SOCIAL MEDICINE: PRENATAL CARE IN A GROUP SETTING

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A dissertation submitted to the faculty of the University of North Carolina at Chapel Hill in partial fulfillment of the requirements for the degree of Doctor of Philosophy in the Department of Anthropology.

Chapel Hill
2017

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ABSTRACT

Taylor A. Livingston: Social Medicine: Prenatal Care in a Group Setting
(Under the direction of Karla Slocum)

CenteringPregnancy (CP) is a facilitative, non-hierarchal group prenatal healthcare program, which challenges the traditional provider-patient model of prenatal care and its central tenet that women and their pregnant bodies need medical professionals' surveillance and intervention. Research has shown that participants of CP have better birth outcomes than women seeking traditional prenatal care, especially in reducing the rates of preterm and low birthweight babies. This is of special importance as the US, particularly the US South, has the worst birth outcomes of any industrialized nation (National Academy of Science 2013). However, *why* CP participants have better birth outcomes is unknown. Based on an ethnographic investigation of the lived experience of CenteringPregnancy in Durham, NC, I argue that by breaking down the traditional hierarchal divide of patient/provider, combined with a facilitative style rather than didactic, lecture style of health education, Centering increases the participants' cultural health capital. That is, the "repertoire of cultural skills, verbal and nonverbal competencies, attitudes, and behaviors, and interactional styles can influence health care interactions at a given historical moment" (Shim 2010:2). Further, the structure of Centering also allows for the group to become a form of social support for women. The increasing cultural health capital makes women more likely to adopt practices associated with better birth outcomes, while the social support engendered by the group may act as a buffer to the intersectional stressors experienced by women in the South today. Both of these aspects may contribute to better birth outcomes. At the

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same time, how a woman's cultural health capital is enhanced, and how and when they benefit

from the social support engendered by the group is shaped by the intersections of race and class.

Further, the extent to which Centering is successful in combating health disparities in birth

outcomes is limited by its assumption of an autonomous individual who is freely able to make

healthcare decisions.

To Alison Piepmeier who taught me how.

ACKNOWLEDGEMENTS

This work would not have been possible without the participants and healthcare providers of the CenteringPregnancy groups I observed and facilitated. Thank you for allowing me into your circle, letting me participate in your pregnancy experiences, and for sharing the details of your lives. I am forever in your debt.

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CHAPTER 1: INTRODUCTION

This is not your standard prenatal visit: there are nametags, cookies, and group yoga. CenteringPregnancy (CP or Centering) is a group, facilitative, non-hierarchal prenatal care program that provides the services of a traditional, one to one patient-provider model of prenatal care, while also connecting a group of women who have roughly the same due date, to discuss aspects of pregnancy and motherhood. In the 1990s, certified nurse midwife, Sharon Schindler-Rising developed the concept based on her experiences as a healthcare provider at the University of Minnesota in the 1970s. Since then, the program has grown in popularity and geography, spreading all around the country, and most recently, the world.

Background

Unlike the authoritative knowledge practices of obstetrics and gynecology termed the technocratic model of birth by Robbie Davis-Floyd (1992), which views the body as a machine, and pregnancy as a problem that needs to be fixed, the authoritative knowledge practice of CP attempts to create an empathetic, respectful, caring environment. Much of this environment is attributed to CenteringPregnancy's "Thirteen Essential Elements":

1. Health assessment occurs within the group space
2. Women are involved in self-care activities
3. A facilitative leadership style is used
4. Each session has an overall plan
5. Attention is given to the core content; emphasis may vary
6. There is stability of group leadership
7. Group conduct honors the contribution of each member
8. The group session is conducted in a circle
9. Group composition is stable but not rigid
10. Group size is optimal to promote the process
11. Involvement of family support is optimal
12. Opportunity for socializing within the group is provided
13. There is ongoing evaluation of outcomes

Schindler-Rising compares these elements to the key ingredients of what she calls "the Crockpot that is CenteringPregnancy." She notes there is room in the Crockpot for customizing the recipe to appeal to each group's "palate" (Schindler-Rising and Jolivet 2011: 367-8).

CenteringPregnancy programs are composed of eight to fourteen women who have roughly the same due date. There are ten sessions for every cohort of pregnant women, each with a health topic. These sessions correspond with the visits for traditional prenatal care, except for the last Centering session, which is a group reunion. All sessions are open to partners or other support providers, but children are not allowed. The same midwife and nurse lead all of the CP sessions. Meetings usually last two hours, with the first 30-45 minutes reserved for five to eight minute individual meetings with a healthcare provider called "mat time," during which each woman discusses her vitals, listens to the fetal heartbeat, and poses any questions she may have. Upon arriving for the meeting, each woman takes her blood pressure, record their weight, and perform a simple urinalysis by dipping test strips that change color in the presence or absence of markers in the urine: nitrites, leukocytes that signal infection, proteins, and/or ketones, which signal pre-eclampsia or high blood pressure. The remainder of the time is devoted to social interaction while other women are having "mat time," followed by a full group discussion, with topics ranging from birth expectations and breastfeeding, to oral health and stress management (Bell 2012; Centering Healthcare Institute 2014).

CenteringPregnancy programs are widely popular with providers and patients, having a 97% approval rating (Centering Healthcare Institute 2014). Research on CenteringPregnancy programs shows that this type of group prenatal care is effective in increasing knowledge of pregnancy, perceived social support, decreasing anxiety, fostering mothering skills, and improving self-image (Baldwin 2006; Herrman et al. 2012). Further, research also shows that

CenteringPregnancy has improved birth outcomes, decreasing rates of preterm and low-birthweight babies, increasing breastfeeding initiation, and promoting healthy weight gain during pregnancy (Herrman et al. 2012; Ickovicks 2003, 2007; Kennedy et al. 2009; Klima et al. 2009; Novick et al. 2011). This is especially true for low-income, African American women participants who are 47% less likely to have preterm infants than women receiving traditional prenatal care (Picklesimer et al. 2012). This reduction essentially removes the health disparity in preterm and low birthweight babies between African American women as a whole and the general population of American mothers (Giscombe and Lobel 2005).

Research Questions

However, this research does not explore which *aspects* of Centering result in these better perinatal outcomes. Instead, my research focuses on which aspects of the CP experience *possibly* contribute to better birth outcomes for preterm and low birthweight. My research examined women's ideas about and experiences with CenteringPregnancy, and I explored the following questions:

1. Which reasons do women give for choosing CenteringPregnancy programs over traditional biomedical prenatal care?

2. How do women participating in CenteringPregnancy programs incorporate aspects of the program into their antepartum health behaviors and infant care practices? What are the aspects they choose and why?

3. Do race and socioeconomic status influence a woman's participation and adoption of CenteringPregnancy principles into their prenatal care and parenting behaviors? And if so, how?

In order to answer these questions, I undertook research while serving as a facilitator at four Centering groups—two at a public health clinic and two at a private obstetrics, gynecology,

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and midwifery practice. From October 2014-July 2015, I conducted participant observation, carried out semi-structured interviews, and administered surveys to the women who attended these groups. The populations served by these sites were disparate. The health department serves younger low-income, women who are mostly on Medicaid and mostly African American, while the private practice serves an older, white, middle to upper income population that holds private insurance.

I relied on ethnographic methods, allowing for a deeper understanding of the lived experience of CenteringPregnancy, beyond a strict quantitative focus on rates of preterm and low birthweight. An ethnographic focus allows for an exploration of how identities, peer and family networks, relationships with healthcare providers, cultural meanings of motherhood, and cultural and historical views of the intersection of race, gender, and socioeconomics converge, shaping birth outcomes. Using anthropological perspectives and methods to address these issues, I continue the work of Alaka Wali and Leith Mullings (2001) in exploring the role of the larger structural factors that affect a women's experience of pregnancy. Instead of seeing pregnancy as a bounded 40-week event, this perspective examines the ways in which the lived experiences of the intersections of race, class, and female gender shape birth outcomes. My work adds to this an exploration of how these larger structural forces may also shape women's prenatal healthcare experiences. This focus is of particular importance as it may help address health inequalities in maternal and child health, since the United States, and in particular the American South, has the worst birth outcomes of any industrialized nation (Centers for Disease Control and Prevention 2011).

Location

Durham, North Carolina, the "City of Medicine," was home to only these two CenteringPregnancy programs at the time of this research. Durham prides itself on research and

innovation, being home to over 300 medical and healthcare practices, including many global biotech firms. Located in the larger and industrially active Triangle area of North Carolina, Durham represents the ideal of the "New South," having changed its agrarian past reliance on tobacco cultivation to transform itself into a city where one in three residents works in a health-related field. As such, it is a useful site for exploring the connections between race, class, and prenatal care due to the city's connections to medicine, scholarship, race and class demographics, and history.

In 2010, Durham had a population of 228,330. The racial breakdown of the population is: 40% white, 41% African American, 5% Asian, 3.9% mixed race, 2.8% some other race, 14.8% Hispanic or Latino, and 0.5% Native American. As compared with the state of North Carolina, Durham has a higher percentage of African Americans (41% compared to 26%), twice the number of Asians and Hispanic or Latino population, and 30% fewer whites (US Census Bureau 2010). Further, 20% of Durham county residents live in poverty, as compared to 18% in NC, and 14.5% in the US (Partnership for a Healthy Durham 2013). Durham County's low birthweight and preterm birth rates are comparable to the national average of 8% of infants born low birthweight and 11.6% classified as preterm (Centers for Disease Control and Prevention 2014). However, although minorities make up 41% of all Durham births, they account for approximately 57% of all infant deaths and low birthweight. African American babies have the highest rates of infant death and low birthweight babies in the city (Partnership for a Health Durham 2013).

Durham also has a rich African American history. Durham was home to Hayti, an African American settlement that flourished from 1868-1940 (Anderson 2011). Booker T. Washington called Durham "the city of Negro Enterprise" (Washington 1911), and it was noted

by W.E.B. DuBois (1912) for being "tolerant and helpful." Historic Durham was home to one of the nation's strongest historic African American business districts known as "Black Wall Street" (Anderson 2011; Brown 2008). Black Wall Street included the North Carolina Mutual Life Insurance Company, the nation's oldest and largest African American-owned bank in the country. Durham is also home to the first publicly funded liberal arts college for African Americans—North Carolina Central University. All of these institutions mark Durham as having a strong and significant Black middle class.

Durham has a place in the Civil Rights movement as the site of the first sit-ins of the movement (Anderson 2011). In 1957, seven African American men and women challenged segregation law by sitting on the "white side" of the Royal Ice Cream Parlor. The sit-in was led by Rev. Douglas Moore, a classmate at Boston University of Dr. Martin Luther King, Jr. King even joined his fellow classmate at another sit-in at Woolworth's lunch counter in 1960, where he first endorsed direct, but non-violence confrontation with segregation laws (Brown 2008). Given this background, Durham provides an ideal setting to explore the intersections of race and class as related to lived experiences of prenatal care because of its long history of an active and thriving African American population.

Durham, and North Carolina more broadly, has a unique relationship with motherhood, as non-consensual sterilizations were performed there until 1972, with over 7,600 people involuntary sterilized (Klein 2012). Originally, the Eugenics Board of North Carolina established in 1933, targeted poor white women for sterilization (Castles 2002; Schoen 2005). However, beginning in the 1950s as more and more African American families appeared on welfare rolls, welfare officials used the eugenics policy to begin sterilizing African American women in greater numbers. From the 1950s until the late 1960s, over 80% of those sterilized in North

Carolina were African American women (Klein 2012). The state did not apologize for the sterilizations until 2001, and did not give any victims compensation until 2003 (Schoen 2005). In 2012 the state decided to compensate all victims of sterilization with $25,000. However, only victims who were alive could apply for the money, and many did not receive any compensation as funds ran out (Klein 2012; Severson 2011, 2012).

The Argument to Come

My research was informed by this history and cultural context, as well as by various theories from medical and cultural anthropology and feminism. The study reveals that two issues were most salient for women in remediating the likelihood of low birthweight and preterm infants: 1. the social support offered by the group and 2. the non-hierarchal relationship between patient and provider. Drawing on literatures on discordant cultural capital in healthcare experiences, intersectionality and health, and the role of social support, in the chapters that follow, I argue that the facilitative and group structure of CenteringPregnancy enables an increase in women's cultural health capital, which is the "repertoire of cultural skills, verbal and nonverbal competencies, attitudes, and behaviors, and interactional styles can influence health care interactions at a given historical moment" (Shim 2010:2). For middle class white women, it does so because the program provides more biomedical information about their bodies, a mutually respected competency among patients and providers. For low-income, African American women, their cultural health capital increases because the program presents biomedical information in a more receptive, respecting environment than traditional prenatal care. However, there are limitations in the extent to which the program supports Black women because it does not consider their lived experiences of race and class. Further, the structure of the program allows the group to become a form of social support for patients. My data show that this is particularly important for African American women because they have less perceived social

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support than the white women in my sample. Additionally, the program draws upon and builds on social support, an already valued community resource.

Although the program is beneficial to women in these ways, it is still based upon the biomedical notion of the autonomous individual (Kittay 2016). This program conveys that better health must be brought about through adopting individual healthy behaviors, and does not address or acknowledge that patients are rarely autonomous individuals who have the ability to make free choices about their health. Indeed, most patients' choices and decisions are constrained by larger, systemic, intersectional hierarchies of power. When the role of these larger structures is acknowledged, it is only by the Centering healthcare providers and not the larger CenteringPregnancy organization. In this way, the program cannot eradicate the problem of preterm and low birthweight because it focuses on individual change and is not tailored to address the lived realities and needs of women participants who are most impacted by inequality.

Chapter Two elaborates on these theoretical underpinnings of my research. I review the literature on intersectionality, cultural health capital, and social support. At the end of the chapter, I explain in depth my overall argument for this dissertation. Chapter Three discusses the methods used to conduct this research, and provides detailed information about the sites of this ethnography. It also discusses how my social location shaped and influenced the relationships I was able to form and the information I was able to obtain. Chapter Four explores the theme of non-hierarchal, facilitator power relations and the effects it has on the participants and care providers. Particularly, it shows how women are able to increase their cultural health capital through CP healthcare interactions. Chapter 5 focuses on race and class differences in the experience of CenteringPregnancy. It provides a detailed discussion of the history of Durham, NC and the enduring legacy of biomedical abuses of Black bodies. Chapter 6 presents the

findings about Centering and social support, using interview and Perceived Social Support

survey data. Additionally, it explores the different ways African American and white women

benefit from the support Centering creates. Chapter 7 is a summation of the study, and discusses

the importance of the research.

CHAPTER TWO: REVIEW OF THE LITERATURE

This research brings insights from related literatures on the anthropology of reproduction, intersectionality and health, the role of social support, and discordant cultural capital in healthcare experiences. Below is a review of this literature, which frames and guides my investigation and analysis. First, I review the field of the anthropology of reproduction. Next, I review public health and anthropological perspectives on perinatal health disparities and the connection between stress and health. Finally, I review the literature on a recent (2010) theoretical perspective aiding to understand health disparities—cultural health capital. I conclude with remarks about how all of these bodies of literature shape my understanding of the lived experience of CenteringPregnancy, and how this affects perinatal outcomes.

Anthropology of Reproduction

With the 1970's "second-wave[1]" of feminism and women's health movement came inspiration for more work in anthropology on the analysis of reproduction as an experience of both power and subordination (Ginsburg and Rapp 1991). Beginning in the late 1980s and early 1990s, medical anthropologists explored the experiences of pregnancy in the United States and cross-culturally with an analysis of the production of authoritative knowledge (Davis-Floyd 1992; Jordan 1983; Martin 1987). This scholarship explored how biomedical knowledge became authoritative and legitimate, thereby devaluing and dismissing all other ways of knowing as backwards or ignorant (Jordan 1993). Many of these scholars challenged the way American and other Western women gave birth, comparing the preferred supine position of obstetrics and its

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[1] See Thompson 2002 for a discussion and critique of the feminist wave metaphor

various and arguably unnecessary technologies as emblematic of biomedicine's hegemony (Davis-Floyd 1992; Davis-Floyd and Sargent 1997). Since the request of Rayna Rapp and Faye Ginsburg in "The Politics of Reproduction" (Ginsburg and Rapp 1991) that anthropologists explore all aspects of reproduction, many have heeded the call (e.g., Bledsoe 2002; Greenhalgh 1994; Hay 1999; Kahn 2000; Inhorn 2006; Rivkin-Fish 2005; Thomas 2003; Whittaker 2010). This includes Gertrude Fraser's (1995) work tracing the genealogy of the rise of obstetrics and gynecology at the expense of traditional African American midwifery.

Later in the decade and into the new millennium, anthropologists of reproduction focused on new reproductive technologies, such as amniocentesis and *in vitro* fertilization (e.g., Inhorn 2003; Rapp 1999; Thompson 2005). More recent work in the anthropology of reproduction has continued to focus on new medical technologies and pregnant bodies. This includes Elly Teman's (2010) work on surrogacy and Jacquelyne Luce's (2010) exploration of assisted reproductive technologies among non-heteronormative families.

Much of the work of medical anthropologists of reproduction has examined how women's class position in the US correlate with the ways they relate to traditional biomedical notions of pregnancy as an authoritative source of knowledge. An important example of this is Emily Martin's (1987) comparison of the differences in how women with higher education and working class women described female bodily reproductive processes. Revealing how dominant, traditional biomedical understandings described woman's reproductive processes through a series of highly derogatory metaphors, Martin examined whether different socio-economically positioned groups of women accepted these metaphors. She found that white women with higher education and a middle-to upper class positioning were far more likely to echo these metaphors than working class women. She noted that "those at the bottom of the heap tend to see more

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deeply and clearly the nature of the oppressions enacted by those at the top of the heap" (Martin 1987: 202).

My work builds upon the work in the anthropology of reproduction by expanding the focus on reproduction to include the whole pregnancy experience—from the beginning of prenatal care to new motherhood. Specifically, my work engages with the scholarship on biomedicine as an authoritative knowledge to demonstrate that CenteringPregnancy challenges the technocratic model (Davis-Floyd 1992) of biomedicine by empowering women through teaching them about their bodies. The technocratic model of birth and prenatal care, the traditional biomedical model, makes decisions about women and their pregnancies based on objective, scientific facts and measurements from tests and techniques. The opposite of the technocratic model is the holistic model, which views birth as a spiritual and natural process, and prenatal care as a means to make sure the mother is physically and emotionally healthy as determined by the mother's intuitive knowledge of her body (Davis Floyd 1992: 160-162). The holistic view is often associated with midwifery, not the midwifery of certified nurse midwives (CNM), but of certified practicing midwives (CPM). Certified nurse midwives are registered nurses who have biomedical training, while lay midwives' training is comprised of observing and assisting in a number of births. Lay midwifery is closely aligned with the historical practice of traditional midwifery.

Until the advent of obstetrics and gynecology in the second half of the 19th century, women who had experience aiding women in birth, and who were called midwives, delivered babies (Smith 1995). With the rise of obstetrics and gynecology, more women began to trust doctors with the delivery of their infants (Wolf 2001). However, the practice of midwifery continued in rural areas, and especially the South. During the antebellum period and continuing

until after WWII, midwives in the South were mostly black women, who delivered the babies of black and white women (Fraser 1998; Smith 1995). Surrounded by female kin and a midwife, women were offered emotional support and herbal concoctions to keep spirits up, as birth was seen as a natural part of life (McMillen 1990). From the 1900s-1960s, states passed increasing regulations for the practice of African American midwifery. Biomedical and Public Health campaigns at the time attributed the high infant and maternal mortality rates in the South to African American midwives, and not to the poverty of the rural areas, even though there was evidence to the contrary (Fraser 1998; Smith 1995). The basis of many of these campaigns was to increase the authority and role of doctors, mostly male, over births, shifting control away from female midwives. However, even with all of these imposed regulations, Southern African American women and even some white women still preferred using midwives over doctors well into the 20th century. Midwives were often preferred because they viewed birth as a common occurrence instead of a medical event needing intervention, doing little to interfere in the process except offering support (McMillen 1990). Further, unlike midwives, doctors had limited knowledge of birth (McMillen 1990), and were less likely to treat African American women with respect (Smith 1995) and understanding for their social locations. Ultimately, lay midwifery became increasing regulated and developed into certified nurse midwifery in the mid-1940s (Varney 2015).

A resurgence of lay midwifery began during the women's health movement in the 1970s (Morgen 2002), championed by Ina May Gaskin and her Tennessee midwifery training center, The Farm, and the publication of her book, *Spiritual Midwifery* (1975). Sharon Schindler-Rising, the creator of CenteringPregnancy, based many of the principles of the program off of the resurgence of midwifery during the second wave of feminism, as well as her training as a

certified nurse midwife at Yale. As such, Centering blurs the boundaries between traditional biomedical prenatal care and alternative healing system.

CenteringPregnancy lies in the middle of the spectrum from "technocratic" to "wholistic" birth models[2] (Davis-Floyd 1992). While it challenges the technocratic idea that pregnancy is a pathology, and the separation of the mind and body (Davis-Floyd 1992), it does ascribe to certain biomedical premises, such as pregnancy should be monitored through testing. The clearest example of Centering's "yes, but" approach is its ideology surrounding vitals. While Centering upholds the ideology that scientific tests, such as monitoring of blood pressure, weight, and urinalysis are necessary to ensure a healthy pregnancy, the program teaches patients how to perform these tests. Once they have been taught, patients perform these tests without a medical professionals' surveillance, and they keep track of their vitals in their Centering notebooks, which serve as their medical record.

Thus, by not completely adhering to the technocratic model of birth, and incorporating aspects of the formerly alternative medical model of midwifery, particularly the notion that birth is a natural process, Centering teaches women about their bodies. This approach of Centering increases what Shim (2010) calls, cultural health capital, making women more likely to adopt Centering's healthcare practices that are known to improve perinatal outcomes. This is especially true for women of non-dominant race and class positions.

For this study, I move beyond Martin's (1987)[3] assumption that the categories of oppression sexism, racism, and classism, are discrete. This view assumes that these categories are additive (Nuval-Davis 2006) and get "piled on," like a stack of bricks; one must deal with the

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[2] See Table 4.1 for more information. Davis-Floyd uses "wholsitic" instead of holistic, so this is the terminology I use throughout.

[3] Later in her career, Martin does adopt the lens of intersectionality (see Martin 2006)

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crushing weight of these oppressions separately. However, this neglects the ways the intersection of race, class, and gender could affect how authoritative knowledge in biomedicine is viewed. Instead, I incorporate the theory of intersectionality brought to anthropology by Black feminist anthropologists[4], to examine how the intersections of race and class come to bear on women participating in Centering programs, and how it shapes their adoption of CP's form of authoritative knowledge.

