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Reproductive Justice in the Heartland

Mothering, Maternal Care, and Race in
Twenty-First-Century Iowa

LINA-MARIA MURILLO AND NATALIE FIXMER-ORAIZ

AS SCHOLARS OF reproductive justice, it feels impossible to write an essay about motherhood without examining our contemporary moment. We are one year into a global pandemic that has rocked the foundations of motherhood. People across class and colour have had to rearrange and reimagine their connections to productive and reproductive labour. The cruelty and devastation wrought by COVID-19 has proven deeply uneven. Frontline workers are disproportionately women, immigrants, low-income workers, and people of colour (Rho et al.). Catastrophic job losses have hit women hardest—particularly young women, Black women, Latinas, and women with disabilities (Ewing-Nelson). Mothers have been more likely than fathers to reduce or eliminate work altogether in order to meet caregiving needs (Ranji et al.). Reproductive and birthing rights have been curtailed by COVID-19 “precautionary measures,” despite expert advice to the contrary (Fyfe) while reproductive healthcare disparities have worsened (Andaya and Bhatia). Mothers of colour bear the brunt of these hardships.

In the United States (US), the pandemic was compounded by a season of social unrest as millions of people across the country protested the murder of George Floyd at the hands of then-police officer Derek Chauvin in Minneapolis, Minnesota. Floyd’s traumatic last minutes of life were captured on video as he pleaded for breath, calling for his mother. Police violence against Black and Brown people surged as a parallel pandemic, bringing to the fore continued demands by the Black Lives Matter movement and a coalition of others seeking to dismantle institutions premised on white supremacy and racial capitalism. Now as in the past, from Mamie Till to Sybrina Fulton, the mothers of victims have become the mothers of the movement (Latif and Latif).

At this critical moment we draw greater attention to reproductive justice as a theoretical, rhetorical, and historical tool for contemplating mothering and motherhood. In what follows, we offer a brief overview of reproductive justice and elaborate upon its centrality as a paradigm-shifting lens in maternal theory through three case studies in Iowa.

Defining Reproductive Justice

Reproductive justice (RJ) is a powerful framework and organizing tool “that identifies how reproductive oppression is the result of the intersection of multiple oppressions and is inherently connected to the struggle for social justice and human rights” (Ross and Solinger 69). RJ foregrounds three principles: 1) the right to have a child; 2) the right not to have a child; and 3) the right to parent in safe and sustainable environments. And, importantly, it is considered an “open-source code” (Ross and Solinger 71), as new and more dynamic definitions emerge from the ground up (Zavella). Angela Moreno, board member for leading RJ organization SisterSong, explains RJ as “continuously in motion ... it is in between even though it has room for absolutes ... it is a map and also a continuous confirmation that nothing is static and everything is relational and interdependent” (qtd. in Zavella, 19).

RJ is rooted in the lived experiences of women of colour and emerges from the rich history of women of colour-led grassroots organizing against reproductive oppression (Zavella). Its antecedents include, for example, the welfare rights movement and feminist organizing against forced sterilizations of Indigenous women, Black women, and Latinas in the 1960s and 1970s (Gutiérrez; Lawrence; Nadasen; Theobald; Roberts). RJ was explicitly named and theorized in 1994 by twelve Black feminists gathered at a conference in Chicago. According to Loretta Ross, one of the founders of RJ and a key figure in the movement to date: “[We] collectively questioned the primacy of abortion, but not its necessity. We placed *ourselves* in the center of our analysis and made the case that while abortion was a crucial resource for us, we also needed health care, education, jobs, day care, and the right to motherhood” (qtd. in Ross and Solinger 64). Although RJ claims reproductive rights as a cornerstone of social justice, it radically insists on the social, economic, and political transformations that would allow all families and communities to thrive.

RJ offers an instructive intervention in the mainstream reproductive rights movement. Whereas middle-class white women largely led prochoice activism, focusing narrowly on asserting the right to privacy in reproductive decision-making, RJ refuses the logic of individual choice. It clarifies how one’s health, sovereignty, and capacity for family formation are intimately entwined with the broader social, political, and cultural landscape. As a result, RJ centres struggles that may seem peripheral to the mainstream prochoice movement—for example, prison abolition, environmental racism, fair working conditions, eradicating poverty, and immigrants’ rights.

