait for care compared to other factors, and a higher proportion of Medicaid recipients shared that concern. Five percent of Native American and 4% of Hispanic women said the care they received was not culturally appropriate compared to about 2% of other women.

SATISFIED WITH PRENATAL CARE WAIT TIME

Percentage of population who were satisfied with their prenatal care wait time, 2016-2018



	%	LOWER	UPPER
Age			
<20 years	89.0	85.2	92.6
20-24 years	88.4	86.0	90.7
25-34 years	88.2	86.7	89.7
35 or more years	91.2	88.5	93.7
Maternal Education			
Less than high school	90.2	88.0	92.3
High school	86.7	84.3	89.0
More than high school	89.1	87.6	90.5
Marital Status			
Married	88.9	87.4	90.4
Not married	88.6	86.9	90.1
Federal Poverty Level			
<=100%	87.3	85.3	89.1
101-185%	90.7	88.6	92.7
>185%	89.7	87.7	91.5
Insurance for Prenatal Care			
Medicaid	88.6	87.2	90.0
Private	88.5	86.3	90.6
Other	90.4	86.5	94.1
None	~~86.3~~	77.1	95.4
Mother's Race/Ethnicity			
White	87.6	85.3	89.7
American Indian	89.4	86.3	92.3
Hispanic	89.3	87.7	90.7
Black	~~84.9~~	74.3	95.4
Asian/ Pacific	~~85.4~~	75.6	95.1

SATISFACTION WITH PRENATAL ADVICE

NM PRAMS FINDINGS

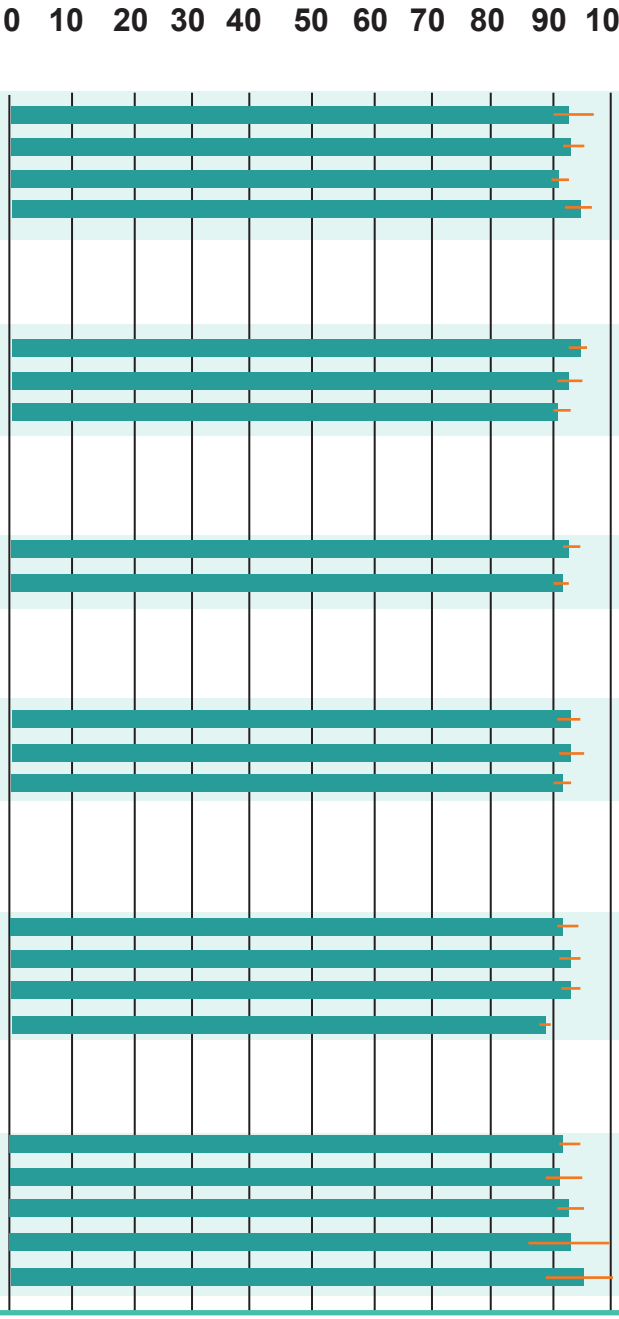
The PRAMS survey asks if people were satisfied with the advice they received in prenatal care. Those reporting a higher rate of satisfaction included people with less than a high school education level, those with insurance compared to those without, and those 35 years and older.

For satisfaction with the amount of time people had with their prenatal care provider, there were few differences, but married people were more likely than unmarried to report satisfaction, and insured people were more likely than uninsured.

No statistically significant differences were observed for the respect shown people in prenatal care, and American Indian people were marginally less likely to be satisfied with cultural understanding demonstrated than others.

SATISFIED WITH PRENATAL CARE ADVICE RECEIVED

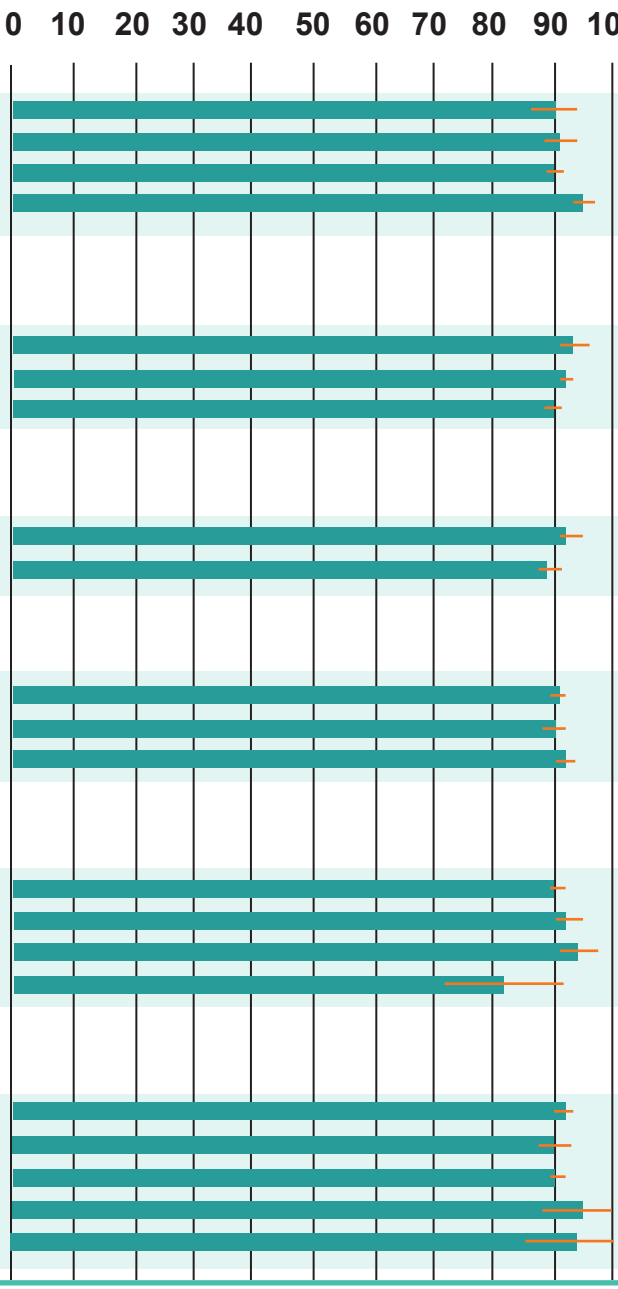
Percentage of population who were satisfied with prenatal care advice, 2016-2018



	%	LOWER	UPPER
Maternal Age			
<20 years	93.7	90.8	96.5
20-24 years	93.9	92.0	95.6
25-34 years	92.0	90.6	93.2
35 or more years	94.7	92.6	96.8
Maternal Education			
Less than high school	95.1	93.5	96.6
High school	93.6	91.8	95.2
More than high school	91.9	90.6	93.2
Marital Status			
Married	93.7	92.4	94.8
Not married	92.2	90.8	93.5
Federal Poverty Level			
<=100%	93.4	91.9	94.9
101-185%	93.4	91.6	95.1
>185%	92.0	90.3	93.6
Insurance for Prenatal Care			
Medicaid	93.0	91.8	94.1
Private	93.2	91.5	94.8
Other	93.0	91.8	94.2
None	88.5	87.0	89.0
Mother's Race/Ethnicity			
White	92.8	91.0	94.5
American Indian	91.5	88.7	94.3
Hispanic	93.2	92.1	94.4
Black	93.2	86.6	99.8
Asian/ Pacific	95.3	88.3	100.0

SATISFIED WITH AMOUNT OF TIME WITH PRENATAL CARE PROVIDER

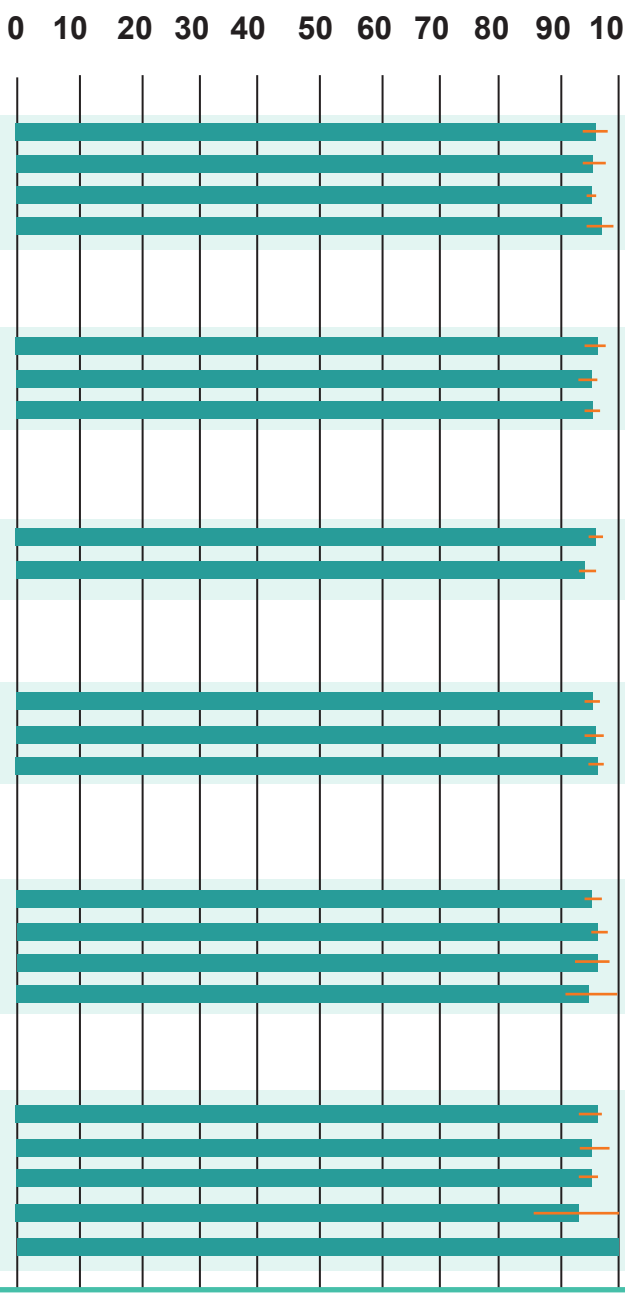
Percentage of population satisfied with amount of time prenatal care provider gave them, 2016-2018



	%	LOWER	UPPER
Maternal Age			
<20 years	90.3	86.7	93.8
20-24 years	91.2	89.0	93.3
25-34 years	90.5	89.0	91.8
35 or more years	95.6	93.8	97.4
Maternal Education			
Less than high school	93.5	91.8	95.2
High school	92.0	90.1	93.9
More than high school	90.4	88.9	91.7
Marital Status			
Married	92.8	91.4	94.0
Not married	89.9	88.3	91.4
Federal Poverty Level			
<=100%	91.2	89.5	92.8
101-185%	90.6	88.4	92.7
>185%	92.3	90.6	93.9
Insurance for Prenatal Care			
Medicaid	90.7	89.3	92.0
Private	92.6	90.8	94.4
Other	94.0	91.0	96.8
None	~~82.2~~	72.5	91.7
Mother's Race/Ethnicity			
White	92.1	90.3	93.9
American Indian	90.4	87.4	93.3
Hispanic	90.9	89.5	92.2
Black	~~94.8~~	87.3	100
Asian/ Pacific	~~93.2~~	85.4	100

SATISFIED WITH RESPECT SHOWN IN PRENATAL CARE

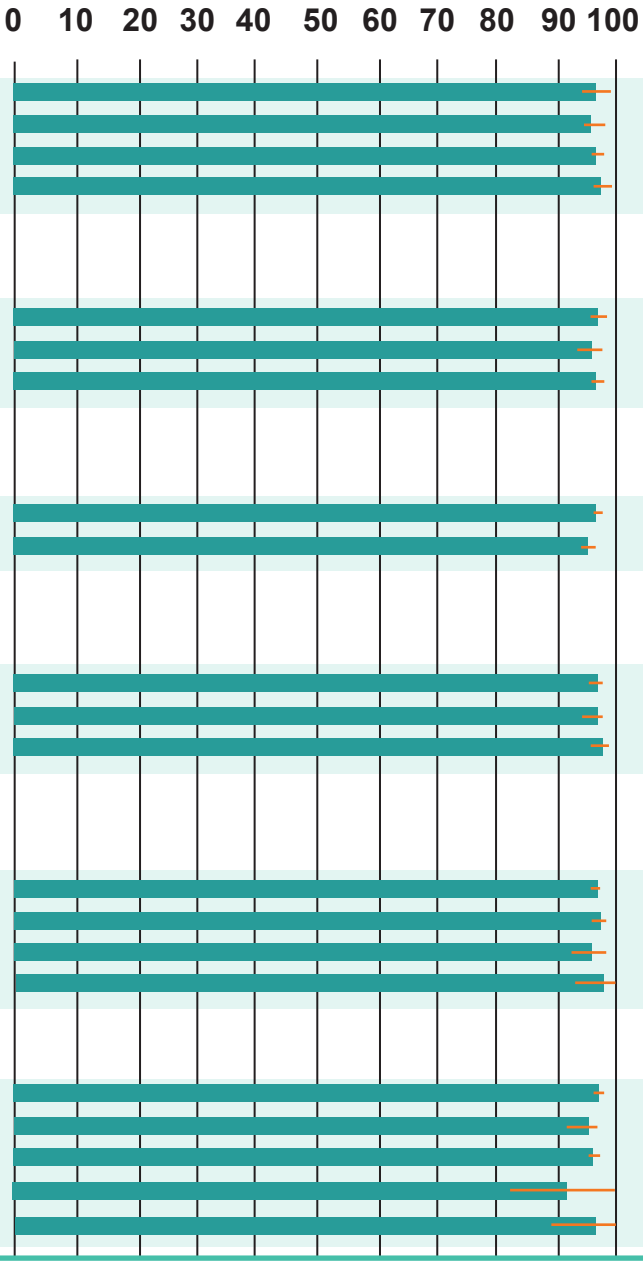
Percentage of population who were satisfied with respect shown in their care, 2016-2018



	%	LOWER	UPPER
Maternal Age			
<20 years	96.5	94.2	98.6
20-24 years	95.7	94.1	97.1
25-34 years	95.4	94.3	96.3
35 or more years	98.0	96.7	99.2
Maternal Education			
Less than high school	96.3	94.9	97.6
High school	95.4	93.8	96.8
More than high school	95.9	94.9	96.9
Marital Status			
Married	96.7	95.8	97.6
Not married	95.0	93.8	96.0
Federal Poverty Level			
<=100%	95.5	94.3	96.7
101-185%	96.2	94.8	97.6
>185%	96.3	95.1	97.5
Insurance for Prenatal Care			
Medicaid	95.7	94.7	96.6
Private	96.4	95.1	97.6
Other	96.1	93.6	98.4
None	95.6	90.5	100
Mother's Race/Ethnicity			
White	96.3	94.9	97.6
American Indian	96.0	93.9	98.0
Hispanic	95.5	94.5	96.4
Black	~~93.5~~	85.5	100
Asian/ Pacific	~~100~~	100	100

SATISFIED WITH CULTURAL UNDERSTANDING IN PRENATAL CARE

Percentage of population satisfied with the cultural understanding demonstrated in their care, 2016-2018



	%	LOWER	UPPER
Maternal Age			
<20 years	96.9	94.8	99.0
20-24 years	95.7	94.2	97.1
25-34 years	96.2	95.2	97.1
35 or more years	97.8	96.4	99.1
Maternal Education			
Less than high school	96.8	95.5	98.0
High school	95.6	94.0	97.0
More than high school	96.5	95.6	97.4
Marital Status			
Married	96.9	96.0	97.7
Not married	95.8	94.7	96.7
Federal Poverty Level			
<=100%	96.4	95.3	97.4
101-185%	96.2	94.7	97.7
>185%	97.3	96.3	98.3
Insurance for Prenatal Care			
Medicaid	96.1	95.2	96.9
Private	97.5	96.3	98.5
Other	96.3	93.8	98.6
None	97.3	93.6	100
Mother's Race/Ethnicity			
White	97.8	96.7	98.7
American Indian	95.1	92.9	97.3
Hispanic	96.0	95.0	96.9
Black	~~92.2~~	83.9	100
Asian/ Pacific	~~96.4~~	89.6	100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PHYSICAL ABUSE BEFORE OR DURING PREGNANCY

BACKGROUND

Physical abuse during pregnancy can have detrimental effects on both the woman and fetus. According to the American College of Obstetricians and Gynecologists (ACOG), physical abuse is a pattern of threatening or controlling behavior where the partner abuses the other partner on purpose and more than once. Physical abuse includes hitting, slapping, kicking, choking, and pushing. Sometimes abusers focus their violence on the pregnant woman's belly (March of Dimes, 2020). Most cases of domestic physical abuse are not reported, and most victims are women.

In the U.S., 1 in 6 women first experiences abuse during pregnancy (March of Dimes, 2020). Physical abuse of pregnant women is a public health concern as it can have dangerous physical and psychological results for both the woman and the unborn baby. These dangers include stillbirth, miscarriages, perinatal deaths, depression, vaginal bleeding, pelvic fractures, placental abruption, fetal injury, preterm delivery, and babies born with low birth weights (ACOG, 2020). Historically, the rates of physical abuse reported by women before and during pregnancy have declined; however, disparities continue to persist among American Indians and younger women (NMDOH, 2012).

NM PRAMS FINDINGS

The PRAMS survey asks about physical abuse before and during the most recent pregnancy. The survey asks if anyone has physically hurt women in any way (push, hit, slap, kick, or choke). Most (94.6%) NM women were not physically abused in the 12 months before or during their recent pregnancy.

Still, those more likely to experience abuse were under the age of 20, had a high school or less than a high school education, were not married, earned less than 100% of the FPL, had Medicaid as a payer of care, and were American Indian or Hispanic.

SOURCES

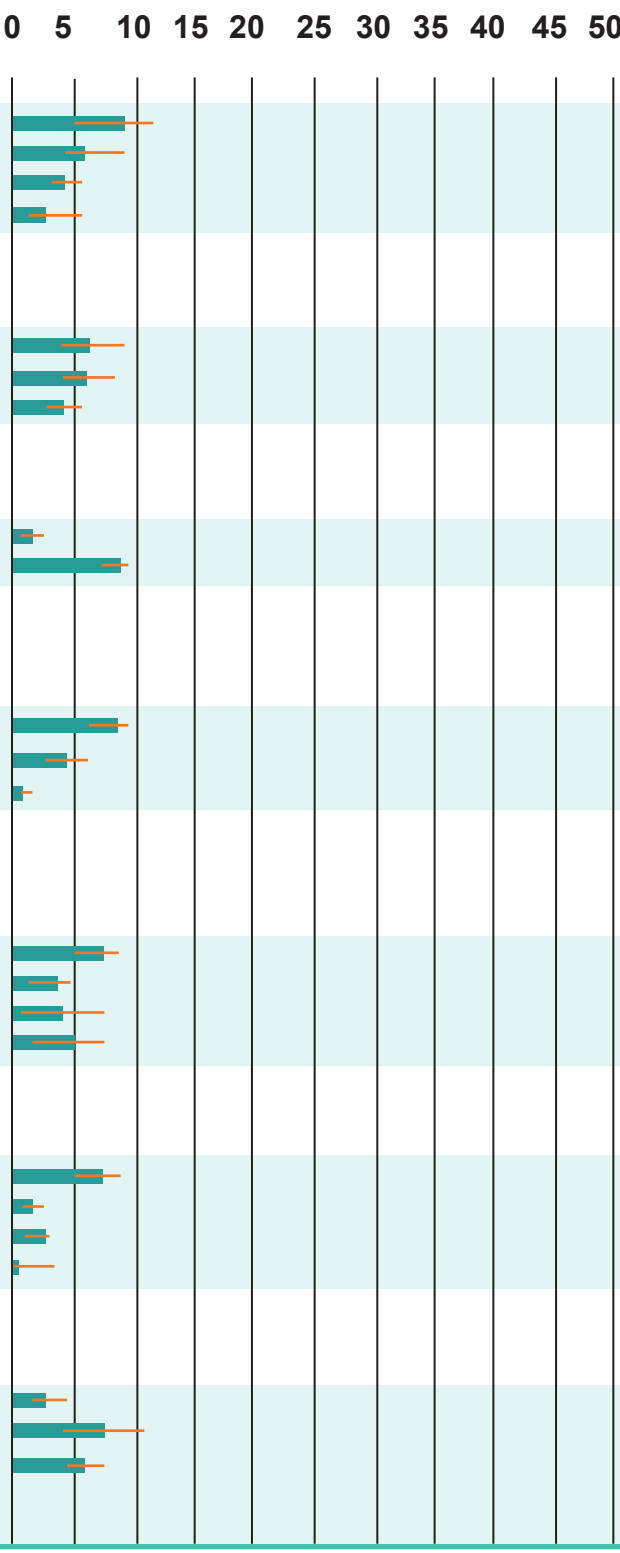
American College of Obstetricians and Gynecologists. (2020, January). Intimate Partner Violence. Retrieved from https://www.acog.org/womens-health/faqs/intimate-partner-violence

March of Dimes. (2020). Abuse during pregnancy. Retrieved from https://www.marchofdimes.org/pregnancy/abuse-during-pregnancy.aspx

New Mexico Department of Health PRAMS Surveillance Report (Rep.). (2012, October).