Race, Class, and Gender

Intersectionality, the idea that race, class, gender, and other hierarchies of privilege and oppression are not additive, but connecting and simultaneously experienced categories (Andersen and Collins 1994; Crenshaw 1991; Mullings 1997, 2005), provides an important lens to understand how lived experience of interlocking oppressions connects to health outcomes (Schultz and Mullings 2006). With roots in Black Feminist Theory, intersectionality demonstrates that culturally constructed categories interact on multiple levels. As such, the traditional bounded categories of discrimination—racism, classism, heterosexism, sexism—do not act independently of one another, but intersect and manifest to varying degrees and configurations in each person's life (Collins 2000; Crenshaw 1991).

In her 1997 work, *On Our Own Terms: Race, Class, and Gender in the Lives of African American Women*, Leith Mullings brought the concept of intersectionality, developed in the disciplines of sociology and legal studies, to the field of anthropology. Applying the lens of intersectionality to her exploration of African American women's reproductive experiences in Central Harlem, Mullings found that the stress of racism, sexism, and classism, such as inadequate living conditions and job insecurity, had a negative effect on birth outcomes. Women,

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[4] See McClaurin 2001 for a discussion of Black feminist anthropology

who experienced poor housing, low income, no childcare, and a lack of support in their lives, had higher rates of preterm birth, low birthweight babies, and infant mortality (Mullings and Wali 2001). Mullings (2005) terms the combined effects of these stressors "The Sojourner Syndrome." "The Sojourner Syndrome" was inspired by "John Henryism," Sherman James' moniker for the coping mechanism of strength and perseverance in the face of psychosocial stress and low-socioeconomic status in African Americans, which negatively impacts health (James 1994; Mullings 2005). The "strong behavioral disposition" (James 1994: 163) was named after the famed African American railroad worker who competed against a steam-powered drill. Although he won the race, Henry immediately dropped dead of exhaustion (James 1994).

Adding the lived experience of gender to James' model, Mullings (2005) named "The Sojourner Syndrome" after feminist, abolitionist, and former slave, Sojourner Truth. In "Ain't I a Woman?" Truth states,

> *That man over there says that women need to be helped into carriages, and lifted over ditches, and to have the best place everywhere. Nobody ever helps me into carriages, or over mud-puddles, or gives me any best place! And ain't I a woman? Look at me! Look at my arm! I have ploughed and planted, and gathered into barns, and no man could head me! And ain't I a woman? I could work as much and eat as much as a man - when I could get it - and bear the lash as well! And ain't I a woman? (*1851)

In this speech, Truth acknowledges the interlocking categories of sexism and racism— the concept of intersectionality—over 200 years before the term was coined. Mullings' choice of Truth for representing the syndrome is trenchant, acknowledging the direct approach that Truth took to her rhetoric. When two white men heckled her, questioning her femininity, Truth bared her breasts to them and asked if they wanted to suckle (Washington 2009).

While "The Sojourner Syndrome" has many costs, including negative health outcomes, it is a strategy of resilience, as it has allowed for the continuity of African American communities in spite of slavery, segregation, and institutionalized racism (Mullings 2005). "The Sojourner

Syndrome" recognizes women's agency and their struggles to ameliorate their living conditions through actions such as taking negligent landlords to housing courts, or going out of their way to purchase affordable fresh fruits and vegetables (Mullings and Wali 2001).

The "Sojourner Syndrome" serves a metaphorical model showing that the influences of race, class, and sexism on African American women "cannot be understood by looking separately at the categories of race, class, and gender" (Mullings 2005: 87). Mullings uses the "Sojourner Syndrome" to bring the concept of intersectionality into the field of public health (see Schultz and Mullings 2006). In doing so, she challenges public health individual risk, instead encouraging researchers to shift the focus to examine the interlocking matrix of social hierarchies that form the basis of our society. Using this framework, we can "recognize and name" these over-arching social structures to explore how they are interlocking and embodied.

These over-arching structures have roots in American history, such as the fact that African Americans were not considered citizens of the US until the passage of the 16th Amendment, nor were women until the passage of the 19th in 1920. In delving into the particularities and situatedness of these histories and location, I argue the specifics of place and local histories continue to haunt the present by shaping medical encounters, and thus birth outcomes for African American women in the South today.

The resilience of African American women and the importance of social support are at play during CenteringPregnancy programs through two of the "Thirteen Essential Elements of Centering": a facilitative style of leadership is used, and the group honors the contributions of each member (Centering Healthcare Institute 2014). These "Essential Elements" allow women to openly share their lived experiences of pregnancy and all of the stressors they face. Further, traditional power hierarchies between healthcare provider and healthcare consumer are broken

down, possibly allowing for a deeper, more understanding relationship. In essence, these elements enable the group to become a source of social support—a type of resilience to combat the stressors of being a pregnant woman in the South, particularly, an African American woman in the South. My investigation of the lived experience of CenteringPregnancy displays that despite the multitude of stressors that all pregnant women face (Mullings and Wali 2001); the context of CenteringPregnancy programs becomes an intervention that impacts perinatal outcomes. This is largely due to group support, a key aspect of CenteringPregnancy.

Cultural Health Capital

In addition to the literature on stress and its impact on health, recent public health research has shown that the mismatch of ideas over which aspects of history and culture are important in healthcare encounters for providers and patients shape health outcomes as well (Shim 2010). Cultural health capital is the "repertoire of cultural skills, verbal and nonverbal competencies, attitudes, and behaviors, and interactional styles that can influence health care interactions at a given historical moment" (Shim 2010:2). Cultural health capital stems from Pierre Bourdieu's concept of cultural capital (1986), and the work of other scholars who have used his concept to understand healthcare interactions (Dubbin et al. 2013 also see Wall 1995, Malat 2006, and Abel 2008). Cultural capital is knowledge or skill that establishes or improves a person's status in society (Bourdieu 1986). Cultural capital develops through repeated acts of cultural practices and appropriating cultural goods. Bourdieu calls this process of repeated acts and appropriation embodiment. He notes that it is one of the ways inequalities can be reproduced, as those without the cultural resources and skills that are valued in a specific setting are devalued (Bourdieu 1986; Chang et al. 2016; Missine et al. 2014).

These processes of embodiment build a habitus, or a system of dispositions based on past experiences that originate from one's class and related social positioning (gender, race, sexuality,

etc.) in society's hierarchy. This habitus becomes the lens through which one views and engages

with the world (Bourdieu 1990). Shim theorizes cultural health capital as a specific type of

cultural capital that can be used as power in healthcare interactions. Shim (2010: 2) states, "a

proactive attitude towards accumulating knowledge, the ability to understand and use biomedical

information, and an instrumental approach to disease management" are specific aspects of

cultural health capital that are viewed positively by healthcare workers in the US's current

healthcare system. But like Bourdieu's cultural capital, cultural health capital can reveal the

inequality between social groups (Abel 2008; Abel and Frohlich 2012; Cokerman 2007,

Mirowsky and Ross 2003; Shim 2010), as "micro-level practices are linked to the broader

macro-structural level of the unequal distribution of resources" (Missine et al. 2014: 1261). Thus,

healthcare interactions between patient and provider can reveal differing educational

understandings of biology, as linked to structural class differences.

The ability to accumulate and deploy cultural health capital is not intentional, but is based

on preexisting knowledge and behaviors, largely related to one's class habitus (Shim 2010:5).

This may result in a widening health disparity between those who possess cultural health capital,

and those who do not. In the current American healthcare landscape, demand is placed on

patients to cultivate cultural skills, navigate healthcare bureaucracy, and take control of their own

care due to time-constrained doctors (Shim 2010: 6). But, this goes beyond health literacy, the

ability to obtain and understand health information required to make appropriate health

decisions, because cultural health capital has a transactional and interactional nature. For

example, a patient who is health literate and uses biomedical terms is more likely to create

mutually satisfying relationships with providers, enabling the negotiation of conflicts or

misunderstandings and resulting in better outcomes. Further, this ability to use biomedical

concepts may serve as a means of exchange—cultural health capital—that positively influences providers' perceptions of patients. As such, Shim (2010:7) argues that patients who use cultural health capital "to present themselves and their health issues in approval-garnering and medically intelligible ways can generate 'cascades' of subsequent interactions and actions […] that may enhance communication and care.". Through these practices, patients can continually build their cultural resources to navigate healthcare. Further, healthcare professionals may use the cultural resources that patients display to help them accrue more cultural health capital by providing additional information and skills.

Conversely, they may also discourage patient cultural health capital (Sudhinaraset et al. 2016). Shim posits that if health professionals do not view patients' cultural resources positively, the care they provide may be technically appropriate but may not resonate with the patient's values nor enhance the patient's cultural health capital by opening up avenues for richer health understandings, information, and skills (Shim 2010:8). In the current healthcare system, discordant cultural health capital has been shown to disadvantage minority patients, as a "mismatch" between patient and provider cultural health capital (Dubbin et al. 2013; Madden 2015; Sudhinaraset et al. 2016). Further, Erin Madden (2015) argues that the skills and values of the cultural health capital concept are those of white upper middle class standards of healthcare. In an effort to combat a "deficit" view of cultural health capital, Madden (2015) contends oppressed groups use their own cultural resources called "community cultural wealth," a term borrowed from Tara Yosso (2005). "Community cultural wealth" is the way marginalized communities employ community-based forms of cultural health capital, such as using social support and social networks, to meet healthcare needs.

This mismatch, as will soon be shown, was evident in my research when women spoke about their previous healthcare interactions while receiving traditional biomedical prenatal care. Though the prenatal healthcare information is technically correct, due to discordant cultural health capital between healthcare provider and consumer, the information may not resonate with women. However, since pregnancy information provided by CenteringPregnancy is delivered in minimized hierarchal fashion, health information may resonate more and/or allow women to improve their own cultural health capital.

The discordance of cultural health capitals between pregnant women and their traditional, biomedical prenatal care providers may account for the differential perinatal outcomes between traditional prenatal care patients and those choosing CenteringPregnancy. My data show that providers using CenteringPregnancy's "facilitative rather than didactic style" (Centering Healthcare Institute 2014) of providing prenatal care and health information are able to create mutually agreeable healthcare interactions in which women are respected, welcomed, and not judged. This makes women more receptive to the prenatal care recommendations of Centering, and facilitates an increase in their cultural health capital. This may enable better health outcomes.

Health Disparities

Many hypotheses have been proposed to explain health disparities in the US, especially the disparities between the contentious categories of African Americans and whites (Schultz and Mullings 2006). One particular area of concern is infant and maternal morbidity and mortality. The US has the highest rates of preterm and low birth-weight babies in the industrialized world, driven in part by the disparity between African American women's birth outcomes and those of white women. Even when controlling for socioeconomic status African American women are twice as likely to have premature or low-birthweight babies (Braveman et al. 2015; Doyle et al. 2004; Orr 2002), rendering their children more likely to have lower cognitive abilities and higher

attention problems at age six (Talge et al. 2010). Further, low birthweight infants are more likely to develop high blood pressure, high cholesterol, type two diabetes, and vascular diseases as adults (Hoffman et al. 2004; Parkinson et al. 2013).

Previous public health and biomedical explanations for the racial disparity in infant health focus on biological, rather than social determinants of health (Hillier et al. 1995; Rawlings et al. 1995). However, public health literature in the past two decades has increasingly focused on the social determinants of health, "factors other than medical care that can be influenced by social policies and shape health in powerful ways" (Braveman and Gottleib 2014:19). These factors include the health conditions of neighborhoods, such as: are the neighborhoods walkable, or do they contain recreational areas, and access to fresh, healthy food? Increased attention and research in this area has been bolstered by the World Health Organization's Commission on Social Determinants of Health (2008) and similar US-only contexts funded by the MacArthur and the Robert Wood Johnson Foundations[5]. The focus of this research has been on how the "upstream" areas of social determinants, socioeconomic status, educational attainment, and racial discrimination shape the "downstream" determinants—individual health behaviors (Braveman et al. 2010). Research in this area has focused on socioeconomic factors, particularly wealth and educational attainment (Adler et al. 1999; Braveman and Gottleib 2014; Koch et al. 2010). Some studies argue that, after accounting for socioeconomic factors, racial differences in health disparities disappeared or were greatly diminished (Braveman et al. 2005; Fuller-Thompson et al. 2009; Williams and Collins 1995). This research does not account for the high discrepancy in birth outcomes between white and Black women, as the discrepancy is the highest among highly educated women (Braveman 2011).

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[5] See Braveman et al. 2010 for a review of the literature.

Research exploring how racial discrimination affects birth outcomes (e.g., Braveman et al. 2015; Krieger 1999) has shown that stress from daily racism shape the rates of low birth weight infants and preterm births (Mustellio et al. 2004; Rankin et al. 2011; Rosenburg et al. 2002; Slaughter-Acey et al. 2016).

Notably, research into the area of social determinants of health rarely uses the theory of intersectionality (e.g.Bowleg 2012; Hankivisky and Christoffersen 2008), with the exception of the work of Nancy Krieger (1999) and Lynn Weber (2006). As suggested above, when exploring the connections between social environment and health generally only one determinant is examined, while the others are controlled for using statistical analysis. This runs counter to the theory of intersectionality, which argues that categories of social identity are interlocking and simultaneous, thus cannot be examined separately. Instead, research should focus on how these social identities converge to shape experiences of privilege and oppression. Failing to do so can lead to "analyses that are less policy relevant and analytically sound than would otherwise be the case." (Phoenix and Pattynama 2006:189 as cited in Hankivisky and Christoffersen 2008:271). Much of the problem on how to incorporate intersectionality into public health results from difficulties related to methodology (Bowleg 2012; Hankivisky and Christoffersen 2008). There is a lack of information available on how to conduct intersectional research, and research that does use an intersectional approach use methods that are qualitative or mixed-methods (e.g. McCall 2005). Further, it is difficult to use solely quantitative analysis to reveal intersectionality (e.g. McGrath and Johnson 2003) as many statistical tests rely on assumptions of "linearity, unidimensionality of measures, and uncorrelated error components" (Bowleg 2012:1270).

Social Support and Health

One particular area of research in examining one's social environment and the effect it has on health is investigating the role of social support. Public health researchers have defined

social support as "the resources provided by other persons," (Cohen and Syme 1985:4), particularly by family and friends. Social support is often further divided into three categories: emotional, instrumental, and informative. Emotional support is the care and warmth provided by partners and friends. Informational support provides the resources of knowledge and advice, while instrumental support provides tangible resources, such as money or assistance with tasks (Harley and Eskenazi 2006). For the past thirty years, public health has paid particular attention to the influence of social support of health and well-being (e.g., Berkman and Glass 2000; Cohen et al. 1985). This interest has roots in the work of the French sociologist, Emile Durkheim (1897) and his work on suicide. Durkheim's work suggested that those who are more socially integrated have better health, while those who are more socially isolated do not, as he found that persons less socially integrated into society were more likely to commit suicide.. Public health and medical research have continued to explore this relationship and arrived at two different mechanisms for how social support and health are related.

One proposed mechanism is that social support has a direct positive effect on health, such that increased social support has an inverse relationship with morbidity and mortality (see Uchino 2009 for a review of the literature). The other proposed mechanism is that social support acts as a buffer between stressors and health by social support networks operating as a cognitive and behavioral effort to handle specific demands, which are beyond the resources of the individual (Razurel et al. 2013:75); thus, it is a type of coping mechanism (Orr 2004). However, Cohen (1988) has also proposed the idea that both mechanisms are involved in the relationship between social support and health.

Research exploring the relationship between social support and health during pregnancy has become a popular area of interest in public health as reducing low birthweight and preterm

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births is a major public health challenge in the US (Orr 2004). Both observational and intervention studies have been conducted. Observational studies have shown that the more social support a woman has, the better her pregnancy outcomes. Many studies have shown that social support in the early postpartum period is negatively associated with depressive symptoms (e.g., Checker et al. 2014; Dennis et al. 2004; Howell et al. 2006; Huang 2007; Razurel et al. 2013). Further, research has also shown than social support during the prenatal period is correlated with less distress (e.g., Glazier et al. 2004; Leigh and Milgroom 2008; Lua and Wong 2008; Moss et al. 2009; Razurel et al. 2013). Both prenatal and postpartum social support studies did not a make a distinction between the types of social support. A more recent study by Razurel and Kaiser (2015) showed that emotional and informational support from friends were related to better health outcomes, and emotional support from healthcare professionals was negatively correlated with prenatal anxiety and postnatal depressive symptoms. Further, women who had more support from peers and healthcare professionals were more likely to feel prepared for their births (Razurel and Kaiser 2015: 174-6). This research is of particular importance as literature suggests that mothers experiencing distress and depressive symptoms are at an increased risk of experiencing birth-related complications (e.g., Dunkel Schetter 2011; Hobel et al. 2008; McKee et al. 2001) and increase birthweight among at-risk pregnant women (e.g., Chae et al. 2016; Feldman et al. 2000).

Research studies on maternal social support and birth outcomes suggest there is a statistically significant relationship between the size of a woman's social network and the birthweight and maturity of her baby at delivery (e.g., Feldman et al. 2000; Hetherington et al. 2015; Orr 2004; Zachariah 2009). Intervention studies seeking to increase social support for women identified as having low social support, primarily through home visits by healthcare

providers, have reported some connection between increased social support and better pregnancy outcomes. However, these associations were not statistically significant (e.g., Orr 2004). Finally, Harley and Esknazi (2006) note social support may be connected to better birth outcomes because social support may increase health behaviors in pregnancy, such as smoking and drug cessation, but there are few research studies in this area.

Anthropologists have critiqued the public health investigations of the relationship between social support and birth outcomes discussed above as myopic. Fleuriet (2009) notes that by quantifying, often by counting friends and family, something that is qualitative—social support—important nuances are obscured. For example, she notes researchers go in with pre-conceived notions of social support and pregnant women are not able to define what the term means to them. Thus, if a woman has many friends but does not receive what she considers social support from them, it will appear as if she has a great deal of social support, but in reality, she is not getting the support she desires. Further, Fleuriet argues there is an implicit assumption in public health research that perceived and available social support are equal to the type of social support women desire. This may not be the case, and this assumption may gloss over other important influences on social support and pregnancy, such as the desirability of the pregnancy, which may impact birth outcomes (Fleuriet 2009:58).

Mullings and Wali (2001) also note that the desirability of the pregnancy may affect the correlation between social support and birth outcomes. In their study of reproduction in Central Harlem, they found: "Positive feelings about being pregnant improved attitudes towards self-care, which may be important in shaping pregnancy outcomes" (Mullings and Wali 2001:163). Additionally, Mullings and Wali note that simply quantifying social support does not capture the concordant positive and negative aspects of social support, which are influenced by

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intersectionality. In their work, they found middle income African American women relied more on friends for social support because they felt they would have to give something –often money—in return to family members who supported them, which could strain relations. Low-income African American women relied more on their families for social support; however, because money was scarce, family members could provide less instrumental support, straining familial networks (Mullings and Wali 2001:163). This research upholds Carol Stacks' findings in her work, *All Our Kin* (1974), that there was a much stronger obligation to give, particularly money, to family networks than to friends. This often led those who constantly gave to complain that they were going without.

My research shows that Centering programs serve as a type of informational support, providing knowledge that shapes health behaviors, perhaps influencing better birth outcomes. Additionally, Centering programs also increase emotional support for women who public health literature would deem as having low social support, as these women may not have the quantitative number of friends that would support public health notion's of high emotional support. However, the relationships CP establishes are meaningful. In this way, the social support provided by CP is anthropologically meaningful because it provides a valued resource that is used. CP creates this support through the creation of a community due to its facilitative and non-hierarchal characteristics. This support may act as a buffer for the intersectional stressors pregnant women face.

Community

Community has long been a subject of all fields of anthropological inquiry (e.g., Arensberg 1961; Redfield 1955). Post-World War II studies of community focused on living in a shared location (e.g., Keller 2003; Warren 2004). Community, for these studies, was a unit larger than the family and groups, but smaller than society's more complex components, such as cities

and states. The community unit was significant because it provided socialization for cultural norms as well as a means of social control (Hyland and Bennett 2005). Since the late 1980s, the idea of community has shifted from location being central, to instead, a focus on the "ongoing, often invisible practices" (Helperin 1998:5) that enable people to "protect themselves, acquire resources that provide for their needs […] and provide social values that give purpose to survival" (Hyland and Bennett 2005:5). Another shift in the conception of community occurred by the early 2000s with a focus on how people build communities (e.g., Hyland and Bennett 2005; Keller 2003; Kretzmann and McKnight 1993; Putnam 2000). Putnam's book, *Bowling Alone* (2000), sought to answer how communities develop and persist in the face of capitalism and individualism, which creates a widening distance between classes as well as people from each other (Saegert et al 2001). Central to Putnam's argument is that social capital, resources such as "skills, knowledge, reciprocity, norms, and values" (Hyland and Bennett 2005:7) facilitate community (Putnam 2000). Kretzmann and McKnight (1993) also use the concept of social capital, but divide it into different types of community assets (Hyland and Bennett 2005; van Willigen 2005).

Kretzmann and McKnight's (1993) *Building Communities from the Inside Out* advocates for communities to use and build upon their extant assets to solve their needs and problems. These assets are divided into three major categories: individuals, associations, and institutions. Individual assets are skills and capabilities; associations are "vastly underestimated" (Kretzmann and McKnight 1993:6) assets that are pushed beyond their original purpose, while institutional assets include schools, hospitals, and businesses. In order for communities to solve their problems, they must draw upon these assets to reestablish connections (Kretmann and McKinght 1993; van Willigen 2005). However, John van Willigen (2005) criticizes Kretzmann and

McKnight's assets as being too narrow. He adds to their categories of assets community institutions and community knowledge. Drawing on Ward Goodenough's (1963) concept of community institutions, van Willigen argues these institutions include procedures and arrangements to which people are committed. Community knowledge is the information and practices of locals, in contrast to expert knowledge. Van Willigen (2005) argues that all of the assets, individual, association, institutional, community institutions, and local knowledge are necessary for a community to reach its goals.

In order for a community to reach its health goals, Chrisman (2005) argues that anthropological ideas of community assets, which enable community building, must be applied to public health. For this to be accomplished, anthropologists must communicate ideas of culture, gained from ethnographies with communities to public health researchers. This way, micro-level projects in public health can be linked to the macro-level systems—social determinants—of health. In doing this work, Chrisman argues (2005:189) anthropologists must strike a balance between public health needs and community assets so that communities can mobilize their assets to formulate their own health projects.