Focused on structural and institutional inequalities, RJ is central to discussions of motherhood and mothering. It centres the lives and experiences of women of colour and low-income women, thereby destabilizing the primacy afforded whiteness, wealth, and citizenship in the theorization of reproductive care and motherhood. In doing so, it clarifies how white supremacy has fundamentally shaped—and continues to shape—the politics of reproduction and motherhood.

RJ in the Heartland

We explore how RJ can elaborate understandings of motherhood through three case studies in Iowa. It may seem counterintuitive to center Iowa, given the relative homogeneity of its population. According to recent census data, Iowa is 85 per cent white; Black, Latinx, Indigenous, and Asian peoples make up roughly the remaining 15 percent (US Census Bureau). Iowa, however, reveals how a majority-white state views poor communities, immigrant communities, and communities of colour. Iowa is increasingly on the frontlines of extreme policies that not only entrench reproductive injustices for historically marginalized people but also create resource deficits for poor white constituents (Metzl).

Iowa persists in the US imagination as the “American heartland,” tethering whiteness, traditional family values, and rurality to idealized, mythic Americanness (Johnson). These myths obscure the continued assault on historically minoritized people in Iowa. Our chapter explores both the conditions that produce reproductive injustice as well as how historically marginalized communities—often led by women, queer people, and mothers of colour—are at the forefront of bringing social justice to their communities.

Our case studies demonstrate that the struggle for RJ is alive in Iowa. Additionally, Iowa is home to the oldest independent feminist reproductive healthcare clinic in the US, the Emma Goldman Clinic. As faculty at Iowa’s flagship university, we co-direct an RJ Working Group sponsored by the Obermann Center for Advanced Studies. This dynamic, spirited collective is composed of advocates, attorneys, artists, midwives, doulas, scholars, students, healthcare providers, and community organizers—all working to make RJ real.

Our colleagues brought these case studies to our attention. For this chapter, we interviewed three experts and practitioners in the fields of epidemiology and maternal health. They provided us with critical information and paradigm-shifting scholarship to support our examination of RJ and motherhood, particularly as we attended to critical dimensions of geography. Our interviewees are from Iowa or the broader Midwest, thus intimately connected to their work in the region.

Our chapter reflects our colleagues’ expertise in three key areas: Black maternal health, migrant motherhood, and rural care deserts. These issues cut across gender, racial, ethnic, and geographic boundaries as communities defy facile categorization. For instance, as one of our interlocutors explained, Black maternal health statistics in Iowa encompass all Black women—without differentiation of Black refugees/migrants (Sudanese, Somali, Ethiopian, Burundian, and Congolese) and African Americans. This reality undermines understanding of access to state-sponsored support or the effects of compounded systemic racism. This research also reveals that rural does not always equal white. Black, Indigenous, Asian, and Latinx communities are part of rural geographies—often ignored as a substantive demographic and,

much like their white counterparts, in dire need of healthcare. These case studies complicate superficial assessments of Iowa and the broader Midwest, disrupt conservatives' purported support for traditional motherhood, and expand analyses of motherhood across race, class, gender, and citizenship.

Our case studies highlight the third prong of the RJ framework—to parent children in safe and sustainable environments. We write energized by feminist of colour theories that name white supremacy, economic deprivation, and state violence as central threats to claiming the human right to mother in the first place (Hill Collins; Abrego).

Maternal Health and Anti-Black Racism

To understand Black maternal health, we spoke with Lastacia Coleman, who is a native Iowan and the only Black midwife in the state. She holds a terminal degree in nursing and is a certified nurse midwife and a clinical assistant professor in the Department of OB-GYN in the College of Medicine at the University of Iowa. She is currently pursuing a PhD in public health. Coleman's commitment to RJ is lived: She is the director at large for the American College of Nurse Midwives Iowa affiliate, a board member of the Emma Goldman Clinic, active in the Iowa Maternal Quality Care Collaborative (IMQCC), and a founder of the Black Maternal Health Collective in Iowa.