EXPERIENCED PHYSICAL ABUSE BEFORE OR DURING PREGNANCY

Percentage of population who experienced physical abuse before or during their pregnancy, 2016-2018



	%	LOWER	UPPER
Age			
<20 years	8.9	5.4	12.3
20-24 years	6.5	4.7	8.2
25-34 years	4.9	3.8	5.8
35 or more years	3.9	1.9	5.8
Level of Education			
Less than High School	6.8	4.9	8.5
High School graduate	6.2	4.5	7.8
More than High School	4.6	3.5	5.6
Marital Status			
Married	2.3	1.5	3.0
Not married	8.6	7.1	9.9
Federal Poverty Level			
<=100	8.0	6.4	9.5
101-185%	4.8	3.1	6.3
>185%	1.8	1.0	2.6
Insurance Before Pregnancy			
Medicaid	7.0	5.6	8.2
Private	3.7	2.5	4.8
Other	4.2	0.8	7.4
None	5.0	2.8	7.1
Insurance for Prenatal			
Medicaid	7.0	5.8	8.1
Private	2.7	1.5	3.7
Other	3.6	1.4	3.7
None	1.3	0.0	3.8
Mother's Race/Ethnicity			
White	3.2	2.0	4.3
American Indian	7.6	4.8	10.2
Hispanic	6.1	4.9	7.2
Black			
Asian/ Pacific			

Data points for Black and Asian/Pacific Islander populations are not shown because values do not meet small number rules for NMDOH or CDC PRAMS.

CIGARETTE SMOKING DURING PREGNANCY

BACKGROUND

Smoking during pregnancy, whether it be cigarettes, pipes, cigars, or e-cigarettes, can adversely affect a woman's pregnancy and overall health. Adverse effects on the pregnancy may include miscarriage, an ectopic pregnancy which can lead to miscarriage, placental abruption, which can cause bleeding and loss of oxygen and nutrients to the fetus; placenta previa, which can cause severe bleeding during pregnancy and delivery, preeclampsia which can cause placental abruption and premature births, and premature births which can impact the overall health of the newborn.

Risks to the baby include congenital disabilities and an increased risk of Sudden Infant Death Syndrome or SIDS (CDC, 2020; March of Dimes, 2019). SIDS is the sudden death, usually during sleep, of a seemingly healthy infant less than a year old (Mayo Clinic, 2020). Congenital disabilities related to smoking during pregnancy include damaged lungs and brain, cleft lip, cleft palate (or both).

In previous years, higher proportions of non-Hispanic White, unmarried, poor people, or those who received Medicaid benefits reported smoking during pregnancy (NMDOH, 2012).

NM PRAMS FINDINGS

PRAMS surveys women about cigarette smoking before and during pregnancy. About 17% smoked in the preconception period, and close to 7% smoked during pregnancy, resulting in a greater than 50% cessation rate during pregnancy.

People under the age of 20 years were significantly less likely to smoke during pregnancy compared to those of all other age groups, and just 2.5% of married women smoked compared to 9% of unmarried women. Federal poverty level (FPL) was significantly associated with prenatal smoking: 10% of people with household incomes 100% or less than the FPL, compared to fewer than 2% of those with incomes 185% or greater, smoked during pregnancy. Eight percent (8%) of Medicaid recipients reported smoking, while 1-2% of people with all other forms of coverage or no insurance coverage smoked.

About 9% of non-Hispanic white women smoked during pregnancy, nearly twice the proportion of Hispanic and three times the rate among American Indian women.

SOURCES

March of Dimes. (2019, January). Smoking during pregnancy. Retrieved from https:// www.marchofdimes.org/pregnancy/smoking-during-pregnancy.aspx#

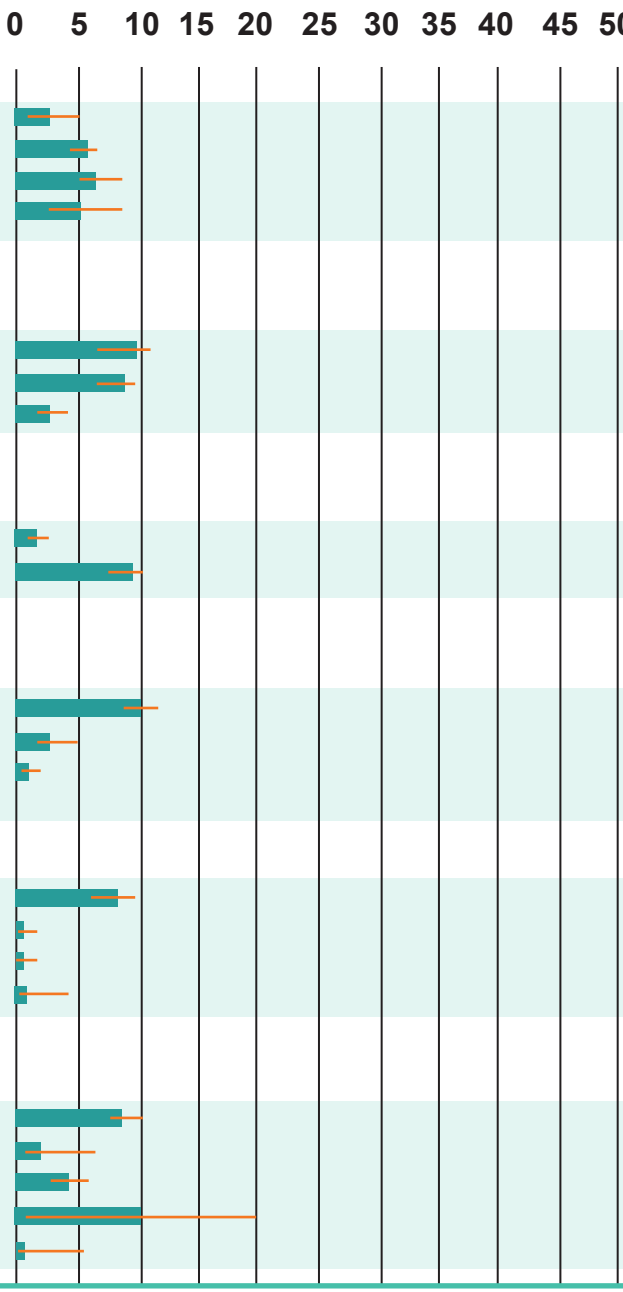
Mayo Clinic. (2020, May 20). Sudden infant death syndrome (SIDS). Retrieved from https:// www.mayoclinic.org/diseases-conditions/sudden-infant-death-syndrome/symptoms-causes/syc-20352800

New Mexico Department of Health PRAMS Surveillance Report (Rep.). (2012, October).

Substance Use During Pregnancy. (2019, February 25). Retrieved from https://www.cdc.gov/reproductivehealth/maternalinfanthealth/substance-abuse/e-cigarettes-pregnancy.htm

SMOKING CIGARETTES DURING PREGNANCY

Percentage of population who smoked during pregnancy, 2016-2018



	%	LOWER	UPPER
Maternal Age			
<20 years	3.3	1.2	5.2
20-24 years	5.8	4.1	7.4
25-34 years	6.3	5.1	7.5
35 or more years	5.1	3.0	7.2
Maternal Education			
Less than high school	9.3	7.1	11.3
High school	7.6	5.7	9.4
More than high school	3.9	2.9	4.8
Marital Status			
Married	2.5	1.7	3.2
Not married	9.1	7.6	10.5
Federal Poverty Level			
<=100%	10.3	8.5	12.0
101-185%	3.8	2.4	5.1
>185%	1.7	0.8	2.4
Insurance for Prenatal Care			
Medicaid	8.0	6.8	9.2
Private	1.7	0.8	2.5
Other	~~1.2~~	0.0	2.4
None	~~1.6~~	0.0	4.6
Mother's Race/Ethnicity			
White	8.9	7.1	10.7
American Indian	2.6	1.1	4.0
Hispanic	4.9	3.8	5.9
Black	~~10.9~~	1.4	20.3
Asian/ Pacific	~~1.9~~	0.0	5.5

BACKGROUND

Food security is defined as "the disruption of food intake or eating patterns because of lack of money and other resources (Nord, 2005)." This definition includes the quality of the food as well as the quantity of food available to expectant women. Having consistent access to healthy food before, during, and after pregnancy has been associated with long term health implications for both mother and infant. Food insecurity is associated with obesity among women (Yang et al., 2019) and obesity in women has been further associated with adverse birth outcomes. For instance, women diagnosed with obesity are at risk for the following outcomes: gestational diabetes mellitus, pre-eclampsia, caesarean delivery, preterm births, infants large for gestational age (LGA), and infants admitted to neonatal intensive care upon delivery. In addition, maternal overweight has been associated with postpartum depression (Yang et al., 2019). Health risks associated with infants born to mothers without significant access to quality food sources include neural tube defects, orofacial clefts, and conotruncal heart defects (Carmichael et al., 2007).

These potentially adverse outcomes are a public health concern and reducing food insecurity is significant to the health and well-being of both mother and infant.

NM PRAMS FINDINGS

PRAMS asks if women ate less because they did not have enough money to buy food. Most women (90.2%) reported that they did have enough money to buy food and did not eat less. Those that did report food insecurity were likely to be between 20-24 years of age, had a high school or less than a high school education, were not married, earned less than 100% of the FPL, had Medicaid as a payer of care, and were American Indian.

SOURCES

Carmichael, S. L., Yang, W., Herring, A., Abrams, B., & Shaw, G. M. (2007). Maternal food insecurity is associated with increased risk of certain birth defects. The Journal of nutrition, 137(9), 2087–2092. https://doi.org/10.1093/jn/137.9.2087

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Nord M, Andrews M, Carlson S. Household food security in the United States, 2005 [Internet]. Washington: USDA Economic Research Service; 2005 [cited 2017 Nov 27].

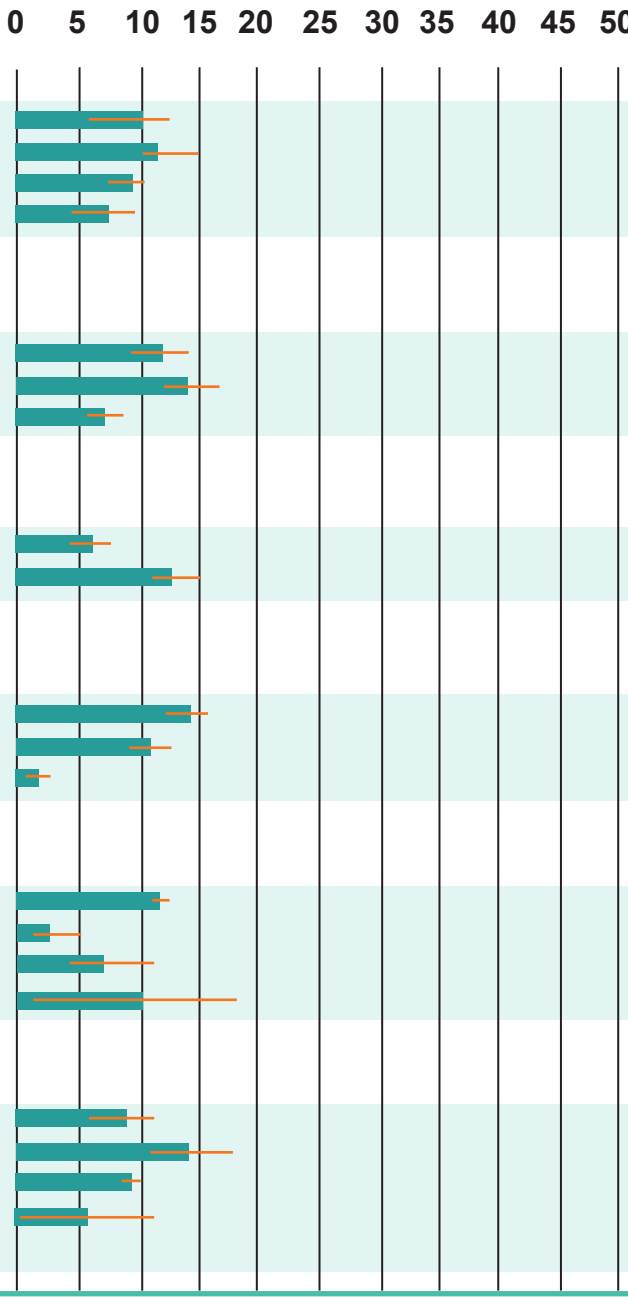
Report No.: ERR-29. Available from: https://www.ers.usda.gov/webdocs/publications/45655/29206_err29_002.pdf?v=41334 [PDF – 880 KB]

Yang, Z., Phung, H., Freebairn, L., Sexton, R., Raulli, A. and Kelly, P. (2019), Contribution of maternal overweight and obesity to the occurrence of adverse pregnancy outcomes. Aust N Z J Obstet Gynaecol, 59: 367-374. https://doi.org/10.1111/ajo.12866

Rachel S. Gross, Alan L. Mendelsohn, Mayela M. Arana, Mary Jo Messito (2019), Food Insecurity During Pregnancy and Breastfeeding by Low-Income Hispanic Mothers. Pediatrics Jun 2019, 143 (6) e20184113; DOI: 10.1542/peds.2018-4113

FOOD INSECURITY DURING 12 MONTHS BEFORE BABY BORN

Percentage of population experiencing food insecurity in 12 months before their baby was born, 2016-2018



	%	LOWER	UPPER
Maternal Age			
<20 years	10.0	6.4	13.4
20-24 years	12.9	10.5	15.2
25-34 years	9.2	7.7	10.5
35 or more years	7.1	4.6	9.5
Maternal Education			
Less than high school	12.3	9.9	14.6
High school	14.6	12.1	17.0
More than high school	7.0	5.7	8.2
Marital Status			
Married	6.0	4.7	7.1
Not married	13.7	11.9	15.3
Federal Poverty Level			
<=100%	14.2	12.2	16.2
101-185%	11.2	8.9	13.5
>185%	2.3	1.3	3.2
Insurance for Prenatal Care			
Medicaid	12.5	11.0	13.9
Private	3.8	2.4	5.0
Other	7.7	4.4	10.9
None	10.0	2.0	17.8
Mother's Race and Ethnicity			
White	8.9	6.9	10.8
American Indian	14.8	11.2	18.3
Hispanic	9.5	8.1	10.8
Black	~~6.7~~	0.2	13.1
Asian/ Pacific			

Data points for Asian/Pacific Islander populations are not shown because values do not meet small number rules for NMDOH or CDC PRAMS.

FLU VACCINATION

BACKGROUND

According to the Centers for Disease Control and Prevention, the flu is a contagious respiratory illness. This virus infects the upper (nose and throat) and lower (lungs) respiratory tracts. The virus ranges from mild to severe, with the severe sometimes causing death. Annual vaccination can prevent and reduce the burden of influenza-associated deaths and hospitalizations (Thompson, 2019). Pregnant women are at high risk of severe illness; therefore, a flu shot is recommended before delivery.

Prenatal flu vaccination is also recommended because it provides antibodies which offer protection to neonates before they develop their own immunity (Swamy, 2015).

NM PRAMS FINDINGS

The PRAMS survey asks women whether they received a flu shot before the delivery of their newborn. In this survey question, 35% of women reported no, and 63% responded yes. Women least likely to receive a flu shot were more likely to be 20-24 years of age, have a high school education, were not married, earned less than 185% of the FPL, had Medicaid as a payer of care, or were uninsured, and were White or Hispanic.

SOURCES

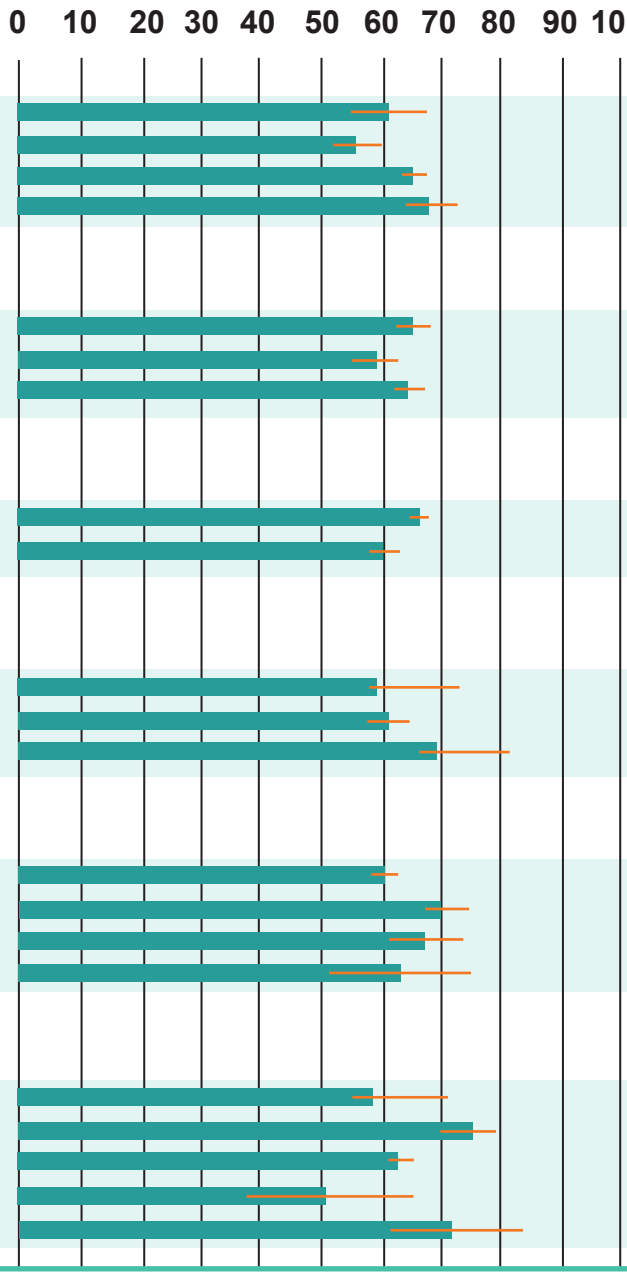
Thompson et al. Influenza Vaccine Effectiveness in Preventing Influenza-associated Hospitalizations During Pregnancy: A Multi-country Retrospective Test Negative Design Study, 2010–2016; Clinical Infectious Diseases, Volume 68, Issue 9, 1 May 2019.

Centers for Disease Control and Prevention. “People at High Risk For Flu Complications.” Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 1 Dec. 2020, www.cdc.gov/flu/ highrisk/index.htm.

Swamy G, Heine R. Vaccinations for Pregnat Women; Obstet Gynecol. 2015 Jan; 125(1): 212–226.

FLU SHOT 12 MONTHS BEFORE DELIVERY

Percentage of population who had a flu shot twelve months before their baby was born, 2016-2018



	%	LOWER	UPPER
Maternal Age			
<20 years	61.7	55.8	67.5
20-24 years	56.5	52.8	60.1
25-34 years	65.6	63.3	67.8
35 or more years	68.9	64.5	73.1
Maternal Education			
Less than high school	65.5	62.1	68.9
High school	59.1	55.7	62.4
More than high school	64.9	62.6	67.2
Marital Status			
Married	66.6	64.3	68.9
Not married	60.3	57.9	62.8
Federal Poverty Level			
<=100%	60.7	57.9	63.5
101-185%	60.9	57.3	64.4
>185%	69.8	66.9	72.6
Insurance for Prenatal Care			
Medicaid	60.0	57.8	62.2
Private	71.0	67.8	74.0
Other	~~67.6~~	61.9	73.2
None	~~63.4~~	51.3	75.5
Mother's Race/Ethnicity			
White	58.5	55.2	61.7
American Indian	75.2	70.9	79.4
Hispanic	63.6	61.3	65.8
Black	~~51.7~~	37.2	66.1
Asian/ Pacific	~~73.1~~	61.9	84.2

PRENATAL DENTAL CARE

BACKGROUND

Oral health is essential during pregnancy. Women are more prone to gingivitis, periodontal diseases, loose teeth, tooth erosion, and dental cavities during pregnancy (March of Dimes, 2019; CDC, 2020). It is crucial to safeguard the health of mother and child by practicing good oral hygiene (brush, floss, regular dental visits). Untreated tooth decay is a risk factor for preterm birth and low birthweight (CDC, 2020).

Further, children of mothers with untreated cavities are three times more likely to have cavities in childhood, and, if untreated, children miss more school due to dental pain (CDC, 2020). Studies have shown that periodontal disease has been connected to diabetes, heart disease, obesity, and pneumonia (ADA, 2019). Historically, almost 40% of women went to a dentist during pregnancy. Further, income level has had a positive relationship with dental visit prevalence (NMDOH, 2012).

NM PRAMS FINDINGS

Fifty-five percent (55%) of women did not receive a dental cleaning and 45% reported having their teeth cleaned. Those less likely to have a dental cleaning were 20-24 years of age, with lower education levels, unmarried people, those earning less than or 100% of the FPL, or uninsured people.

SOURCES

ADA Science & Research Institute, LLC. (2019, September 23). Oral-Systemic Health. Retrieved from https:// www.ada.org/en/member-center/oral-health-topics/oral-systemic-health

CDC. (2020, May 01). Disparities in Oral Health. Retrieved from https://www.cdc.gov/oralhealth/ oral_health_disparities/index.htm

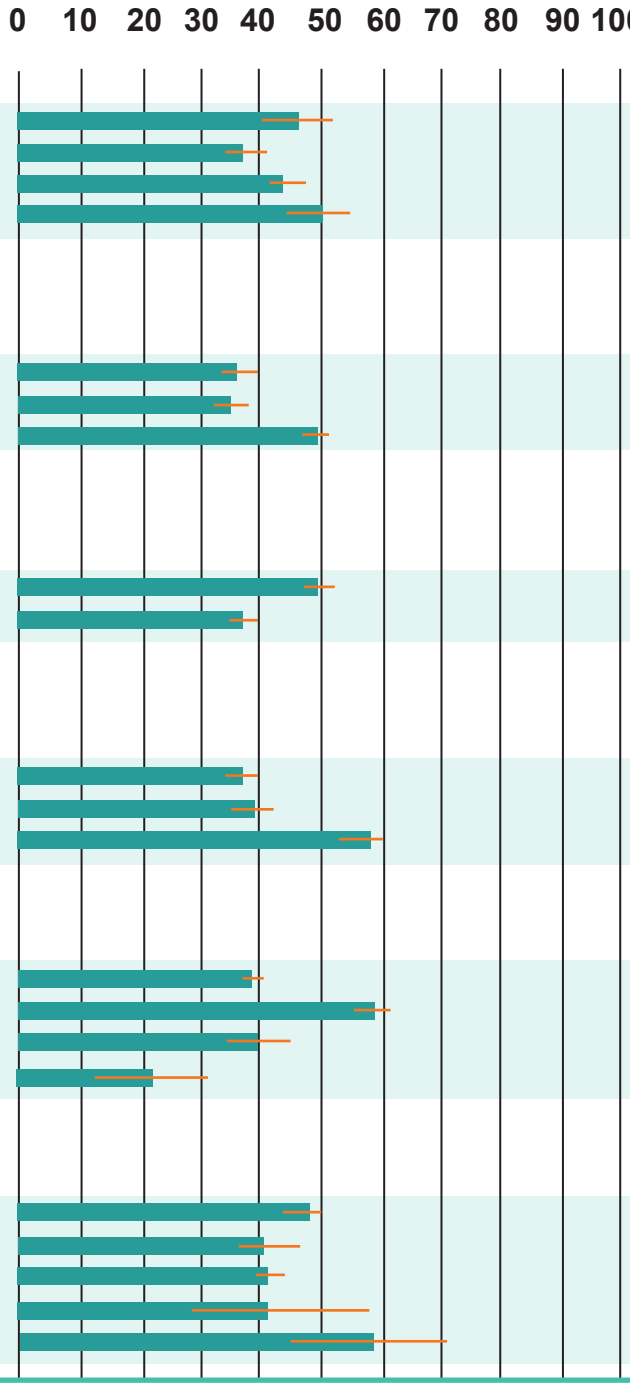
Division of Oral Health, National Center for Chronic Disease Prevention and Health Promotion. “Pregnancy and Oral Health Feature.” Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 19 Feb. 2019, www.cdc.gov/oralhealth/publications/features/pregnancy-and-oral-health.html.