The structure of CenteringPregnancy, namely having group prenatal care where participants are encouraged to interact with one another and their healthcare provider, is to facilitate community (Schindler-Rising 1998). Within the sessions, members share the social capital of their skills and resources, their community knowledge to create associations, which fosters a sense of community. However, the importance of this community varies based on race and class. For African American women, the community networks and assets built upon in these groups is one of these "community cultural health" resources Madden (2015) refers to that oppressed groups employ in order to meet their healthcare needs. As the work of Carol Stack

(1974) and Leith Mullings (1997; 2005) have shown, social support is particularly important in navigating and surviving in a racist, classist, sexist society. As such, because CenteringPregnancy builds on this already valued cultural capital in its healthcare interactions between patients and providers and between patients themselves, Centering patients who are low income and/or African American are more likely to view these healthcare interactions positively. Thus, I suggest patients are more likely to adopt the medical advice given by Centering healthcare providers, which has been shown to have more positive birth outcomes. For white women, the importance of community was more important after the birth of their babies. White and upper class women tended to rely more on the community network created to help them adjust to being a mother.

Over-Arching Argument

In order to understand how the lived experience of CenteringPregnancy shapes perinatal outcomes, I use the theories and concepts discussed above. Weaving these together and in the chapters that follow, I argue that:

1. Women who, because of race/class/gender social locations, have felt excluded and mistreated in conventional healthcare are attracted to and benefit from CenteringPregnancy because it enhances their cultural health capital. This leads to more positive healthcare interactions, and thus compliance to the program's recommendations, which may lead to improved perinatal outcomes.

2. The nature of the attractiveness of CP varies for women based on their race and class. Centering is attractive to low income and African American women who employ coping mechanisms such as the "Sojourner Syndrome" (Mullings 2005) or "community cultural wealth" (Yosso 2005) to navigate systems of oppression. As Centering Pregnancy creates a sense of community and acts as a source of social

support, those women who already have social support as an important community cultural capital resource, recognize the importance of social support, and are better able to benefit from CenteringPregnancy information and advice, which contributes to better birth outcomes. Centering is attractive to white, affluent women because it builds upon their knowledge and trust of biomedicine. Further, the social support and community relationships engendered through Centering are important to upper class white women because it helps them cope with the demands of being a new mother.

CHAPTER THREE: METHODOLOGY AND ETHNOGRAPHIC CONTEXT

To explore the lived experiences of women participating in CenteringPregnancy, at a local health department and private obstetrics/gynecology and midwifery practice, I used the anthropological methods of participant observation, surveys, and semi-structured interviews.

Field Sites

Of particular importance to my investigation of CenteringPregnancy programs was to understand how race and class differences came to bear on women's perceptions of and involvement in the program. As such, I chose two different fieldsites, a private obstetrics, gynecology, and midwifery practice and a public health clinic comprising women of various backgrounds who represent the city of Durham, North Carolina.

Recruitment and Profile of Women

I began fieldwork in October of 2014 after learning about CenteringPregnancy from a lactation consultant who volunteered for the program. I helped facilitate two groups each at the health department and private practice, participating and observing all ten sessions of the CenteringPregnancy program. The health department predominately served an African American, Medicaid-recipient, lower-income, younger, single group of women, most of whom already had children. Conversely, the private practice served a primarily white, private insurance, middle to upper income, highly educated, married, and older group of women pregnant with their first child.

I began my fieldwork at the health department. While initially I was interested in using Centering for recruiting for a project on infant feeding decisions, the midwife in charge of the

program at the health department informed me that if I wanted to recruit, I needed to become a facilitator for the program. This midwife, Abra[6], was the regional training director for Centering Healthcare International. As such, I was able to join a training she had scheduled later that month for a large, private research hospital in this area's Family Medicine Leadership Program medical students and their attending physicians.

As mentioned in the introduction, each Centering cohort is composed of eight to fourteen women, one midwife and one facilitator, usually a nurse. Centering at the health department was structured slightly differently. Each cohort had a midwife and nurse, but also one to two additional facilitators. Extra facilitators are needed because the groups are on the larger side, and the nurse for the group is in charge of all of the Centering patients—making sure they have the necessary tests, appointments for ultrasounds, and if applicable, meeting with their case worker. This makes it difficult for the nurse to actually facilitate the sessions, as she is running back and forth between her office and other parts of the clinic tracking down information and people to make sure all of these appointments are scheduled and attended.

Centering groups are divided into two groups, a Spanish-speaking and an English-speaking group at the health department. All of the midwives, who work at the clinic and the private research hospital, are given two Centering groups. At the time of my fieldwork, there were six Centering groups—four English speaking, two Spanish-speaking. As only two of the midwives are fluent in Spanish, they are assigned one of these groups each. Only one nurse at the health department is fluent in Spanish, so she is assigned to the Spanish-speaking groups. The other nurses are randomly assigned to the sessions. One midwife, Abra, and one nurse, Antonia, are the heads of all the Centering programs at the clinic. Abra is a Jewish woman in her mid-

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[6] All names are pseudonyms.

fifties. She is extremely empathic and compassionate about her work and the life situations of her patients. She is warm and kind, often serving as a maternal figure to many of her Centering patients. She is a "true believer" in the CenteringPregnancy model, and the program survives and thrives because of her dedication. Antonia is an older African American woman. A no-nonsense, former military, self-identified "church lady," she has lived and worked in the community for over thirty years. She acts as a grandmother to the group, and often the "bad cop" to what she would consider to be Abra's overly empathetic "good cop," hounding women about missed appointments, lack of following through on issues they previously discussed, and impatience for behaviors she deems unacceptable. Abra forgives all, and Antonia thinks you should know better because she already told you. They are the backbone of the Centering program at the clinic, working far more than required or compensated.

Antonia and Abra are in charge of assigning midwives and nurses to the programs. Abra is in charge of all Centering Healthcare Institute paperwork—certification and birth outcome information, while Antonia is in charge of recruiting for Centering programs at the health department. Centering sessions at the health department are "opt-in," meaning women attending their first prenatal check-up are given information on the program, and if seen by Antonia, are encouraged to attend. In her interview with me, Antonia mentioned that she targets certain women at the clinic for the Centering class, those who "need some extra loving." Most of the women I interviewed mentioned they joined because of Antonia's information about the program, and her stressing they would not have to wait as long as they would in the clinic before being seen by a healthcare professional. Often Antonia would recruit women into the groups up until the third session to make sure the health department had the necessary five people for the Centering program to still be scheduled.

Centering sessions at the private obstetrics and gynecology practice are also organized by one head midwife, Cora. Cora is a sixty year old, jovial, fun-loving African American woman who is exceedingly joyful, but also grounded and pragmatic. She is always happy and positive, but will let you know when she thinks you are being ridiculous, unrealistic, or over-reacting. Additionally, when not with patients, and once she knows you share a similar worldview, can be incredibly direct, displaying her anger at systemic inequalities. Trained as a minister and therapist, Cora brings these insights to her work. She often states that "everything is a conversation."

Sessions at the private practice differ markedly from those at the health department. At the private practice, sessions are smaller, limited to five to eight women. Only healthcare providers who volunteer to lead Centering programs are assigned to them, although most do volunteer. There are two designated Centering nurses who are the facilitators for all the groups. The private practice only offers English-speaking classes, as they do not have a large Spanish-speaking clientele. Additionally, while health department classes last the Centering Healthcare International mandate of two hours, those at the practice last an hour and a half. Programs at the practice also deviated from the Centering International model because the same midwife was not the facilitator throughout all of the sessions. However, Centering at the practice, like the health department, is also opt-in with pregnant women being told about the program at their first prenatal appointment.

In order to recruit for this research, I identified myself as a graduate student at UNC Chapel Hill who was interested in women's experiences of Centering, at the beginning of the first session, and for the second and third session at both sites, when introductions are still taking place. I stated that if women consented, I would conduct an interview with them after their baby

was born, asking about their thoughts about the program. Women who were interested were invited to fill out their contact information on a sheet stating the purpose of my research, which was placed by the Centering sign-in sheet.

I was able to recruit 22 women out of 27 women who participated in the four Centering sessions. The five women who were not recruited did consent and provided contact information. However, after several attempts to schedule and re-schedule interviews, they stopped responding to my emails and texts. I assume this was due to childcare or other responsibilities. One woman from the health department was in the process of moving, one was visiting family in Mexico, while another mentioned she was having family difficulties. The other woman never responded to my calls or emails. The one woman from the private practice that I was unable to interview had a child with special needs. The overall willingness of these women to participate in my research is testament to the bonds developed during CP. Eleven of the women were recruited from the health department, while the remaining eleven were recruited from the private practice. While both sites target group size was of eight women, the private practice had one group of seven and one group of five. The health department had one group of twelve and one group of three women[7]. Demographic information about the populations of the two sites is presented in Table 3.1.

Although my study sample is small, the sample size allows for simple quantitative analyses. It also includes women from differing class and racial backgrounds. Finally, the qualitative data I gathered from the sample allow for analyses of women's perceptions and experiences within CenteringPregnancy.

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[7] The group of three was dissolved at the health department because it fell short of the minimum number of five women. Throughout the first couple sessions of the group, there were as many as seven women; however, all of these women quit coming to the program. Unfortunately, I was not able to obtain their contact information beforehand to interview them about their Centering experiences. More information about this group and speculations by healthcare providers as to why women quit attending is in Chapter Five.

Table 3.1: Sample Demographics

Demographic Characteristic	Health Department	Private Practice
Age		
<20	3	
20-25	4	
25-30	3	7
30+	1	4
Education		
<High School	1	
High School	7	
Some College	2	
College	1	8
College+		3
Income	Health Department	Private Practice
10-20K	1	
20-30K		
30-40K		
40-50K	1	
50K+		10
Does Not Know/Does Not File Taxes	9	1
Race		
Black	10	1
White		10
Latina	1	
Employment		
Employed	3	9
Unemployed	7	1
Employed Before Birth	1	1
Marital Status		
Single	8	
Married	2	11
Widowed	1	
Number of Children (including this pregnancy)		
1	6	9
2	4	1
3	1	1

Data Collection

Methods of data collection included: surveys, semi-structured interviews, participant observation, and data on CenteringPregnancy program birth outcomes for the private practice and health department. Unfortunately, data that could be used to compare Centering and non-Centering birth outcomes are not available, as neither site collects statistics on non-Centering birth outcomes. Since it is a requirement of Centering Healthcare Institute, data on Centering participants' birth outcomes are collected.

Surveys ascertained three types of information: demographic, birth outcomes, and social support measures (Appendix 3). At the beginning of each interview, I collected quantitative data for each mother including age, number of children, years of education, marital status, length of residency in Durham, household composition, and approximate household income. After the birth of their child, I recorded the birth weight and the gestational age of the infant at delivery, vaginal or Cesarean-section delivery, labor pain management strategies, and health status of the child immediately after birth. To measure social support the Perceived Social Support Family (PSS-Fa) and Perceived Social Support Friends (PSS-Fr) scales were used. These are 20-item scales with high internal consistency and validity. The scale is inversely associated with symptoms of distress and psychopathology (Procidano and Heller 1983). In keeping with the critiques of anthropologists about instrumental measures of social support (Fleuriet 2009; Mullings and Wali 2001), women were also asked about their causes of stress, and their definition of and desire for social support. They were told to use this definition when answering the survey.

I conducted semi-structured interviews with all pregnant women, focusing on why women chose CenteringPregnancy over traditional prenatal care, what they liked and disliked about the program, how receptive they were to the information presented, and whether they

incorporated that information into their prenatal health behaviors and/or infant care. A full list of

questions for women is in Appendix 1. Women were interviewed at a location of their choice—

their home, business, or public place. Most interviews lasted between 45 minutes to one and one-

half hours.

In addition to conducting interviews with women participating in Centering, I

interviewed the healthcare providers who facilitated Centering sessions. The purpose of these

interviews was to gain providers' perspective on the program and whether they believe race and

class differences manifest in the experiences of the program. Example questions included: "What

attracted you to Centering?" "Is there anything about the program you would change?" "What do

you think contributes to the high rates of preterm delivery and preterm birth among African

American women?" "Why do you think Centering lowers the likelihood of preterm and low

birthweight among its participants?" A full list of provider questions is in Appendix 2.

Trained as a CenteringPregnancy facilitator, I participated in all the sessions of all four

groups including the reunions. However, the way that I participated was different in each

session, and with each healthcare provider. My first group at the health department was led by

Abra and Antonia. From the first day I began my research, this group was turned over to me as

lead facilitator. I regularly laid out the nametags and snacks, and decided what activity or

discussion the women would participate in as they waited for everyone to rotate through mat-

time.

The first few sessions of this group, I focused less on picking the activities and discussion

topics, and instead helped women navigate taking their vitals—teaching them how to take their

blood pressure and perform urinalyses. I was surprised that I was expected to be a lead facilitator

when I did not work for the health department, had only attended a two-day training session

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about CenteringPregnancy, and only had health skills related to breastfeeding. I quickly adapted to this new role, learning where all the supplies were, and how to correctly take blood pressure using a cuff machine and perform the urine tests—both of which I had not done before my first Centering session.

Once the women became familiar with taking their vitals and how Centering sessions run, I became more involved in planning activities. Some sessions, such as the one on the stages of labor where women draw their ideal birth scene, Abra had a plan for what we would do. Most of the time, she left this up to me, so I would peruse the Centering notebook for ideas before the start of the session, selecting an easy activity or talking point. One of my "go to" activities was prenatal yoga. The CenteringPregnancy kits come with prenatal yoga cards with various positions that alleviate some common discomforts of pregnancy. As an occasional practitioner of yoga, I was comfortable leading the women through these fairly simple positions. Once all the women were seen for mat-time, Abra would take over to lead the discussion on the topic of the session. We would sit across from each other in the circle, and I would jump in as needed with a questions or comment to keep the conversation flowing. Antonia, the nurse for the group, went back and forth between the clinic and Centering room. When she was in the room, she rarely sat in the circle, as she did not have time, and would interject comments or her opinion to the discussion, often giving her advice while referring to herself in third person. After the first few sessions, when she decided I could be trusted to facilitate, she would only appear at the beginning or end of the session. After these sessions, Abra, the medical student shadowing her, and I would debrief about the meeting, discuss what went well, what we needed to work on as led by the Centering International worksheets rating the sessions, if any of the women in the group were having any problems in their lives outside of Centering that needed special attention

or referral. This rarely happened in the other health department group and never happened at the private practice.

The other health department group was with Jane, a thirty-something year old, white midwife. My role in this group was similar to my other health department group. I set out nametags and snacks, and helped women navigate taking their vitals. I never truly facilitated as I did in the other group because this group was beset with problems from the beginning. First, we never had a full group, as women joined, and then left the group. They did not leave the group for prenatal care in the clinic; they just occasionally came to Centering, and then stopped coming for prenatal care all together. We only had three regular participants, and the group was eventually cancelled because we did not have enough participants to warrant a Centering group according to Health Department policy. Prior to this, there was one session that was conducted with one patient and her support partner. As a result, the penultimate session was not held, but a reunion was. Additionally, the group never started on time. Women would come in five to thirty minutes late. Because of this, and low enrollment, there was not a reason to plan activities or discussions because women were seen by Jane immediately. The presentation of health topics was more didactic than the other group since there were as many facilitators as patients.

In the groups at the private practice, I was much more an observer than participant. As the private practice had more staff and a dedicated Centering room, nothing ever needed to be set up; it always was set up already. Further, the nurses of these groups would help the women with their urine analysis and other vitals. The blood pressure cuff at the private practice, a wrist measurement rather than upper-arm, was much easier to use so women rarely needed help. When the nurse was helping another woman, I would help the women who looked confused or were waiting to ask for help. This usually amounted to me reminding women to uncross their legs for

a more accurate blood pressure reading. Unlike the health department, which was much more reliant on the Centering facilitator notebook and kit, I never saw these at the private practice. When I requested to see the notebook once, no one knew where it was. As such, there were few activities or discussions held while women waited to be seen by the midwife. Instead, women chatted with each other about their pregnancies and lives. I participated in these discussions, but only ever truly facilitated the Centering session when it was on breastfeeding I was not pregnant, do not have children, but I am an International Board Certified Lactation Consultant (IBCLC).

For the sessions on breastfeeding, as at the health department, I was given complete control of how to run the meeting. Since the notebook and the supplies of the Centering kit were missing, I facilitated these sessions by having everyone take a breastfeeding object the practice had on display—nipple shields, a belly ball set (uses common objects to represent a newborn and neonate stomach capacity), nipple cream, and breast pads—and perform a modified version of "show and tell." This was not uncommon, as the practice often brought in guest speakers, such as the head nurse from Labor and Delivery at the hospital associated with the practice, and a physician from a nearby pediatrician's office to lead sessions on what to expect in the hospital and well child checkups. The rest of the sessions, the healthcare provider led the discussion of the health topic. These were much less activity based and much more presentation style of question and answer. For example, while the health department groups used a ping pong ball and balloon to showcase the stages of active labor, the private practice just discussed the stages and what women could expect. Other than my session on breastfeeding, the only time an activity was used was to discuss possible birth scenarios by drawing them out of a box of chocolates. I often reminded Cora, the midwife, and Melissa, the white, fifty year old physician's assistant, who led sessions that I was happy to help, and explained what I did at the health department; they never

took me up on my offer to be more active, except for the breastfeeding session. As a result, I was

treated by the facilitators and women as the breastfeeding expert, only asked questions and for

commentary when the topic was mammary related. These experiences shaped the relationships I

was able to establish with women at both sites. I developed closer relationships with the women

at the health department because I was their group facilitator. They viewed me as being part of

their healthcare team, and a few invited me to their births or called me when they were in labor.

This was not the case at the private practice. The relationship I was able to establish with these

women more closely resembled that of a medical student or researcher—I was there to learn

about their experiences. I was also viewed as a breastfeeding expert, and was only contacted

outside of Centering sessions and our interviews for breastfeeding information. These

relationships influenced our interviews and my analysis of them.

After all of the sessions at both sites, I wrote fieldnotes about what happened at that day's

session. I paid particular attention to the topic of the session, how it was presented, and how the

women responded. Additionally, I also noted how the women engaged with each other, and the

facilitators.

Data Analysis

Two UNC Chapel Hill human subjects certified transcriptionists and myself transcribed

all interviews verbatim. I uploaded and coded all interviews and fieldnotes in Atlas.ti 7.0. Coding

was an iterative process. Drawing on the constant comparison approach (Leech and Onwuebuzie

2007), textual data were systematically analyzed. During the first analytical round, I read all

transcripts, making notes and broadly coding content in response to my research questions.

Initial and final codes emerged from this review of the transcripts. Once all interviews were

analyzed a second time, the coding framework and themes were finalized. Some of the final

coding themes included: "taking the time," "social support," "examples of cultural health

capital," and experiences with traditional prenatal care." A codebook was initially developed

from interview questions and added to as new codes emerged from textual analysis of the

interviews and fieldnotes. Following the initial coding of the transcripts, all codes were

examined for overlap and value. Redundant codes were combined, and the core meanings of

codes were distilled. Codes sharing similar meanings were grouped together, a process known as

abstraction (Kyngas 2008). For example, the final code, "taking the time," is a "super code"

encapsulating other codes that were connected to the over-arching theme of women being

respected in healthcare interactions. During the coding process, attention was paid to minimizing

my bias by not "reading" too much into the quoted text or seeing connections that were not

actually there. I attempted to interpret the quotes verbatim, and not code them for what I thought

the women were intonating.

Two themes emerged as especially salient and form the basis of the next three chapters:

1) Centering as a form of social support, and 2) relationship between patient and provider. Most

of the codes in the codebook were related to these two themes, as each of my interviews

discussed what women consider to be social support and how CP fits into that definition.

Additionally, when asked about the program and their experience of it, women mentioned their

healthcare interactions—the relationships they were able to establish with the providers and the

information they learned from Centering.

Code reports of all codes related to these themes were run, and analyzed by demographic

information with particular attention to interviewee's race, class, and CenteringPregnancy group.

The quotes that appear in each chapter are excerpted from these reports. To ensure other themes

from the data were not missed, the co-occurrence query tool in Atlas.ti was run to ensure all co-

occurring relationships among codes were exported and analyzed. An abbreviated matrix of these themes is in Appendix 5.

Survey data were analyzed for differences in the amount of perceived support from family and friends between women of different race and class backgrounds in Excel. These data are discussed in Chapter Five, and appear in aggregate in Appendix 4.

Relationships in the Field

In conducting this fieldwork, I ascribed to a feminist activist ethnographic methodological strategy, which requires stressing equality, dialogue, and reciprocity between researcher and participant (Davis 2013; Davis, and Schuller 2014; Mullings 2000). As such, I shared my preliminary findings with the Centering healthcare providers at both sites, and asked for feedback and suggestions. A copy of my dissertation will be made available to both practices, as well as Centering Healthcare International. Additionally, I have discussed my findings and thoughts with the women with whom I am still in contact. It was also important to me to offer women something in return for their time and participation in this project. Each woman who was interviewed was given a $20 gift card to Target or Wal-Mart, thanks to the generosity of Peggy Bentley, Professor of Nutrition and Associate Dean of the Gillings School of Global Public Health, and her Carla Smith Chamblee research funds. I also offered my services as a lactation consultant, providing home visits to all women who participated in the Centering groups. Finally, I attended the births of all of the women who called me in labor and asked me to come to the hospital.

Insider/Outsiders and Vulnerable Observers

One of perils of doing "native" or insider anthropology, particularly for feminists, Slocum (2001) reminds us, is our ability to control how and to what extent the fluid and constructed nature of our identities can connect us to the people with whom we work. As such,

my relationships in the field were informed by my own attempts to situate myself, and how my participants situated me.

My insider/outsider status varied from group setting and audience. For all groups, I had the presumed insider status of being American, living in the area, and being a woman of reproductive age. For the participants at the healthcare center, my "outsider" status included being white, highly educated, childless, and middle class. Most of the healthcare providers at the clinic and the private practice saw me as an insider because of my training as a lactation consultant. The presumed divide between insider and outsider status at the private practice was narrower, as the same identifiers that set me apart at the health department site were points of connection in this one. The only differences I held with most of the participants at the private practice were that I am from a lower class background, was pursuing a doctorate, was not married, and I was not pregnant.