Grounded in her experiences as a midwife, activist, and community organizer, we asked Coleman to provide an overview of maternal health and its intersection with anti-Black racism:

Every year in the US, about seven hundred women die during pregnancy or in the postpartum period (up to one year postpartum). The data varies a bit from state to state, based on whether the dataset includes deaths that are medically related to pregnancy in addition to deaths from other causes. In Louisiana, for example, the most common cause of maternal death is homicide. In Iowa, we include all cases of maternal mortality, both direct and indirect.

The majority of pregnancy-related deaths are preventable, and since 1990, maternal mortality has steadily declined in most regions worldwide (Centers for Disease Control and Prevention; Kassebaum et al.). The US, however, claims the worst maternal mortality rate in the industrialized world, where maternal mortality has steadily risen for the past two decades (Martin and Montagne). Moreover, anti-Black racism compounds this frightening trend, as Coleman clarifies: “The rates for Black women in the US are higher, about three to four times the rate of white women. In Iowa, Black maternal mortality is six times higher than white women. Asian American and Pacific Islander women are also particularly vulnerable in Iowa.” Between 2015 and 2018: “Iowa's pregnancy-related maternal mortality was 9.4 per 100,000

livebirths overall. The rate for non-Hispanic White women was 6.0, for non-Hispanic Black women 36.9, for Asian/Pacific Islander 23.5 and for Hispanic women 9.7” (Iowa Maternal Mortality Review Committee). These sobering statistics are followed by Committee recommendations for addressing disparities; e.g. early detection of life-threatening conditions during pregnancy and expansion of Medicaid coverage. As Coleman states: “We need to do things differently to address maternal health disparities. We need to do something new.”

Coleman is involved in numerous change-making efforts. Some of this work is in partnership with large institutions and funded through federal grants for maternal health innovation, prompting the formation of the IMQCC as “a system-wide solution to address common problems.” Coleman is also involved on a grassroots level, for example, in the founding of the Black Maternal Health Collective:

We started the Black Maternal Health Collective at the beginning of 2019 as a group of Black women professionals in the local community—healthcare providers, business people, social workers, and people in public health. Initially, we met to discuss education and advocacy efforts in reproductive health policy, and we provided time for people to share their stories. We wanted to ensure it was a welcoming environment, so we made food and childcare available.

The main take-away from our initial work was that we needed more education for the people caring for Black birthing people. We planned a conference, the Black Maternal Health Conference, which happened in August of 2020. Now we are figuring out structure and sustainability for the long term in order to be as effective as possible.

We asked Coleman to draw from her experiences as a provider, a researcher, and a community organizer to elaborate key concerns:

A lot of places where [reproductive health policy] decisions are being made don’t even have women at the table. I have elbowed my way into some of these spaces like the Medicaid Maternal Health Task Force and the State of Iowa’s maternal mortality review committee. There just aren’t many people who can properly advocate for the changes that need to happen. A lot of people are very happy to leave things the way that they are. For a lot of Black birthing people, it’s a disempowering experience being a pregnant person in Iowa. And that’s not how it should be.

Recent research bolsters this claim (Iowa Maternal Mortality Review Committee; Krebs). Reporting in December 2020, Iowa Public Radio

described maternal health in Iowa as evidence of a “deep racial divide in health care” (Krebs). The report describes mistreatment of Black women by medical professionals, who ignored or dismissed substantive medical concerns. The report also highlights the stories of Black women becoming birthworkers (e.g., doulas or midwives) to provide high quality, compassionate care for Black birthing people in Iowa.

Racial disparities, Coleman notes, far exceed mortality and reflect a system that demeans and disempowers pregnant and parenting people of colour:

Maternal death is the worst outcome, but many more women have one or more maternal morbidities—things like stroke, seizure, heart attack, blood loss, hysterectomy. And mistreatment is very common. The *Listening to Mothers* study showed that one in three women of colour felt mistreated during pregnancy [Vedam et al.]. We must address maternal mortality, but the harm is more common if people are mistreated at that level.

It makes me really sad that people come to me specifically because they're Black or another person of colour. They're coming to me because they think I can save them. And I can't promise that. I'm not there every minute. I'm not the nurse that's going to take care of them and ensure everything goes correctly. I'm not going to be at the WIC [Women, Infants, and Children Nutrition Program] office with them, making sure someone is helping them properly with breastfeeding. We tend to think about complications as just medical problems, but it's so much more than that. The whole system is very disconnected.