March of Dimes. “Dental Health during Pregnancy.” Dental Health During Pregnancy, June 2019, www.marchofdimes.org/pregnancy/dental-health-during-pregnancy.aspx.

New Mexico Department of Health PRAMS Surveillance Report (Rep.). (2012, October).

PRENATAL DENTAL VISIT

Percentage of population who had their teeth cleaned during pregnancy, 2016-2018



	%	LOWER	UPPER
Maternal Age			
<20 years	46.1	40.1	52.0
20-24 years	37.7	34.1	41.2
25-34 years	44.7	42.4	47.0
35 or more years	50.4	45.8	54.8
Maternal Education			
Less than high school	36.7	33.2	40.1
High school	36.0	32.7	39.2
More than high school	49.6	47.2	51.9
Marital Status			
Married	49.9	47.4	52.2
Not married	37.9	35.4	40.2
Federal Poverty Level			
<=100%	37.4	34.6	40.1
101-185%	39.2	35.7	42.7
>185%	57.0	53.9	60.0
Insurance for Prenatal Care			
Medicaid	39.5	37.3	41.6
Private	58.5	55.1	61.7
Other	40.1	34.2	45.9
None	~~22.1~~	12.3	31.9
Mother's Race/Ethnicity			
White	47.5	44.3	50.7
American Indian	41.8	36.9	46.6
Hispanic	42.1	39.7	44.3
Black	~~42.9~~	28.4	57.4
Asian/ Pacific	~~58.2~~	44.9	71.3

MATERNAL MORBIDITY

Maternal morbidity is physical or mental illnesses and/or disabilities during pregnancy, during delivery, and after pregnancy. These illnesses, not always life-threatening, include cardiovascular problems, diabetes, high blood pressure, infections, blood clots, bleeding, anemia, nausea and vomiting, and/or depression/anxiety (USHHS, 2020). According to the Centers for Disease Control and Prevention, 55,000 women are affected with severe complications (severe maternal morbidity or SMM) during pregnancy each year. Factors associated with SMM include maternal age, pre-pregnancy obesity, pre-existing chronic health conditions, and cesarean deliveries. The consequences of SMM include higher health service use, higher direct medical costs, extended hospitalization stays, and long-term rehabilitation (CDC, 2021).

- Gestational Diabetes
- Depression
- Hypertension

BACKGROUND

Gestational diabetes is diabetes that develops and may be diagnosed during pregnancy. It causes high blood sugar (Mayo Clinic, 2020). The effects on the mother can include high blood pressure and preeclampsia, the need for a c-section, and a higher risk for future diabetes. Potential risks for the baby include excessive birth weight (macrosomia), preterm birth, severe breathing difficulties, low blood sugar, stillbirth, and risk for obesity and diabetes later in life (Mayo Clinic, 2020).

Ten percent of U.S. pregnancies are affected by gestational diabetes. According to the Centers for Disease Control and Prevention, in recent years, 2000 to 2010, the cases of gestational diabetes have increased by 56% (CDC, 2018). Thus, gestational diabetes is a public health concern. Furthermore, the prevalence of diabetes before or during pregnancy nearly doubled between 2000 and 2010 from 7% to 14% (NMDOH, 2012).

NM PRAMS FINDINGS

From 2016-2018, 11% of birthing women were diagnosed with gestational diabetes (GDM; diabetes starting during pregnancy). Diabetes is associated with maternal age, and the highest prevalence was among those at least 35 years (20%). Fifteen percent (15%) of Native American women, 23% of Asian women (unstable estimate) and 10% of Hispanic women developed diabetes during their pregnancy. Just 7% of non-Hispanic White had gestational diabetes diagnoses. Poverty level, payer of care and education level were not associated with gestational diabetes in NM. Marital status was significantly associated with GDM: 11% among married people v. 8% among unmarried. Women that earned less or equal to 100% of the FPL were less likely to report gestational diabetes.

SOURCES

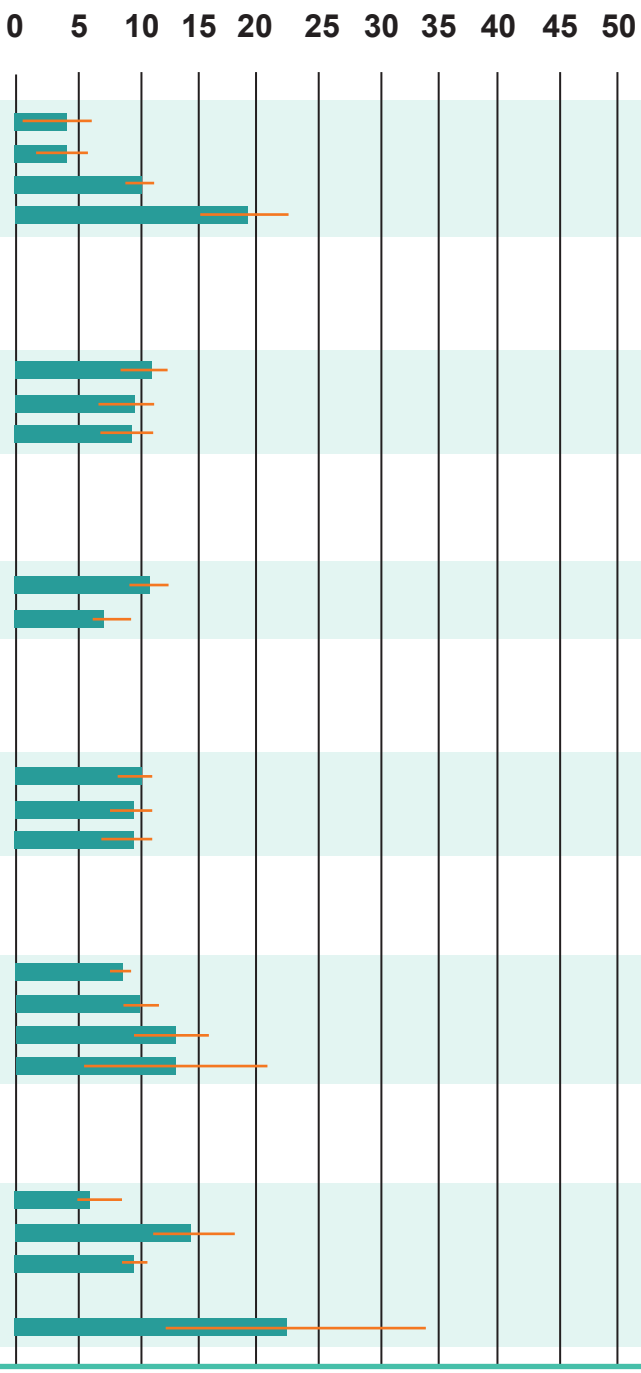
Centers for Disease Control and Prevention. (2018, June 12). Diabetes During Pregnancy. Retrieved from https://www.cdc.gov/reproductivehealth/maternalinfanthealth/diabetes-during-pregnancy.

Mayo Clinic. (2020, August 26). Gestational diabetes. Retrieved from https://www.mayoclinic.org/diseasesconditions/gestational-diabetes/symptoms-causes/syc.

New Mexico Department of Health PRAMS Surveillance Report (Rep.). (2012, October).

GESTATIONAL DIABETES

Percentage of population who had diabetes that started during pregnancy, 2016-2018



	%	LOWER	UPPER
Maternal Age			
<20 years	4.0	1.8	6.3
20-24 years	4.1	2.5	5.6
25-34 years	10.1	8.7	11.5
35 or more years	19.5	15.9	23.0
Maternal Education			
Less than high school	10.5	8.3	12.6
High school	9.4	7.4	11.4
More than high school	9.2	7.8	10.6
Marital Status			
Married	11.2	9.7	12.7
Not married	7.7	6.4	9.0
Federal Poverty Level			
<=100%	10.1	8.4	11.8
101-185%	9.5	7.4	11.7
>185%	9.3	7.5	11.1
Insurance for Prenatal Care			
Medicaid	8.5	7.3	9.8
Private	10.2	8.1	12.2
Other	13.0	9.1	16.9
None	~~13.4~~	5.4	21.5
Mother's Race/Ethnicity			
White	6.7	5.0	8.4
American Indian	14.6	11.1	18.1
Hispanic	9.4	8.0	10.8
Black	.	.	.
Asian/ Pacific	~~23.5~~	12.6	34.4

Data points for Black population are not shown because values do not meet small number rules for NMDOH or CDC PRAMS.

BACKGROUND

Hypertension, also known as high blood pressure, happens 1 in every 12 to 17 pregnancies, according to the Centers for Disease Control and Prevention (CDC, 2021). Due to the maternal complications associated with hypertension, the diagnosis is a public health concern. These complications can impact both mother and infant. The adverse effects for pregnant women may include preeclampsia or high blood pressure, that untreated can lead to kidney or liver damage. Eclampsia is a rare but dangerous condition of untreated or undiagnosed preeclampsia. Eclampsia includes seizures or coma and requires emergency delivery. Chronic hypertension also is problematic for pregnant women as it can place mothers at higher risk for cardiovascular disease later in life (Agrawal et al., 2020). Complications from untreated hypertension that have adverse effects on infants may include preterm delivery, low birth weight, newborn intensive care unit admission, or perinatal death (Agrawal et al., 2020).

Moreover, it is significant to note that hypertensive disorders are associated with maternal mortality (Lo et al., 2013). Therefore, pregnant women must receive the necessary prenatal care services to treat hypertension at early stages to reduce complications. Historically, twelve percent of New Mexican women reported high blood pressure as a medical problem during their pregnancy (NMDOH, 2012).

NM PRAMS FINDINGS

Hypertension during pregnancy impacted an estimated 1 in 7 or 14% of birthing people, 2016-2018. Those with Medicaid or private health insurance were more likely to experience prenatal hypertension than those with other forms of insurance coverage (military, unspecified) or those without any insurance (14% v. 9%). There was no statistically significant variation by ethnicity, age, education, marital status or by poverty level.

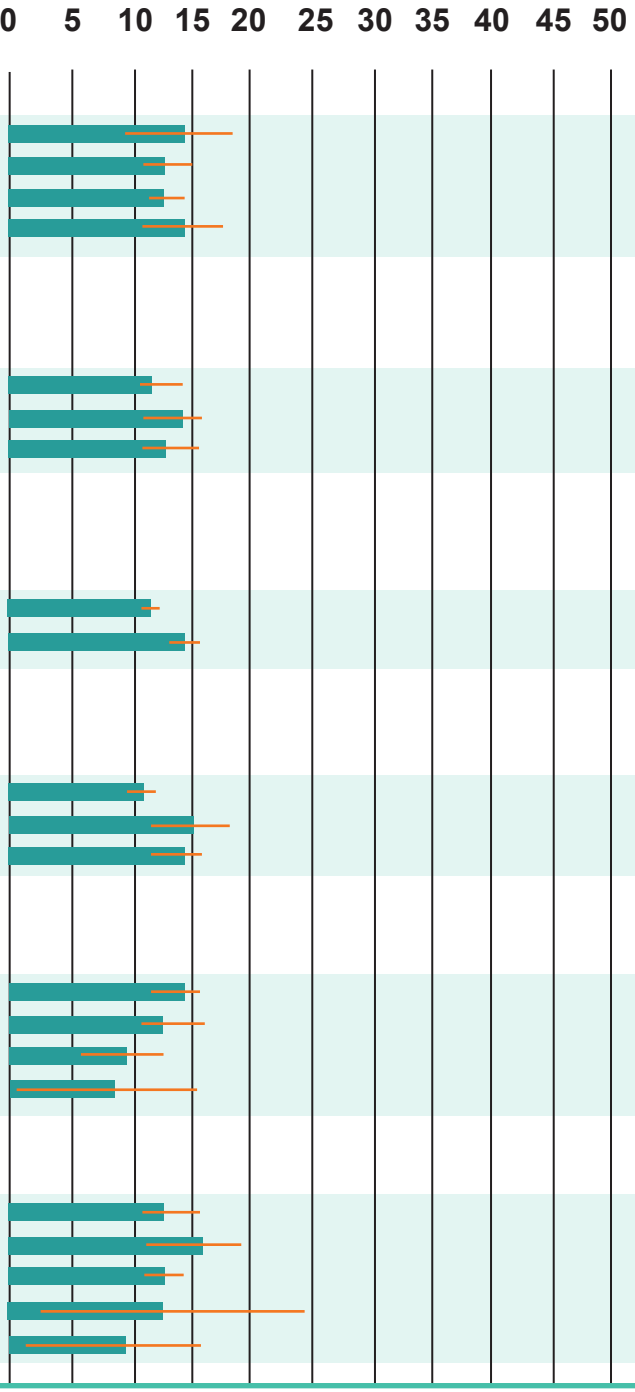
SOURCES

Agrawal, A., & Wenger, N. K. (2020). Hypertension During Pregnancy. Current Hypertension Reports, 22(9). doi:10.1007/s11906-020-01070-0

Centers for Disease Control and Prevention. (2021, May 06). High Blood Pressure During Pregnancy. Retrieved from https://www.cdc.gov/bloodpressure/pregnancy.htm

HYPERTENSION DURING PREGNANCY

Percentage of population who had hypertension during pregnancy, 2016-2018



	%	LOWER	UPPER
Maternal Age			
<20 years	14.2	9.8	18.5
20-24 years	13.1	10.6	15.5
25-34 years	13.4	11.7	14.9
35 or more years	14.6	11.4	17.8
Maternal Education			
Less than high school	12.5	10.1	14.8
High school	14.0	11.6	16.4
More than high school	13.7	11.4	15.3
Marital Status			
Married	12.2	10.6	13.8
Not married	14.9	13.0	16.6
Federal Poverty Level			
<=100%	11.8	9.9	13.5
101-185%	15.1	12.4	17.7
>185%	14.5	12.3	16.7
Insurance for Prenatal Care			
Medicaid	14.3	12.6	15.8
Private	13.6	11.2	15.9
Other	9.7	6.2	13.0
None	8.3	1.0	15.5
Mother's Race/Ethnicity			
White	13.5	11.3	15.7
American Indian	15.9	12.2	19.4
Hispanic	13.4	11.7	14.9
Black	~~13.9~~	3.7	24.0
Asian/ Pacific	9.6	2.6	16.4

The postpartum period begins after the delivery of a baby. Recovery from labor and delivery and focusing on maternal health needs happen along with meeting the needs of a new baby. Postpartum depression, learning how to care for a new infant, and difficulty breastfeeding are challenges women may experience during the postpartum period. Topics addressed in the New Mexico PRAMS survey during the postpartum period include contraception use and method, postpartum checkup, postpartum depression, and counseling for depression.

- Postpartum Contraception
- Postpartum Check up

POSTPARTUM CONTRACEPTIVE METHODS

BACKGROUND

Contraception allows women to decide when and if they want to have children. In the postpartum period, women can become pregnant as early as 3 weeks after delivery even if the mother is breastfeeding and has not yet had her period. Knowing how early a woman can become pregnant in the postpartum period is important so women can plan on contraception. In public health, family planning is important as there are health and economic implications to birth spacing for unplanned or mistimed births. Unintended births have been linked to babies born preterm, babies born with low birth weights, and/or born with birth defects (ODPHP, 2020). Further, unintended pregnancies can be linked to delays in prenatal care, reduced likelihood of breastfeeding, increased risk of maternal depression, and increased risk of physical violence during pregnancy (ODPHP, 2020).

Short interpregnancy intervals (less than 18 months between pregnancies) are associated with poor pregnancy and birth outcomes, and recommended spacing allows families to prepare for a healthy birth.

For these reasons, access to contraception choices is a public health concern to ensure that women can make the best decisions about pregnancy timing and spacing.

NM PRAMS FINDINGS

Looking at the chart below, 84.2% of respondents reported using postpartum contraception.

Women who were less likely to use a birth control method in the postpartum period included those <20 years or aged 35+ years, unmarried people, those with a household income at or below 100% of FPL, people insured by Medicaid or other insurance, i.e., not private insurance, and people of color.

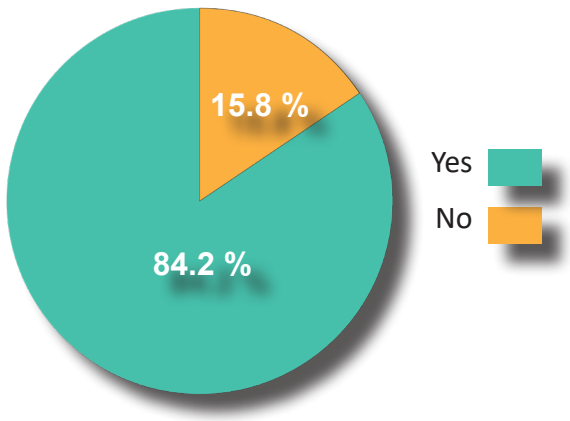
Among people using postpartum contraception, condoms were the most common form (28%), followed by IUD insertion (21%), birth control pills (19%) and tubal ligation or implant (11%). The least common methods were contraceptive patch (1.2%) and natural family planning (4.2%).

SOURCES

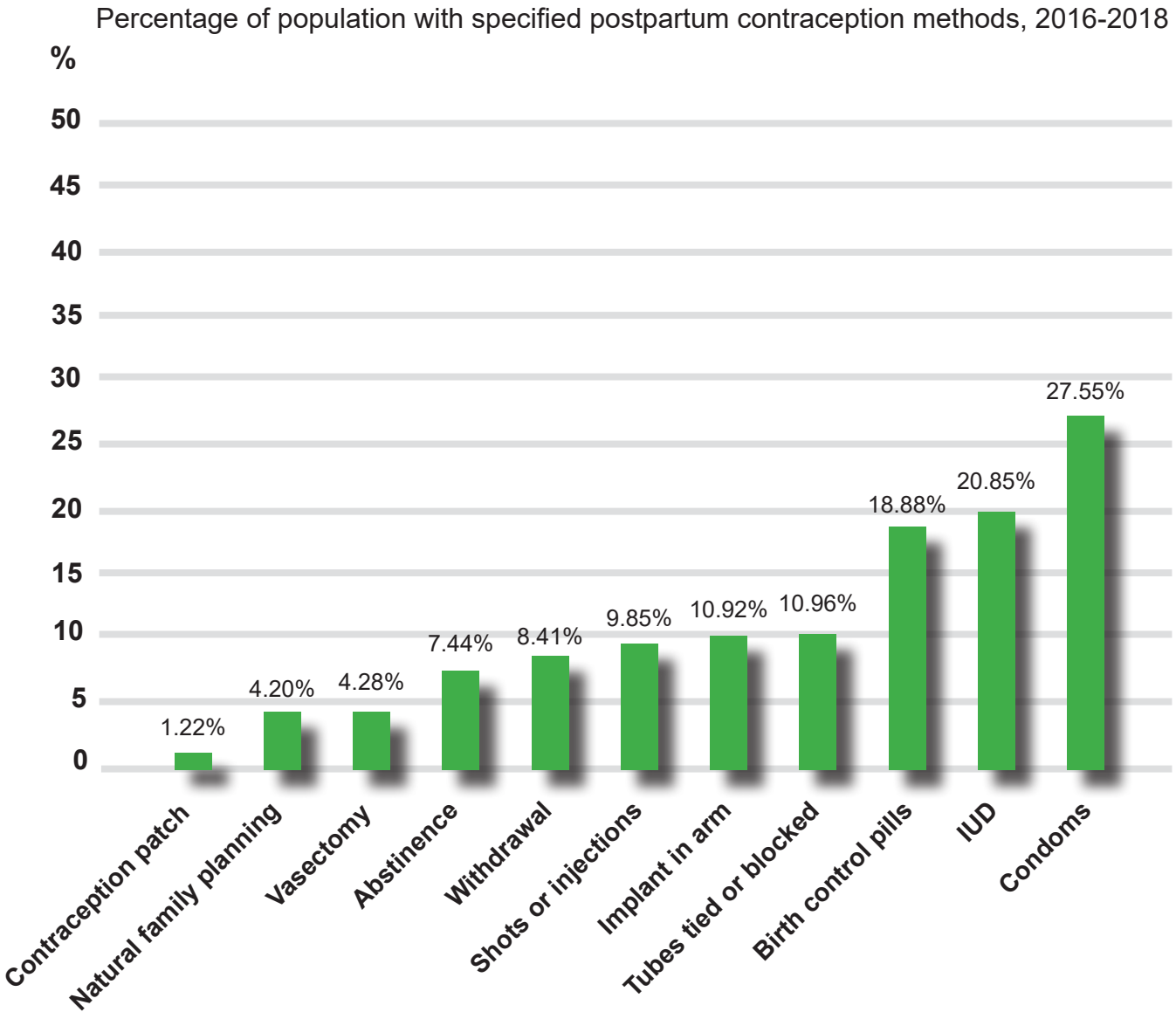
Mayo Clinic. (2020, February 05). Pregnancy spacing: Tips for family planning. Retrieved from https:// www.mayoclinic.org/healthy-lifestyle/getting-pregnant/in-depth/family-planning/art-20044072

Office of Disease Prevention and Health Promotion. (2020). Family Planning. Retrieved from https:// health.gov/healthypeople/objectives-and-data/browse-objectives/family-planning

Postpartum Contraception, 2016 - 2018



AMONG PEOPLE USING A BIRTH CONTROL METHOD, PERCENT USING THE FOLLOWING METHODS



POSTPARTUM HEALTHCARE

BACKGROUND

Postpartum checkups are essential in the health care of recently pregnant women. These checkups allow healthcare providers to determine if there are any health complications related to the recent pregnancy. Postpartum health complications can be severe and life-threatening, so mothers must know the warning signs, receive an accurate and timely diagnosis as well as quality care (CDC, 2020). Two out of three pregnancy-related deaths in the U.S. are preventable, and the leading cause of these deaths is heart conditions and stroke (March of Dimes, 2018).