I thought, and still think a good deal, probably too much, about the aspects of my identity which made me an insider or outsider, and which aspects I sought to "tug to the front" (Slocum 2001) in establishing relationships. In building relationships with women at the health department, I took advantage of certain moments to be completely honest about aspects of my life that were similar to theirs. During Session Four, the group shares aspects of their lives they would like to bring into their family and aspects they would like to leave behind. Even though this is an early session, and people have known each other for only six hours, over the course of the session, participants shared incredibly painful childhood experiences. In this moment, I chose to fully commit to being a "vulnerable observer" (Behar 1996), and share that like some of the participants, I, too, had an absentee father, was poor a portion of my childhood, and also grew up in an alcoholic, tempestuous home. For the women at the private practice, I attempted to situate

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myself as an insider by focusing on shared educational backgrounds and being peers. For example, one woman in the private practice I established a close relationship with had a PhD in Sociology.

What actually shaped my relationships with women in the field were less these instances of insider/outsider status and trying to establish similar identities and backgrounds, and more the role I played in each group. Although nominally a "facilitator" at each site, this role took on different iterations, which shaped how participants situated me.

As stated above, at the health department I was a true facilitator, directing and leading the topics of each session. I was often left by myself to lead the group in an activity while the midwife was seeing patients during "mat time," and the nurse was out of the room getting paperwork and making sure everyone had necessary tests or immunizations scheduled. Conversely, at the private practice I was more of a non-pregnant attendee or expert speaker— depending on the topic. This led to differing perceptions of my role at the practice and health department. Women at the health department assumed I was a nurse or a staff member for the clinic, even asking me questions about childbirth and pregnancy. Women at the private practice thought of me more as a researcher and lactation consultant, only asking me breastfeeding related questions and requesting lactation visits once they delivered.

These assigned positions also shaped our interviews. Women at the health department were more likely to perceive me as being a staff member of the Health Department. One participant even identified me as being one of the Centering healthcare providers in her answers. As a result, most of the interviews with health department participants are shorter, and women tend to give answers that focus on the benefits of the program. I attempted to mitigate this

response once I identified it by reminding women I was not employed by Centering or the health department, and anything they said was confidential.

Conversely, women at the private practice tended to view me as a non-pregnant peer who happened to be a lactation consultant. Their interviews tended to be longer, as women were more likely to open up to me about the difficulties they experienced breastfeeding and transitioning to a life as a new mother. Even though the role I played in the Centering groups seemed to be more salient than any aspect of my identity, undoubtedly, race and class also shaped participants perceptions of me.

In all ethnographic encounters, both the researcher and the participant mutually construct how close and how distant their relationship will be. Part of the feminist activist ethnographic methodology and "outsider within"[8] positioning, involves adopting reflexivity, examining how my own social location in regard to the social location of the women with whom I work (Davies 2008). As such, I adopted Harrison's (1997:2) idea of "decolonizing anthropology" through a commitment to adopting feminism, which "underscores the impact race and class have on gender". In this effort, I attempted to cultivate my second-sightedness, the idea of a dual consciousness that women and minority populations have (Du Bois 1903; Harrison 1997; Huizer 1979), to reconcile the differences in our social locations through "combating [my] internalized racism and the privileges of Whiteness and affluence" (Harrison 1997:89) to build a common ground. It is my hope that by learning to how to see out of more than one eye (Cole 1987:34), my research in the chapters that follow continues the critical anthropological project of a socially and political responsible ethnographic process, which "illuminates the interlocking dynamics of culture, power, and political economy, nuanced by historical depth" (Harrison 2008:44).

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[8] See Collins 1986 for a detailed discussion of "outsider within" status

CHAPTER FOUR: "MY BODY KNOWS WHAT TO DO"

CenteringPregnancy programs are built on three components of care: health assessment, including self-assessment and private time with a healthcare provider; education, especially teaching women how to be healthcare consumers; and support. These three components of care are based on feminist theory, midwifery theory, social cognitive theory, and adult learning theory (Centering Healthcare International, 2014). Feminist theory informs the non-hierarchal power structure in health assessments when women take their own vitals. Midwifery theory of care proposes a patient- and relationship-centered care; while social cognitive theory supplies ideologies of social support and self-efficacy. Finally, adult learning theory offers the underlying idea that healthcare education must take place through active learning (Manant 2011). This mélange results in a program of group prenatal care built on facilitative group discussion, which provides basic prenatal care, but also seeks to empower women through sharing knowledge, listening to patient concerns, and lifting the veil of biomedicine through a detailed discussion of what is happening to their bodies and having women monitor their own pregnancies through learning about and taking their own vitals.

Using interview and fieldnote data, in this chapter I argue that through Centering's facilitative structure of sharing knowledge about women's bodies and pregnancy, women in my study are more empowered in their birth experiences because they are informed about the processes and what is medically necessary. This empowerment allowed them to advocate for themselves, pushing back against the authoritative knowledge of biomedicine and its doctor's

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decisions and routinized practices on their bodies. Further, the facilitative style not only

empowered women, but also increased their cultural health capital, the skills and knowledge that

shape healthcare interactions. As such, I suggest women may be more likely to employ Centering

advice regarding health behaviors, which have been shown to lead to better health outcomes for

mom and baby (e.g., Ickovicks 2007; Kennedy et al. 2009). However, the ways in which

Centering increases a woman's cultural health capital varies based on her race and class.

Knowledge is Power

I was most struck by two aspects of CenteringPregnancy (CP) that are completely

different from traditional prenatal care: patients take their own vitals and the facilitative rather

than didactic discussion of health topics. As a case study, I use Session 3 of my CP group

facilitated by Abra on breastfeeding: women entered the CP room, and took their weight, blood

pressure and urinalysis. Until women were comfortable doing this for themselves, facilitators

stood around the bathrooms and blood pressure cuffs ready to help. Women recorded and

charted their vitals in their CP notebooks. This was their medical record, containing all of their

tests and information. Their vitals were discussed with the midwife, and recorded in the

electronic medical record, but were not retaken or medically supervised. The notebook

explained how much weight they should gain in the course of their pregnancy based on their pre-

pregnancy weight. The notebook and the facilitator also explained what a "healthy" blood

pressure was, and which blood pressure levels would signal that something is amiss. In the

restroom, there were test strips and a piece of paper that explained what the strips measure, and

why this was important. This information was also explained by a facilitator. For example, if a

woman had a 1+ for the category of leukocytes on her test strip, this may have meant she had an

UTI, so she should tell the midwife if experiencing painful urination or other symptoms. Women

in all of the groups enjoyed taking their own vitals. Ada, a 38 year old, white first time mother noted:

> *It's so much better to go in* [at Centering] *and be able to do all your own stuff and not have it be this secret hidden away like what my weight is, what my blood pressure is. Just feeling way more like a patient instead of like a person. That was the whole mantra throughout the pregnancy was straight out of Cora's* [the midwife] *mouth. Trust your body.*

As Ada notes, through taking her own vitals, she was not kept in the dark about what her weight and blood pressure were, not to mention if they were in the range of what is considered normal for pregnancy. She was taught all of this information at Centering, and was responsible for recording her own vitals in her Centering notebook, without it being checked by someone with a health degree or certification.

Indeed, "trust your body" was the mantra throughout the pregnancy. All Centering sessions followed a schedule: women would enter, grab their nametags, take their weight, blood pressure, and perform urinalysis. Then, they would pick a seat in the circle, help themselves to snack and water provided, fill out the paperwork in their CP notebooks for that session, make small talk with the other women in the circle, and wait for the midwife to call them back for their "mat time." After the provider had seen every woman, the midwife joined the circle for the day's group discussion, and other activities on the topic. In the early sessions, "ice breakers" were used so that everyone could get to know each other. After the discussion, there was a group closing: everyone stood in the circle, holding hands and shared well wishes, or recited the CP mantra "my body knows what to do." This statement, repeated over and over emphasizing different words of the phrase, aided in reminding women that pregnancy and birth are natural processes, and that women can take control over their bodies and their pregnancies by understanding medical knowledge and actively participating in it.

As epitomized in this mantra, not only does Centering provide basic prenatal care, but also seeks to empower women through sharing knowledge, listening to patient concerns, and lifting the veil of biomedicine by explaining changes in their body throughout the pregnancy and discussing their birthing options. Women use this knowledge to push back against the authoritative knowledge of biomedicine and its desire to use medical interventions in their birth experiences. This can be seen in Ann, a 28 year old white woman's birth story. Ann recounts:

> *I went to work on Wednesday, July 8th, and worked a full day and was going to come to Centering. My water broke at work at three o'clock. I was in the bathroom. I got out of work without anyone knowing that my water broke and I came home and called the clinic and was like, "Hey, what am I supposed to do? Am I supposed to come to the class even though my water broke?" They said, "Yeah, come in," so I came in and it was probably about 4:30, 4:45, and so everyone was gone, basically, who was there. They said that they didn't really have anyone to check me. Yeah, of course. They put me in a room and then scrambled to find someone, and they found Dr. Gunter. He came in and he said I was not really dilated at all and said that I should probably start Pitocin because I only had 24 hours. Yeah. I was like, "Wait, no, that's not what I've learned this whole time. We can't start there." He was like, "Or we need to monitor and make sure he's okay." I went in, was monitored for half an hour there, and then I was like, "I'm fine. I'm going home. There's nothing going on."*

Ann pushed back against the doctor's assertion that she needed to start Pitocin, a drug to induce contractions, to expedite her labor. She countered the doctor with the information she learned in Centering that Pitocin was not necessary, as she had not reached the medically indicated time frame for intervention, when labor stalls for 24 hours, which led him to agree that she should be monitored before she returned home to labor.

Women who participated in Centering were more likely to see their medical birth encounters as "conversations." Chloe, a thirty year old, white first time mother stated that she asked more questions in her birthing medical encounters about what was actually medically necessary. She did not want to get an IV port put in her arm before she absolutely had to because

it would have prevented her from laboring in the tub, an option she learned was available to her

from Centering. She states,

> *I think it was helpful to get a sense of the hospital from the Centering class and to know what is standard. Things like just remembering to ask conversationally about things. The nurse came in and said. "I'm ready to put your I.V. port in." Even at centering, they said, that's pretty standard. You'll probably have to. I thought, why not, I'll just ask. Do I have to have it? No, so I didn't get it. Things like that were helpful.*

The fact that Chloe could ask "conversationally about things" was something she learned in

Centering. "Everything is a conversation" was a slogan women often heard from the private

practice's head midwife, Cora.

Like Chloe, other women who attended Centering programs at the private practice and at

the health department knew they could ask questions, and even challenge the healthcare

providers. Angela, a 22 year old, African American mother of two exemplifies this noting,

> *I think Centering it opens your eyes a lot more about things that happens during your labor, because the doctor, they're pretty much going to tell you* [what they are going to do] *but with Centering is they get more in-depth into those. I feel like with* [her first child] *like I didn't have my older sister there at the time and a lot of questions I had was having her I wouldn't have known certain things or what to expect basically, but with Centering you do get to feel out what you're going to go through.*

Jennifer, a white first time mother, echoes Angela's comments, adding that Centering taught her
to advocate for herself. She states,

> *For me, Centering was all asking for what I needed. I remember that something Melissa* [her Centering midwife] *really pushed for was always to ask for what you need. Advocate for what you want. I kept on saying to the OB/GYNs that I was saying, I was expressing concern with how big he was and how big I was measuring, and I felt like no one was really listening to me, but every time I went back to Melissa, she always was hearing what I was saying, and she advocated for what I wanted, which was to be induced. That's the biggest thing that I took from it was to always say what I need because at the end of the day, that's all that really matters. That's something that I always have a hard time with in the first place. I think that it taught me that to ... advocating what I need. If you don't advocate for yourself, then you're not really advocating for your baby.*

Unlike Ann, who pushed back against the doctor's intervention, Jennifer advocated for an

intervention, induction, which the doctors told her she didn't need. Jennifer ended up having an

induction, and later, a C-section because her instinct to be concerned about the size of her baby was correct. His ten-pound body, even before 40 weeks gestation, was too large to be vaginally delivered due her slight five-foot frame. Empowered by Centering, she advocated for what she believed to be right.

The women in the groups I researched were not isolated incidences of pushing back against doctor's advice and medical opinions. All the midwives stated in their interviews that Labor and Delivery nurses could always tell who was a Centering patient because they asked more questions. Antonia, the Centering nurse at the health department recounted:

> *You can always tell my Centering ladies because when they come into the hospital, they're more knowledgeable and the fear factor, it's really decreased. They're fearful because it's still fear of the unknown but they feel more in control. Centering ladies, that's what tells them, you're going to feel more in control of your whole pregnancy and definitely more in control when you go into labor and delivery because you know you have options. If you give somebody an option, that really, you know, that's one of the benefits. We tell them what's normal, what's abnormal with the blood pressures. That's why we have them take their blood pressure, so then they become aware when their pressure goes up. We tell them the signs and symptoms of preeclampsia. We had one lady she called the hospital, she was on vacation, and she told them she thought she may be developing preeclampsia. They just blew her off and she actually went and she was just that and ended up having an emergency C-section. I've been so proud of some of my ladies. They know that they have a right to refuse. Most people will say, "The doctor or the nurse said this, [so I have to do it]." This one lady said, "Nope. I'm not having a C-section. Am I okay? Is my baby okay?" "Yeah, but it's just been so many hours." "Is my temperature okay?" She held fast and she ended up having a vaginal delivery and even the docs had to admit she was right; she was just that determined. […] I just love the knowledge, that they're so much more knowledgeable and knowledge is power, that's what I tell them. Now you have all this knowledge so now you have all this power over a lot of things. You don't feel as powerless.*

As Antonia states, knowledge is power, and one of the reasons women participating in CenteringPregnancy have better birth outcomes than women receiving traditional prenatal care may be due to this.

Acquiring more knowledge about their pregnant bodies and learning more detailed information about their options with labor and delivery lessens stress in the prenatal and birth processes. Research has shown negative effects of stress on pregnancy (e.g., Mullings and Wali 2001; Mustellio et al. 2004; Rankin et al. 2011; Rosenburg et al. 2002; Slaughter-Acey et al. 2016). Many of the Centering midwives I interviewed answered that this was why Centering patients had better birth outcomes. Melissa, a white, late forties, physician's assistant at the private practice, exemplified this, stating, "They have information. They, maybe, feel less anxious about their pregnancy, have less anxiety. I think that might be it." Melissa noted that this is something unique to Centering because it is "prenatal care plus," while birthing classes, designed to reduce the fear of labor, only discuss positions and not going into nearly as detailed information about pregnancy and birth processes.

An extreme example of knowledge as power possibly leading to better birth outcomes is Stacy's, a 19 year old, African American first time mother, birth experience. Stacy echoes Antonia's and Melissa's comments about the reduction of anxiety as a result of Centering noting:

> *In a traditional doctor's appointment you don't learn all the stuff you learned at Centering. I feel like during Center it helps you, because I was very scared to have a baby, but when I went to Center it helped me more not being afraid to have a baby and to learn more about a baby and to learn more about your body when you're pregnant in a traditional doctor's appointment you don't learn it. You have to learn it on your own, but at the Center you have people who are there to teach you and guide you and help you learn about it. That's why I like it.*

It is probably a very good thing that Stacy learned about birth and was not scared to have a baby as she delivered at home without a medical professional. Stacy's mother who came with her to all of the Centering meetings delivered the baby. She tells the birth story:

> *Lord have mercy, we was in total chaos in his house. All I know is the baby was born, but Centering. I think Centering prepared us for that, cause you never know what's gonna happen with labor. You never know what to expect, you know.* [Taylor: How do you think Centering prepared you?]*Cause you know, the baby was gonna come out and crowning.*

I learned about crowning in Centering. I had five caesarian, so what she went through, I never went through that myself. When she told me the baby head was coming out, my response to her was no, it feels like that, the baby head is not coming out, that's just the pressure, that's what it feels like. When she was like, "No ma, I think the baby's head coming out," so when I pulled on her pants and I see the baby crowning. I learnt that from Centering cause I never knew what crowning was. That's the baby's head coming out, so that's got to be crowning. I see the baby's pretty head, what in the world is going on. Yeah, I learnt that. [Stacy comments: I like the squatting position.] *She squatted here right on that* [the rug]. *She kept saying that, when she had the baby, she wanted to squat. When she was going through her contractions, that's what she would do.*

Stacy and her mother learned about crowning and squatting from the Centering meetings. They also learned to be prepared for anything. This reduced their anxiety about the birth process, allowing Stacy and her mother to deliver a healthy baby boy in their living room. Stacy's body knew what to do.

Lamaze and the Bradley Method

Two of the most popular birthing classes are Lamaze and the Bradley Method. The Lamaze program, whose mission is promote and support healthy and safe births through education, was introduced by Dr. Fernand Lamaze in France based on his observations of birthing practices in Russia. These practices included childbirth education classes, breathing techniques, and continuous emotional support from a woman's husband and specially-trained nurse. The method spread to the US in the 1950s, and gained popularity in the late 50s when Marjorie Karmel wrote of her childbirth experience assisted by Dr. Lamaze in a book, *Thank You, Dr. Lamaze*. Shortly thereafter, Karmel met Elisabeth Bing and the two began working together to teach the method. In 1960, they formed the non-profit Lamaze to popularize the method and train childbirth educators and healthcare providers (Lamaze International 2017).

The Bradley Method or husband-coached childbirth" method was developed by Dr. Robert Bradley during the 1940s. Inspired by watching animals give birth, and noting that animals sought safe and quiet places when in labor, Bradley sought to make the hospital

experience a similarly relaxing environment for women by teaching them how to relax (Bradley 1984). Unlike the Lamaze method, which teaches sequenced breathing, the Bradley method does not because of its differing philosophical positions on the connection between the mind and body. The Lamaze method emphasizes the separation of the mind and body, giving the woman a task to complete, sequenced breathing, which is being a "good, cooperative patient" (Rothman 1981:169) with her husband's help, essential turning him into another member of the staff by helping her move through medical routines while the doctor delivers the baby (Davis-Floyd 1992; Rothman 1981). Conversely, the Bradley Method emphasizes the connection between the mind and body, urging the woman to breathe normally to achieve full relaxation (Davis-Floyd 1992; McCuthcheon-Rosegg 1984:91). Davis-Floyd argues that because the Lamaze method emphasizes a separation between mind and body, it upholds the technocratic model of birth, the belief that the doctor should have all the power in making medical decisions, as Lamaze's practice of sequenced breathing does not interfere with or challenge the doctor's routinized care or decision making. Viewing the body and mind as connected, and essential in relaxation, the Bradley Method advocates for a natural childbirth without medical intervention and with the laboring woman in charge of all decision-making (McCutcheon-Rosegg 1984). The Bradley Method runs counter to the technocratic model of birth, and more in keeping with the holistic, woman-centered, model, rather than doctor-centered care (Davis-Floyd 1992). Davis-Floyd argues the Lamaze method is the most popular method of childbirth education in the US today because it upholds the technocratic model.

Both the Lamaze and Bradley method differ from Centering. Unlike Centering's approach, which enables women to share information, and learn from one another, both childbirth methods rely on a lecture-style delivery system of information. Further, both the

Lamaze and Bradley method rely on a very heteronormative type of support by requiring the baby's father to the sole source of support for the laboring woman. This is not the case in Centering as women are allowed to choose who and how many support persons come to Centering sessions. Centering creates a network of support among women's chosen support partners, other women in the group, and their healthcare providers.

Centering and Cultural Health Capital

Women in Centering may be more likely to adopt and retain the information they receive from the Centering providers because the facilitative nature of the program engenders conditions where women are more receptive to the information they are receiving. Providers treat women with care, making them more receptive to the biomedical information and recommendations, thus facilitating an increase in the women's cultural health capital. Cultural health capital develops through repeated acts, building a habitus (Bourdieu 1986), or a system of dispositions based on past and current healthcare experiences that originate from one's class and related positioning in society's hierarchy.

An example of mutually agreeable health interaction resulting from increased cultural health capitals established through repeated acts of care delivered with respect comes from Antonia, the nurse for the Centering programs at the health department:

> *They're more compliant, they do keep their appointments, the ultrasound appointments. My Centering patients are more compliant. We have a better outcome. Abra has all the data. Once I looked at the data, I went wow. That's what I presented to the Board of Health to try to get us more funding, to get us more money that we have a lower pre-term birth rate, just lower everything. All the benefits, all the good stuff about Centering. More people breastfeed, higher birth weights, lower infant mortality, just everything.*
> [Taylor: Why are they more compliant?]
> *Because they feel like they know us. If you see a different provider every time you come, if you see a different nurse every time you come, you don't have a connection so you don't feel like you can open up and tell them anything. If you tell them, they're not going to remember. They're right, they're not going to remember. Just like my doc, I told him something last time I went. They're like, "Antonia is too funny. Refresh my memory on what you had a problem and he really tried. You had a problem but I can't for the life of*

me remember what it was and did we resolve it, is it better?" All you've got to do is look in the computer but just talking before he even put up the computer. In Centering, they know that we know them. I know what was going on last time.

Antonia shows that she and her patients have similar ideas of how patients should be treated because they both value knowing that their provider views them as a person—they know them. They are someone with a history, and who are remembered from session to session. This welcoming environment makes women feel satisfied in their healthcare interactions, rendering them more likely to show up to appointments and follow Centering healthcare advice, both of which increase a patient's cultural health capital. This satisfies providers because patients attend their appointments, and follow their healthcare advice.

Antonia's comments also display the tension in CenteringPregnancy between the wholistic and technocratic models of birth, summarized in Table 4.1.