This understanding of interlocking systems leads Coleman to a RJ framework:

The problem with healthcare is that our goal is the floor. We haven't even started to get to the ceiling of what is good. Safety is not the only thing that matters to people. It's actually very much not what matters to people. So what is good? Compared to what?

We [the University of Iowa Hospitals and Clinics] are nationally ranked, and I think we do provide really good, high-quality care. We have everything you need here if something goes wrong, but most pregnant people don't need all of that. They just need supportive care and people to listen to them.

I try to think about reproductive justice in everything I do. I try not to make assumptions and to consider broader issues, even if I can't help individuals with issues that stem from policy or structural

concerns. Using reproductive justice as a framework to address structural racism is where I'm at right now.

Situated squarely within the RJ framework, Coleman shows how the experiences of Black women and Black birthing people matter profoundly to a robust, intersectional understanding of motherhood and parenting in the early twenty-first-century US. Put simply, Coleman's work highlights one basic and devastating fact—that for people of colour in particular, there is no guarantee that pregnancy will not kill you. In Iowa, a place where racial disparities in maternal mortality outpace disparities across the country, Coleman dedicates herself to building networks of care for safety, dignity, and empowerment in pregnancy and childbirth.

Maternal Health and Migrant Mothering

Nicole Novak is a native Iowan appointed in the College of Public Health at the University of Iowa. As a social epidemiologist, Novak considers how social factors shape health advantages and disparities. Her research focuses on two issues related to reproductive health and justice: sterilization abuse and how immigration policies impact birth outcomes.

Novak elaborates the key issues facing migrant communities in the state. First, she narrates the migratory waves that made Iowa a destination for different migrant communities, beginning in the late nineteenth century and ebbing and flowing with agricultural and other labour demands. This long history of Latina/o/x migration to the Midwest is just now commanding the attention of historians and other scholars (Valerio-Jimenez et al.). Starting in the late twentieth century, Iowa welcomed refugees from Africa, Southeast Asia, and the Marshall Islands, producing robust pockets of thriving international coalition building within migrant and refugee communities. More recently, as conservative politics became overtly tied to xenophobia, resources and policies meant to support migrants and refugees have been attacked by the Iowa legislature. Novak explains:

There are many barriers to having a safe place to raise families in Iowa. People are very creative and resilient but—and this is where I find the reproductive justice frame really helpful—often when people think of maternal health, they just think of healthcare. That is important, but there are also numerous barriers that shape the ability to safely care for your family and to provide your children with the same resources to which other children in the state are entitled.

In terms of maternal health, about 10% of births in Iowa are to Latina/Latino birthing people—a number that has nearly tripled since 1995. Latinos in Iowa are about six percent of the population

overall. Many people are focused on building their family and many say they migrated to Iowa in hopes of finding a safe place to raise a family.

As Novak affirms, a RJ framework allows us to ask more complex questions about why people migrate and what migrant families need to thrive.

Although Novak suggests we should think beyond access to maternal care as the singular marker for understanding maternal health and migrant motherhood, she nonetheless provides a critical assessment of obstacles to care:

A huge concern is access to perinatal care coverage. Pregnant women, lawfully residing in Iowa, are supposed to wait five years before they can access Medicaid. That's true nationwide. There is an exception for emergency Medicaid for delivery, and the landscape for prenatal care is complicated. But there is a lot of fear about accessing those supports. Once children are born, US-born children or lawfully residing children can access Medicaid or state insurance. But there's no state provision for health insurance for undocumented children in Iowa. There are federally-qualified healthcare centers which people can access regardless of immigration status, as well as school-based clinics in bigger cities. But simply qualifying for healthcare is an enormous barrier for many immigrant women in Iowa.

Public institutions, like the University of Iowa, have been partnering with local communities to reduce obstacles to basic healthcare. In 2002, an initiative assembled students from across disciplines to provide healthcare to immigrants, refugees, migrant farmworkers, individuals experiencing homelessness, poverty, or those in rural communities across Iowa (Palma, et al.). The University of Iowa's Mobile Clinic (UIMC) has been instrumental in providing key services for historically marginalized communities in the state.