NM PRAMS FINDINGS

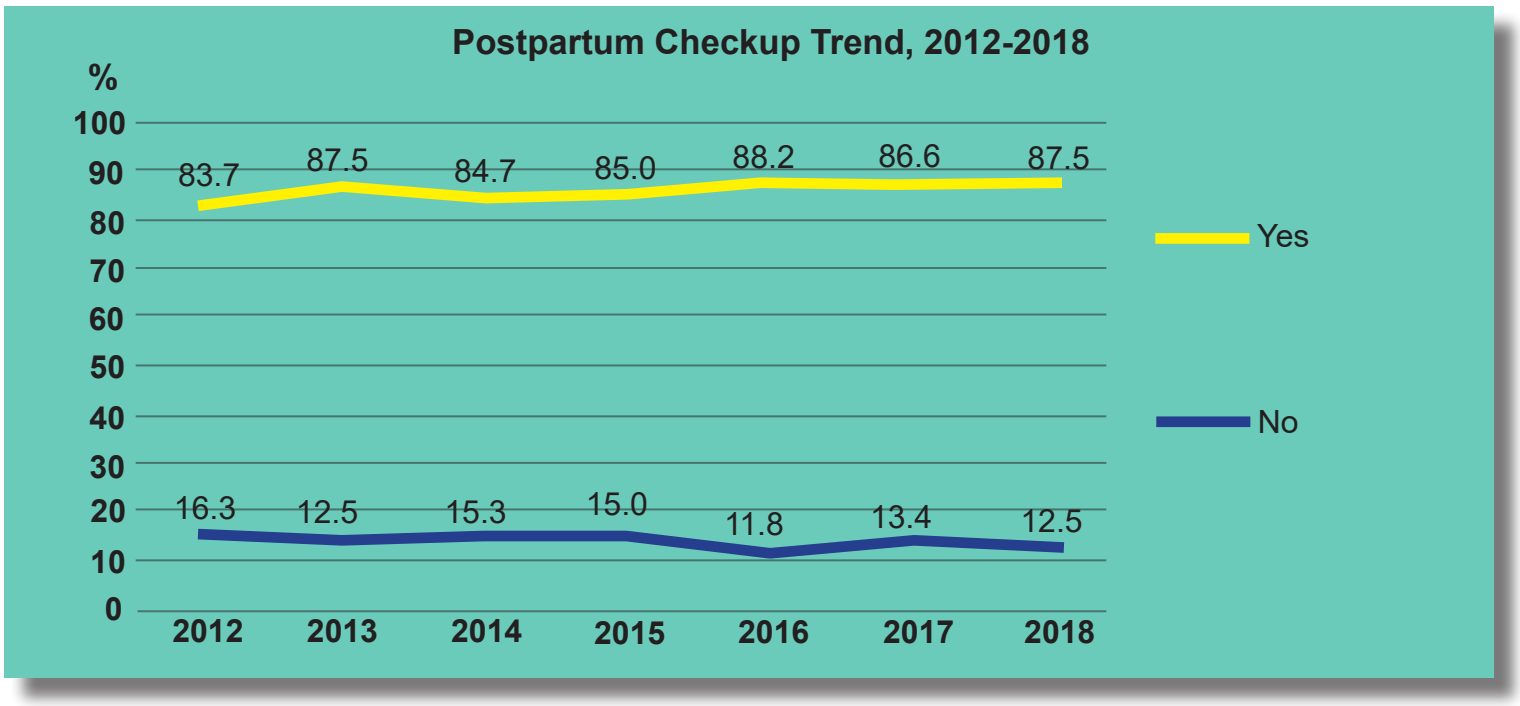
New Mexico ranks last among the states for postpartum health visits at 87.5% compared to the 90.7% US state average (AHR 2019). Women should receive a postpartum checkup six weeks after delivery to identify and address any health concerns. Not receiving a postpartum checkup was associated with age, education and marital status. Those least likely to attend a postpartum visit were aged <20 years, had a high school education or less, were unmarried, lower income, had Medicaid, no insurance or were Asian/ Pacific Islander, American Indian or Black.

SOURCES

Centers for Disease Control and Prevention. (2020, August 04). Pregnancy-Related Deaths in the United States. Retrieved from https://www.cdc.gov/hearher/pregnancy-related-deaths/index.html

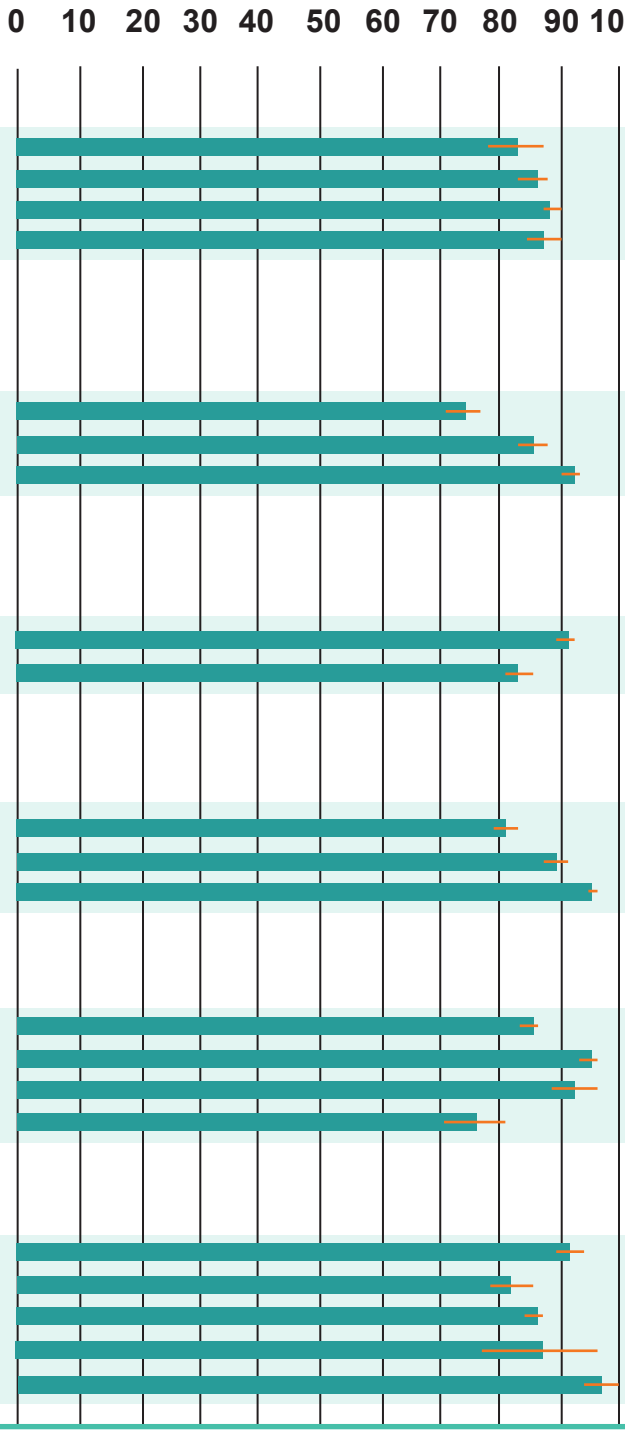
March of Dimes. (2018, July). Your postpartum checkups. Retrieved from https://www.marchofdimes.org/pregnancy/postpartum-care.aspx

America's Health Rankings (2022); https://www.americashealthrankings.org/explore/health-ofwomen-and-children/measure/postpartum_visit/state/ALL



POSTPARTUM CHECK UP

Percentage of population who had a postpartum doctor checkup, 2016-2018



	%	LOWER	UPPER
Maternal Age			
<20 years	83.3	78.7	87.7
20-24 years	86.2	83.7	88.6
25-34 years	88.6	87.1	90.0
35 or more years	87.3	84.2	90.3
Maternal Education			
Less than high school	74.8	71.6	77.8
High school	85.7	83.3	88.1
More than high school	92.3	90.9	93.6
Marital Status			
Married	91.2	89.9	92.5
Not married	83.7	81.8	85.4
Federal Poverty Level			
<=100%	81.8	79.6	83.9
101-185%	89.4	87.1	91.5
>185%	95.4	94.1	96.7
Insurance at Time of Survey			
Medicaid	85.1	83.4	86.7
Private	95.1	93.6	96.5
Other	92.3	88.3	96.3
None	76.4	71.7	81.0
Mother's Race/Ethnicity			
White	91.5	89.7	93.3
American Indian	82.2	78.3	85.9
Hispanic	86.3	84.7	87.8
Black	~~87.2~~	77.5	96.7
Asian/ Pacific	97.2	93.4	100

BACKGROUND

Postpartum depression is a serious life challenge for new mothers and their infants. Maternal and postpartum depression are associated with physical abuse, lack of partner or familial support, and financial hardships or stress (Mayberry et al.,2007; Rich-Edwards et al., 2006; Certain et al., 2008). Previous history of depression, especially during the prenatal period is highly predictive of postpartum depression (Kim et al., 2008). Risks associated with postpartum depression include tobacco use in the last 3 months of pregnancy, physical abuse before or during pregnancy, traumatic stress, and financial stress during pregnancy.

NM PRAMS FINDINGS

Depression is measured by asking about self-reported depression during pregnancy and about symptoms someone is experiencing after the birth of their baby.

Depression during pregnancy: Women who had Medicaid for prenatal care had a higher prevalence of maternal depression compared to those with other forms of insurance (14% v. ~9%). Poverty level was also associated with self-reported depression: prevalence was almost twice the proportion among people with the lowest income level (100% FPL) compared to those with those over 185% federal poverty.

Close to 15% of birthing people experienced postpartum depression symptoms. Married women were less likely to experience postpartum depression symptoms compared to unmarried women (12% v 16%). People with Medicaid were more likely to experience postnatal depression than those with other insurance payers (16% v. 12%), and only 8% of uninsured people reported symptoms.
Poverty was associated with postpartum depression with those at the lowest FPL more likely to have postpartum depression compared to women earning greater than 185% of the FPL (17% v. 12%).

SOURCES

Certain HE, Mueller M, Jagodzinski T, Fleming M. Domestic abuse during the previous year in a sample of postpartum women. J Obstet Gynecol Neonatal Nurs. 2008 Jan-Feb;37(1):35-41. doi: 10.1111/j.1552-6909.2007.00200.x. PMID: 18226155.

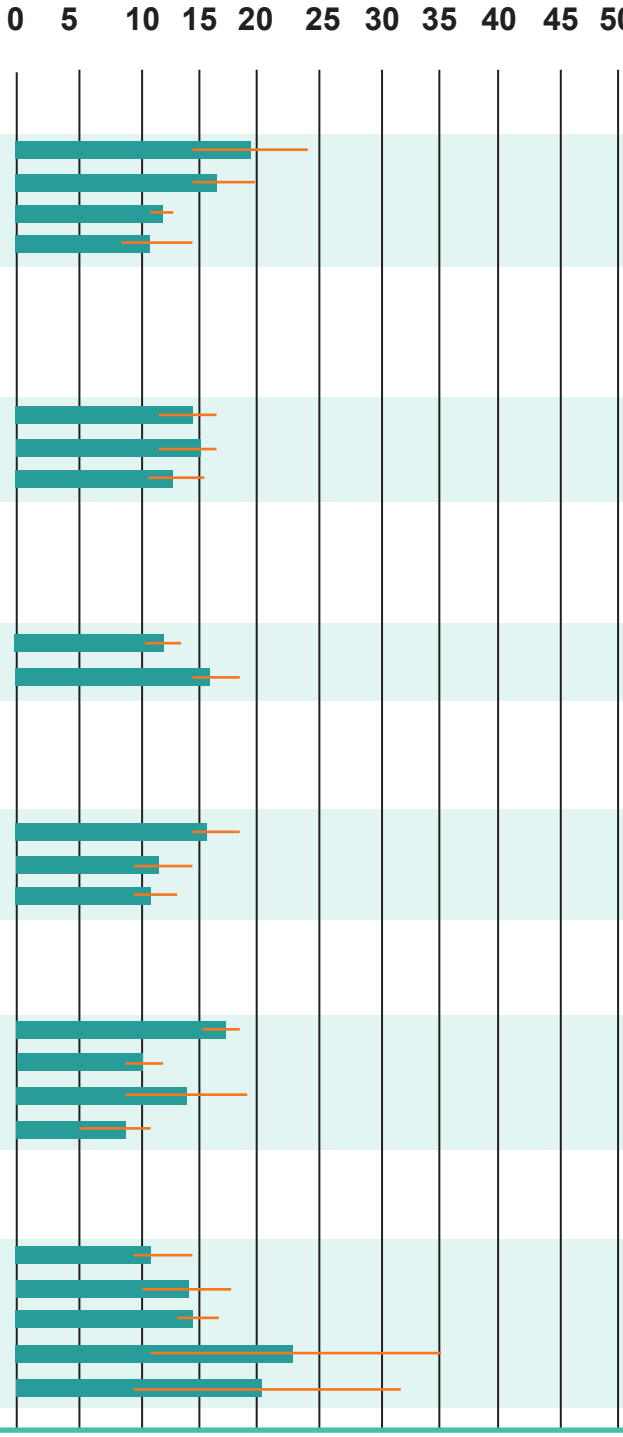
Kim YK, Hur JW, Kim KH, Oh KS, Shin YC. Prediction of postpartum depression by sociodemographic, obstetric and psychological factors: a prospective study. Psychiatry Clin Neurosci. 2008 Jun;62(3):331-40. doi: 10.1111/j.1440-1819.2008.01801.x. PMID: 18588594.

Mayberry, L. J., Horowitz, J. A., & Declercq, E. (2007). Depression symptom prevalence and demographic risk factors among US women during the first 2 years postpartum. Journal of Obstetric, Gynecologic & Neonatal Nursing, 36(6), 542-549.

Rich-Edwards, J. W., Kleinman, K., Abrams, A., Harlow, B. L., McLaughlin, T. J., Joffe, H., & Gillman, M. W. (2006). Sociodemographic predictors of antenatal and postpartum depressive symptoms among women in a medical group practice. Journal of Epidemiology & Community Health, 60(3), 221-227.

POSTPARTUM DEPRESSION SYMPTOMS

Percentage of population with postpartum depression symptoms, 2016-2018

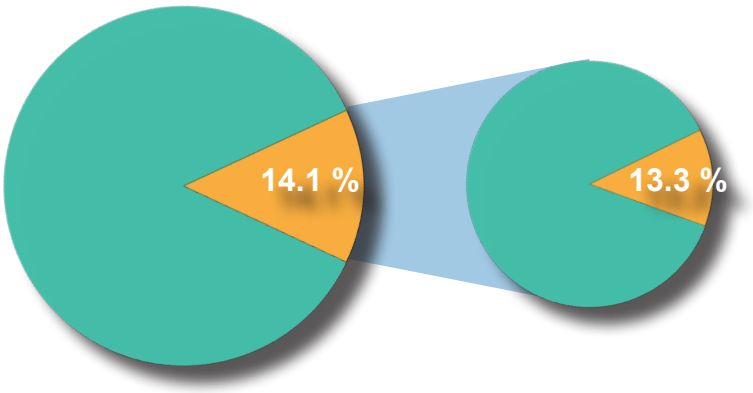


	%	LOWER	UPPER
Maternal Age			
<20 years	19.7	14.8	24.5
20-24 years	17.7	14.9	20.4
25-34 years	12.3	10.7	13.8
35 or more years	11.7	8.7	14.7
Maternal Education			
Less than high school	14.7	12.1	17.2
High school	15.0	12.5	17.4
More than high school	13.6	11.9	15.2
Marital Status			
Married	12.0	10.3	13.6
Not married	16.3	14.4	18.0
Federal Poverty Level			
<=100%	16.6	14.4	18.6
101-185%	12.3	9.9	14.7
>185%	11.9	9.8	13.9
Insurance at Time of Survey			
Medicaid	17.0	15.2	18.7
Private	10.7	8.5	12.7
Other	14.0	8.5	19.3
None	8.4	5.4	11.3
Mother's Race/Ethnicity			
White	11.9	9.7	14.0
American Indian	14.3	10.8	17.7
Hispanic	14.9	13.2	16.6
Black	~~23.4~~	10.9	35.9
Asian/ Pacific	~~20.9~~	9.2	32.6

NM PRAMS FINDINGS

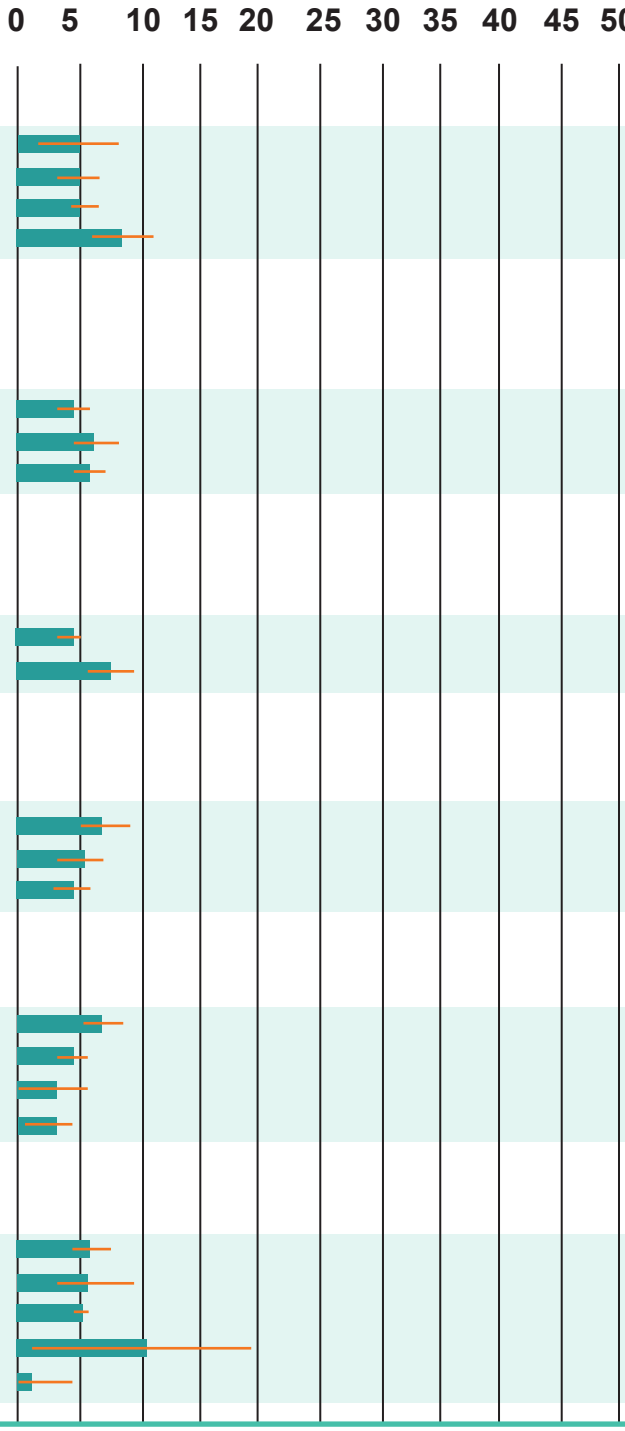
The PRAMS questionnaire asks if people received counseling and/or support for postpartum depression. Among all respondents, women ages 35 and older were more likely to have counseling or a support group for depression, compared to younger people, and uninsured people, were least likely to not have counseling or support for depression (3%). Medicaid recipients had higher rates (7%) of counseling or support compared to those with private (5%) or other insurance coverage (4%). Of the 14.1% of respondents that reported postpartum depression, 13.3% had postpartum support or counseling for depression.

Postpartum Depression and Support for Depression, 2016 - 2018



POSTPARTUM DEPRESSION COUNSELING OR SUPPORT

Percentage of population who received counseling or support for postpartum depression, 2016-2018



	%	LOWER	UPPER
Maternal Age			
<20 years	5.1	2.5	7.6
20-24 years	5.1	3.5	6.7
25-34 years	5.5	4.4	6.5
35 or more years	8.4	5.9	10.9
Maternal Education			
Less than high school	4.7	3.1	6.1
High school	6.2	4.5	7.9
More than high school	5.9	4.7	6.9
Marital Status			
Married	4.1	3.2	5.0
Not married	7.4	6.0	8.7
Federal Poverty Level			
<=100%	6.9	5.4	8.2
101-185%	5.2	3.6	6.8
>185%	4.8	3.5	6.1
Insurance at Time of Survey			
Medicaid	6.9	5.7	8.0
Private	4.8	3.4	6.1
Other	3.5	0.6	6.3
None	3.1	1.2	4.9
Mother's Ethnicity/Race			
White	5.9	4.3	7.4
American Indian	6.1	3.6	8.4
Hispanic	5.4	4.3	6.4
Black	~~10.4~~	1.5	19.4
Asian/ Pacific	~~1.6~~	0	4.6

UNEQUAL HEALTH CARE EXPERIENCE

BACKGROUND

Discrimination in healthcare and unequal treatment are documented contributors to low or insufficient preventive healthcare utilization in the United States. As many as 1 in 5 U.S. adults experience discrimination in a healthcare system, and the most common type of discrimination is based on patient race or ethnicity (Nong, 2020).

NM PRAMS FINDINGS

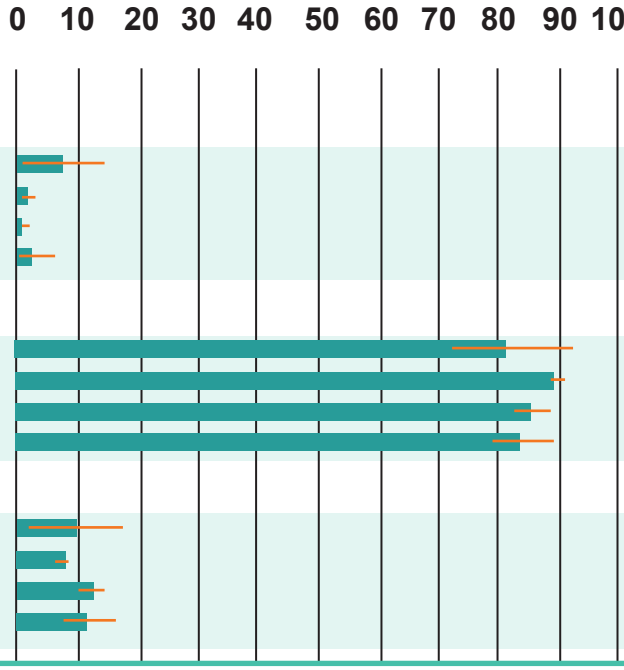
New Mexico PRAMS asks if in the 12 months prior to the survey people felt their healthcare experience was worse than that of people from different racial or ethnic identities, the same as others or better than that of others. Respondents may also indicate that they do not know or that they only encountered people of the same identity during their healthcare experiences.

While only 1.3% of privately insured people indicated they were treated worse than people of another population, 8% of those with Indian Health Services or Tribal 638 coverage said they were treated worse than others (the only statistically significant difference observed). A higher proportion of Medicaid recipients felt they were treated better than others, compared to those with other insurance types. By source of prenatal care services, those seen at federally qualified health centers (FQHC) felt they were treated worse than others compared to those receiving care in other clinical settings. People receiving care in hospital clinics reported a higher prevalence of better treatment compared to those with care in other locations.