Table 4.1: Wholistic and Technocratic Models of Birth

Wholistic	Technocratic
Female perspective	Male perspective
Female-centered	Male-centered
Woman = subject	Woman = object
Wholistic, integrated approach	Classifying, separating approach
Mind and body are one	Mind and body are separate
Female body = healthy organism	Female body = defective machine
Pregnancy and birth are healthy	Pregnancy and birth are pathological
Importance of people	Importance of science
Experiential and emotional knowledge valued as highly as technical knowledge	Only technical knowledge is valued
Labors can be short or take several days	Birth must happen within 26 hours
Labor can start and stop, follow its own rhythms of speeding up and slowing down	Once labor begins, it should progress steadily
Woman doing what she feels like is appropriate	Woman in bed hooked up to machines with frequent exams is appropriate
Midwife = skillful guide	Obstetrician = supervisor/manger/skilled technician

(adapted from Davis-Floyd 1992: 160)

Antonia states that Centering patients are "more compliant" demonstrating the authority and dominance of the biomedical system over the knowledge of their pregnant bodies women possess. However, she also states, "In Centering, they know that we know that we know them. I know what is going on last time." This is in contrast to her comment about her own doctor who remembers her, but does not remember what they discussed last time. Centering healthcare goes beyond the technocratic model of biomedicine and its best practices of continuity of care with the same healthcare provider each time. Although Antonia has the same provider, he does not remember what they resolved last time. He does not treat her as a complete person. He is only concerned with making sure her medical needs were taken care of and solved—even if he cannot remember what they were. Centering, conversely, treats the whole person. It is woman-centered care, in that women have decision making power, where the providers know the woman—who they are as people and what ailments they are dealing with—because they view all of these things as integral to understanding a woman's health. This model of healthcare is more in-line with a wholistic model. So, while Centering provides biomedical information, as it is in the technocratic model, the woman's personality and previous healthcare experiences are viewed as connected, as in the wholistic model. Because of this, Centering represents a hybridization of the technocratic and wholistic method.

Additionally from Antonia's quote, we see that women's cultural resources of interactional styles—part of their cultural health capital—are respected by Centering healthcare providers. Because these cultural resources and skills are valued, providers are more likely to provide women with more information because they see that their patient has a similar shared practice of how patients should be treated. For Centering patients and providers, women being treated as a whole person with valid opinions and experiences is this shared practice.

However, if health professionals do not view patients' cultural resources positively, the care they provide may be technically appropriate but may not resonate with the patient's values nor enhance the patient's cultural health capital by opening up avenues for richer health understandings, information, and skills (Shim 2010:8).

The increased cultural health capital that results from the way Centering provides information in a welcoming atmosphere, which leads to more, thorough care, was explained by a Centering facilitator Sara, a white, late twenties, medical student. Sara brought up an instance where she thought Centering patients receive more thorough care than those receiving traditional prenatal care:

> *For one, I would think contraception. We* [in Centering] *talked a lot about the different types of contraception, how effective they are. It was a very educational discussion. We have the women put like, "Well, what do you think about this? What have you heard about this?" It was more, I think in the normal prenatal visit, you don't get that much education. You're not told all the options. You're just kind of told ... From what I've heard because I didn't get this see this very often, what I've heard from my classmates is that basically just tell everyone to get an IUD. At the health department, they don't really talk about other options. They just want everyone…You're told to get something but then you're not really told what it is. They told it in that cold environment. It's not really an open environment to ask questions. Whereas in Centering, we talked about every single form of birth control and what it is and what it means. They learn about other options. You do not get that type of education in that regular office setting. There should be time, but there's, time's not spent explaining all those things.*

While at traditional prenatal care visits, women were encouraged to get an IUD, without being informed about the different types of contraceptives, at Centering women were given much more information about contraceptives[9]. Courtney recalls the impact this session had on her:

> *Learning about the birth control, I actually have the Implanon or the Nexplanon now* [hormonal implant]. [Taylor: Did you know about that before?] *I heard about it, but I wasn't really sure* [how it worked], *but you all gave me more information, and I decided*

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[9] Sara probably thinks of the example of the family planning session of Centering because we facilitated this discussion. Most of the women had not heard of other birth control methods besides "the pill." Keeping with Centering tradition of minimizing power differentials, Sara and I, somewhat uncomfortably, shared our experiences with the birth control methods with which women were not familiar.

to do that because the pills, I was on pills before and that just made everything irregular, like my cycle and all of that.

As Courtney notes, women's cultural health capital was enhanced in their Centering interaction—she was able to take biomedical information she learned in Centering into her postpartum healthcare interactions. In this session, different birth control methods were passed around the circle. Women were asked what they knew about each method, if they had used the method themselves, and ask questions about the method. Because women were able to ask questions and discuss different family planning methods, their biomedical knowledge increased. As providers are more likely to view those patients who can use biomedical knowledge and language more positively and as having similar cultural health capital (Shim 2010), women who attended Centering will continue to benefit in their healthcare interactions.

Centering healthcare providers are able to show they have a shared set of practices (part of cultural health capital) that patients have about how patients should be treated through the facilitative style of Centering. This style allows for a breakdown in the power divide between patient and provider, where women's healthcare opinions and thoughts are valued and respected. Cora, a midwife at the private practice, commented on the importance of this style noting,

> *There's a difference in Centering when everybody is seated in a circle, than when you're at an individual visit and you have a care provider that doesn't even sit down in the chair to look at you. If you're still standing, that's a problem. "I don't want to hear it." That's what that says. Yeah, there's a difference. There's that difference. But, I think there is ... The way a patient processes that, even though you don't measure those things, a patient's response to you as you are having that interaction because you're seated and because you're looking at their face and because you're addressing their questions or concerns and because there are other people in this conversation. It's this whole conversation with people together. I think that changes you—the relationship and the sense of expectancy from the patient.*

Cora notes that by sitting in a circle, it signals to patients that the healthcare provider and they are treated as equals, and they are listening to, and valuing what you have to say. Both signal to the patient that the healthcare provider has similar notions of healthcare interactions.

Abra, the midwife at the health department, echoes her sentiment and highlights that learning from each other—the facilitative nature of Centering—this demonstrates that the provider is genuinely interested in their lives. She states:

> *Anything that happens in a brief prenatal encounter, the fundal height, the fetal heart tones, the review of the labs, the addressing questions for the mom, happens within a five to 15 minute span, depending on what health system you work in. The basic bones of the prenatal visit are addressed in both models, but in traditional care you have much less time. The power dynamic is set. The patient is the patient. The provider is there to answer questions. If you have a shy patient, she might not ask a question for her entire pregnancy, or she might feel shame or embarrassment about a question that has to do with sexuality, or relationships, or sexually transmitted infection. In a Centering group, that same shy person could sit, and benefit from all the questions and the conversations, and the dialogue that are shared in the group. If it goes really well, they kind of forget that you're there, and you get a bird's eye view into their life. That informs your care, and it's this very lovely exchange that I think benefits all of us.*

Abra's quote illustrates the importance of the facilitative nature of Centering because it disperses power beyond the perceived expert in the room, the healthcare provider, and creates multiple sources of support, as well as authority on the subject matter.

An example of this facilitative style comes from Session 3 on breastfeeding. While waiting on "mat time," women were invited to participate in yoga poses to alleviate their common discomforts of pregnancy—the topic of the last session. Once all women were seen, we began to discuss breastfeeding. Instead of the traditional prenatal care model of stating that breastfeeding is best and giving women literature, women were asked to write on a sheet of paper, "I have heard that breastfeeding _____." These were put in a bag, and each woman drew one from the bag and read it. Contrary to popular discourses in public health, which assume women do not know the benefits of breastfeeding, women listed them: fewer trips to the doctor,

helping to lose weight, promoting bonding. In response, they were asked by facilitators, "Ok, why? Do you have any ideas or advice?" In this way, women were able to learn from each other instead of being lectured to by the healthcare providers. If information provided by the women is not in keeping with traditional biomedical explanations, the women are not corrected outright. Instead, a facilitator asks the woman for more information, and if the other members of the group have heard similar or different explanations. The facilitators wait for other women to "correct" the woman, agree with her, and go into detailed information explaining the "correct" line of reasoning. Centering is not so much about making sure women adhere to biomedical understandings and explanations, as to making sure women are aware of understandings and explanations so that they can make the best informed decision for their current situation.

In addition to breastfeeding, Session 3 also prepares women for the glucose test, which occurs the next session. Instead of being told, "You cannot eat an hour before this test, and this test checks for gestational diabetes." women are asked, "Do you know what a glucose test is? What have you heard about it?" As with the breastfeeding activity, women in the group initiate providing information about this medical practice, why this is important, and what color drink is the least objectionable (apparently, orange). For example, in this group women answered the question by stating, "Oh, that's the nasty stuff you have to drink to check and see if your baby is getting too much sugar." By answering the questions themselves, women learn from each other, with minimal interjection from the healthcare provider.

Reaching women patients with biomedical information through the facilitative style and persuading women of its value made women attending Centering programs more likely to follow through on healthcare providers' recommendations and Centering's messaging. For example, Shonda was staunchly opposed to breastfeeding throughout all of the Centering sessions. She

mentioned that she had tried with her previous children, but it hurt too badly, and so she was not

going to try with her new baby. However, shortly after Shonda gave birth to her son, she asked

me to help her position the baby so that he could latch on to breastfeed. When I asked her if she

was sure that's what she wanted because she mentioned she did not want to breastfeed this baby,

she assured me that she did—at least to see if it was different this time. Shonda perhaps made the

decision to breastfeed because she was more informed about the process and what causes pain

from the Centering sessions.

Other women also noted that they changed their behavior to adopt Centering's medical

advice. Keyona, a twenty year-old, African American mother of one, mentioned that she had

stopped smoking during her pregnancy because she wanted to breastfeed her baby.

> *The only thing was my biggest thing was, if I could produce, then I wanted to breastfeed. That was my whole thing as far as like ... because everybody kept saying breastfeeding was the best way and too, people were suddenly there would help with your weight. It would help the baby with, like the stuff that we learn. It's good for their teeth. It's good for their immune system. Most babies they breastfeed, it's just good for nurturing and then, to be honest with you, I was a smoker before. Then, if I breastfeed her, I know I can't smoke. That's just how I thought to myself. I was just telling you how I thought to myself. If I breastfeed her, I know I can't smoke. I think I'm going to stop smoking to breastfeed her. It helped too because I stopped smoking. Even during my pregnancy, I was still smoking here and there. It was like once I got further, further along, once I got down maybe my last three months, I had fully stopped smoking. That was actually my New Year's Resolution.*

Another woman, Sharon, 32 year-old mother of two also mentioned that she had changed her

behaviors because of Centering.

> [Taylor: What are your favorite parts of Centering?] *Giving us more information about stuff. It was basically the information. I'm just down for getting information. Then, we talk about it and stuff. That's what really did it--the headline for centering, me getting just information, you know what I'm saying, just new stuff that's going on. Like with you, me, you told me to get the slow flow nipple, that's what I get. You told me to feed my baby sitting up, that's what I do. See? Little stuff like that. Stuff like that is very helpful. That's how I feed him though and he burps so easily and quick when I do that, though. He really do. That's how I feed him.*

Both Keyona and Sharon were more receptive to the information they received from CP because their healthcare providers had similar approaches to the relationship between patient and provider. This coupled with the facilitative context in which the information was provided, enabled the information to be heard, understood, and be given authority. As such, each woman's cultural health capital was improved, as they gained more biomedical knowledge that would be viewed positively in future healthcare interactions.

In addition to providing advice on the birthing process and caring for a newborn, Centering sessions also provide information on how to deal with stress. Antonia, the nurse from the health department, notes that Centering providers give advice on ways to alleviate stress based on women's lived realities. She states:

> *We can't change the finances; we can't find you somewhere to stay. What we do is give you optional ways to relieve the stress with what you have. Use what you have. You've got the air right there, you can walk. As long as you're not on bedrest, you can walk. You can take the nice warm bath with candles. I said, "try it!" Honest to goodness they've come back, yeah it sounded a little crazy because come to find out,* [some women] *just don't take baths.* [Maybe they] *grew up without a shower. I did, so baths are my thing. They go like, "you want us to take a bath? That takes too long." Okay, that's exactly what I want you to do. Spend some quiet time; it does take longer than a shower. The ones that would actually do it, somebody in the group would go like, "just try really. It works." Or swimming, but I can't swim. The ladies that can swim, can we swim. Yeah. Several of them when the pool opened, they said they went swimming. Things that they just wouldn't have thought about that actually will relieve stress for a while.*

These ways to relieve stress that are cognizant of women's lived realities based on their class habitus, which informs the class habitus of their patients, were mentioned as being adopted by women in the Centering programs. For example, Lupita, a twenty year old, Latina, first time mother, is estranged from her mother and father as she married someone of whom they do not approve. She noted that she adopted some of the stress-relieving practices mentioned in Centering when I asked her about stress:

Taylor: We talked about one of the big things that causes your stress, but is there anything else?

Lupita: That I'm in the house 24/7. That's what stresses me out and I'm not working right now. When she cries a lot, that gives me so much stress. I don't like her to be in pain and so, that stresses me out too.

Taylor: How do you deal with that?

Lupita: Well, just breathe like 10 seconds. Go outside or just play with her. I'd be playing with her and talking to her and that's it.

Taylor: Where did you learn that?

Lupita: Centering.

Taylor: Does that help?

Lupita: Well, yeah, it does a lot. Or sometimes when she's just crying, I just go to the bathroom, scream, then come back, and I'm okay. It's more stressful because I'm by myself. I don't have nobody to talk with, only with her and the TV. And with the phone, my husband, that's it.

The information displays that the healthcare providers understand their patient's class habitus, which informs the cultural health capital of their patients. Because Centering providers are able to show through the facilitative style of the program that they understand their patients' class positions, and have similar ideas of how patients should be treated in a healthcare setting, women are more likely to adopt this advice, as Lupita did. Additionally, due to the connections between stress and health, women who adopt these practices are more likely to have better birth outcomes.

Of Crockpots and Blankets: The Difficulties of Overcoming the "Baggage" of Race and Class

Although Sharon Schindler-Rising describes the CenteringPregnancy program as a "Crockpot," which can be adjusted to offer a meal for different tastes, (Schindler-Rising and Jolivet 2011: 367-8), what happens when the recipe cannot be adjusted to suit all who partake?

The instances mentioned above occur when everything in Centering goes as planned.

When this occurs, women's cultural health capital is improved as they learn more about their

bodies and pregnancy, and women adopt the healthcare practices that are shown to increase

perinatal outcomes. However, this is not always the case. Sometimes the CenteringPregnancy

program is unable to overcome the larger structural issues women face in their daily lives. This

includes poverty, racism, sexism, and interpersonal violence.

Part of this problem is that Centering Healthcare International, the parent company for

CenteringPregnancy, doesn't acknowledge such larger structural issues exist. In fact, dealing

with the women's experiences of these systemic inequalities is left to the Centering facilitators.

When discussing some of the aspects of Centering she would like to change, Jane, a midwife at

the health department commented:

> *I think that we have a very blanket program right now, and so any kind of cultural competencies that are addressed have to be done through your facilitator, and if you didn't have a facilitator- Antonia is brilliant, because Antonia has lived in East Durham[10] her whole life. She knows everybody and their grandmothers and their kids, and she knows where people go home to and where people go to church. I feel like Centering absolutely, without a doubt, works at the Health Department because of Antonia. Ideally your provider would also have that kind of background. It's not the case in most places, but I think there should be every, every, every effort made to find facilitators that are really part of the fabric of the community, really understand, because that is where that sort of magic happens. That's where you feel like, "Somebody actually gets me. This is a safe space."*

Jane believes that Centering works at the health department because Antonia, and other

facilitators like her, are part of the community. As such, Antonia, is not naïve to the realities her

clients face. She knows them and their problems. She also knows Centering is supposed to be a

universally adaptable-for-all model of healthcare, where women equally benefit from the

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[10] East Durham is a predominately poor, African American neighborhood in Durham.

program no matter their race and class. But, Antonia acknowledges that this is not always the case.

A study performed by Julia Phillipi and Carol Myers (2013) sought to understand why pregnant women in two area clinics in Appalachia[11] were not using the program. The program was adopted in the area because women there who are mainly poor and white have high rates of preterm and low birthweight. Despite efforts to recruit or place women into the program, low participation and high attrition rates made the program not financially sustainable. When asked why they did not join or were dropping out of the program, women stated that they feared being emotionally exposed in group meetings, as they did not want to discuss their bodies in a group setting, and feared becoming emotional when discussing topics. They said consequently that they preferred one-on-one care. Further, women also had concerns about matters of privacy and their partners' view of the group model. In addition to preferring one-on-one care for these reasons, women also stated that they were not able to attend the Centering meetings because of a lack of public transportation and the needs of their preexisting children (Phillipi and Myers 2013). The research as to why women in Appalachia declined or dropped out of CenteringPregnancy programs shows that its adaptable recipe does not always work in practice. Poor, white women in this area were not attracted to the program because their concerns about privacy and barriers did not outweigh what they perceived to be its gains.

Similar concerns about the barriers to Centering were also mentioned by midwives in the groups I facilitated when sometimes the structural inequalities of race and class proved too big of barriers for the program to overcome. When discussing the group that was plagued by low

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[11] Appalachia is a large and diverse region. However, the authors only refer to the clinics' locations this way to protect respondent anonymity.

attendance and attrition, which Jane and I facilitated together, I asked why she thought that group was not successful. Jane stated,

> We would like to think that people can put down their baggage and walk in that door and be completely available, but that's an unfair assumption about women. I wish that were the case for them. I wish they could sit down and be completely available, but ...

The "baggage" Jane is referring to is the consequences of living in an unequal society. The group she is discussing had a low attendance and attrition rate partially because all of the women relied on public transportation to get to sessions. While the health department does give women bus passes, it can only give each woman two passes each visit. The department is not allowed to give bus passes to the women's support person who may come to the meeting with her, or other family members. Due to childcare constraints, some women brought their children even though Centering does not allow children. At least one child was present at every session of Centering at the health department.

Jane questions the role of male support providers because one woman in the group was in an abusive relationship with her support partner. She only later confided this to one of the Centering providers. Keyona, who attended the other Centering sessions, often came to meetings with bruises, black eyes, and broken blood vessels because she "fell down." When asked about these issues she denied the violence, but her partner's control seeped into the answers she gave in our interview noting that her partner did not allow her to breastfeed, even though she wanted to, and she was "not allowed" to use birth control. As a result, by the time her child was three months old, she was pregnant again.

I do not mean to suggest that domestic violence is only a problem for poor, African American women. Domestic violence knows no race or income level. However, situations of domestic violence are exacerbated by poverty when one's abuser could be the primary or higher

income earner, or if a woman does not have access to her own means of transportation to flee the situation. Further, because of historic and current problems of police violence, brutality, and racism, women of color may be less likely to report problems of domestic violence or access state-sponsored resources of orders of protection and victim advocates.

The healthcare providers I worked with were not naïve to these systemic problems. Their goal in providing service was to give the best care they could to the women they served. While the healthcare providers were not naïve to these problems, some midwives, such as Cora, the African American midwife from the private practice, believes that "the Crockpot" was denying the power and effects of these systemic inequalities. She states,

> *They had a Centering consortium meeting for the state of North Carolina. I think it was back in April. There's another one coming up in October. I'm looking at this group of people. Nice mix of people. I knew a lot of the people from across the state. Those were wonderful people that I've worked with over the years and people had sent in videos or they talked about the different practices and diverse group of women. I said, to the ... They sent this guy down to represent Centering where you can ask him questions and all that. Great. So, I said to him, I said, "I was looking at all these people and all these videos and all the women you serve, but I'm looking at your trainers, too, across the US. How many women of color do you have?" "One. One of 20." And this chick that keeps calling me from Centering [the international office], I asked her one day. I said, "You know what?" I said, "I'm just dying to know. I know you're Asian American. How many other women of color are there that work here?" She said, "me." Okay. I understand how that works. I mean, that's how it is in many places. But, you know, that really gets on my last nerve. That you say one thing and then you do something else. That's why I hate Centering.*
>
> *It's the people that ... Yeah, you have to be in that circle. Their circle is mostly white women, but most of the women that they serve ... I thought, it's such a variety that they want to reach out to and I said ... It's a shame, because culturally they miss some things. When I first looked into Centering, and again, this will change as your population ages out. I had patients that if they brought their mother with them, you are not going to get on the floor. You will not get on the floor. Completely understood that. I absolutely understood that, and that's because you're African American, you're not going to let your child get on the floor like that. You know, what are you thinking? The reason I said that is because people my age ... There was a difference in the cabin at the white pediatrician's office. There was the colored waiting room and there was the white waiting room. There was the carpeted floors there was cement floors. There was a tropical fish tank, there were goldfish. There were upholstered chairs, they were the plastic chairs. There was the*

Qasis water fountain with a refrigerator, there was the ceramic ... There's a difference. You getting on the floor? Hell, no I'm not getting on that floor." You know ..." Again, it's cultural changes that, you know ... that sometimes because of your perspective, you can be blind to what the needs are for another culture. Sometimes it's something simple. Simple in your eyes, but a big deal to the patient. And time will take care of some of it, but I just think that the Centering Healthcare Institute needs to take a look at themselves. It's a good product. It really is a good product. I've got no problem with the product itself, but how they administer the product, it's not always the best way.

Cora points out the oversights of the people who created the "Crockpot." Cora, who lived through Jim Crow laws and the Civil Rights Movement, believes that because these were white, upper to middle class women, they were naïve to the historic and current systemic inequalities that would make African American women less likely to initially choose Centering over traditional prenatal care, much less lay on the floor for an examination. She notes that this ignorance or naïveté is unlikely to change because Centering Healthcare International only has one woman of color.

Failing to acknowledge these larger structural oppressions, CenteringPregrancy puts the onus of change on the women in the program. Centering prioritizes compliance to their healthcare behaviors and advice. There is not an acknowledgement of the effects that the intersections of race, class, and gender have on birth outcomes or women's advice. There is simply the encouragement to adopt healthy practices as prescribed by the program. The larger Centering program does not acknowledge that Lupita may be under an inordinate amount of stress because of her social location, or that it may be difficult for Keyona to breastfeed due to controlling relationships, or that Keyona may smoke because it alleviates some of the stress she feels in her everyday life. Instead, the program emphasizes steps the individual, with seemingly unhindered choices and constraints, can take to improve their health outcomes. This is not solely the problem of Centering; it is a problem of Western biomedicine (Rivkin-Fish 2004, 2005). Even part of the idealized version of biomedicine—patient-centered care, which is supposed to

be more in line with the wholistic method of birth, is predicated on the notion that patients are "activated and engaged autonomous individuals" (Shimcet al. 2016: 240) that is free to make decisions about their health.

While Centering enables women to feel empowered and increases their cultural health capital, it does so by teaching women to be healthcare consumers—how to interact in a system that privileges white, affluent cultural health capitals, and assumes that all patients are able to freely make decisions about their health unconstrained by the matrix of interlocking systems of power.

CHAPTER FIVE: CENTERING RACE, CLASS, AND PLACE: AFRICAN AMERICAN WOMEN AND CENTERING PREGNANCY

"Memory is a strange thing in the South. Some never forget. Some want to forget. Others simply cannot remember." William Ferris, *The South in Color*

As noted in the quote above, history and memory have a unique relationship in the American South. The past and the present intermingle from buildings and institutions built from the sweat of Black bodies to statues commemorating the white fallen who defended the Southern way of life. One's relationship with memory, having the luxury to forget or the burden to remember is tied to the intersections of race, class, and gender.