Yet continuing in the spirit and framework of RJ, Novak asks us to "think beyond the clinic" and examine the wider range of issues that impact migrant parents in a state like Iowa. She explains:

Accessing services for a healthy pregnancy and baby includes WIC—the Women, Infants, and Children Nutrition Program—as well as SNAP, food assistance for low income people. A big perceived barrier to those programs are recent laws related to public charge. While many immigrant women in Iowa still could access WIC, SNAP, and Medicaid for their US-born children, fear and confusion prevent access. Depending on the community, social service agencies may or may not let people know they are eligible. This is where the rural-urban divide is shaping access—some communities are work-

ing to ensure access and others are passive about it. In some cases, there are anecdotal reports of staff being overtly racist or exclusionary to people even though they qualify.

Although restrictive policies can hamper migrants' abilities to parent safely, geography also creates hurdles to life-sustaining programs.

Like Coleman, Novak's observations about geography get to the heart of misconceptions about the urban-rural divide in Iowa. The Midwest is racialized as a singularly white space, a stereotype that harms all poor people and especially communities of colour. This myth constructs Iowa—and the rural Midwest—as conservative, backward, and an impediment to nationwide progress on issues like abortion access and humane immigration laws. Middle America becomes the literal space where Americanness is born and preserved. White conservative legislators weaponize racism and xenophobia to enact draconian policies that destroy crucial public services and resources in order to protect this vision of America. Novak states:

The percentage of Latina births in Iowa is evenly distributed across rural and urban areas. So 10 per cent of rural births are to Latina moms; 10 per cent of urban births are to Latina moms. This is related to the histories of migration to Iowa. Immigrants have been actively recruited to live and work in rural Iowa. But as the policy context has become more polarized in the last twenty to thirty years, the experience of living in a rural area versus an urban area is very different.

Writing on RJ, demographic changes, democracy, and the erosion of the social safety net, Loretta Ross argues that basic needs—food, shelter, healthcare, etc—have become tethered to citizenship; only those viewed as legitimate citizens are granted access. Migrants are lured to states like Iowa to work in some of the most dangerous jobs, such as meatpacking and agriculture, and under some of the most dangerous conditions, but they are not afforded access to the social services they need to live.

Additionally, migrants face intense forms of state-sanctioned surveillance and violence. Local enforcement, such as police and state troopers, plus federal enforcement, such as ICE (Immigration and Customs Enforcement), CBP (Customs and Border Protection), and Border Patrol, have created a chilling environment for migrants and their families. Novak elaborates:

Iowa has a history of large worksite raids in rural communities, including in Marshalltown, Postville, and Mount Pleasant. The bulk of immigration arrests in Iowa, however, are the everyday steady drumbeat of frequent encounters with local police that lead people to be held or handed over to federal agents. And it's not just

that you're fearing ICE is going to show up, it's that you have to go talk to ICE yourself in immigration proceedings. So asylum seekers or applicants for a U visa for those victimized by crimes (often domestic violence) must travel to bigger cities to check in or give their fingerprints or attend a hearing.

Novak's epidemiological studies demonstrate the impacts of policing on migrant and US-born Latinx communities. Her research found that immigration policies adversely impact not only migrants, but also possess spill-over consequences for US-born Latinx families such as preterm birth and low-birth weight (Novak et al.). Immigration policies and xenophobia devastate Latinx communities across generations.

Novak works with community partners to bring these concerns to the fore. She recently partnered with the Prairielands Freedom Fund (PLFF), a local abolitionist organization, to launch a storytelling project. RJ concerns emerged organically as stories centred "parents and children not being together, family members detained, or the compromised ability to work and care for their family." PFF produced a short social media project featuring RJ to clarify how ICE detention affects migrants' abilities to raise their children in safe and sustainable environments.

For Novak, the work of RJ scholars and advocates is to follow the community's lead. She explains that "more research" is not necessarily needed. Rather, communities are "already taking action to protect themselves and their families." Her hope is "in amplifying those efforts, providing resources, encouraging partnerships." In short she states: "The answers are already there. It is a matter of power and political will and resources to make the changes that people need."