SOURCES

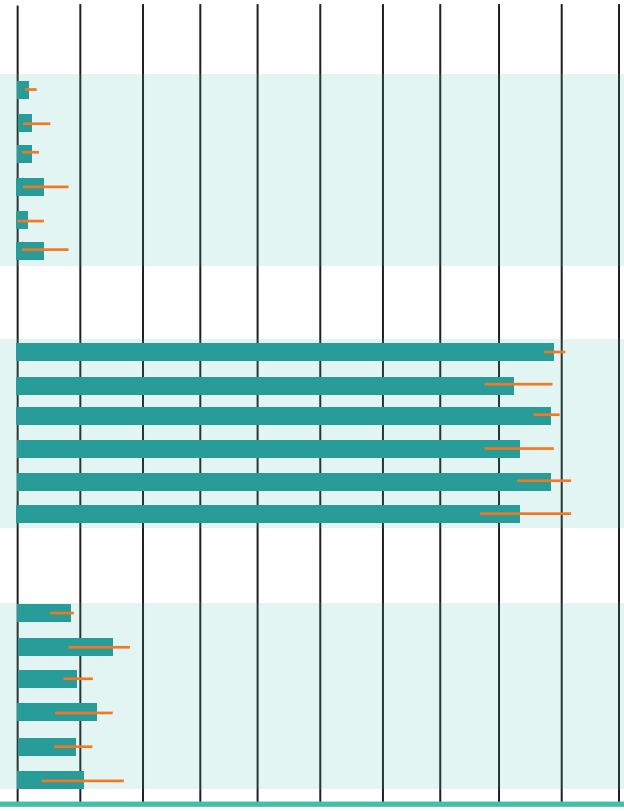
Nong P, Raj M, Creary M. Patient-Reported Experiences of Discrimination in the US Health Care System; JAMA; 2020.

Percentage of population's health care experience by insurance provider, 2016-2018



Insurance	%	LOWER	UPPER
WORSE THAN OTHERS			
IHS/638	7.9	1.1	14.7
Medicaid	2.8	1.9	3.6
Private	1.3	0.6	2.1
Other	3.3	0.3	6.3
SAME AS OTHERS			
IHS/638	82.4	72.7	92.0
Medicaid	89.6	88.1	91.1
Private	86.1	83.5	88.6
Other	84.9	79.9	89.9
BETTER THAN OTHERS			
IHS/638	~~9.6~~	2.1	17.0
Medicaid	7.5	6.2	8.8
Private	12.4	10.0	14.9
Other	11.7	7.5	16.0

Percentage of population's health care experience by source of prenatal care, 2016-2018



Source of Prenatal Care	%	LOWER	UPPER
WORSE THAN OTHERS			
Private	2.4	1.4	3.4
Hospital Clinic	2.7	0.3	5.1
Health Department	2.6	1.6	3.7
FQHC	4.8	1.3	8.3
IHS/638	2.0	0.0	4.2
Other	4.4	0.5	8.2
SAME AS OTHERS			
Private	89.3	87.3	91.2
Hospital Clinic	83.9	78.2	89.6
Health Department	88.1	86.0	90.2
FQHC	84.0	78.2	89.7
IHS/638	88.4	84.7	92.1
Other	84.8	77.5	92.1
BETTER THAN OTHERS			
Private	8.2	6.5	9.9
Hospital Clinic	13.3	8.0	18.6
Health Department	9.1	7.3	10.9
FQHC	11.1	6.2	15.9
IHS/638	9.4	6.3	12.6
Other	10.7	4.2	17.2

INFANT CARE AND WELLNESS

Infant health care begins with a healthy full-term pregnancy, including the mother receiving regular prenatal checkups and avoiding unhealthy behaviors. Healthcare providers should support the mother with breastfeeding after the delivery of the infant. The CDC has noted this is "the healthiest option for both mothers and infants." And further, infants that are breastfed have reduced risks for respiratory infections, asthma, sudden infant death syndrome (SIDS), and obesity (CDC, 2020). Healthy infants also require a safe home environment devoid of second-hand smoke and with a safe sleep environment. Second-hand smoke is associated with respiratory illness, SIDS, and ear infections. A safe sleeping environment requires parents to place infants on their back, place infants to sleep on their own in a crib, bassinet or cradle, sleep close to but not on the same surface as parents, with a firm mattress, without any soft objects (pillows, toys, etc.) or loose bedding (sheets, mattress bumpers) in the sleeping area. Safe sleep environments can reduce the outcome of sleep-related infant deaths and other sudden unexpected infant deaths (CDC, 2020).

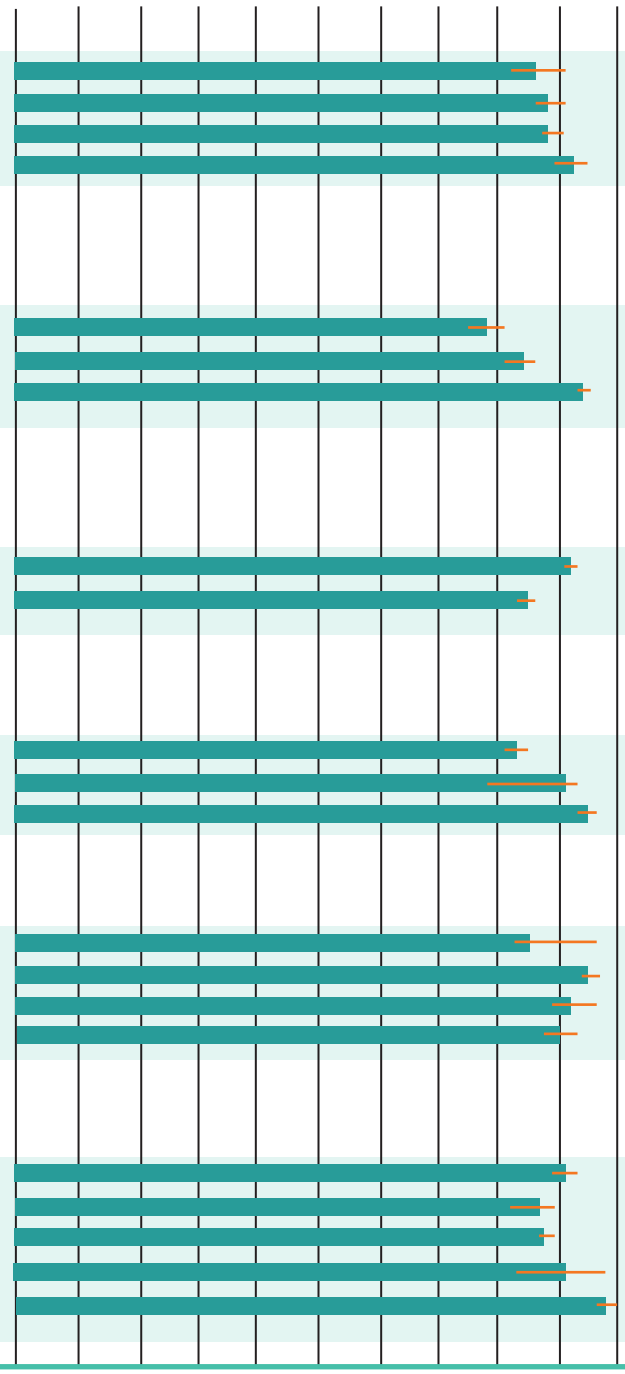
- Breastfeeding
- Infant sleep position
- Infant wellness and sick visits

NM PRAMS FINDINGS

Most women in New Mexico begin breastfeeding or pumping milk for their infants, and the prevalence of any breastfeeding has remained close to or exceeded 90% from 2012-2018. While Asian and Pacific Islander people were the most likely to breastfeed in 2016-2018 with nearly 100% initiation, there were no additional statistically significant prevalence differences by maternal race or ethnicity. Over ninety percent of both non-Hispanic white and Black women started breastfeeding, and over 85% of American Indian and Hispanic women did so.

BREASTFEEDING OR PUMPING MILK

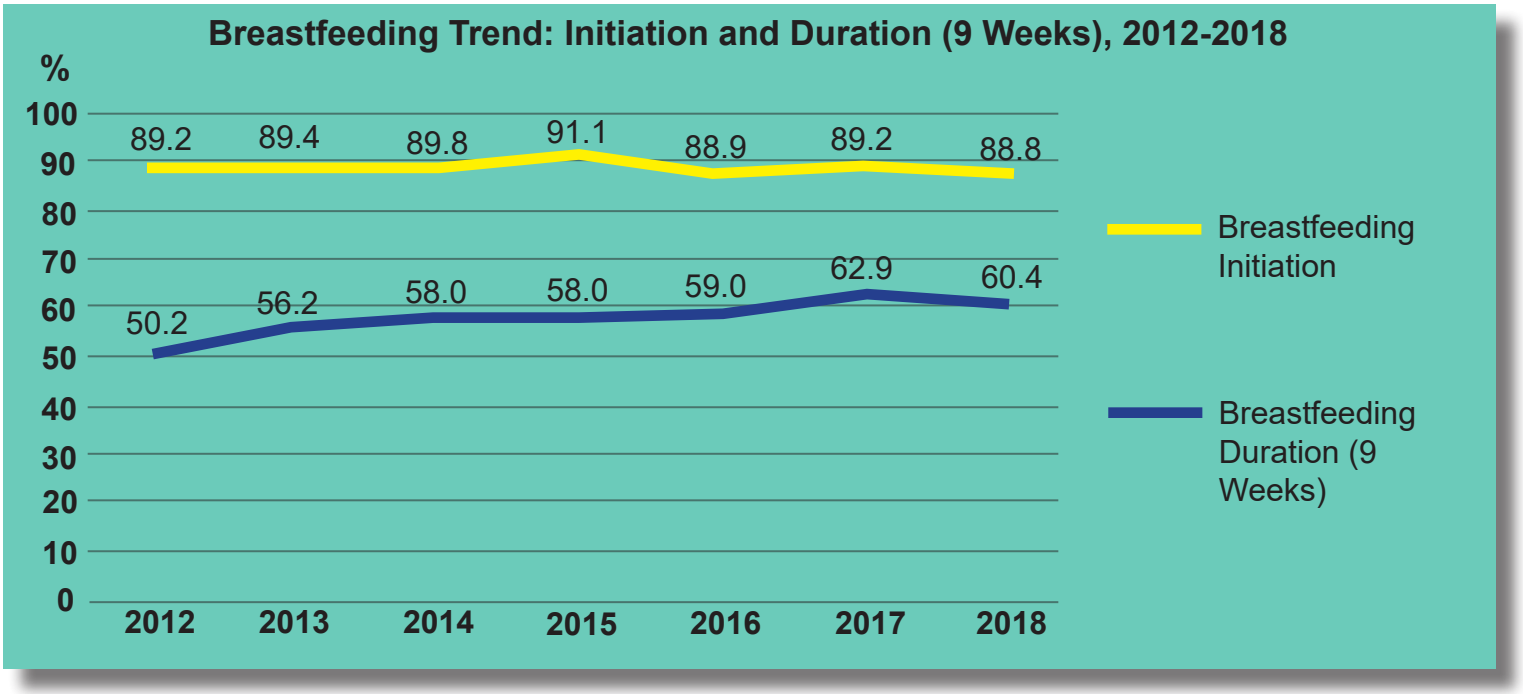
Percentage of population that started breastfeeding or pumping milk, 2016-2018



	%	LOWER	UPPER
Maternal Age			
<20 years	86.7	82.7	90.6
20-24 years	88.5	86.2	90.6
25-34 years	88.9	87.4	90.2
35 or more years	91.8	89.3	94.3
Maternal Education			
Less than high school	78.5	75.6	81.4
High school	84.2	81.6	86.7
More than high school	94.5	93.3	95.5
Marital Status			
Married	92.7	91.4	93.9
Not married	85.2	83.4	86.8
Federal Poverty Level			
<=100%	83.8	81.8	85.8
101-185%	91.2	89.1	93.1
>185%	95.5	94.2	96.7
Insurance at Time of Survey			
Medicaid	84.9	83.2	96.5
Private	95.9	94.6	97.1
Other	92.3	88.2	96.4
None	90.4	87.3	93.4
Mother's Race/Ethnicity			
White	91.7	89.8	93.4
American Indian	86.1	82.8	89.3
Hispanic	87.7	86.1	89.1
Black	91.2	83.7	98.7
Asian/ Pacific	98.7	96.2	100

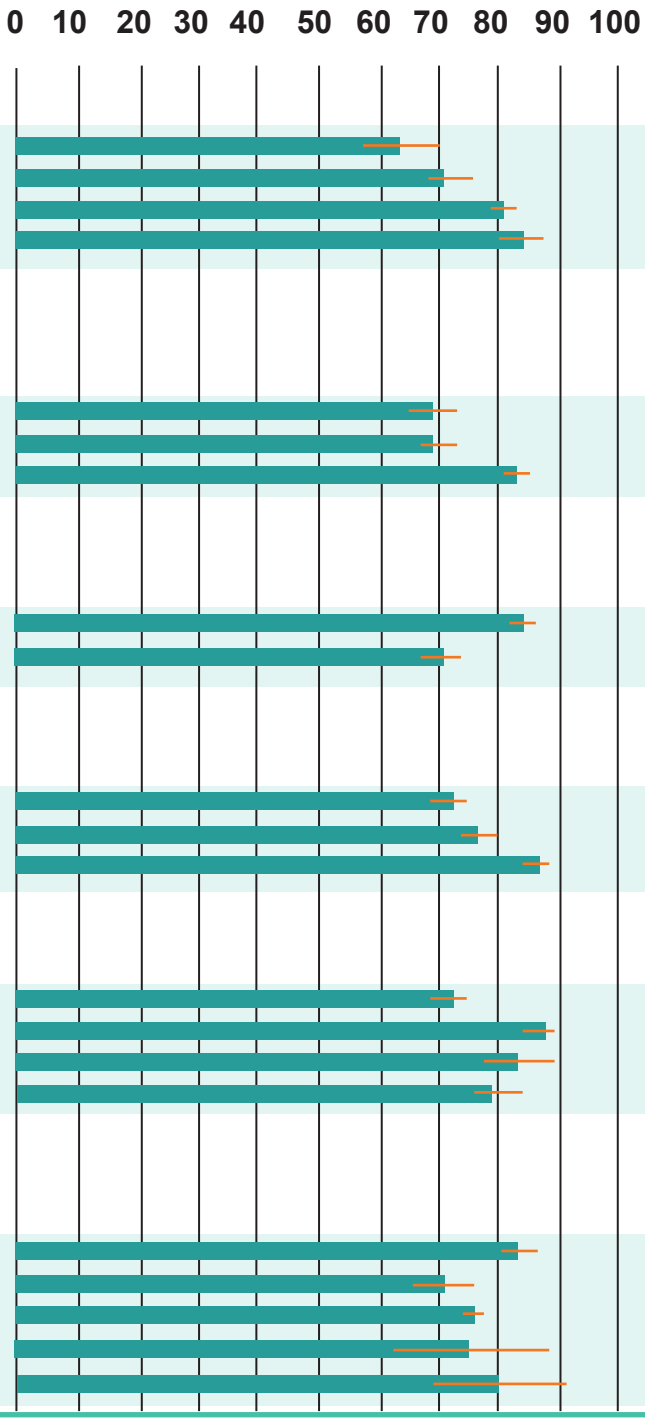
NM PRAMS FINDINGS

Among people who initiated breastfeeding (2016-2018), 78% continued breastfeeding at least nine weeks. Non-Hispanic white women were significantly more likely to continue breastfeeding compared to Hispanic, American Indian women and marginally more likely compared to Black and Asian/PI women. Poverty was a notable predictor of breastfeeding continuation: eighty-seven percent with incomes greater than 185% of federal poverty continued to breastfeed compared to 72% of those with incomes at or below 100% of federal poverty. Among all NM births (irrespective of breastfeeding initiation) 61% of infants were breastfed at least nine weeks. This measure of breastfeeding among the birth population is known as breastfeeding 'duration'.



BREASTFEEDING CONTINUATION MORE THAN 2 MONTHS

Percentage of population that continued to breastfeed more than 2 months, 2016-2018



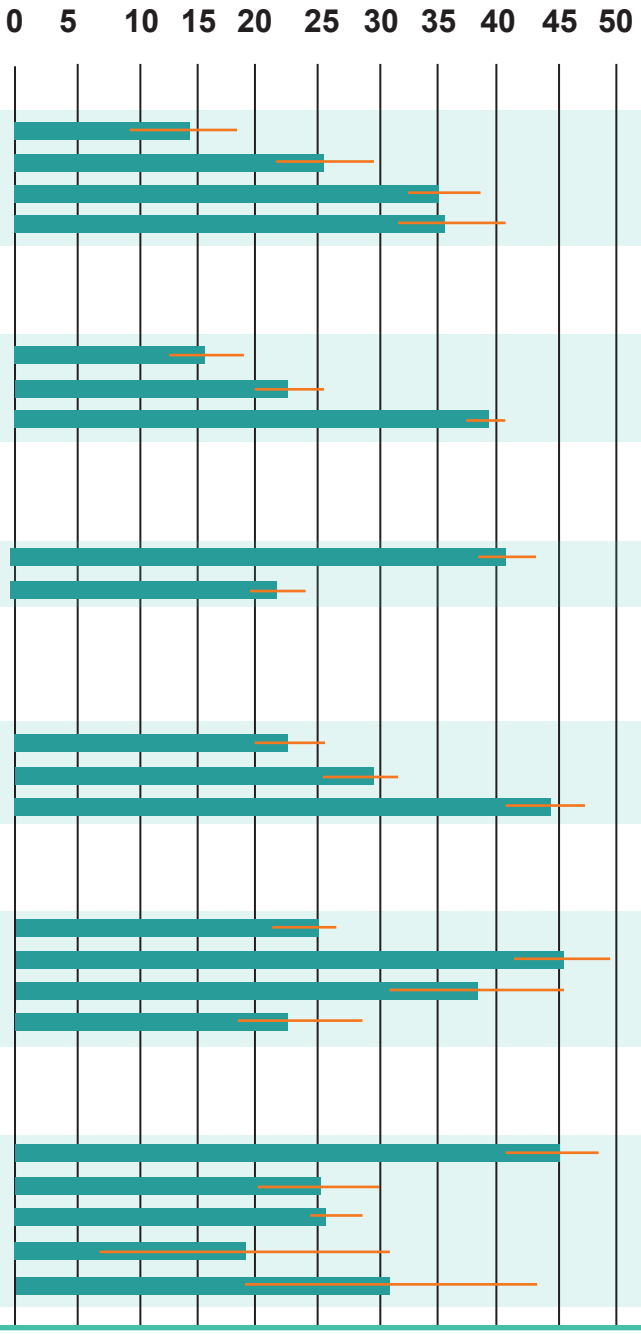
	%	LOWER	UPPER
Maternal Age			
<20 years	63.9	57.7	70.0
20-24 years	71.6	68.1	75.1
25-34 years	81.3	79.3	83.2
35 or more years	84.3	80.7	87.8
Maternal Education			
Less than high school	69.5	65.8	73.2
High school	69.8	66.4	73.2
More than high school	83.5	81.5	85.3
Marital Status			
Married	84.4	82.5	86.2
Not married	71.1	68.7	73.5
Federal Poverty Level			
<=100%	72.2	69.3	74.9
101-185%	77.0	73.7	80.2
>185%	86.6	84.3	88.7
Insurance at Time of Survey			
Medicaid	72.2	69.9	74.4
Private	87.1	84.7	89.4
Other	84.0	78.0	89.8
None	79.9	75.2	84.6
Mother's Race/Ethnicity			
White	84.0	81.4	86.4
American Indian	71.6	66.7	76.4
Hispanic	76.2	74.0	78.3
Black	~~75.5~~	62.6	88.3
Asian/ Pacific	~~80.3~~	69.1	91.3

NM PRAMS FINDINGS

Married women were about twice as likely to feed their infants exclusively with breastmilk as unmarried, and the prevalence among those with more than a high school education was almost three times as high than those with less than a high school education. Similarly, the proportion of privately insured people with exclusive breastfeeding was twice as high as for those without any insurance coverage. This indicates that the most economically advantaged and educated people in NM can sustain optimal breastfeeding at least in the immediate postpartum period, but others cannot.

BREASTFEEDING WITHOUT ANY OTHER LIQUIDS (AT TIME OF SURVEY)

Percentage of population that had only breastfed and not introduced other liquids, 2016-2018



	%	LOWER	UPPER
Maternal Age			
<20 years	14.1	9.5	18.6
20-24 years	26.4	22.8	29.8
25-34 years	35.8	33.4	38.1
35 or more years	36.7	32.0	41.2
Maternal Education			
Less than high school	16.1	13.1	19.0
High school	23.4	20.2	26.5
More than high school	39.6	37.1	41.9
Marital Status			
Married	41.1	38.6	43.5
Not married	22.1	19.8	24.3
Federal Poverty Level			
<=100%	23.4	20.7	26.0
101-185%	29.4	25.9	32.8
>185%	44.6	41.4	47.7
Insurance at Time of Survey			
Medicaid	25.0	22.8	27.2
Private	46.2	42.8	49.4
Other	38.9	31.1	46.5
None	23.2	18.0	28.3
Mother's Race/Ethnicity			
White	45.3	41.9	48.7
American Indian	25.3	20.6	30.0
Hispanic	26.7	24.5	28.9
Black	~~19.9~~	7.4	32.3
Asian/ Pacific	~~31.7~~	19.5	43.8

BACKGROUND

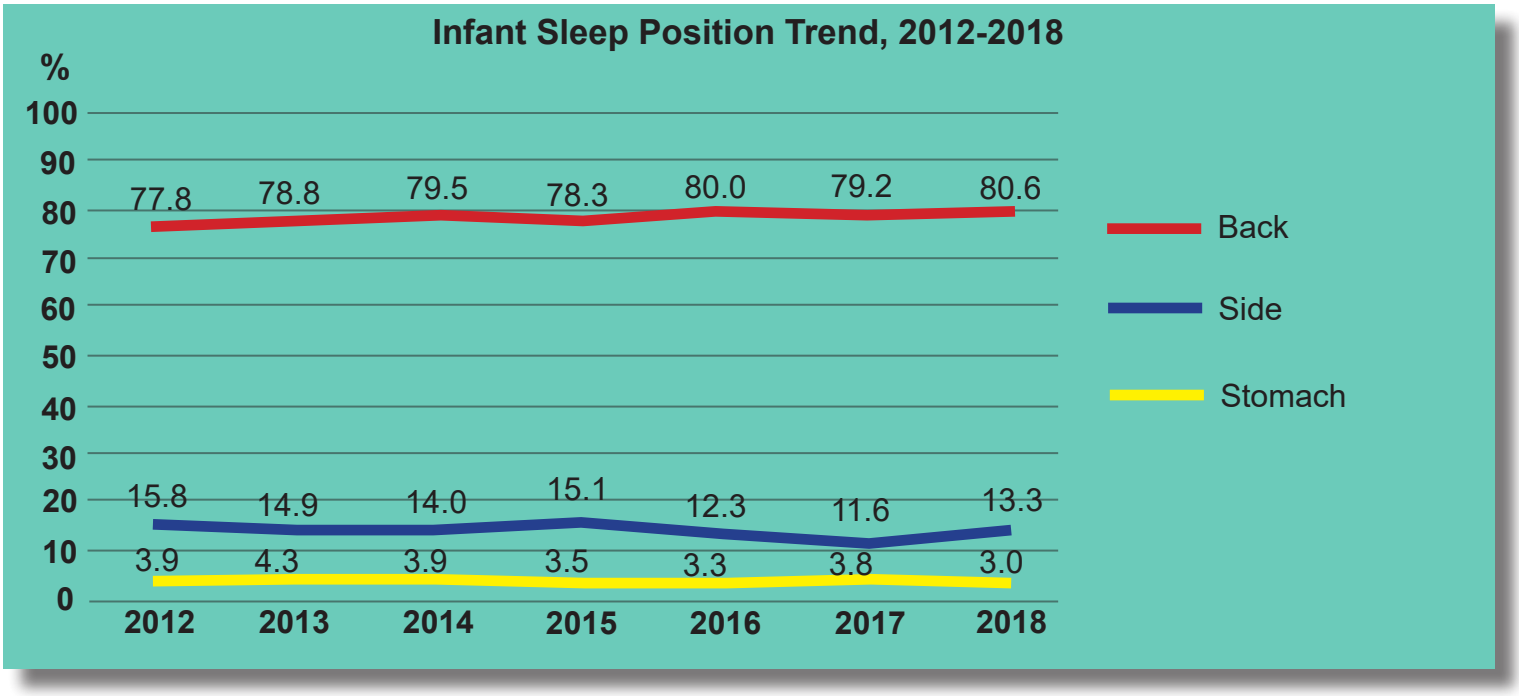
The American Academy of Pediatrics recommends placing infants to sleep in the supine (back) position, alone on a sleep surface and on a firm mattress, without blankets, loose sheets, pillows or toys for naps and at night. They also recommend breastfeeding and avoiding cigarette smoking during pregnancy and postpartum. Supine sleep position is associated with a reduced risk for Sudden Unexpected Infant Deaths (SUIDs), and bed sharing (also called co-sleeping) may increase the risk for SUID.