In this chapter, I explore the "strange thing" of memory in the South and its connection to CenteringPregnancy. I begin by reviewing the history of Black bodies and the field of biomedicine, arguing that this history is one of the reasons African American women find CenteringPregnancy more appealing than traditional prenatal care. Finally, I conclude the chapter with a discussion of how place, history, race, and class come to bear on the experience of CenteringPregnancy using the theory of cultural health capital (Shim 2010) and the history of Durham. Picking up on the last section of the previous chapter, I explore how the supposedly universally adaptable model of Centering often succeeds, but sometimes falls short of its healthcare goals because it fails to account for the structural limitations of the intersections of race and class.

The Burden of Southern History: Race and Gender and Biomedicine

In addition to understanding the connections between history, race, and space, it is important to consider the intersections of history, race, and medicine. Not doing so, Harriet

Washington (2006:20) states, "is like trying to treat a patient without eliciting a thorough medical history: a hazardous, and probably futile approach." It is so, because much of what we consider the roots of modern biomedicine, particularly obstetric and gynecological medicine is the result of experimentation on Black bodies. The relationship between race, class, and gender and the history of medicine color current healthcare interactions. These past experiences with medicine become part of the habitus (Bourdieu 1986) of one's cultural health capital, shaping interactions with healthcare providers.

Gynecology and Obstetrics

The advent of what is now obstetrics and gynecological medicine began with the work of James Marion Sims, MD. Born in South Carolina, Sims practiced medicine in Alabama, gaining regard as a plantation physician, practicing "medicine" on slaves. Sims gained his status as the father of gynecology because of his work on the vesicovaginal fistula, an opening between the vagina and bladder and/or rectum causing incontinence that is the result of prolonged or difficult labor. In June 1845, on a plantation outside of Montgomery, AL, Sims was brought to assist in the delivery of seventeen year old Anarcha's baby. Anarcha was in labor for three days. On the third day, Sims was brought in to deliver the baby using obstetrical forceps, a tool he was not used to using (Washington 2006). This was not unusual for doctors of the day, due to Victorian morals; most physicians were not used to seeing women's naked bodies (McGreggor 1989, 1998). Anarcha's baby died shortly after delivery, and though Anarcha initially seemed to be healthy after the birth, she soon developed a vescovaginal fistula. While physicians often blamed fistulas on "unclean" African American midwives, Sims noted that the incidence of vescovaginal fistula increased with the use of forceps (Washington 2006:64).

At the time, there was no cure for vescovaginal fistula, so Sims purchased Anarcha as well as ten other slave women with the condition to perform experimentations in a search for a

cure for the next four years. Since the women were slaves, and viewed as less than human, Sims was not bound by Victorian morals to not look upon a woman's naked body. Indeed, Sims developed a special speculum so he as well as other physicians, prominent citizens, and local apprentices he brought to his exam room could see what Sims said, "no man had seen before" (Washington 2006:65). The repeated painful surgeries were performed on the women without anesthesia, as Sims thought the procedures not painful enough for use of ether. However, once he perfected the surgery fixing the fistula, Sims did use ether when operating on his white patients because they were more sensitive to pain (Washington 2006).

Sims was not alone his in experimentation on slave women for the benefit of obstetric and gynecological medicine. Dr. Francois Marie Prevost used enslaved women to perfect the technique for Caesarian sections in 1831. Additionally, Prevost's contemporary and fellow southern doctor, Dr. Ephraim McDowell performed the first ovariotomy, removal of an ovary, successfully in Kentucky, practicing the procedure on his four female slaves (Washington 2006).

Eugenics

The shift in medical research from the nineteenth to the twentieth century moved from experimentation on Black bodies and the creation of new fields of biomedicine, to the control of African American's reproduction through eugenics.

Eugenics, Greek for "well born", was coined by Sir Francis Galton, a cousin of Charles Darwin, who, using the simple ideas of human genetic inheritance of the time, believed that social problems could be solved through the selective breeding of humans (Washington 2006). Galton's idea became exceedingly popular in the late 1920s and in the 1930s in America. Fueled by the threats of immigration and birth control technologies leading to the outnumbering of American-born white people, subscribers to the eugenic ideology worked to get legislature passed in the US that would sterilize members of the population who they deemed undesirable

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(Schoen 2005). Once the US Supreme Court upheld this legislation in the 1927 case of *Buell vs. Buck*, where the court upheld the right of the state of Virginia to sterilize Carrie Buck and her mother because they were "feebleminded," legislation followed in other states, including North Carolina in 1929 (Schoen 2005).

While not alone in its ascription to eugenic ideas and practices, the Eugenics Board of North Carolina was the only one in the nation that gave social workers the ability to petition the board to have someone sterilized. In order for the board to qualify a candidate for sterilization, the individual had to have "inheritable feeblemindedness." This designation was based on an IQ score of less than 70, and inheritable was described as anything "'you got from your parents' regardless of whether it was transmitted by genes or germs" (Schoen 2005:83). Over the years, the state expanded the definition of "feeblemindedness" to include not just IQ scores, but also whether one was capable of competing economically with others, meaning most of North Carolina's sterilization victims were poor. Additionally, not having a job and receiving welfare were also considered indications for "feeblemindedness." In the 1930s and 1940s eugenic scientists argued that sexual promiscuity also indicated one was "feebleminded." Since sexual promiscuity was more worrisome among women, a majority of those individuals sterilized in the nation, and in North Carolina were women (Schoen 2005:95).

The news of eugenic practices in Nazi Germany in early 1940s saw the decline of sterilization in many parts of the nation, but not in North Carolina. North Carolina saw an expansion in the number of individuals sterilized largely because of the work of one woman, Ellen Winston. Winston was the commissioner of public welfare for North Carolina and strove to provide equal access to state services for whites and African Americans. However, Winston also

viewed sterilization as a solution to poverty and illegitimacy, so she expanded the state's eugenic program (Schoen 2005).

In addition to the news of eugenic practices in Nazi Germany leading to a decline in state-sponsored eugenics, the science behind eugenics had largely been discredited by the 1940s. However, the Eugenics Board of North Carolina justified the continued practice, and even expansion of eugenic sterilization through the notion that undesirable qualities were still heritable, as they were passed on through socialization (Schoen 2005). Thus, because one could not discern if undesirable qualities were nature or nurture, sterilization was still considered a viable option to stem the tide of undesirable children.

As more and more African Americans received state and federal assistance due to federal reforms and Winston's commissionership, additional African American women in the state began to be targeted for sterilization. The proportion of the rates for sterilization for African Americans rose from 23% in the 1930s and 1940s to 59% in the 1950s and finally to 64% in the 1960s (Schoen 2005:108). Additionally, African American women were far more likely to be sterilized, not only because of the concern of sexual promiscuity, but because African American women received higher rates of welfare as they were more likely to be separated, divorced, or widowed. Further, racist notions about the hypersexual Black woman—the Jezebel—also contributed to the larger number of African American women sterilized (Klein 2012; Schoen 2005).

By the early 1970s, the popularity for eugenic sterilization had waned as more effective birth control methods that could control fertility became more widely available. Further, the fact that social workers and a four-person board controlled the ability to sterilize citizens came under scrutiny. The Eugenics Board was formally dissolved in 1974 with the passage of the "Bill for

Sterilization of Persons mentally Ill or mentally Retarded (sic)." This bill gave the power to sterilize citizens over to judges (Schoen 2005). This law as well as the 1927 Supreme Court *Buell v. Buck* decision has not been repealed.

By the conclusion of the Eugenics Board of North Carolina, over 7,600 people had been involuntarily sterilized (Klein 2012). The state did not apologize for the sterilizations until 2001 and did not give any victims compensation until 2003 (Schoen 2005). In 2012 the state decided to compensate all living victims of sterilization with $25,000 (Klein 2012; Severson 2011, 2012). The specter of forced sterilizations haunts North Carolinians today. As part of a painful recent history, women of reproductive age may know someone who was subject to the racist and sexist eugenic practices of the state, making them less likely to trust the same medical establishment that may have denied their female kin the right of reproductive freedom.

Midwifery

However, not all aspects of this history are negative. During the antebellum period and continuing until after WWII, midwives in the South were mostly black women, who delivered the babies of black and white women (Smith 1995; Fraser 1998). These women described being called to the profession by God, and learned through apprenticeship with other midwives (Fraser 1998). Patients of midwives were often family members or kin of the women; if not, they were usually within ten miles of her home. Birth was considered a female family affair, as a woman's primary caretaker during pregnancy and birth was her mother. Surrounded by female kin and a midwife, women were offered emotional support and herbal concoctions from this community to keep her spirits up, as birth was seen as a natural part of life (McMillen 1990). When it was a "woman's time," the midwife traveled over country roads to deliver the baby. She would stay with the woman as long as it took to deliver. After the birth, midwives stayed with the woman during her period of seclusion lasting anywhere from two weeks to one month (Fraser 1998).

The beginning of the end of African American midwifery in the South occurred in the early 20th century during the Jim Crow era in the South. From 1900-1960, public health and government officials launched a campaign to increase the number of Southern women giving birth in hospitals under a doctor's care. This had already successfully taken place in the North, and much of the rest of the country. Southern officials attributed the high maternal and infant mortality rates in the South to "dirty" midwives, and not to the poverty of the rural areas, even though there was evidence to the contrary (Fraser 1998; Smith 1995).

In an effort to decrease rates of infant and maternal mortality, white public health nurses were brought in to instruct midwives on the virtues of cleanliness and the benefits of modern biomedicine. The short-term goals of these programs were to regulate midwifery. However, the long-term goals were to wipe out the practices, and get their patients to use obstetricians and give birth in hospitals. At first, midwives had to register with the state and attend courses. These courses stressed the importance of not using dirty quilts for births or imploring the supernatural in difficult births, instead emphasizing the importance of hygiene, white aprons and hats, and clean linen. Often "sing-and-do" songs were taught to midwives to encourage them to wash their hands and practice other forms of hygiene, as these rural, African American women were thought to be childlike because many were poor and illiterate (Fraser 1998; Smith 1995).

Later on, midwives had to fill out birth certificates immediately after birth, or risk fines. This was not in keeping with traditional rural Black Southern beliefs, as many people waited days or weeks to name the baby. Further, since many midwives were illiterate, the bureaucratic regulations forced some out of the profession. In addition, midwives were prevented from performing vaginal exams, and bags containing their birth instruments were subject to search. Any midwife found having rubber gloves in her bag of scissors, bleached linen, and uniform was

fined (Fraser 1998). Rubber gloves were taken as a sign that midwives were performing vaginal examinations. This symbol of biomedicine, representative of technology and belief in germ theory, was decidedly unacceptable for the hands of "folk practitioners."

Even with all of these imposed regulations, Southern African American women and even some white women still preferred using female midwives over male doctors well into the 20th century. Midwives were cheaper than doctors, were more accessible as they were local and more willing to travel, and provided comfort to women before, during, and after delivery. Further, midwives were often preferred because they viewed birth as a common occurrence instead of a medical event needing intervention, doing little to interfere in the process except offering support (McMillen 1990).

As hospitals and doctors became more readily available, few women chose them as options since they were viewed as unsafe. At this time, much first-hand medical knowledge was gained from practicing skills on poor patients. More women began to give birth in hospitals and to use doctors for their delivery in the middle of the century with the professionalization of physicians, the advent of the fields of gynecology and obstetrics, and particularly the idea that male physicians should be involved in birth. Birth became thought of as pathology. This ideological shift coupled with the "heroic era of medicine," led to doctors trying multiple often harmful or deadly interventions to alleviate a woman's pain and hasten the delivery. Unlike midwives, doctors had limited knowledge of birth (McMillen 1990), and were less likely to treat African American women with respect (Smith 1995) and understanding for their social locations.

Durham, NC: Capital of Black Middle Class to City of Medicine

Durham, North Carolina, the "City of Medicine," lies within this Southern milieu of history and memory, adding its own context of a rich African American history. The city of Durham was formed in 1848 when the small towns of Dillardsville and Prattsburg were united

by a railroad station on land purchased by Dr. Bartlett Leonidas Durham (Anderson 2011). Once the North Carolina Railroad began to use the station in 1854, Durham became home to tobacco industries including Julian Carr's Bull Durham smoking tobacco, and shortly thereafter James B., Washington, and Benjamin Duke's cigarette factory. The success of tobacco factories soon brought other businesses to the Bull City, including Erwin Cotton Mills, Golden Belt Bag Company, and Durham Hosiery Company (Janiewski 1985). The success of these businesses brought many rural North Carolinians, including free Blacks from nearby Orange County to the city (Anderson 2011).

At the end of the Civil War, Durham's mills and factories provided work for Freedmen, and particularly Freedwomen, who were the primary source of labor for the tobacco factories (Brown 2008). In addition to offering profitable jobs in opposition to sharecropping, Durham also offered a growing African American community. Most African American workers lived outside the town limits, across the railroad tracks from the town of Durham and white residents, in an area known as Hayti, a settlement that flourished from 1881-1940 (Anderson 2011). Hayti grew after the establishment of a school and church on the corner of Pettigrew and Fayetteville Streets by Edian Markum (later Markham) originally called Union Bethel. When the church joined the African Methodist Episcopal (AME) Church, it was referred to as St. Joseph's AME Church (Anderson 2011).

Durham was rumored to have excellent race relations between African Americans and whites. This myth was largely built on the fact that African Americans and whites rarely interacted except to do business (Anderson 2011; Brown 2008). The establishment of Hayti allowed for a process of "upbuilding," defined by W.E.B. DuBois (1903) as the "social and economic" building of the Black community after slavery (Brown 2008:10). Upbuilding, as

Brown (2008:10) notes, required "black folk to survive on mutual aid, wit, and hard work […] to embrace themselves as whole beings, […] as a community […] [to create an] oppositional politics […] and an intentional future." This intentional future included Durham becoming renowned in the larger Black community for its successes. Booker T. Washington called Durham "the city of Negro Enterprise."

Black Durham gained even more regard in 1921, when whites destroyed the Black Wall Street of Greenwood, the Black community of Tulsa, OK. Durham became the new Black Wall Street because of its many Black-owned businesses including the North Carolina Mutual Life Insurance Company, the nation's oldest and largest African American-owned bank in the country, Mechanics and Farmer's Bank, founded by Richard Fitzgerald, and the National Negro Finance Company (Brown 2008). Durham's recognition also included the US's first publicly funded liberal arts college for African Americans—North Carolina Central University. All of these institutions led the town to be christened the "Capital of the Black Middle Class" in 1925 by E. Franklin Frazer (Brown 2008:14).

Despite being the "Capital of the Black Middle Class," in the 1920s and 30s this middle class was rather small, since a majority of the African Americans living in Durham were in poverty (Brown 2008). Many of those in poverty were African American women who were the labor backbone of Durham's tobacco factories and cotton mills (Anderson 2011). Exemplifying this class divide, and the experience of two different Durhams, one side of Durham was the prosperous city on a hill of Black Wall Street, while the other a city of poverty and poor health. The experience of this divide is exemplified by Richard Fitzgerald's family. Richard Fitzgerald was one of the well-to-do African American Durhamites who established the Mechanics and Farmer's Bank, an institution that survived the banking crisis of 1933 (Brown 2008). Richard

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Fitzgerald, grand-uncle of Pauli Murray, the civil rights and feminist activist, was involved in many businesses and made his money by starting a brick company in Hayti. Richard's brother, Robert Fitzgerald, also started a brick company, but was not as successful as his brother, largely because he was losing his vision, which made him susceptible to being swindled by his workers and customers (Brown 2008). Robert and his wife Cornelia were forced to rely on their daughters' income as schoolteachers to survive (Murray 1956). Their living situation was often so dire that Cornelia suffered from pellagra (Murray 1956), a disease of malnutrition that plagued the poor in the American South.

The divide between the upper and middle class African Americans and the lower income African Americans came to an impasse in the 1930s. As Brown (2008) states: "Durham's black male leaders believed in racial cooperation, but by that, they really meant that black folk should step back and allow its leaderships to guide the direction of race progress" (335). Through the politics of respectability, Black leaders developed a good reputation with whites, and did not want to risk this tenuous relationship, nor their ability to shape the future of Black Durham (Brown 2008). As such, leaders did not support activism against Jim Crow in their backyard. This often left national organizations, such as the NAACP aligning itself with workers, most of whom were African American women, and Black leaders in opposition. This was the case in the fight for better wages among African American teachers and members of the Tobacco Workers International Union (Brown 2008).

The growing resentment between Durham's Black leaders, who hoped that race relations would improve through the good business relations they were cultivating with whites, and the lower income African Americans who were fighting for change continued throughout WWII and into the burgeoning Civil Rights Movement. In addition to lower income African Americans,

those who were advocating for change were the younger generations of Black Durham (Brown 2008).

Durham is of particular note in the history of the Civil Rights Movement, as the site of the first sit-ins of the movement in 1957 at the Royal Ice Cream Parlor. Led by Rev. Douglas Moore, a classmate at Boston University of Dr. Martin Luther King, seven African American men and women challenged segregation law by sitting on the "white side" of parlor (Brown 2008).

At the same time as the Civil Rights Movement was growing in Durham, the town itself was growing. Many residents, particularly white residents of the city of Durham moved away from downtown to South Durham, the suburbs, as many Americans did after WWII. This continued after the establishment of Research Triangle Park in 1958. Located in the south of the county, Research Triangle Park was the idea of two men. The first, University of North Carolina professor Howard Odum, wanted a satellite location independent of the university, but that could draw upon its resources, which would conduct independent research and disseminate knowledge. The second man, Romeo Guest, a Greensboro, NC native and business entrepreneur was inspired by all of the industrial research centers in between Harvard and MIT. Guest thought a similar idea could be applied to the "research triangle" of the University of North Carolina at Chapel Hill, Duke University, and North Carolina State University. Both Odum and Guest's idea came to fruition in 1959 when Chemstrand decided to build in the park, followed shortly thereafter by the branches of the federal government building offices for the National Center for Health Statistics, the Air Pollution Control Office, and Environmental Protection Agency. Other large corporations followed in 1965 when IBM built its offices in the park (Anderson 2011).

According to Anderson (2011), although the southern part of Durham saw a population boom, downtown Durham suffered from the exodus of residents and shops moving to the suburbs (Anderson 2011). In the 1960s, Durham began a project of "urban renewal." This renewal included plans to put in an expressway to connect downtown to the recently built Research Triangle Park. Unfortunately, the plan for this expressway ran right through Hayti. While the town promised to rebuild an even better Hayti, it did not (Anderson 2011). As a result of Hayti's destruction and other renewal efforts of the city, the remaining residents of downtown Durham, who were mostly African American, were forced to relocate into newly built housing developments that many African Americans could not afford. This forced African Americans into areas of the city that were previously occupied by whites. Though the neighborhoods were decaying, and the dwellings dilapidated, white landlords raised the rents. Even after changes to federal housing laws, conditions remained largely the same. In 1976 one in five Durham families occupied substandard housing with many African Americans living in poor conditions, but charged more rent than whites in better homes (Anderson 2011)[12].

The condition for residents of downtown Durham only worsened with changes in the national and international economy. Many of the factories that created the success of Durham closed or moved their facilities overseas where labor was cheaper. Further, tobacco, the product that made Bull City, was no longer as much in demand. This was due to the 1964 finding of the US Public Health Department that cigarettes are a major cause of lung cancer. The bond between tobacco and Durham was snubbed in 1979 when Liggett and Meyers moved its headquarters to New York and American Tobacco closed its Durham plant (Anderson 2011).

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[12] The paragraph is cited from the single source of Anderson (2011), as it is the only publication to date to detail this fairly recent history.

The loss of jobs and horrible housing conditions contributed to the problems of crime and drugs that plagued Durham in the 1980s. Wanting to change the image of its town, the local government of Durham and Duke University began a second process of urban renewal. The local government contributed funds to promote the history and art of Durham, revitalizing St. Joseph's Church as the home of the Hayti Heritage Center and the Carolina Theatre for film and live performances. Efforts to revitalize the downtown were helped further by the arrival of the Atlanta Braves' feeder team, the Durham Bills to the city. The new baseball stadium brought more local businesses and tourists to the area (Anderson 2011).

The revitalization of downtown Durham continues today as more businesses, such as Burt's Bees, owned by the Clorox Company, move into the old tobacco factories and cotton mills. However, this revitalization has also brought gentrification. As more businesses move into the downtown, so do more white people, effectively pushing African Americans out of their historic and even relocated neighborhoods. Thus, the place of Blacks downtown has been transformed. Most African Americans who live downtown occupy the poorer areas of East and North Durham (Preserve Durham 2014). While more affluent families are gentrifying these areas, South Durham, and more specifically Southwest Durham close to the Research Triangle Park are still the home to mostly white, affluent residents. This effectively creates two Durhams. Those who live closer to Downtown, particularly in East and North Durham are lower class, predominately African American and Latinx, while those living in Southwest Durham are predominately higher income and white.

These past experiences of humiliation, violence, and loss of dignity experienced by African Americans, and African American women in particular, as a result of American apartheid in the South and the local histories of North Carolina, and Durham, are important to

consider to ascertain the reasons behind many African Americans' distrust of or at least cautious skepticism of medical professionals (Bird and Clayton 2002; Reverby 2008; Washington 2006).

"Taking the Time": Race, Class, Cultural Health Capital, and Centering

The intersections of race, class, and gender in the history of Durham and the history of biomedicine shape women's lived experience of CenteringPregnancy. Women's physical and social location shapes their healthcare interactions through cultural health capital. As argued in the last chapter, while all women's cultural health capital was enhanced by participation in Centering pregnancy racial and class differences shaped women's experience of the program.

Using ethnographic and interview data, in what follows, I argue African American women are more likely to be satisfied with the healthcare interactions in CenteringPregnancy than with traditional prenatal care. This is because their notion of healthcare interactions, which is part of their cultural health capital, is more consistent with welcoming, non-judgmental healthcare interactions. This is largely a result of the respect and empowerment engendered in Centering healthcare interactions, which is vastly different from what most African American women experience in their healthcare interactions. Conversely, the white women at the private practice's cultural health capital were enhanced because Centering built upon their pre-existing knowledge of biomedicine, a cultural resource that both patients and providers valued.