Maternal Health, Incarceration, and Rural Care

Our final interviewee brings rurality, healthcare deserts, opioid addiction, and incarceration concerns to the attention of motherhood and RJ frameworks. To explore the challenges facing rural communities, we spoke with Meagan Thompson, a clinical assistant professor of obstetrics and gynecology at the University of Iowa. Thompson's credentials include a doctorate of nursing practice with a specialty in nurse-midwifery care. She is a certified nurse midwife, a trained doula, and a certified lactation consultant. Her research focuses on reducing health disparities, with an emphasis on substance use disorders and incarceration. She is on a team of specialists running a Maternal Use Substance Clinic for the University of Iowa.

Thompson began by offering an overview of the local landscape for her work:

The field of perinatal substance use is still very small. There is no one

centre for perinatal substance use disorders in Iowa, so we are working to create a network of providers across the region to standardize care.

Primarily, the people we serve in our substance use clinic are white and live in poverty; many come from rural areas. They live chaotic lives—meaning instability and co-occurring mental illness, compounded by living in maternity care deserts with poor access to transportation. In many rural portions of the state, obstetrical units are closing due to a lack of providers, shrinking population, and high rates of Medicaid reliance, rendering hospitals unprofitable.

Muscatine is one of the more recent hospitals to have closed, and we hired a midwife there. Anecdotally, the women coming from Muscatine are disproportionately women of colour, including African and Latinx immigrants. Many people living in rural Iowa are poor or have recently immigrated to the US, many work in large factories in rural towns. Sadly, these are often the first places that hospitals close.

The accelerated loss of care in the rural US is profound. According to the American College of Obstetricians and Gynecologists (ACOG), “less than one half of rural women live within a 30-minute drive to the nearest hospital offering perinatal services” (2). Between 2004 and 2014, the percentage of “rural counties with hospital-based obstetric services declined from 55% to 46% ... with less-populated rural counties experiencing more rapid declines” (Kozhimannil et al. 1239). Living in a maternity desert often delays prenatal care and is correlated with higher rates of hospitalization, preterm birth, and infant mortality (Lewis et al.).

Thompson notes the complexity of struggles facing rural communities, including patients with substance use disorders in pregnancy. In the US, substance use disorders correlate with incarceration and mental health issues:

Many people that we see in our clinic have been incarcerated, or currently are incarcerated, or are possibly going to be incarcerated. Perinatal mental healthcare is also a challenge because there are few providers in the state. Rural women do not have connections to people who specialize in perinatal mood disorders, including postpartum depression as well as anxiety and depression during pregnancy, which is often unrecognized.

Research demonstrates that mental illness and substance use disorders intersect and impact rural communities disproportionately (Snell-Rood et al.). Deepening economic exclusion and hardship, service scarcity, and other structural conditions exacerbate vulnerability to domestic violence (Snell-

Rood et al.). Thompson observes the following: “People that have substance use disorders are often unable or unwilling to leave their partner. There are high rates of domestic violence in this population, sometimes sex trafficking and exchange of sex for substances. Leaving their partner is often not an option.”

A growing theme among our case studies is how the lack of public services and support exacerbates these problems. Thompson notes that there is “little support for this work without grant assistance, and working within institutional settings like prisons can compound challenges.” In her capacity, she tries to “focus on shared goals like helping patients and offering compassionate guidance to those who may not be steeped in trauma-informed care.” Thompson maintains that there is growing recognition of these issues and “innovation is coming.” For example:

There are people who work for the Iowa Department of Mental Health who share our mission, and we are creating innovations through the grant-funded IMQCC, which has identified substance use, mood disorders, and mental illness as contributors to maternal mortality and morbidity. We are also partnering with the DHS to figure out how to best serve people with substance use disorders during pregnancy.