NM PRAMS FINDINGS

Women who were least likely to place their infant in a back sleeping position were under 24 years, unmarried, earning 185% or less of FPL, had a high school education or less, insured by Medicaid or uninsured, and Black or Hispanic. Although most people do practice supine sleep, there has been little improvement since 2012.

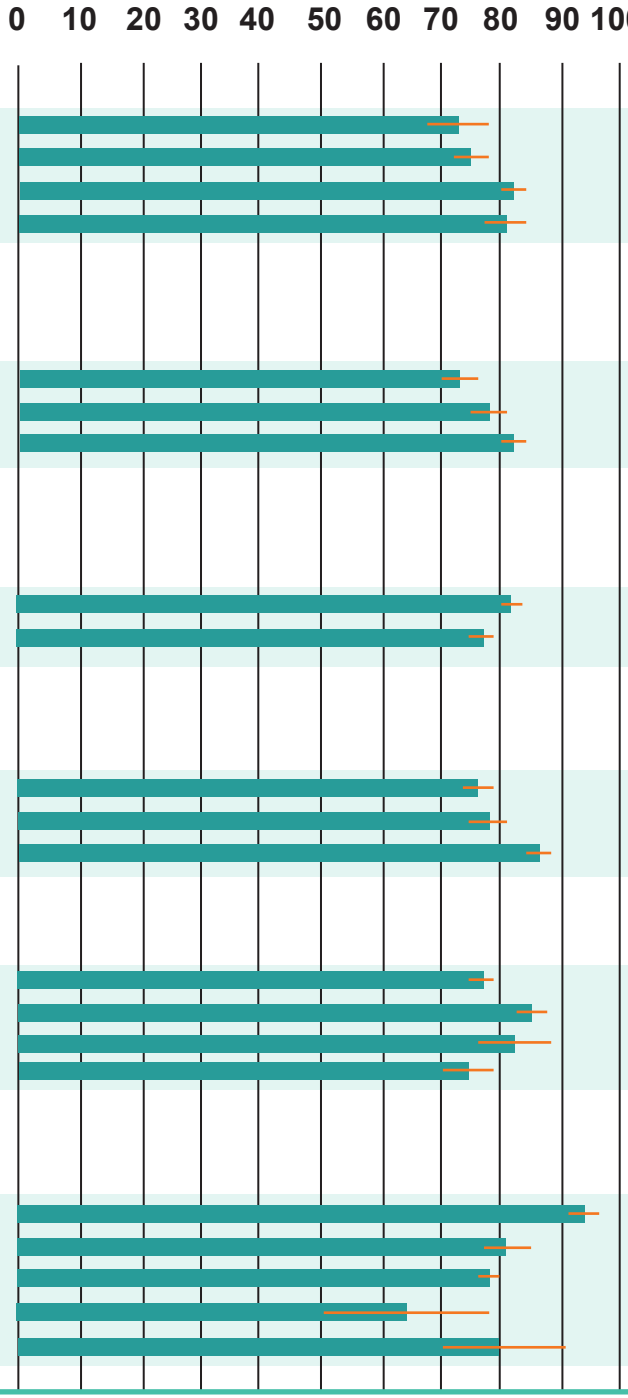
SOURCES

American Academy of Pediatrics. (2021). Safe Sleep. Retrieved from https://services.aap.org/en/patient-care/safe-sleep/



INFANT BACK TO SLEEP (SUPINE) POSITION

Percentage of population usually placing baby to sleep on their back, 2016-2018



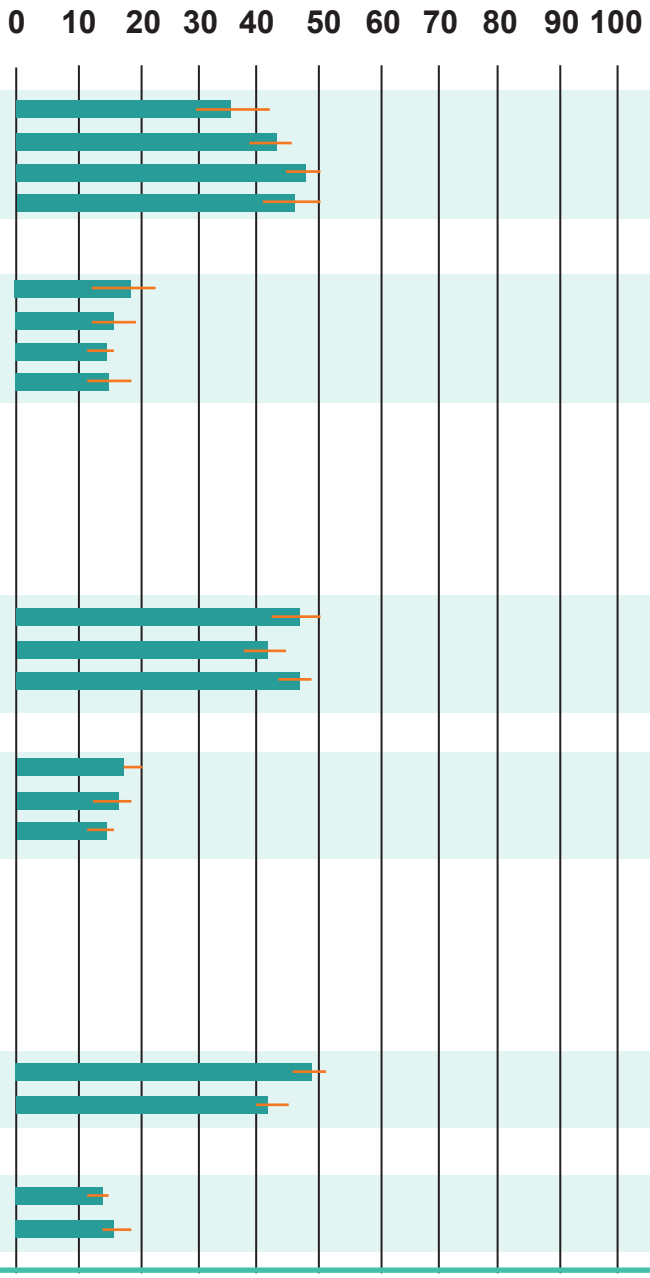
	%	LOWER	UPPER
Maternal Age			
<20 years	73.7	68.4	78.8
20-24 years	75.6	72.4	78.7
25-34 years	82.3	80.5	84.1
35 or more years	81.4	77.8	84.9
Maternal Education			
Less than high school	73.7	70.5	76.8
High school	78.3	75.4	81.1
More than high school	82.6	80.7	84.4
Marital Status			
Married	82.0	80.0	83.8
Not married	77.8	75.7	79.8
Federal Poverty Level			
<=100%	76.7	74.3	79.1
101-185%	78.9	75.9	81.8
>185%	86.7	84.5	88.8
Insurance at Time of Survey			
Medicaid	77.8	75.8	79.7
Private	85.2	82.8	87.6
Other	82.1	76.1	88.0
None	75.1	70.4	79.8
Mother's Race/Ethnicity			
White	84.0	81.5	86.3
American Indian	80.9	77.0	84.7
Hispanic	78.1	76.1	80.0
Black	~~64.5~~	50.6	78.3
Asian/ Pacific	~~80.7~~	70.5	90.9

NM PRAMS FINDINGS

Placing infants to sleep on a separate but close surface next to parents is recommended to keep them safe at least until six months of age. In NM 36% of caregivers under age 20 reported placing their infants in a separate sleep space compared to 47% of those over the age of 24. Privately insured people were more likely to use a separate sleep surface, and just 35% of American Indian people reported a separate sleep area compared to 53% of non-Hispanic white people.

BABY ALWAYS OR NEVER SLEEPS ALONE

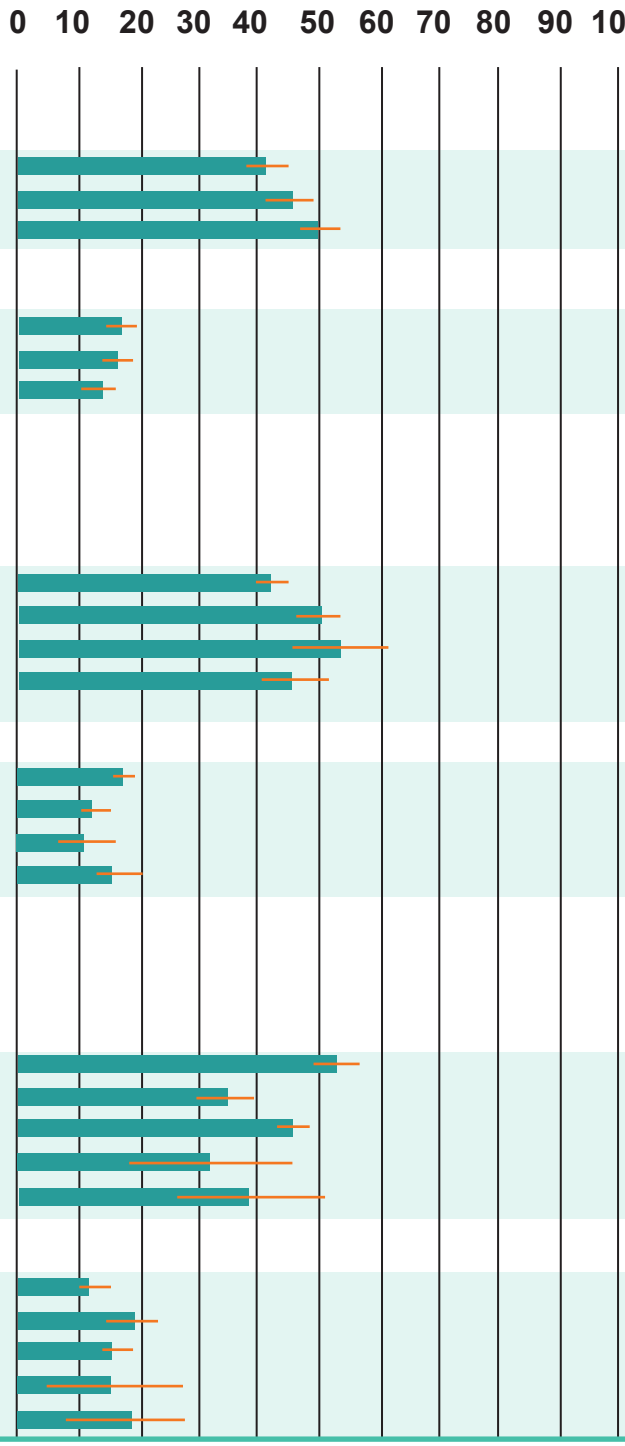
Percentage of population whose baby always or never sleeps alone, 2016-2018



	%	LOWER	UPPER
Maternal Age			
Always			
<20 years	36.6	30.7	42.3
20-24 years	43.2	39.5	46.8
25-34 years	48.2	45.8	50.5
35 or more years	46.2	41.6	50.7
Never			
<20 years	18.1	13.5	22.5
20-24 years	16.7	13.9	19.4
25-34 years	14.4	12.7	16.1
35 or more years	15.3	12.0	18.4
Maternal Education			
Always			
Less than high school	47.1	43.5	50.6
High school	42.0	38.6	45.4
More than high school	47.1	44.7	49.5
Never			
Less than high school	17.4	17.7	20.1
High school	16.3	13.7	18.8
More than high school	14.2	12.4	15.8
Marital Status			
Always			
Married	49.0	46.5	51.4
Not married	42.6	40.1	45.0
Never			
Married	14.1	12.3	15.7
Not married	16.7	14.8	18.5

BABY ALWAYS OR NEVER SLEEPS ALONE

Percentage of population whose baby always or never sleeps alone, 2016-2018



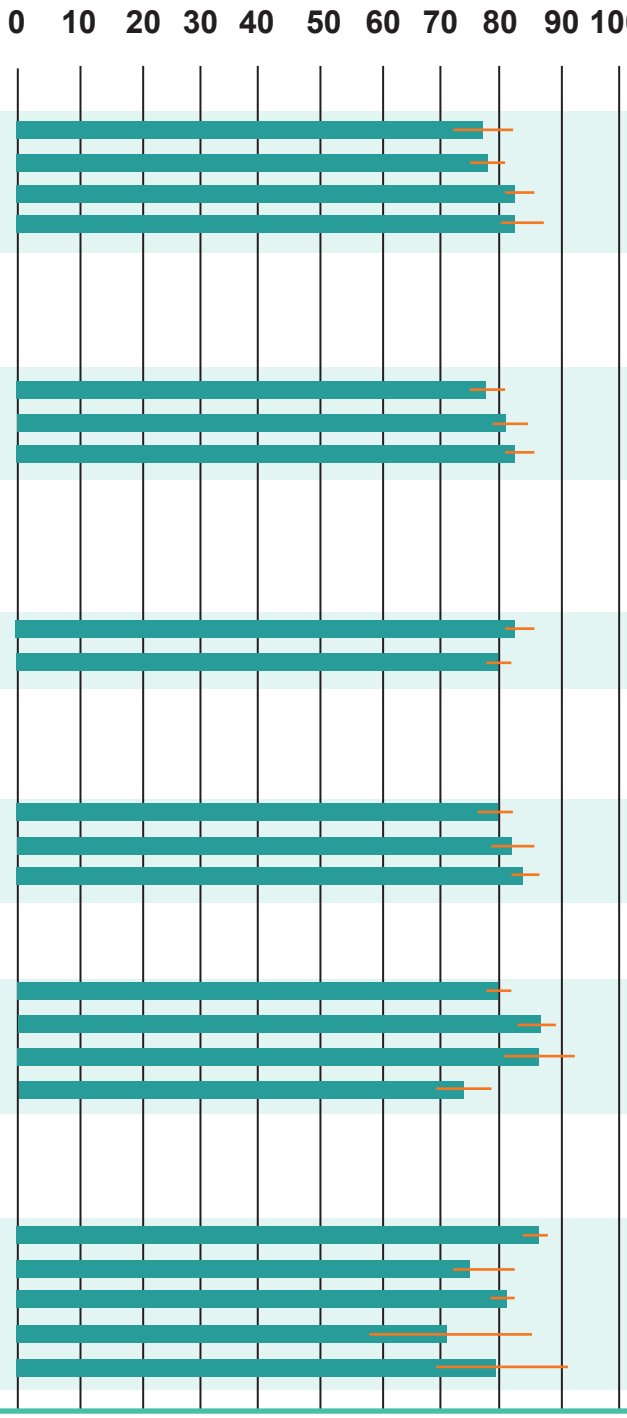
	%	LOWER	UPPER
Federal Poverty Level			
Always			
<=100%	42.6	39.7	45.3
101-185%	46.1	42.5	49.7
>185%	49.9	46.8	53.0
Never			
<=100%	16.9	14.7	19.0
101-185%	15.8	13.2	18.4
>185%	12.7	10.6	14.8
Insurance at Time of Survey			
Always			
Medicaid	42.7	40.3	45.0
Private	50.2	46.9	53.4
Other	53.5	45.8	61.3
None	46.5	40.8	52.0
Never			
Medicaid	17.0	15.2	18.8
Private	12.4	10.2	14.5
Other	11.1	6.0	16.1
None	16.4	12.4	20.3
Mother's Race/Ethnicity			
Always			
White	52.5	49.2	55.7
American Indian	34.3	29.6	39.0
Hispanic	45.9	43.5	48.2
Black	~~31.8~~	18.3	45.2
Asian/ Pacific	~~38.4~~	25.7	51.0
Never			
White	12.4	10.1	14.5
American Indian	18.7	14.9	22.5
Hispanic	16.1	14.3	17.8
Black	15.9	4.5	27.2
Asian/ Pacific	~~18.2~~	7.8	28.5

NM PRAMS FINDINGS

Women under 24 years of age, those with lower education levels, living at or below 100% of FPL, or insured by Medicaid or uninsured, or who were women of color were less likely to usually place their infant sleep in a crib to sleep. Privately insured, older women and non-Hispanic white women were more likely to report using a crib for their infant.

BABY USUALLY SLEEPS IN CRIB, BASSINET OR PACK AND PLAY

Percentage of population whose infant usually sleeps in crib, a bassinet or pack and play, 2016-2018



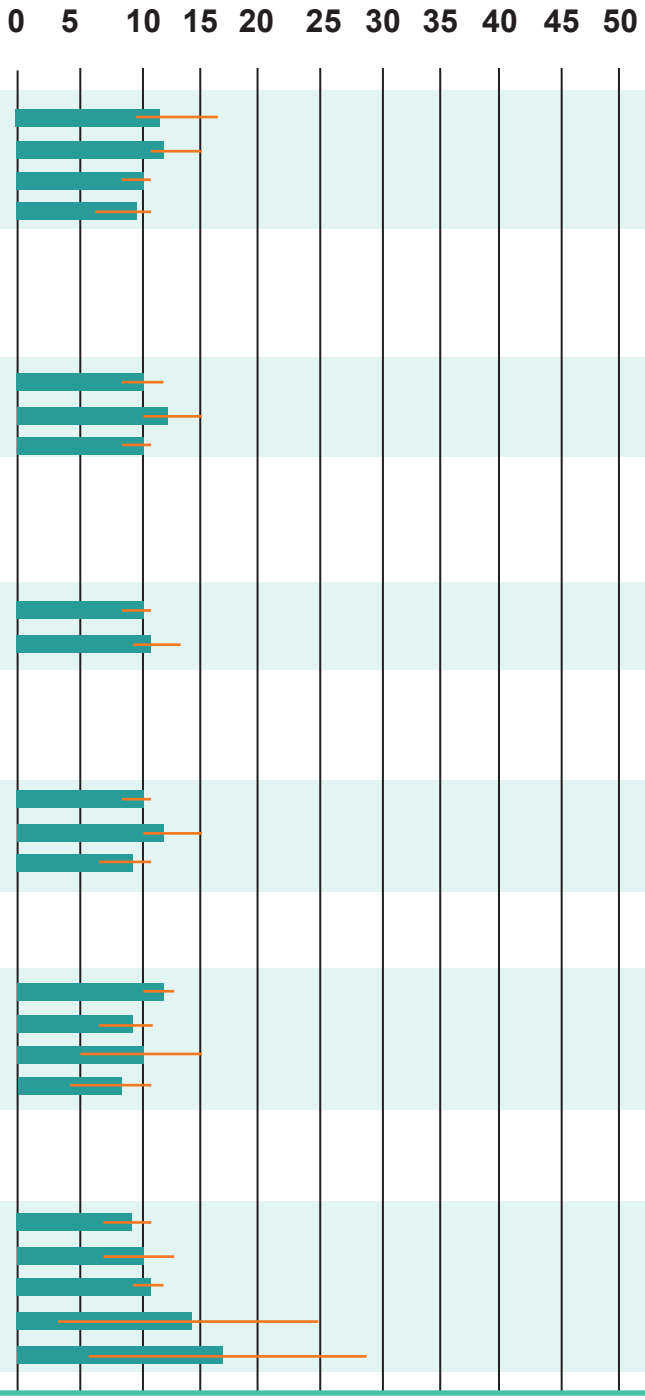
	%	LOWER	UPPER
Maternal Age			
<20 years	77.1	72.1	82.0
20-24 years	78.3	75.1	81.3
25-34 years	83.6	81.8	85.3
35 or more years	83.9	80.6	87.2
Maternal Education			
Less than high school	78.1	75.1	81.0
High school	81.8	79.1	84.4
More than high school	83.2	81.4	85.0
Marital Status			
Married	83.4	81.5	85.2
Not married	80.3	78.3	82.3
Federal Poverty Level			
<=100%	80.0	77.7	82.2
101-185%	82.3	79.4	85.0
>185%	84.6	82.3	86.9
Insurance at Time of Survey			
Medicaid	80.6	78.6	82.4
Private	86.5	84.2	88.7
Other	86.8	81.3	92.2
None	74.8	69.9	79.6
Mother's Race/Ethnicity			
White	86.2	83.9	88.5
American Indian	78.1	73.9	82.1
Hispanic	80.9	79.0	82.7
Black	~~71.7~~	57.8	85.5
Asian/ Pacific	~~80.7~~	69.8	91.5

NM PRAMS FINDINGS

Soft objects in the sleep space are associated with risks for accidental suffocation and strangulation in bed (ASSB). People more likely to have an infant sleeping with soft objects were aged <24 years, had achieved a high school education, had a household income under 185% of FPL, or were insured by Medicaid during pregnancy and postpartum.