All of the women I worked with preferred CenteringPregnancy to traditional prenatal care. The women have experiences with traditional prenatal care either through previous pregnancies, at their first prenatal appointment, or when they must come in for ultrasound appointments. The similar cultural health capitals of the lower income, African American women attending CenteringPregnancy meetings are evident when I asked Centering attendees to compare traditional prenatal care to CenteringPregnancy.

This can be seen in Shonda's, a 25 year old mother of three, interaction with traditional prenatal care versus CenteringPregnancy:

Taylor: So can you walk me through a traditional prenatal care visit?

Shonda: With my daughter, it was hell. Every time. I was at Lincoln, the main building, and it was so slow. My last appointment, actually my second to last appointment, I didn't go to my last appointment, I went to the ER, and that's how she ended up coming out. I had high blood pressure. But it was so slow. That second to last time, it took 2 almost 3 hours for them to call me back, and then another hour and a half to see the doctor. That made me so mad. And with him, it [the doctor] was quick. I had to go to Duke perinatal […] because I was high-risk. I had a hemorrhoid and it grew. They thought it cancerous, thought it was a tumor…they had me going through all that…

Shonda: Um, hm. And I had it when I was pregnant with her; that's the thing, like, primary care isn't...I would say, it wouldn't be at the top of my list, cause for them to miss it then, and I had it since I was probably about eleven.

Taylor: Oh, yeah?

Shonda: Yeah, and I had her in '08 and nothing was said, nothing was done. And then when I had him, it probably grew some more, because of all of the pressure when I had her. Even when I went to my postpartum appointment nobody still did anything. So, like, going to see one-on-one therapy, or however they have it, um, it's no big deal to me.

Shonda views the doctor as being "wrong" about her hemorrhoid because she has had it since she was 11. She knows it is not cancerous. She values the doctor spending time with the patient, and not making her wait for hours. After these interactions and exchanges, she is less likely to trust other doctors, and what they say, as her healthcare appointments are viewed as "no big deal." However, the doctor clearly does not appreciate her health capital as high enough to "understand" her own health. She is seen as a "low information" patient who must be seen by specialists and tested to get results, rather than asked about her own body and her understanding of the condition.

Shonda's view of her healthcare interactions in Centering was completely different:

Taylor: […] how do you think CenteringPregnancy compares to traditional prenatal care?

Shonda: It's better.

Taylor: How was it better?

Shonda: Because the doctors, and the nurses, they was around took the time. Everybody took the time to get to know each other. Instead of just looking at them as a patient.

Shonda's mother: Y'all took the time. Y'all was just happy they were there. You didn't judge them, just was there helping and supporting them.

Shonda's and her mother's cultural health capital were appreciated by the Centering providers; they thought patients should be treated as people, understood as a complete person with a history, not just another number. Additionally, they both believed patients should be treated with dignity. As part of the Centering model, everyone's values, beliefs, and contributions are valued, and respected.

Many of the other women in Centering I interviewed, also mentioned the importance of "taking the time." They noted that one of the things they enjoyed about Centering was that they did not have to wait for hours before being seen by a doctor. While all the women I interviewed mentioned preferring Centering because they did not have to wait several minutes to an hour before seeing the doctor as they did when they received traditional prenatal care, only the low income, African American women stated they preferred Centering because of the way they were treated. They also said that they shared information with a healthcare provider they otherwise would not have.

An example comes from a young, first-time, African American mother, Raven, who described how she waited so long in her prenatal care visits that the lights, on a motion sensor, would go off periodically. Raven told the midwife, medical student, and me one day after a session when she was pregnant, that she was concerned because she did not feel love for her baby. When she brought this up in our interview, I asked why she thought she wouldn't have told

a provider in the clinic this. She responded that it seemed as if the other providers did not care about her as she was shuffled through vitals, waiting for someone to come in a room, only to have them spend five minutes with her. Additionally, it was a different person each time. By contrast, with Centering, she was able to open up about difficult issues, which she would not have been able to do in traditional prenatal care.

Crystal, a 28 year-old mother of two also stated that she opened up more in Centering than she did receiving traditional prenatal care:

> *The ob/gyn I had with my daughter was, the one who helped me give birth to my daughter, he was really straight forward. He was strictly business in that he wasn't really informative, but he did do his job. He made sure that he did everything that he was supposed to do, but he didn't talk you through it and let you know, okay, at 28 weeks we do this test, just I'm drawing your blood and bye.* [This time] *I actually knew what was going on at each point in my pregnancy. We* [at Centering] *went through the stages, first trimester this is this, second trimester… you guys, even though all of us were definitely, pretty much going through the same thing. Just the support and just feeling comfortable. I felt comfortable with my doctor cause I would've changed him but he, like I said, he was just like strictly about his job. He wasn't trying to make friends. I feel really comfortable in the Centering group cause I probably opened up there more than I opened up to any doctor.*

Because the providers at Centering "took the time," they displayed their caring. Further, because the provider's cultural resources of how patients should be treated, based in the wholistic method of midwifery, were similar to the cultural resources of Centering patients, such as Raven and Crystal, they were more willing to share information that they would have not have shared in traditional prenatal care settings, possibly allowing for more appropriate care.

As mentioned above, while all women mentioned time as a factor favoring Centering over traditional prenatal care, only African American women mentioned that Centering providers treated them better. Because of the enduring legacy of past abuses of Black bodies by biomedicine (Washington 2006), African American women may prefer CenteringPregnancy to traditional prenatal care because Centering treats them respectfully. Specifically, when

considering Durham's destruction of the historic Black neighborhood of Hayti to form Highway

147 (Anderson 2011), and the eugenic sterilizations of African American women, coupled with

the recent history of the fact that African Americans were not able to receive care at a facility

other than Lincoln Community Health Center Centering until 1976 (Reynolds 2001),it is

evidenc eof an enduring legacy of the disregard for Black bodies. As such, Centering offers an

alternative healthcare practice that treats women with respect. Keyona, a 19-year-old, first time

mother, shows how this may be the case:

> *Keyona: I think the clinic, they were a little rude in the clinic.*
>
> *Taylor: What do you mean?*
>
> *Keyona: Centering. Let me explain, the clinic* [traditional prenatal care] *and Centering different because the clinic, one time I was in it and I had to go to the bathroom and the lady was like ... This was when I first started going to the clinic.*
>
> *Taylor: Mm-hmm*
>
> *Keyona: The lady would told me she was getting ready to tell me I couldn't go to the bathroom. Back there, where the bathroom is, behind the door.*
>
> *Taylor: Right.*
>
> *Keyona: Because I hadn't become a patient. Something she was saying. It was my first time going there. She was basically like, I had to become a patient to use the bathroom. I gave her like a mean look, like you're rude to me. I can't go to the bathroom and you see me here pregnant? She was like, "Come on back." It kind of hurts for a second to think what she was going to tell me because she started to say, "You're not a patient." And blasé, blasé, and we was out in front of a lot of different people too because she just had the door open. I was just like, "I need the restroom." She started to say no and I just gave her a look. She changed her mind, was like, "Come on back." I think she knew that it kind of was making me mad when she said that. Centering is more like a family. It's just more of a family. Even like the reunion, we got to see each other's babies and got to exchange phone numbers to keep in contact with each other. Centering was just more as a family because in the clinic, they don't teach you everything as far as how to be a parent. They're just taking your weight, your blood pressure, and might ask you how you're doing. That's it. Centering is more like comfort. You all make us feel like we're somebody. Make us feel welcomed and just you all just working with us. It just feels family oriented. It makes your pregnancy go a lot better and smoother because not everybody got that*

family and support at home. When you come to Centering class and you got it there, it makes you feel happy.

Keyona's experience of not being treated like she was "somebody" in the clinic by a provider shows that patients who are judged to have lower cultural health capital are deemed "inferior," and are treated rudely. This rudeness becomes a source of patients' disconnect and distrust from traditional prenatal care providers. The mismatch between cultural health capital between patient and provider as seen in Keyona's quote often exacerbates the mistrust between African American women and healthcare providers, making them less likely to accept the healthcare recommendations and advice offered. African American women's stories of discordance of cultural health capitals between pregnant women and their traditional, biomedical prenatal care providers may account for the differential perinatal outcomes between traditional prenatal care patients and those choosing CenteringPregnancy.

In addition to only African American women noting that they preferred Centering because of the way they were treated, the intersection of race and class came to bear on women's experience of the program were evident in other ways. Even though the health department and the private practice were four miles away from one another, they were worlds apart. Before the Centering groups officially began, women at the private practice would discuss topics ranging from gender-neutral colors to paint their nurseries to prenatal yoga and birthing classes. In contrast, women at the health department often discussed where they could receive free car seats.

It is no surprise that the women attending the private practice primarily lived in more affluent area of Southwest Durham, while those attending the health department lived in the poorer areas of East and North Durham. This maps on to the gentrified and historical changes to the city of Durham discussed above. The different experiences of the program because of the larger structural barriers related to the intersection of race and class are evident in women's birth

stories. Both Crystal and Keyona, mothers who attended the health department groups, had to

use alternative transportation to get to the hospital when they were in labor. Crystal recounts:

> *I was having really bad contractions and it was becoming unbearable so I tried to wait it out. It got really unbearable, I took a taxi, he was at work at the time, so I took a taxi to the hospital. I'm trying to remember exactly what happened. They said it was too early so I had to come back. I came home, rested, went through pain all night and tried to do the hot showers and tried to do everything you guys told me. I was just like, I can't take it anymore so I had my neighbor, which is also my coworker, across in the other building, she came and got me. I said, I may call you again because I feel like I got to go back. I went back again, they sent me home again. I caught a cab back the next morning, I believe, and she said, "You're four centimeters so I'm going to go ahead and admit you." They did that, got me a room and got it all set up, got my epidural. We just kind of waited it out.*

Keyona also had to find another way to get to the hospital when she was in labor. She states,

> *My car was a wreck. We don't have a car anymore. Our head gasket blew in March, which was my due date in March. It blew at the beginning of March. We drove a rental car during the time that I was still working. Then, once I got my last little paycheck, we put that up to the side and that was it. We're riding the bus now.*

> *Taylor: Right. You went to the hospital-*

> *Keyona: In an ambulance.*

> *Taylor: How did you get home?*

> *Keyona: I came home on the bus, on the city bus. They sent us home with two bus passes.*

In opposition to these two stories, two of the women from the private practice, Ada and Jamie,

began their birth story with, "I called my doula." While the higher income, white women could

afford to pay someone to be an additional source of emotional support during their delivery;

some of the African American women could not afford private transportation to the hospital

when in labor.

Further, while African American women were more likely to mention how they were

treated as a reason they preferred Centering to traditional prenatal care, women at the private

location who were mostly white and affluent, were more likely to prefer Centering because it

built upon their preexisting biomedical knowledge. As noted above, I asked all women I interviewed to recount their birth stories. However, only wealthy white women mentioned requesting biomedical pharmaceutical interventions to aid in their delivery. This can be seen in the birth stories of Chloe and Jennifer. Chloe states,

We got to the hospital by 3:30 and at 4:00, 4:30, Carol checked me. I was eight centimeters dilated and fully effaced. So they're like, you're going to have this baby by six or seven. I just thought I really don't want to. This is all happening too fast and totally out of control. I had really bad back labor the whole time. At 7:00, I remembered I could get the saline shot, which was in my plan. I had it written out. That was the only thing I know I wanted if I had back labor. I remembered. I thought they're [the shots] *brilliant.*

As noted in the previous chapter, Jennifer wanted a medical intervention in her delivery before she began the labor process. She recounts the story of her induction:

I went a different way about things. His head was not dropping very much, and I was literally limping and in so much pain because ... Goodness, get it out. His head was resting on my back hip bone, and so we had an ultra sound because we were always worried ... We were always worried about how big he was and how big his head was, so I had multiple ultrasounds because they could never tell the difference between his head and his butt. Three days before he was born, I had an ultrasound, and they said that he was over 9 pounds. I got very anxious about a 9-pound baby coming out of me, so I decided to be induced, and I requested for my membranes to be swept, and the next day to have Cytotec, and I had 3 rounds of that.

Taylor: That's the film?

Jennifer: It's the pill that's inserted inside to get your cervix to dilate.

In addition to requesting these interventions, several women from the private practice mentioned that they would have preferred that Centering performed greater surveillance of their bodies—running more tests, having more visits. This coupled with the requests of medical interventions by name, supports Emily Martin's (1987) claim that women of higher class and racial standings in our racist and classist society are more likely to align themselves with the biomedical view of the body because biomedicine is viewed as a highly valued skill by people in upper classes. Only two African American women noted they would have preferred more surveillance. One woman,

Tanya, was a nurse, so arguably, her biomedical training could allow her to more readily adopt this view. The other African American mother was Raven, the 19 year old first time mother. Her preference for more medical surveillance could be attributed to the fact she was receiving Medicaid, as Khiara Bridges (2011) argues African American women receiving Medicaid are accustomed to being under constant surveillance.

The fact that African American women noted that they preferred Centering over traditional prenatal care because of the way they were treated and for the most part did not comment that they would have liked more surveillance, may be an enduring legacy of the history of biomedical abuses of Black bodies. As Reverby (2002) and Byrd and Clayton (2000) note, past abuses at the hand of biomedicine color African Americans' healthcare interactions today. It is no surprise that most African American women did not request more surveillance given this history of the field of obstetrics, and the state's recent historical practice of forced sterilizations. The perceived empowering and less hierarchal power relations between patient and provider may be more attractive to African American women because of this history and the aspects of midwifery with roots in African American midwifery that Centering provides.

CHAPTER SIX: CIRCLES OF SUPPORT

In addition to allowing all women to enhance their cultural health capital, the structure of Centering also engenders social support. The design of the program of having eight to fourteen women who have similar due dates meet over the course of six months to receive prenatal care and share their experiences creates a type of community that women can turn to when they need social support. However, as with increasing cultural health capital, the meanings of this social support and the role it played in these women's lives varied by race and class.

Community, in the anthropological sense is a group of people who "protect themselves, acquire resources that provide for their needs […] and provide social values that give purpose to survival" (Hyland and Bennett 2005:5). Part of the way they acquire these resources and social values is through the sharing of social capital—knowledge, skills, and resources (Putnam 2000). This social capital can further be divided into community assets, such as individual, community institutions and community knowledge (Kretzmann and McKnight 1993; van Willigen 2005). Centering provides all of these assets. Centering builds on community institutions because it is held at healthcare offices, which have social capital in communities because they provide necessary services. The individual and community knowledge assets are provided through the sharing of information. Additionally, these assets are shared for the goal of acquiring resources that women need in pregnancy: support and prenatal care.

One of the ways community is built in Centering is through the sharing of social capital in the circle where group discussions take place. Sharon Schindler-Rising designed the program so that support is one of the three components (education and health assessment are the other two

(Schindler-Rising and Jolivet 2009)). Taking her inspiration partially from author Sue Monk Kidd's quote[13] about the power of stories, Schindler-Rising believes that the power of women sharing their stories with each other engenders support. She writes:

> *Sue Monk Kidd's words illuminate the power of women sharing with other women: That power is what fuels the CenteringPregnancy group prenatal care model. Pregnant women in group care reflect, learn, and share ideas and self-disclosures with other pregnant women. In so doing, they experience an affirmation of self that nourishes them as they participate in CenteringPregnancy groups.* […] *Groups provide a dynamic atmosphere for learning and sharing that is impossible to create in a one-to-one encounter. Hearing other women share concerns that mirror their own helps women in CenteringPregnancy groups to normalize the experiences of pregnancy. Groups are also empowering because they provide support to the members and increase individual motivation to learn and change* (Schindler-Rising and Jolivet 2009: 365).

Schindler-Rising's words suggest that Centering programs meet the needs of pregnant women by providing prenatal care, having information about their pregnancies and making sure women and their babies are healthy, and support in this time of change and anxiety through having their concerns normalized and shared by women in a similar situation.

Hearing other women share their concerns about their pregnancies was also mentioned by the women in the Centering groups I facilitated. Ann, a 28 year old, white mother from the private practice Centering group stated,

> *Well, the relational aspect of Centering is the social support that I … It was a lot of what I thought it was going to be in that there are other people that not only are available if you need someone to talk to, but they also are going through the same thing. There's a mutual need for each other in the same aspects of life. I think that pregnancy is super stressful and parenting is super stressful. Just having the same people there was helpful.*

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[13] "Sometimes another woman's story becomes a mirror that shows me a self I haven't seen before. When I listen to her tell it, her experience quickens and clarifies my own. Her questions rouse mine. Her conflicts illumine my conflicts. Her resolutions call forth my hope. Her strengths summon my strengths. All of this can happen even when our stories and our lives are very different" (Monk Kidd 1995: 172– 73).

The relational aspect of Centering, of being a group of women going through the same thing at the same time, was also mentioned by Chantel, a 19 year old, African American mother who attended Centering at the health department:

> *Hearing others, what they go through or what they went through, and you're going through the same thing, that is social support, seriously. When you're pregnant, you're so emotional over certain things, so nobody can really understand that unless they're going through it, if they've experienced it. I think that actually helped a lot.*

As quotes from Ann and Chantel demonstrate, the sharing of experiences of women who are going through similar life events at the same time and place and are establishing relationships because of this, creates a type of community (Hyland and Bennett 2005). This community functions as a type of social support for the pregnant women because the support is a helpful resource in this stressful time.

Centering's role in creating support is especially important because research has shown that social support in pregnancy reduces the likelihood of negative birth outcomes (Feldman et al. 2000; Hetherington et al. 2015; Orr 2004; Zachariah 2009). Further, as one story Antonia tells, the support offered by the community of Centering may be important in helping to cope with negative birth outcomes:

> *In the five years I have been with Centering we have had three babies that have died. but all of them were pre-term. One was maybe viable but the other ones were like 22-23* [weeks pregnant] *but I think I had one that could have been viable and we never did find out what happened. The groups embraced them. Moms brought in pictures and they brought in the little thing they give them. At Durham Regional, we give them a little white box but only with a dry eye in there. Her and her boyfriend they were actually going to the beach to get married that weekend and she went into labor. What we discuss and what I have found out, we have structure. We have things that we're supposed to talk about each group. If something like that occurs, I let the group lead and that's what we dealt with was grief and how we could help her. They stayed in contact; her and the guy came back to our reunion because they said they had an investment in the ladies. Every time I think about it I get emotional. That was one of the most emotional ones.*

Based on my interviewee's comments, the support created by the structure of CenteringPregnancy is crucial in navigating the stressful and anxious time of pregnancy.

Race and Class Differences

In order to investigate the role of social support in Centering and how it possibly shapes the better birth outcomes for women receiving this group prenatal care rather than traditional prenatal care, I administered the Perceived Social Support Family (PSS-Fa) and Friends (PSS-Fr) Surveys (Appendix 3), and asked women about the connection between Centering and social support. The aggregate results of the survey are in the tables below.

Table 6.1 CenteringPregnancy Health Department Groups

Participant	CP Facilitator	Race	PSS-Fa	PSS-Fr	TOTAL	Average
Crystal	Abra	Black	18	17	35	17.5
Sharon	Abra	Black	18	15	33	16.5
Stacy	Jane	Black	18	17	35	17.5
Chantale	Abra	Black	15	17	32	16
Lupita	Abra	Latina	19	19	38	19
Keyona	Abra	Black	6	20	26	13
Michelle	Jane	Black	19	18	37	18.5
Shonda	Abra	Black	20	17	37	18.5
Tanya	Abra	Black	0	7	7	3.5
Angela	Jane	Black	13	20	33	16.5
Raven	Abra	Black	15	18	33	16.5
Group Average			14.636	16.895		
Group Median			18	17		

According to the survey's measurement, the closer a woman's numbers are to 20, the more support she perceives she has. Women in the health department Centering groups had lower scores on the PSS-Fa and PSS-Fr scores than women in the private practice Centering groups. While the averages for perceived social support from friends varies slightly between the two groups, the differences between the means for perceived social support from family is significantly different between the two groups. This may be an example of what Wali and

Mullings (2001) and Stack (1974) found among low income, African American women who were more likely to rely on their friends for support because these women felt as if they could not rely on family members without giving more support in return.

Table 6.2: CenteringPregnancy Private Practice Groups						
Participant	Cp Facilitator	Race	PSS-Fa	PSS-Fr	TOTAL	Average
Jamilla	Melissa	Black	15	20	35	17.5
Chloe	Cora	white	18	18	36	18
Monique	Cora	white	16	11	27	13.5
Ada	Cora	white	19	20	39	19.5
Kimberly	Melissa	white	19	16	35	17.5
Emma	Melissa	white	20	20	40	20
Christa	Melissa	white	20	20	40	20
Jemma	Melissa	white	19	19	38	19
Jennifer	Cora	white	20	20	40	20
Janice	Cora	white	20	5	25	12.5
Ann	Cora	white	20	18	38	19
Group Average			19.1	17		
Group Median			19.5	18.5		

The results of the survey are also notable because of a few "outliers." The reasoning behind the scores can be suggested through my interview data. Tanya has very low scores because most of her family is currently living in Jamaica, and she does not feel comfortable confiding in her work colleagues to establish friendships. Jamilla's low family score may be attributed to her recent relocation to the area and being separated from her family by several states. Monique's low score on the PSS-Fr may be due to the fact that she is a stay-at-home mom with a PhD in musicology, so she may feel socially isolated in her peer-group. Janice's low PSS-Fr score may be explained because she lives with her family in a very rural part of Durham. This greater understanding of the quantification of social support is provided by ethnographic data. Further, while Lupita's score for PSS-Fa are high, the number obscures the fact that she is estranged from her parents. She technically has the individual members of her family to call

upon for support, but other circumstances prevent these support resources from being available. The qualitative analysis of support from my data showcases the critiques made of quantifying social support by Fleuriet (2009) about what is missed by relying solely on a quantitative analysis of social support.

Additionally, in my interview data, low income, African American women at the health department were more likely to mention the support they received from the group during their pregnancy as being particularly important to them. Conversely, higher income, white women at the private practice were more likely to mention the support they received from the group after they had delivered their baby.

Further, low-income African American women were more likely to allude to the facilitative style of Centering as fostering the social support. This facilitative style was one of the reasons Shonda, an African American mother in the health department CP group, preferred Centering to the traditional prenatal care she used for her two other pregnancies:

> *S: It was a whole lot better. Sitting in there staring at the wall, waiting for someone to come in [in traditional prenatal care visits]. We had some fun in there [the Centering sessions]. Laughing at everybody. Clowns.*
>
> *T: So what did you like better about it?*
>
> *S: Just the interaction with everybody. Rather than sitting in there by myself and waiting and asking questions. Coming out to make another appointment to do it all over again.*

But CP sessions are not just about having "fun and laughter." In addition to providing all aspects of a traditional prenatal care visit, Centering sessions tackle difficult issues. In session 4, which focuses on family planning and domestic violence, an activity asks participants to pick one aspect of their childhood they will bring to their new family, and one they would like to leave behind. Even in this early session, health department participants shared very personal parts of the childhood, stories that do not often come up with relative strangers or in traditional prenatal care visits. Several participants spoke of wanting to leave behind financial struggles they

witnessed their parents experience as children, violent and alcoholic homes, and absentee fathers.