Like Coleman and Novak, Thompson is invested in building better systems of care to address disparities. This work includes research with mentors to document outcomes for people giving birth while incarcerated as well as studying how maternal substance use disorder clinics can provide better care. Thompson considers how “a clinic that provides harm reduction, trauma-informed, and relationship-based care leads to less emergency room utilization, less time in triage, and less time in antepartum units.” She is also focused on building models for “holistic, high-quality wrap around care”—care that would allow patients more time with a provider as well as access to a social worker and counsellor. This work is at the cutting edge of healthcare provision, so Thompson is learning from other providers as she collaborates on sustainable models for Iowa:

The way forward is a spoke and hub model—not only for birth but also for perinatal mental illness and for substance use treatment. Under this model, we send providers into maternity deserts to eliminate transportation as a barrier. Still, patients will have to drive two hours to deliver, which means that sometimes people deliver in their car or in emergency departments without a trained obstetrical provider on site. This disproportionately impacts poor women of colour.

We asked Thompson to reflect on what her work could tell us about the ability of people to mother or parent under the circumstances she encounters in her clinical practice:

People really struggle. It is really hard to mother or parent in the setting of incarceration, and oftentimes the foster care system does more harm than good. We know that kiddos staying with their mothers in a safe environment is the best. Ideally, we would scaffold services so that people could safely take their kiddos home and stop using, or cut back significantly so that they can parent safely. But of course, we don't have those social structures in place to support people.

When people do go home with custody, they may struggle with relapse or stable housing. Sometimes people deliver and they return to a domestic violence shelter or a homeless shelter, and if they cannot secure housing quickly, they may lose custody. We don't have enough support structures to get people into housing, then the cycle continues.

People carry a lot of guilt and shame for using while pregnant. They are often denied custody of their children and then relapse because that is how they have coped with past trauma. It's important to know that no one wants to be pregnant and have a substance use disorder. We know substance use disorders are intergenerational. We just don't do enough to stop that cycle.

RJ scholars and activists have long insisted on building an infrastructure for safety, wellness, and dignity (Ross and Solinger; Zavella). Thompson actively works in community to create networks of care and situates midwifery within the broader RJ struggle:

Reproductive justice is the framework that informs my practice and ideally most of midwifery. I have always believed that people should have however many children whichever ways they want to. I think that's fundamental to reproductive justice. Part of that is being able to keep that child, not having DHS involved if we don't need to. So how can we in our clinic make it so that we are setting them up for success when they give birth? Then what do the women want? Do they want more children? Do they not want more children? How does that look? How are we making sure that we are providing birth control in an ethical way? When people have substance use disorders and mental illness, it doesn't feel great doing a tubal ligation, even if they want it and have wanted it for thirty days. Using reproductive justice as a framework to navigate that gray area is helpful.

Thompson's interview imparts how economic deprivation, mental health, incarceration, and substance use disorders contour the lives of rural mothers and parents in Iowa, many of whom are, in the words of Jonathan Metz, "dying of whiteness." Social safety nets that have supported a strong working class were eviscerated by Republican state lawmakers in recent years as trade policies evacuated small towns of economic opportunities and fair labour conditions. Racism and xenophobia offer convenient scapegoats within this geopolitical terrain. Thompson strives to expand compassionate, trauma-informed care to vulnerable communities while building a better care infrastructure, asserting as she does the fundamental tenets of RJ: the right to have children, to not have children, and to parent your children in safe and sustainable environments.

Conclusion

These case studies reveal a more nuanced picture of Iowa and the Midwest. They show how RJ, as framework and praxis, can help us understand and address the complexities of motherhood and mothering in the twenty-first-century US. Coleman, Novak, and Thompson's clinical work and analysis imparts how economically disadvantaged mothers and birthing people of colour traverse the day-to-day systems that deny them basic access to reproductive and maternal care. Their experiences providing care to marginalized communities contests colloquial tropes (e.g., "Iowa nice") to disclose how state policies authorize cruelty and violence against the rural poor and communities of colour.

At the same time, our interlocutors made clear how communities across Iowa fight every day against state-sanctioned iniquity. Their resilience is part of a collective struggle exposing the violence of a white supremacist, misogynistic, neoliberal state. RJ, with its focus on human rights and bodily autonomy, shapes how Black, Brown, and poor white mothers organize to keep their families together and safe. These stories of twenty-first-century mothering bring to light the need for a justice-based framework—one that centres dignity, self-determination, and care. It is our hope that RJ provides the critical conceptual tools to bring forth a more equitable and just motherhood.

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