BABY USUALLY SLEEPS WITH TOYS, CUSHIONS OR PILLOWS

Percentage of population whose infant usually sleeps with toys, cushions, or pillows, 2016-2018



	%	LOWER	UPPER
Maternal Age			
<20 years	13.3	9.2	17.4
20-24 years	13.2	10.7	15.6
25-34 years	10.0	8.5	11.4
35 or more years	8.8	5.9	11.5
Maternal Education			
Less than high school	10.6	8.3	12.8
High school	13.0	10.7	15.3
More than high school	10.0	8.4	11.4
Marital Status			
Married	10.2	8.6	11.7
Not married	11.6	9.9	13.1
Federal Poverty Level			
<=100%	10.2	8.5	11.9
101-185%	12.7	10.1	15.1
>185%	9.3	7.4	11.1
Insurance at Time of Survey			
Medicaid	12.3	10.7	13.8
Private	9.2	7.2	11.2
Other	10.8	5.9	15.6
None	8.0	4.9	11.0
Mother's Race/Ethnicity			
White	9.2	7.3	11.1
American Indian	10.8	7.6	13.9
Hispanic	11.2	9.6	12.7
Black	~~14.6~~	3.9	25.3
Asian/ Pacific	~~17.6~~	6.8	28.3

INFANT SLEEP SACK

NM PRAMS FINDINGS

Wearable sleep sacks or wearable blankets that cannot be pulled over the infant's head are recommended for safe sleep. People more likely to place their infant in a sleep sack or wearable blanket were 25 years or older, had more than a high school education, were married, had household incomes above 185% of FPL, had private insurance or were non-Hispanic white. The NMDOH and other state agencies with community partners work to improve awareness and education on safe sleep guidelines to prevent sleep-related deaths. More information on safe sleep guidelines and resources can be found at:

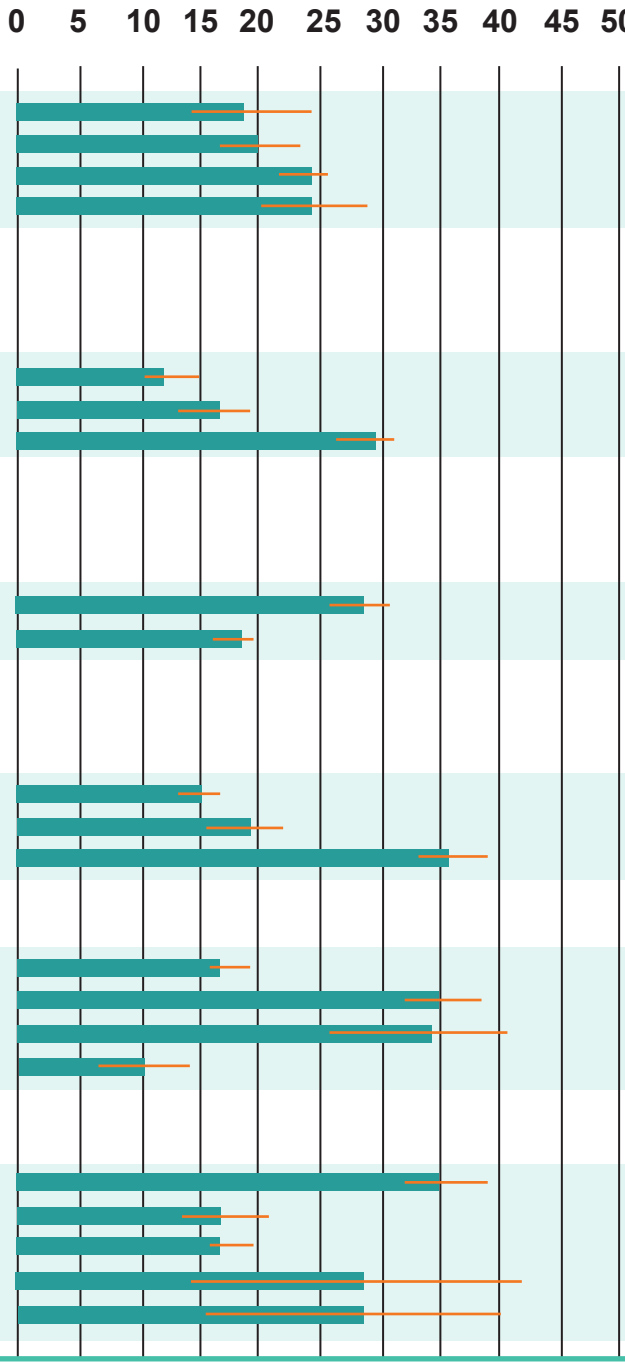
https://safetosleep.nichd.nih.gov/

nmmaternalchildhealth.org/

https://www.aap.org/en/patient-care/safesleep/

INFANT USUALLY SLEEPS IN A SLEEP SACK

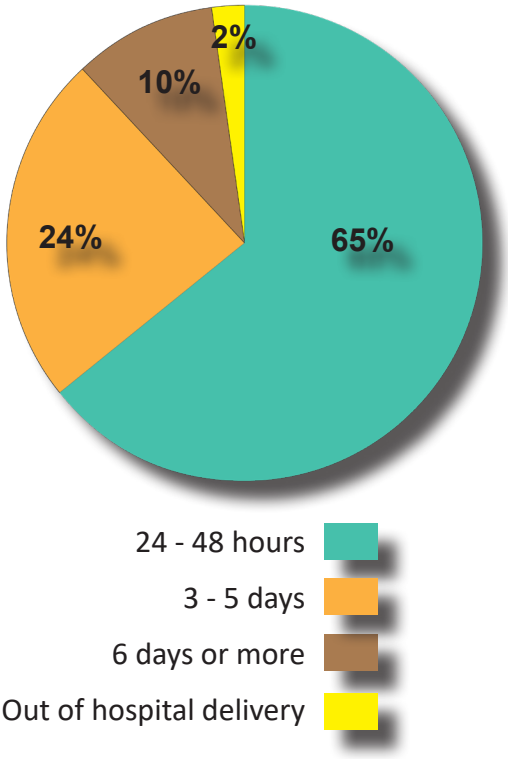
Percentage of population whose infant usually sleeps in a sleep sack, 2016-2018



	%	LOWER	UPPER
Maternal Age			
<20 years	19.6	14.8	24.3
20-24 years	20.0	17.0	23.0
25-34 years	24.9	22.8	26.8
35 or more years	24.4	20.5	28.2
Maternal Education			
Less than high school	12.8	10.4	15.2
High school	17.3	14.6	19.9
More than high school	29.2	27.0	31.3
Marital Status			
Married	28.6	26.3	30.7
Not married	17.9	16.0	19.8
Federal Poverty Level			
<=100%	15.4	13.2	17.4
101-185%	19.5	16.6	22.4
>185%	36.4	33.4	39.3
Insurance at Time of Survey			
Medicaid	17.9	16.1	19.7
Private	35.4	32.2	38.4
Other	34.1	26.7	41.5
None	10.9	7.1	14.5
Mother's Race/Ethnicity			
White	35.9	32.8	39.0
American Indian	17.3	13.2	20.9
Hispanic	17.9	16.1	19.7
Black	~~28.5~~	14.6	42.2
Asian/ Pacific	~~28.4~~	16.6	40.2

INFANT HOSPITAL STAY

Length of Hospital Stay for Infant, 2016 - 2018

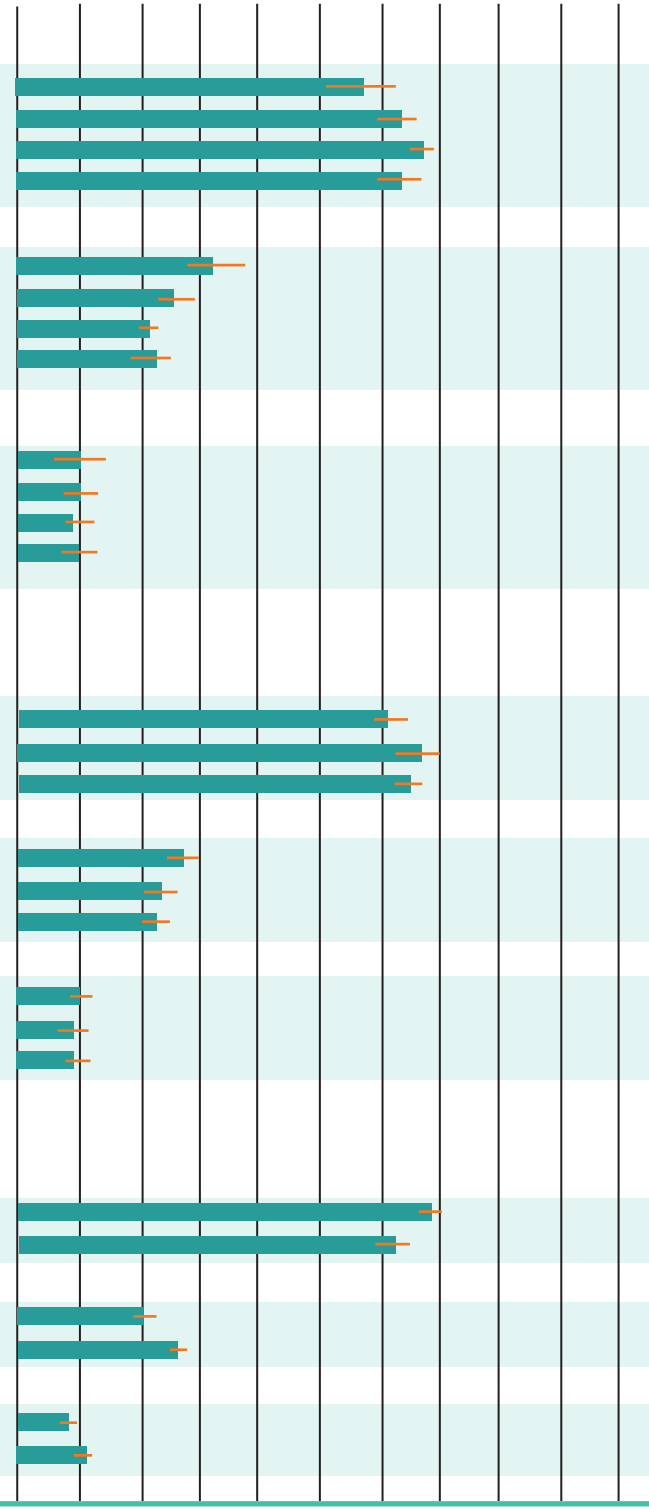


NM PRAMS FINDINGS

Among people giving live birth 2016-2018, 65% had an infant who stayed in the hospital for 24 hours to 2 days. Twenty-four percent (24%) of people had a hospital stay for their infant of 3-5 days, and 10% had an infant in the hospital six days or more. Just under 2% had a delivery outside the hospital.

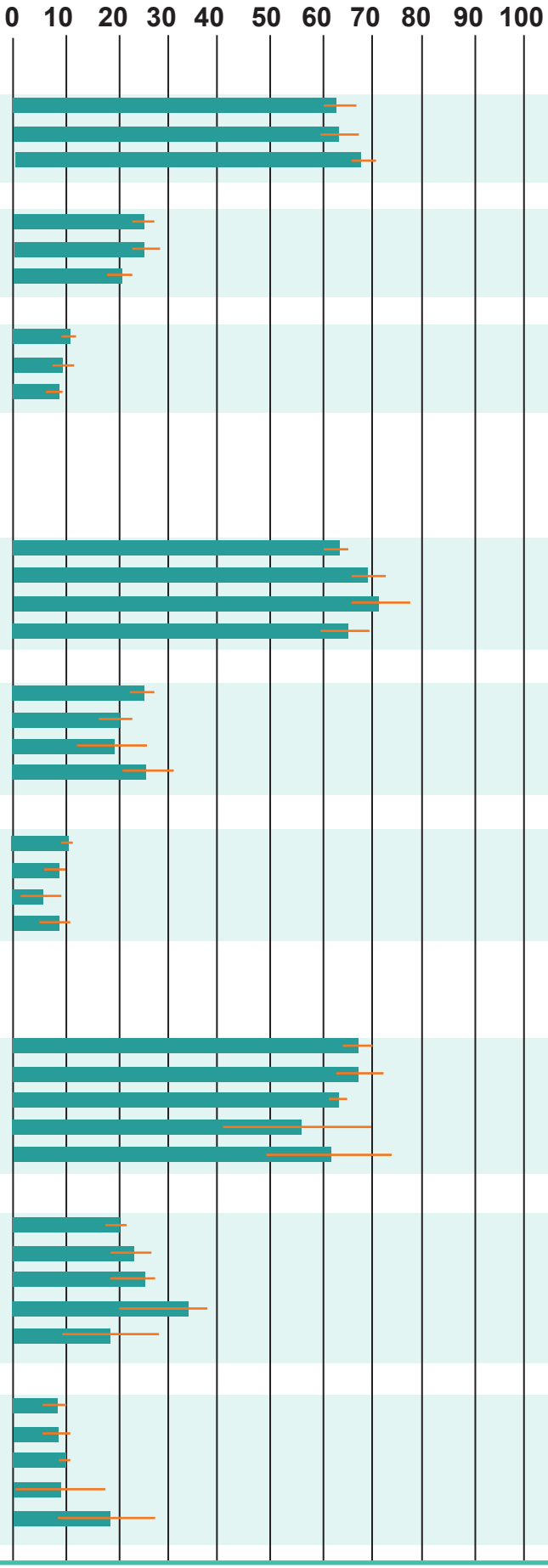
LENGTH OF INFANT'S HOSPITAL STAY AFTER DELIVERY

Duration of infant hospital stay after delivery, 2016-2018



	%	LOWER	UPPER
Maternal Age 24hours-2days			
<20 years	56.6	50.6	62.5
20-24 years	63.0	59.4	66.5
25-34 years	67.5	65.3	69.7
35 or more years	63.5	59.1	67.8
3-5 days			
<20 years	33.0	27.3	38.6
20-24 years	26.0	22.7	29.2
25-34 years	21.5	19.6	23.4
35 or more years	22.2	18.4	25.9
6+ days			
<20 years	10.0	6.4	13.6
20-24 years	10.0	7.7	12.1
25-34 years	9.4	8.0	10.8
35 or more years	10.0	7.1	12.7
Maternal Education 24hours-2days			
Less than high school	61.7	58.2	65.2
High school	67.0	63.8	70.2
More than high school	65.3	62.9	67.5
3-5 days			
Less than high school	27.4	24.2	30.6
High school	23.2	20.3	26.0
More than high school	22.5	20.4	24.5
6+ days			
Less than high school	10.3	8.0	12.4
High school	9.2	7.1	11.1
More than high school	9.8	8.3	11.2
Marital Status 24hours-2days			
Married	68.0	65.7	70.2
Not married	62.0	59.6	64.4
3-5 days			
Married	20.8	18.7	22.7
Not married	26.4	24.2	28.6
6+ days			
Married	8.5	7.1	9.8
Not married	11.0	9.4	12.5

LENGTH OF INFANT'S HOSPITAL STAY AFTER DELIVERY



	%	LOWER	UPPER
Federal Poverty Level			
24hours-2days			
<=100%	63.3	60.5	66.0
101-185%	63.2	59.6	66.7
>185%	68.7	65.8	71.5
3-5 days			
<=100%	25.0	22.5	27.4
101-185%	25.2	22.0	28.4
>185%	20.2	17.7	22.7
6+ days			
<=100%	11.0	9.2	12.8
101-185%	9.3	7.1	11.4
>185%	8.3	6.5	9.9
Insurance at Time of Survey			
24hours-2days			
Medicaid	62.7	60.4	64.9
Private	69.1	66.0	72.1
Other	71.8	64.8	78.7
None	64.6	59.2	69.9
3-5 days			
Medicaid	25.0	22.9	27.0
Private	20.0	17.3	22.6
Other	19.4	13.1	25.7
None	25.9	21.0	30.8
6+ days			
Medicaid	11.2	9.7	12.7
Private	8.2	6.3	10.0
Other	6.1	2.7	9.3
None	8.6	5.3	11.7
Mother's Race/Ethnicity			
24hours-2days			
White	67.3	64.1	70.3
American Indian	67.8	63.1	72.3
Hispanic	63.9	61.6	66.1
Black	56.1	41.5	70.5
Asian/ Pacific	62.1	49.8	74.4
3-5 days			
White	20.2	17.5	22.8
American Indian	22.5	18.3	26.6
Hispanic	25.2	23.1	27.2
Black	34.6	20.6	48.5
Asian/ Pacific	18.7	9.1	28.1
6+ days			
White	8.6	6.7	10.5
American Indian	8.8	6.0	11.5
Hispanic	10.2	8.7	11.5
Black	~~9.3~~	1.4	17.1
Asian/ Pacific	~~18.0~~	8.3	27.6

Please check the box next to your answer or follow the directions included with the question. You may be asked to skip some questions that do not apply to you.

BEFORE PREGNANCY

The first questions are about *you*.

1. How tall are *you* without shoes?

_____ Feet _____ Inches

OR _____ Centimeters

2. *Just before* you got pregnant with your *new* baby, how much did you weigh?

_____ Pounds **OR** _____ Kilos

3. What is *your* date of birth?

____ / ____ / _____

Month Day Year

The next questions are about the time *before* you got pregnant with your *new* baby.

4. During the *3 months before* you got pregnant with your *new* baby, did you have any of the following health conditions? For each one, check **No** if you did not have the condition or **Yes** if you did.

	No	Yes
a. Type 1 or Type 2 diabetes (**not** gestational diabetes or diabetes that starts during pregnancy)	❑	❑
b. High blood pressure or hypertension	❑	❑
c. Depression	❑	❑

5. During the *month before* you got pregnant with your new baby, how many times a week did you take a multivitamin, a prenatal vitamin, or a folic acid vitamin?

- ❑ I didn't take a multivitamin, prenatal vitamin, or folic acid vitamin in the *month before* I got pregnant
- ❑ 1 to 3 times a week
- ❑ 4 to 6 times a week
- ❑ Every day of the week

6. In the *12 months before* you got pregnant with your new baby, did you have any health care visits with a doctor, nurse, or other health care worker, including a dental or mental health worker?

- ❑ No → **Go to Page 2, Question 9**
- ❑ Yes

7. What type of health care visit did you have in the *12 months before* you got pregnant with your new baby?

Check ALL that apply

- ❑ Regular checkup at my family doctor's office
- ❑ Regular checkup at my OB/GYN's office
- ❑ Visit for an illness or chronic condition
- ❑ Visit for an injury
- ❑ Visit for family planning or birth control
- ❑ Visit for depression or anxiety
- ❑ Visit to have my teeth cleaned by a dentist or dental hygienist
- ❑ Other → Please tell us:

_____

8. During any of your health care visits in the *12 months before* you got pregnant, did a doctor, nurse, or other health care worker do any of the following things? For each item, check **No** if they did not or **Yes** if they did.

	No	Yes
a. Tell me to take a vitamin with folic acid	❑	❑
b. Talk to me about maintaining a healthy weight	❑	❑
c. Talk to me about controlling any medical conditions such as diabetes or high blood pressure	❑	❑
d. Talk to me about my desire to have or not have children	❑	❑
e. Talk to me about using birth control to prevent pregnancy	❑	❑
f. Talk to me about how I could improve my health before a pregnancy	❑	❑
g. Talk to me about sexually transmitted infections such as chlamydia, gonorrhea, or syphilis	❑	❑
h. Ask me if I was smoking cigarettes	❑	❑
i. Ask me if someone was hurting me emotionally or physically	❑	❑
j. Ask me if I was feeling down or depressed	❑	❑
k. Ask me about the kind of work I do	❑	❑
l. Test me for HIV (the virus that causes AIDS)	❑	❑

The next questions are about your *health insurance coverage* before, during, and after your pregnancy with your *new* baby.

9. During the *month before* you got pregnant with your new baby, what kind of health insurance did you have?

Check ALL that apply

- ❑ Private health insurance from my job or the job of my husband or partner
- ❑ Private health insurance from my parents
- ❑ Private health insurance from the New Mexico Health Insurance Marketplace, http://www.bewellnm.com, or HealthCare.gov
- ❑ Medicaid or Centennial Care
- ❑ SCHIP or CHIP (New MexiKids)
- ❑ Family Planning or Title X Program
- ❑ TRICARE or other military health care
- ❑ Indian Health Service (IHS) or Tribal-638 health care coverage
- ❑ Other health insurance ⟶ Please tell us:

  _____

- ❑ I did not have any health insurance during the *month before* I got pregnant

10. During your *most recent pregnancy*, what kind of health insurance did you have for your *prenatal care*?

Check ALL that apply

- ❑ I did not go for prenatal care → **Go to Question 12**
- ❑ Private health insurance from my job or the job of my husband or partner
- ❑ Private health insurance from my parents
- ❑ Private health insurance from the New Mexico Health Insurance Marketplace, http://www.bewellnm.com, or HealthCare.gov
- ❑ Medicaid or Centennial Care
- ❑ SCHIP or CHIP (New MexiKids)
- ❑ Discount/State prenatal HRF or sliding scale
- ❑ TRICARE or other military health care
- ❑ Indian Health Service (IHS) or Tribal-638 health care coverage
- ❑ Other health insurance → Please tell us:

  _____
- ❑ I did not have any health insurance for my *prenatal care*

If you had health insurance for your *prenatal care*, go to Question 11. Otherwise, go to Question 12.

11. Did the cost of health insurance for your *prenatal care* cause financial problems for you or your family?

- ❑ No
- ❑ Yes

12. What kind of health insurance do you have *now*?

Check ALL that apply

- ❑ Private health insurance from my job or the job of my husband or partner
- ❑ Private health insurance from my parents
- ❑ Private health insurance from the New Mexico Health Insurance Marketplace, http://www.bewellnm.com, or HealthCare.gov
- ❑ Medicaid or Centennial Care
- ❑ SCHIP or CHIP (New MexiKids)
- ❑ Family Planning or Title X Program
- ❑ TRICARE or other military health care
- ❑ Indian Health Service (IHS) or Tribal-638 health care coverage
- ❑ Other health insurance → Please tell us:

  _____
- ❑ I do not have health insurance *now*

13. Thinking back to *just before* you got pregnant with your new baby, how did you feel about becoming pregnant?

Check ONE answer

- ❑ I wanted to be pregnant later
- ❑ I wanted to be pregnant sooner
- ❑ I wanted to be pregnant then
- ❑ I didn't want to be pregnant then or at any time in the future
- ❑ I wasn't sure what I wanted

DURING PREGNANCY

The next questions are about the prenatal care you received during your most recent pregnancy. Prenatal care includes visits to a doctor, nurse, or other health care worker before your baby was born to get checkups and advice about pregnancy. (It may help to look at the calendar when you answer these questions.)

14. How many weeks *or* months pregnant were you when you had your first visit for prenatal care?

_____ Weeks **OR** _____ Months

❑ I didn't go for prenatal care → **Go to Question 16**

15. Did you get prenatal care as early in your pregnancy as you wanted?

❑ No
❑ Yes → **Go to Question 17**

Go to Question 16

16. Did any of these things keep you from getting prenatal care when you wanted it? For each item, check **No** if it did not keep you from getting prenatal care or **Yes** if it did.

		No	Yes
a.	I couldn't get an appointment when I wanted one	❑	❑
b.	I didn't have enough money or insurance to pay for my visits	❑	❑
c.	I didn't have any transportation to get to the clinic or doctor's office	❑	❑
d.	I couldn't take time off from work or school	❑	❑
e.	I didn't have my Medicaid or Centennial Care card	❑	❑
f.	I didn't have anyone to take care of my children	❑	❑
g.	I didn't know that I was pregnant	❑	❑
h.	I didn't want anyone else to know I was pregnant	❑	❑
i.	The clinic or doctor's office was too far away	❑	❑
j.	I did not believe prenatal care was important or that it would help me	❑	❑
k.	I did not feel prenatal care was culturally appropriate	❑	❑
l.	I didn't want prenatal care	❑	❑

If you did not get prenatal care, go to Question 20.

17. Where did you go *most of the time* for your prenatal care visits? Do not include visits for WIC.

Check ONE answer

❑ Private doctor's office
❑ Hospital clinic
❑ Health department clinic
❑ Community or Federally Qualified Health clinic
❑ Indian Health Service (IHS), Tribal-638, or Tribal Urban health facility
❑ Other → Please tell us:

_____

18. *During any of your prenatal care visits*, did a doctor, nurse, or other health care worker ask you any of the things listed below? For each item, check **No** if they did not ask you about it or **Yes** if they did.

		No	Yes
a.	If I knew how much weight I should gain during pregnancy	❑	❑
b.	If I was taking any prescription medication	❑	❑
c.	If I was smoking cigarettes	❑	❑
d.	If I was drinking alcohol	❑	❑
e.	If someone was hurting me emotionally or physically	❑	❑
f.	If I was feeling down or depressed	❑	❑
g.	If I was using drugs such as marijuana, cocaine, crack, or meth	❑	❑
h.	If I wanted to be tested for HIV (the virus that causes AIDS)	❑	❑
i.	If I planned to breastfeed my new baby	❑	❑
j.	If I planned to use birth control after my baby was born	❑	❑

19. How did you feel about the prenatal care you got during *your most recent* pregnancy? If you went to more than one place for prenatal care, answer for the place where you got *most* of your care. For each item, check **No** if you were not satisfied or **Yes** if you were satisfied.

		No	Yes
a.	The amount of time I had to wait	❑	❑
b.	The amount of time the doctor, nurse, or midwife spent with me	❑	❑
c.	The advice I got on how to take care of myself	❑	❑
d.	The understanding and respect shown toward me as a person	❑	❑
e.	The cultural understanding or respect demonstrated in my care	❑	❑

20. During the 12 months *before the delivery* of your new baby, did a doctor, nurse, or other health care worker *offer* you a flu shot or *tell* you to get one?

- ❑ No
- ❑ Yes

21. During the 12 months *before the delivery* of your new baby, did you *get* a flu shot?

Check ONE answer

- ❑ No
- ❑ Yes, before my pregnancy
- ❑ Yes, during my pregnancy

22. During *your most recent* pregnancy, did you have your teeth cleaned by a dentist or dental hygienist?

- ❑ No
- ❑ Yes

23. During *your most recent* pregnancy, did you have any of the following health conditions? For each one, check **No** if you did not have the condition or **Yes** if you did.

		No	Yes
a.	Gestational diabetes (diabetes that **started** during *this* pregnancy)	❑	❑
b.	High blood pressure (that **started** during *this* pregnancy), pre-eclampsia or eclampsia	❑	❑
c.	Depression	❑	❑
d.	Labor pains more than 3 weeks before my baby was due (preterm or early labor)	❑	❑

The next questions are about smoking cigarettes around the time of pregnancy (before, during, and after).

24. Have you smoked any cigarettes in the *past 2 years*?

- ❑ No → **Go to Question 28**
- ❑ Yes

25. In the *3 months before* you got pregnant, how many cigarettes did you smoke on an average day? A pack has 20 cigarettes.

- ❑ 41 cigarettes or more
- ❑ 21 to 40 cigarettes
- ❑ 11 to 20 cigarettes
- ❑ 6 to 10 cigarettes
- ❑ 1 to 5 cigarettes
- ❑ Less than 1 cigarette
- ❑ I didn't smoke then

26. In the *last 3 months* of your pregnancy, how many cigarettes did you smoke on an average day? A pack has 20 cigarettes.

- ❑ 41 cigarettes or more
- ❑ 21 to 40 cigarettes
- ❑ 11 to 20 cigarettes
- ❑ 6 to 10 cigarettes
- ❑ 1 to 5 cigarettes
- ❑ Less than 1 cigarette
- ❑ I didn't smoke then

27. How many cigarettes do you smoke on an average day *now*? A pack has 20 cigarettes.

- ❑ 41 cigarettes or more
- ❑ 21 to 40 cigarettes
- ❑ 11 to 20 cigarettes
- ❑ 6 to 10 cigarettes
- ❑ 1 to 5 cigarettes
- ❑ Less than 1 cigarette
- ❑ I don't smoke now

The next questions are about using other tobacco products around the time of pregnancy.

E-cigarettes (electronic cigarettes) and other electronic nicotine products (such as vape pens, e-hookahs, hookah pens, e-cigars, e-pipes) are battery-powered devices that use nicotine liquid rather than tobacco leaves, and produce vapor instead of smoke.

A **hookah** is a water pipe used to smoke tobacco. It is not the same as an e-hookah or hookah pen.

28. Have you used any of the following products in the *past 2 years*? For each item, check **No** if you did not use it or **Yes** if you did.

	No	Yes
a. E-cigarettes or other electronic nicotine products	❑	❑
b. Hookah	❑	❑
c. Cigars, cigarillos, or little filtered cigars	❑	❑

If you used e-cigarettes or other electronic nicotine products in the *past 2 years*, go to Question 29. Otherwise, go to Question 31.

29. During the *3 months before* you got pregnant, on average, how often did you use e-cigarettes or other electronic nicotine products?

- ❑ More than once a day
- ❑ Once a day
- ❑ 2-6 days a week
- ❑ 1 day a week or less
- ❑ I did not use e-cigarettes or other electronic nicotine products then

30. During the *last 3 months* of your pregnancy, on average, how often did you use e-cigarettes or other electronic nicotine products?

- ❑ More than once a day
- ❑ Once a day
- ❑ 2-6 days a week
- ❑ 1 day a week or less
- ❑ I did not use e-cigarettes or other electronic nicotine products then

The next questions are about drinking alcohol around the time of pregnancy.

31. Have you had any alcoholic drinks in the *past 2 years*? A drink is 1 glass of wine, wine cooler, can or bottle of beer, shot of liquor, or mixed drink.

- ❑ No → **Go to Question 33**
- ❑ Yes

32. During the *3 months before* you got pregnant, how many alcoholic drinks did you have in an average week?

- ❑ 14 drinks or more a week
- ❑ 8 to 13 drinks a week
- ❑ 4 to 7 drinks a week
- ❑ 1 to 3 drinks a week
- ❑ Less than 1 drink a week
- ❑ I didn't drink then

Pregnancy can be a difficult time. The next questions are about things that may have happened *before* and *during* your most recent pregnancy.

33. During the *12 months before* your new baby was born, did you ever eat less than you felt you should because there wasn't enough money to buy food?

- ❑ No
- ❑ Yes

34. In the *12 months before you got pregnant* with your new baby, did any of the following people push, hit, slap, kick, choke, or physically hurt you in any other way? For each person, check **No** if they did not hurt you during this time or **Yes** if they did.

	No	Yes
a. My husband or partner	❑	❑
b. My ex-husband or ex-partner	❑	❑
c. Another family member	❑	❑
d. Someone else	❑	❑

35. During *your most recent pregnancy*, did any of the following people push, hit, slap, kick, choke, or physically hurt you in any other way? For each person, check **No** if they did not hurt you during this time or **Yes** if they did.

	No	Yes
a. My husband or partner	❑	❑
b. My ex-husband or ex-partner	❑	❑
c. Another family member	❑	❑
d. Someone else	❑	❑

AFTER PREGNANCY

The next questions are about the time since your new baby was born.

36. When was your new baby born?

___ / ___ / 20__

Month Day Year

37. How was your new baby delivered?

- ❑ Vaginally → **Go to Page 8, Question 39**
- ❑ Cesarean delivery (c-section)

Go to Page 8, Question 38

38. Which statement best describes whose idea it was for you to have a cesarean delivery (c-section)?

Check ONE answer

- ❑ My health care provider recommended a cesarean delivery ***before*** I went into labor
- ❑ My health care provider recommended a cesarean delivery while I was in labor
- ❑ I asked for the cesarean delivery

39. After your baby was delivered, was he or she put in an intensive care unit (NICU)?

- ❑ No
- ❑ Yes
- ❑ I don't know

40. After your baby was delivered, how long did he or she stay in the hospital?

- ❑ Less than 24 hours (less than 1 day)
- ❑ 24 to 48 hours (1 to 2 days)
- ❑ 3 to 5 days
- ❑ 6 to 14 days
- ❑ More than 14 days
- ❑ My baby was not born in a hospital
- ❑ My baby is still in the hospital → **Go to Question 43**

41. Is your baby alive now?

- ❑ No → *We are very sorry for your loss.* **Go to Page 11, Question 60**
- ❑ Yes

42. Is your baby living with you now?

- ❑ No → **Go to Page 11, Question 60**
- ❑ Yes

Go to Question 43

43. *Before or after your new baby was born*, did you receive information about breastfeeding from any of the following sources? For each one, check **No** if you did not receive information from this source or **Yes** if you did.

		No	Yes
a.	My doctor	❑	❑
b.	A nurse, midwife, or doula	❑	❑
c.	A breastfeeding or lactation specialist	❑	❑
d.	My baby's doctor or health care provider	❑	❑
e.	A breastfeeding support group	❑	❑
f.	A breastfeeding hotline or toll-free number	❑	❑
g.	Family or friends	❑	❑
h.	Other	❑	❑

Please tell us:

_____

44. Did you ever breastfeed or pump breast milk to feed your new baby, even for a short period of time?

- ❑ No → **Go to Page 10, Question 52**
- ❑ Yes

Go to Question 45

45. *After* your new baby was born, did you receive the kinds of help with breastfeeding that are listed below? For each one, check **No** if you did not receive this kind of breastfeeding help or **Yes** if you did.

		No	Yes
a.	Someone to answer my questions	❑	❑
b.	Help getting my baby positioned correctly	❑	❑
c.	Help knowing if my baby was getting enough milk	❑	❑
d.	Help with managing pain or bleeding nipples	❑	❑
e.	Information about where to get a breast pump	❑	❑
f.	Help using a breast pump	❑	❑
g.	Information about breastfeeding support groups	❑	❑
h.	Other Please tell us: →	❑	❑

46. Are you currently breastfeeding or feeding pumped milk to your new baby?

❑ No
❑ Yes → **Go to Question 48**

47. How many weeks or months did you breastfeed or feed pumped milk to your baby?

❑ Less than 1 week

_____ Weeks **OR** _____ Months

48. Have you used a breast pump to express milk to feed to your new baby?

❑ No → **Go to Question 50**
❑ Yes

Go to Question 49

49. Did your health insurance pay for a breast pump for you to use with your *new* baby?

❑ No
❑ Yes, but I had to make a co-payment
❑ Yes, with no co-payment
❑ I did not have health insurance
❑ I don't know

If your baby was not born in a hospital, go to Page 10, Question 51.

50. This question asks about things that may have happened at the hospital where your new baby was born. For each item, check **No** if it did not happen or **Yes** if it did.

		No	Yes
a.	Hospital staff gave me information about breastfeeding	❑	❑
b.	My baby stayed in the same room with me at the hospital	❑	❑
c.	I breastfed my baby in the hospital	❑	❑
d.	Hospital staff helped me learn how to breastfeed	❑	❑
e.	I breastfed in the first hour after my baby was born	❑	❑
f.	My baby was placed in skin-to-skin contact within the first hour of life	❑	❑
g.	My baby was fed only breast milk at the hospital	❑	❑
h.	Hospital staff told me to breastfeed whenever my baby wanted	❑	❑
i.	The hospital gave me a breast pump to use	❑	❑
j.	The hospital gave me a gift pack with formula	❑	❑
k.	The hospital gave me a telephone number to call for help with breastfeeding	❑	❑
l.	Hospital staff gave my baby a pacifier	❑	❑

51. How old was your new baby the first time he or she had liquids other than breast milk (such as formula, water, juice, or cow's milk)?

_____ Weeks **OR** _____ Months

- ❑ My baby was less than 1 week old
- ❑ My baby has not had any liquids other than breast milk

If your baby is still in the hospital, go to Question 60.

52. In which *one* position do you *most often* lay your baby down to sleep now?

Check ONE answer

- ❑ On his or her side
- ❑ On his or her back
- ❑ On his or her stomach

53. In the *past 2 weeks*, how often has your new baby slept alone in his or her own crib or bed?

- ❑ Always
- ❑ Often
- ❑ Sometimes
- ❑ Rarely
- ❑ Never → **Go to Question 55**

54. When your new baby sleeps alone, is his or her crib or bed in the same room where *you* sleep?

- ❑ No
- ❑ Yes

55. Listed below are some more things about how babies sleep. How did your new baby *usually* sleep in the *past 2 weeks*? For each item, check **No** if your baby did not *usually* sleep like this or **Yes** if he or she did.

		No	Yes
a.	In a crib, bassinet, or pack and play	❑	❑
b.	On a twin or larger mattress or bed	❑	❑
c.	On a couch, sofa, or armchair	❑	❑
d.	In an infant car seat or swing	❑	❑
e.	In a sleeping sack or wearable blanket	❑	❑
f.	With a blanket	❑	❑
g.	With toys, cushions, or pillows, including nursing pillows	❑	❑
h.	With crib bumper pads (mesh or non-mesh)	❑	❑

56. Did a doctor, nurse, or other health care worker tell you any of the following things? For each thing, check **No** if they did not tell you or **Yes** if they did.

		No	Yes
a.	Place my baby on his or her back to sleep	❑	❑
b.	Place my baby to sleep in a crib, bassinet, or pack and play	❑	❑
c.	Place my baby's crib or bed in my room	❑	❑
d.	What things should and should not go in bed with my baby	❑	❑

57. How many times has your new baby gone for care when he or she was sick?

_____ Times

- ❑ None → **Go to Question 59**
- ❑ My baby has not been sick
- ❑ My baby is still in the hospital

→ **Go to Question 60**

58. Has your new baby gone for care as many times as you wanted when he or she was sick?

- ❑ No
- ❑ Yes → **Go to Question 60**

59. Did any of these things keep you from taking your baby for care when he or she was sick?

Check ALL that apply

- ❑ I didn't have health insurance to pay for the visit
- ❑ I couldn't get an appointment
- ❑ I didn't have a regular doctor for my baby
- ❑ I had no way to get my baby to the clinic or doctor's office
- ❑ I didn't have anyone to take care of my other children
- ❑ Other → Please tell us:

_____

60. Are you or your husband or partner doing anything *now* to keep from getting pregnant?
Some things people do to keep from getting pregnant include having their tubes tied, using birth control pills, condoms, withdrawal, or natural family planning.

- ❑ No
- ❑ Yes → **Go to Question 62**

Go to Question 61

61. What are your reasons or your husband's or partner's reasons for not doing anything to keep from getting pregnant *now*?

Check ALL that apply

- ❑ I want to get pregnant
- ❑ I am pregnant now
- ❑ I had my tubes tied or blocked
- ❑ I don't want to use birth control
- ❑ I am worried about side effects from birth control
- ❑ I am not having sex
- ❑ My husband or partner doesn't want to use anything
- ❑ I have problems paying for birth control
- ❑ Other → Please tell us:

_____

If you or your husband or partner is <u>not doing</u> anything to keep from getting pregnant *now*, go to Page 12, Question 63.

62. What kind of birth control are you or your husband or partner using *now* to keep from getting pregnant?

Check ALL that apply

- ❑ Tubes tied or blocked (female sterilization or Essure®)
- ❑ Vasectomy (male sterilization)
- ❑ Birth control pills
- ❑ Condoms
- ❑ Shots or injections (Depo-Provera®)
- ❑ Contraceptive patch (OrthoEvra®) or vaginal ring (NuvaRing®)
- ❑ IUD (including Mirena®, ParaGard®, Liletta®, or Skyla®)
- ❑ Contraceptive implant in the arm (Nexplanon® or Implanon®)
- ❑ Natural family planning (including rhythm method)
- ❑ Withdrawal (pulling out)
- ❑ Not having sex (abstinence)
- ❑ Other → Please tell us:

_____

63. *Since your new baby was born,* have you had a postpartum checkup for yourself? A postpartum checkup is the regular checkup a woman has about 4-6 weeks after she gives birth.

❑ No → **Go to Question 65**
❑ Yes

64. *During your postpartum checkup*, did a doctor, nurse, or other health care worker <u>do</u> any of the following things? For each item, check **No** if they did not do it or **Yes** if they did.

		No	Yes
a.	Tell me to take a vitamin with folic acid	❑	❑
b.	Talk to me about healthy eating, exercise, and losing weight gained during pregnancy	❑	❑
c.	Talk to me about how long to wait before getting pregnant again	❑	❑
d.	Talk to me about birth control methods I can use after giving birth	❑	❑
e.	Give or prescribe me a contraceptive method such as the pill, patch, shot (Depo-Provera®), NuvaRing®, or condoms	❑	❑
f.	Insert an IUD (Mirena®, ParaGard®, Liletta®, or Skyla®) or a contraceptive implant (Nexplanon® or Implanon®)	❑	❑
g.	Ask me if I was smoking cigarettes	❑	❑
h.	Ask me if someone was hurting me emotionally or physically	❑	❑
i.	Ask me if I was feeling down or depressed	❑	❑
j.	Test me for diabetes	❑	❑

65. *Since your new baby was born*, how often have you felt down, depressed, or hopeless?

❑ Always
❑ Often
❑ Sometimes
❑ Rarely
❑ Never

66. *Since your new baby was born*, how often have you had little interest or little pleasure in doing things you usually enjoyed?

❑ Always
❑ Often
❑ Sometimes
❑ Rarely
❑ Never

OTHER EXPERIENCES

The next questions are on a variety of topics.

67. Are you Hispanic, Spanish, or Latina?

❑ No
❑ Yes

68. Which one or more of the following would you say is your race?

Check ALL that apply

❑ American Indian or Alaska Native
Tribe: _____
❑ Asian
❑ Black or African American
❑ Native Hawaiian or Other Pacific Islander
❑ White
❑ Other → Please tell us:
_____

69. Which <u>one</u> of these *best* describes you?

Check ONE answer

❑ American Indian or Alaska Native
❑ Asian
❑ Black or African American
❑ Hispanic, Spanish, or Latina
❑ Native Hawaiian or Other Pacific Islander
❑ White
❑ Other → Please tell us:
_____

70. Within the past 12 months, when seeking health care, did you feel your experiences were worse than, the same as, or better than for people of other races (or ethnicities)?

Check ONE answer

- ❑ Worse than other races
- ❑ The same as other races
- ❑ Better than other races
- ❑ Worse than some races, better than others
- ❑ I only encountered people of the same race
- ❑ I did not have health care in past 12 months
- ❑ Don't know / Not sure

71. During the *month before* you got pregnant, did you take or use any of the following drugs for any reason? Your answers are strictly confidential. For each item, check **No** if you did not use it or **Yes** if you did.

		No	Yes
a.	Prescription for depression or anxiety	❑	❑
b.	Over-the-counter pain relievers such as aspirin, Tylenol®, Advil®, or Aleve®	❑	❑
c.	Prescription pain relievers such as hydrocodone (Vicodin®), oxycodone (Percocet®), or codeine	❑	❑
d.	Marijuana (pot, weed, bud, *mota* or hashish (hash))	❑	❑
e.	Synthetic marijuana (K2, Spice)	❑	❑
f.	Methadone, naloxone (Narcan®), subutex, or Suboxone®	❑	❑
g.	Heroin (smack, junk, Black Tar, *Chiva*)	❑	❑
h.	Amphetamines (uppers, speed, crystal meth, crank, ice, *agua*)	❑	❑
i.	Cocaine (crack, rock, coke, blow, snow, *nieve*)	❑	❑
j.	Tranquilizers (downers, ludes)	❑	❑
k.	Hallucinogens (LSD/acid, PCP/angel dust, Ecstasy, Molly, mushrooms, bath salts)	❑	❑
l.	Sniffing gasoline, glue, aerosol spray cans, or paint to get high (huffing)	❑	❑

72. During *your most recent* pregnancy, did you *receive* any of the following services? For each one, check **No** if you did not receive the service or **Yes** if you did.

		No	Yes
a.	Counseling or a support group for depression	❑	❑
b.	Class or support group to stop smoking cigarettes	❑	❑
c.	Help to reduce violence in my home	❑	❑
d.	Healthy Start	❑	❑
e.	Families FIRST case management	❑	❑
f.	Doula or midwife support	❑	❑
g.	Home visiting program	❑	❑

If your baby is not alive or is not living with you, go to Question 75.

73. *Since your new baby was born*, have you used any of these services? For each one, check **No** if you did not use the service or **Yes** if you did.

		No	Yes
a.	A breastfeeding class or peer counseling support	❑	❑
b.	WIC for me or my baby	❑	❑
c.	Families FIRST case management	❑	❑
d.	Healthy Start	❑	❑
e.	Counseling or a support group for depression	❑	❑
f.	Breastfeeding help from a hospital or clinic	❑	❑
g.	Breastfeeding help from a community program or lactation consultant	❑	❑
h.	Home visiting program	❑	❑

If your baby is still in the hospital, go to Question 75.

74. Please read each statement below about how you feel about your baby's crying or how you manage his or her crying. For each one, check **No** if you did not apply to you or **Yes** if it did.

	No	Yes
a. I can almost always get my baby to stop crying	❑	❑
b. In the past week, I have carried my baby in my arms or in a cloth baby carrier for 5 or more hours every day	❑	❑
c. I think that picking up a baby every time he or she cries will spoil the baby	❑	❑
d. I sometimes feel overwhelmed by my baby's crying	❑	❑

75. At any time during *your most recent* pregnancy, did you work at a job for pay?

- ❑ No → **Go to Question 78**
- ❑ Yes

76. Have you returned to the job you had during *your most recent* pregnancy?

Check ONE answer

- ❑ No, and I do not plan to return → **Go to Question 78**
- ❑ No, but I will be returning
- ❑ Yes

77. Did you take leave from work *after* your new baby was born?

Check ALL that apply

- ❑ I took *paid* leave from my job
- ❑ I took *unpaid* leave from my job
- ❑ I did not take any leave

The last questions are about the time during the *12 months before* your new baby was born.

78. During the *12 months before* your new baby was born, what was your yearly total household income before taxes? Include your income, your husband's or partner's income, and any other income you may have received. *All information will be kept private* and will not affect any services you are now getting.

- ❑ $0 to $16,000
- ❑ $16,001 to $20,000
- ❑ $20,001 to $24,000
- ❑ $24,001 to $28,000
- ❑ $28,001 to $32,000
- ❑ $32,001 to $40,000
- ❑ $40,001 to $48,000
- ❑ $48,001 to $57,000
- ❑ $57,001 to $60,000
- ❑ $60,001 to $73,000
- ❑ $73,001 to $85,000
- ❑ $85,001 or more

79. During the *12 months before* your new baby was born, how many people, *including yourself*, depended on this income?

_____ People

80. What is today's date?

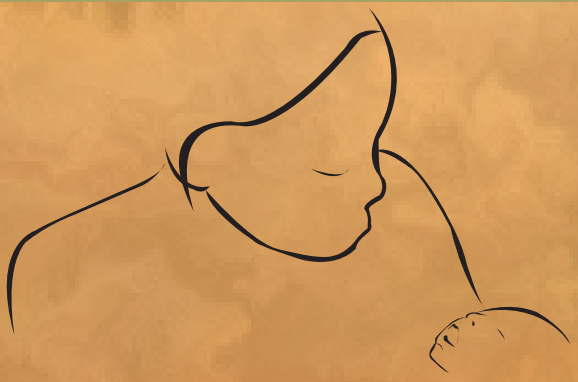
_____ / _____ / 20_____

Month Day Year

Please use this space for any additional comments you would like to make about your experiences around the time of your pregnancy or the health of mothers and babies in New Mexico.

Thanks for answering our questions!

Your answers will help us work to keep mothers and babies in New Mexico healthy.



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