Divulging personal information allowed the bonds formed to become even deeper, as

participants connected and discussed their home life and how they would try to do better for their

children.

As a result of this and many other deep conversations, the women formed true

friendships, and circles of social support. Angela, a young African American mother of two

notes how the interactional style of Centering enabled these circles of support to be formed in

Centering,

> *I like the fact that we sat in a circle and talked about everything. I like that we can do the checkups inside of there also. Of course I love the snacks because I like to eat, but it was overall fun, right, it was exciting to come to. I think I missed maybe one appointment or something like that, but I didn't want to miss them. That was the thing to think about; I liked coming back to it and everything. All you guys are very helpful in any questions that we had and everything. It was just helpful knowing, so I just like that. That we had a lot of support too, because some people were there by themselves, no fathers for their baby or if they didn't, I'm not saying they didn't have them, but people that came to support even if no one came to support you at least you felt like you were supported with the people who were there.*

> *Some people probably came to Centering and then they went home and felt like the world was ending because they're having a baby because your peers and your family can be negative, but then when you go to Centering you get a positive vibe and you feel much better about it. […] Society they bash a lot of young mothers these days I've seen people let it get to them and they mess up their lives and stuff. I'm not saying like 15 you should be pregnant or anything, but I had* [my first daughter] *when I was 19 and even though I was considered an adult still there was a lot of backlash and there still is now even though I'm 22, like, "Wait, you're 22 with two kids?" I was pregnant and I found out, I was feeling like, "Okay, I'm young with these two kids, I need to go to school, I need to do this and blah-blah-blah," But after a while coming there I didn't think whatever, I just thought about myself as being a mother to two kids. They made me feel that with everybody, you guys just made it feel like this is fine. It felt like now I'm seeing the two kids, okay, the world is not ending, so yeah, I think it helped.*

Angela notes that by interacting with fellow pregnant women and providers in a positive

environment, women felt supported. She did not care that others outside of Centering were

judging her for being a young mother of two.

In addition to offering emotional support in a non-judgmental environment, Centering occasionally served as a form of instrumental support for women at the health department. One of the sessions in the middle of the program is a baby shower. Women who wanted to share gifts were encouraged to bring baby diapers to exchange. However, some women, such as Shanora, brought other gifts. Crystal had been sharing with Shanora during the ice-breaking portion that since she had no family in the area, and a few friends and resources, she did not know if she would be able to afford all of the items she needed for the new baby. In response, Shanora arrived at the next session with two bags of old baby clothes and miscellaneous baby items for Crystal.

Two women in the group, Dana and Bianca, were at the hospital in labor at the same time. Upon learning that Bianca had had a long labor, but had delivered her baby, Dana, while still in labor, demanded to go to her room to see the baby and make sure Bianca was well. The bonds created in Centering also lasted longer than the program itself. Many of the women kept in touch after their program ended, visiting each other's' homes and meeting up to spend time with each other and their babies.

The social support aspect of Centering was one of the reasons Tanya, another African American mother in the group chose this model of prenatal care over traditional care a second time:

> *Tanya: This now, is for like, more like support. You know, group support. [...] I don't have family support, as you can see in the question here on those papers [a survey on social support I had respondents answer], I have few friends, I have, you know, coworkers, they live in Raleigh, but, you know, you don't really need people at work to know what's going on in your personal life, so I just felt like, you know, a support group would be good.[...] you know, the story of my husband being in Jamaica.*

Tanya welcomed the group support she was able to receive during her first pregnancy while attending CP sessions. Although Tanya was in what she noted was an abusive, controlling

relationship during her last pregnancy, she greatly benefitted in her from the support offered by the group. This heavily factored into her decision to choose CP over traditional prenatal care, as she felt that she had little support from family and friends, and her husband was living in another country.

By establishing rapport between patients and healthcare providers in a fun, and at times, deeply serious setting, CP is able to serve as a form of social support to low income, African Americans at the health department. This includes women like Tanya, who feel as if they have few shoulders on which to lean. This play between the levity of joking around with other women and the seriousness of discussing not so fond memories of childhood creates an authentic community. It does not mirror real friendship; it is creating *real* friendships.

The facilitative, non-judgmental group style of Centering may be of particular importance to engender social support among the participants and providers because it enables women's cultural health capital to be enhanced. As mentioned in the last chapter, low income, African American women are often viewed as not having cultural health capital that healthcare providers view positively. As a result, they are sometimes treated rudely or their complaints dismissed, as seen in Keyona's story of how she was treated in the clinic and Shonda's traditional prenatal care healthcare encounter.

Erin Madden (2015) argues that the skills and values of the cultural health capital concept are those of white upper middle class standards of healthcare. In an effort to combat a "deficit" view of cultural health capital, Madden (2015) contends oppressed groups use their own cultural resources such as using social support and social networks, to meet healthcare needs.

As the work of Carol Stack (1974) and Leith Mullings (1997,2005) have shown, social support is particularly important in navigating and surviving in a racist, classist, sexist society.

Because CP builds on this already valued cultural capital of low income, African American communities in its healthcare interactions between patients and providers and patients themselves, Centering patients who are low income and/or African American are more likely to view these healthcare interactions positively. As a result, they view Centering's biomedical cultural health capital as more accessible, more comfortable, and more appealing. Additionally, as CP builds on the cultural resources of social support, it allows for the group to become a source of support in itself, buffering the negative effects of stress in pregnancy.

Although all women who attended Centering mentioned sharing the stories and concerns of pregnancy as one of the ways in which social support was engendered, high income, white women at the private practice were more likely to mention Centering serving as an important form of social support for them after their children were born. Ada, a 38 year old mother speaking about how she found Centering supportive stated,

> *I wouldn't call them like my close social support but if I had a question or even watching through email seeing them asking questions was even helpful and kind of opened up people being able to ask questions of each other. What do you think about this? Has anybody else had* [your baby do] *that? Where would you go for this? I think just knowing that these are people you could go to if you had a question or needed something and potentially people can become really close friends out of it or it could be a really tight group depending.*

Emma, a 31 year old mother, at the private practice in a different Centering group also mentioned that the role of support from the group changed after their babies were born. She noted,

> *Me and Jamilla went shopping at that big kids' fair and we actually saw Christa there. When we all met there, we talked just how things were going, and me and her text back and forth a lot. We're on Facebook with all three of them, all three of the other ladies are on Facebook and so any questions, I'll shoot them an email. We've emailed, all emailed. At the reunion we talked about lots of stuff, and then we've met that one time, one time since then. It was nice, we sat there for hours. I didn't know we were going to be there that long but it was fun to hear how everybody was doing. We talked again about our*

birth stories and just how things have gone since then, funny stories that have happened, fails that every mommy's done and what's working well for everybody.

The support offered by the group after the birth of the group's baby's maybe more important to upper class, white women because they did not have this support from their friends. While women at the health department and private practice had similar PSS-Fr survey medians, women at the private clinic were more likely to mention that they were the first in their friend groups to have babies. Jennifer, echoed several other women at the private practice when stating,

> *That's what I loved most about Centering is I'm the first of all of my friends to get pregnant, so nobody else knows what we're going through .I think just that,* [Centering] *for me, it's a group of people to come to or a person to ask questions or somebody to ask questions and somebody to give answers or suggestions or, "This is what I did. Maybe that'll work for you."*

In addition to being the first in their friend groups to become pregnant, women at the private practice were more likely to be first-time mothers than women at the health department. This may also explain why women at the private practice found Centering's social support most important postpartum, while women at the health department found it more helpful during their pregnancies.

The Individual vs. Community

CenteringPregnancy provides all the sub-categories of social support—emotional, instrumental, and informative. It provides emotional support by bringing together pregnant women and having them openly discuss their concerns about their pregnancies and futures, thus creating friendships. CP provides instrumental support by enabling the women in the group to share their skills, knowledge, and resources from other pregnancies. Finally, it serves as an informational type of social support by providing women with knowledge of their bodies in a facilitative, non-hierarchal manner. In these ways, CP acts as form of social support to pregnant

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women enabling them to feel empowered, combating the stressors of their daily lives, which may contribute to better birth outcomes.

But while Centering does provide all of these aspects of social support, I want to return to the quote by Sharon Schindler-Rising at the beginning of the chapter. She states: "Groups are also empowering because they provide support to the members and increase *individual motivation to learn and change*" (Schindler-Rising and Jolivet 2009: 365, italics mine). Even though Centering is creating a community, which serves as a form of social support, the goal of Centering is still to improve the *individual.* In fact, as Schindler-Rising states later in the quote, the group functions as more of a type of peer-pressure to adopt healthcare behaviors than functioning as a group, whose value as a community is greater than the sum of individuals. As mentioned at the end of the previous chapter, although Centering challenges some notions of biomedicine, such as assuming the doctor knows all and is always right, it still is based on the assumption of an autonomous individual who is able to make informed healthcare decisions without the constraints of one's positioning in social hierarchies.

What is striking is that the notion of the autonomous individual is counter to the notion of community. Community assumes that people are reliant upon each other for protection and survival (Hyland and Bennett 2005:55). The idea of the autonomous, Western individual is one who is independent, and does not need others. This renders social support unnecessary because social support assumes that people are always in need of other people for emotional, informational, and instrumental support. This creates an unresolved issue in Centering between the importance of the group, but the need for the individual patient to improve her health through adopting Centering healthcare advice and opinion.

CHAPTER SEVEN: CONCLUSION

The Thirteen Essential Elements of CenteringPregnancy combine to challenge the traditional provider-patient model of prenatal care and its central tenet that women and their pregnant bodies need medical professionals' surveillance and intervention. Through the mélange of these "ingredients", women learn about their bodies, their pregnancies, and biomedicine. Moreover, they learn this from each other, with minimal interjection from the healthcare provider. This fosters relationships between the women, and their healthcare providers, helping women to trust their bodies and their knowledge of their pregnancy, and closes the chasm between healthcare provider and patient. Through Centering sessions, repeated intensive meetings with the same group of women, midwives, and nurses, the group helps women bolster their cultural health capital, enabling women to be more receptive to the healthcare advice of Centering healthcare providers. Further, it also enables women to become more equipped to navigate future healthcare interactions due to the increase in cultural health capital. In these ways, women are more likely to adopt healthcare practices that contribute to better birth outcomes, and have a buffer to the stressors, which may contribute to better birth outcomes

Further, the appeal of Centering varies for women based on their race and class. Centering is attractive to low income and African American women who already consider social support as an important community cultural capital resource, recognize the importance of social support, and thus, are better able to benefit from CenteringPregnancy information and advice. Further, African American women are attracted to the program because of the way that they are treated in their traditional, one-on-one healthcare interactions, which have been historically

fraught. Centering is attractive to white, affluent women because it builds upon their knowledge and trust of biomedicine by enhancing their already biomedically aligned cultural health capital. Through Centering, these women increase their knowledge of biomedical pharmaceuticals and benefit from the support that knowing "everything is a conversation" when it comes to their bodies and pregnancy.

The possible effect of these "ingredients" can be seen in the birth outcome data for the aforementioned CP group. None of the women in any of the four groups I studied at either the health department or private practice setting delivered low birthweight babies, as compared to the 2014 rate of low birthweight infants in Durham County of 13.1% (Partnership for a Healthy Durham 2015). Nor did a woman in the group have a premature birth, as compared to the Durham county rate in 2013 of 9.9% (North Carolina CDC Report 2015).

The data and experiences during my ethnographic investigation show the CenteringPregnancy healthcare is effective in combating some of the historical and structural forces that shape a woman's habitus, and cultural health capital in healthcare settings. However, my work by no means is suggesting that CP is THE solution to inequality as manifested in differential birth outcomes. It is a Band-Aid on a festering wound, and even though it helps, by acting as a buffer to stress, it cannot overcome many of the larger intersectional structural barriers of women's lives. Instead, my work shows that CenteringPregnancy is in many ways blind to these larger overlapping hierarchies.

Centering is an ideological program in tension. Centering teeters between the wholistic birth model of traditional lay midwifery and the technocratic model of modern biomedicine. It is woman-centered, and seeks to empower women and abide by their wishes, but its main focus is adherence to biomedical recommendations regarding pregnancy and birth. While Centering does

enhance women's cultural health capital and encourage them to push back against unnecessary biomedical interventions, it does so through teaching them healthcare's valued capital--biomedicine's lingua franca. Centering is also caught between an ideology of community—a group of people who need group resources to survive (Hyland and Bennett 2005)—and the assumption of an autonomous individual who can make healthcare decisions without being constrained by their social location. The structure of the group, a circle composed of women who share their knowledge and experiences engenders community. They need each other's support to have their fears and anxieties about pregnancy and childbirth assuaged. However, they are supposed to disregard their vulnerabilities, which require them to seek social support from this group and others they are a part of to make unconstrained healthcare behaviors to do what's in the best interest for themselves, as individuals, and their babies.

The festering wound is biomedicine's assumption of an autonomous individual. This individual is assumed to be independent subject who only needs to have their autonomy supported when they are in a temporary state of medical need (Kittay 2016:112). This assumption privileges those with higher social capital, and correspondingly, higher cultural health capital, in that they have the resources and skills to seek medical help in their supposed temporary time of need and make autonomous healthcare actions and choices (Kittay 2016; Shim et al. 2016). What is lacking in this assumption is the realization that very few people fit this model. Indeed, Kittay (2016) argues,

> *the disabled […], the racial minority, the immigrant, and those who are poor are more likely to be judged incompetent. […] They cannot gain from a system not developed to serve them. Like a key attempting to fit into a mismatched lock, these patients cannot unlock the wonders of biomedicine (130).*

When patients are judged incompetent in healthcare interactions it is because they do not have cultural health capital in sync with their healthcare providers, because cultural health capital assumes an autonomous individual with the resources to enable them to freely make healthcare decisions. As Kittay (2016) points out, and as seen in the quotes from low income, African American patients at the health department, this often results in bad feelings on both sides, and a rejection of biomedical advice by the patient.

The use of the lens of intersectionality in this anthropological investigation shifts the focus of explanatory models for birth outcome disparities from the myopic accounts of lifestyle choices, to an examination of the interacting roles of history, power, and inequality. This approach may explain why previous health disparities research has fallen short, as it failed to examine how healthcare interactions between patient and provider shape disparate perinatal outcomes.

What my ethnographic exploration of the lived experience of Centering attempts to do, is to show what anthropological investigations can do by "talking back" to biomedicine by shifting the focus in healthcare interactions to the matrix of social hierarchies that form the basis of our society. Through this framework we can "recognize and name" these over-arching social structures to explore how they are interlocking and embodied, and explore how in some ways, in some healthcare interactions, the manifestations of these structures can be mitigated.

APPENDIX 1

Interview Questions (for patients):

1. Demographics: Age, education level, employment status, approximate household income, number of children, marital status, gestational age at delivery, baby's birthweight and length, how long have they lived in Durham

2. Birth story
   a. incorporate anything they learned from Centering into laboring?

3. Why did you choose CenteringPregnancy over traditional prenatal care?

4. Do you have any previous experience with CenteringPregnancy? With traditional prenatal care?

5. How did you hear about CenteringPregnancy? From whom? What did they say about it?

6. What do you know about CenteringPregnancy? What have you heard about it?

7. How do you think CenteringPregnancy compares to traditional prenatal care?

8. Do you like CenteringPregnancy? Why/not? Favorite aspects? Least favorite aspects?

9. Do you think they can improve on anything?

10. What did you learn from Centering? Incorporate any aspects into parenting?

11. Are you breastfeeding? Did you want to breastfeed before CP? After CP? What does Centering say about breastfeeding? Did your views on breastfeeding change?

12. Did you have any problems breastfeeding? How were they resolved?

13. Are you co-sleeping?

14. How would you describe Centering?

15. What do your friends and family think about CenteringPregnancy?

16. What does your partner (or other support person) think about CenteringPregnancy?

17. Support: How do you define social support? What causes you stress? What makes you feel supported? Do you feel society supports you? Anyway that you would like more support?

18. Does Centering help with any of this?

APPENDIX 2

Interview Questions (for nurse midwives and facilitators):

1. Demographics: Age, education level, approximate household income, number of children, marital status, gestational age of fetus, due date, how long have they lived in Durham

2. How long have you been involved with CenteringPregnancy?

3. How did you get involved with CenteringPregnancy?

4. What attracted you to the program?

5. How do you think CenteringPregnancy compares to traditional prenatal care?

6. What are your favorite aspects? Least favorite aspects?

7. Do you think they can improve on anything?

8. Why do you think CenteringPregnancy has better perinatal outcomes compared to traditional prenatal care?

APPENDIX 3

Perceived Social Support Family (PSS-Fa) and Friends (PSS-Fr) Survey

Directions: The statements that follow refer to feelings and experiences which occur to most people at one time or another in their relationships with <u>family</u>. For each statement there are three possible answers: Yes, No, Don't Know. Please circle the answer you choose for each item.

Yes   No   Don't Know   1. My family gives me the moral support I need.

Yes   No   Don't Know   2. I get good ideas about how to do things or make things from my family.

Yes   No   Don't Know   3. Most other people are closer to their family than I am.

Yes   No   Don't Know   4. When I confide in the member of my family who are closest to me, I get the idea that it makes them uncomfortable.

Yes   No   Don't Know   5. My family enjoy hearing about what I think.

Yes   No   Don't Know   6. members of my family share many of my interests.

Yes   No   Don't Know   7. Certain members of my family come to me when they have problems or need advice.

Yes   No   Don't Know   8. I rely on my family for emotional support.

Yes   No   Don't Know   9. There is a member of my family I could go to if I were just feeling down, without feeling funny about it later.

Yes   No   Don't Know   10. My family and I are very open about what we think about things.

Yes   No   Don't Know   11. My family is sensitive to my personal needs.

Yes   No   Don't Know   12. members of my family come to me for emotional support.

Yes   No   Don't Know   13. member of my family are good at helping me solve problems.

Yes   No   Don't Know   14. I have a deep sharing relationship with a number of members of my family.

Yes   No   Don't Know   15. members of my family get good ideas about how to do things or make things from me.

Yes   No   Don't Know   16. When I confide in members of my family, it makes me feel uncomfortable.

Yes   No   Don't Know   17. members of my family seek me out for companionship.

Yes   No   Don't Know   18. I think that members of my family feel that I am good at helping them solve problems.

Yes   No   Don't Know   19. I don't have a relationship with a member of my family that is as intimate as other people's relationships with family members.

Yes   No   Don't Know   20. I wish my family were much different.

Directions: The statements that follow refer to feelings and experiences which occur to most people at one time or another in their relationships with <u>friends</u>. For each statement there are three possible answers: Yes, No, Don't Know. Please circle the answer you choose for each item.

Yes	No	Don't Know	1. My friends give me the moral support I need.
Yes	No	Don't Know	2. Most other people are closer to their friends than I am.
Yes	No	Don't Know	3. My friends enjoy hearing about what I think.
Yes	No	Don't Know	4. When I confide in my friends who are closest to me, I get the idea that it makes them uncomfortable.
Yes	No	Don't Know	5. I rely on my friends for emotional support.
Yes	No	Don't Know	6. If I felt that one or more of my friends were upset with me, I'd just keep it to myself.
Yes	No	Don't Know	7. I feel that I am on the fringe in my circle of friends
Yes	No	Don't Know	8. There is a friend I could go to if I were just feeling down, without feeling funny about it later.
Yes	No	Don't Know	9. My friends and I are very open about what we think about things.
Yes	No	Don't Know	10. My friends are sensitive to my personal needs.
Yes	No	Don't Know	11. My friends come to me for emotional support.
Yes	No	Don't Know	12. My friends are good at helping me solve problems.
Yes	No	Don't Know	13. I have a deep sharing relationship with a number of friends.
Yes	No	Don't Know	14. My friends get good ideas about how to do things or make things from me.
Yes	No	Don't Know	15. When I confide in friends, it makes me feel uncomfortable.
Yes	No	Don't Know	16. My friends seek me out for companionship
Yes	No	Don't Know	17. I think that my friends feel that I am good at helping them solve problems.
Yes	No	Don't Know	18. I don't have a relationship with a friend that is as intimate as other people's relationship with friends.
Yes	No	Don't Know	19. I've recently gotten a good idea about how to do something from a friend.
Yes	No	Don't Know	20. I wish my friends were much different.

APPENDIX 4

Perceived Social Support Family Scale: Health Department Centering Groups

Participant	My family gives me the moral support I need.	I get good ideas about how to do things or make things from my family.	Most other people are closer to their family than I am.	When I confide in the member of my family who are closest to me, I get the idea that it makes them uncomfortable.	My family enjoy hearing about what I think.	Members of my family share many of my interests.	Certain members of my family come to me when they have problems or need advice.	I rely on my family for emotional support.	There is a member of my family I could go to if I were just feeling down, without feeling funny about it later.	My family and I are very open about what we think about things.	My family is sensitive to my personal needs.
Crystal	1	1	1	1	1	1	1	1	1	1	1
Sharon	1	0	1	1	1	1	1	1	1	1	1
Stacy	1	1	1	1	1	1	1	1	1	1	0
Chantal	1	1	1	1	1	0	1	1	1	1	1
Lupita	1	1	1	1	1	1	1	1	1	1	1
Keyona	0	1	0	0	0	0	0	0	1	1	1
Michelle	1	1	1	1	1	1	1	1	1	1	1
Shanora	1	1	1	1	1	1	1	1	1	1	1
Tanya	0	0	0	0	0	0	0	0	0	0	0
Angela	1	1	0	1	1	1	1	0	1	1	1
Raven	1	1	0	1	1	1	0	1	1	1	1

Perceived Social Support Family Scale: Health Department Centering Groups Continued

Participant	Members of my family come to me for emotional support.	Members of my family are good at helping me solve problems.	I have a deep sharing relationship with a number of members of my family.	Members of my family get good ideas about how to do things or make things from me.	When I confide in members of my family, it makes me feel uncomfortable.	Members of my family seek me out for companionship.	I think that members of my family feel that I am good at helping them solve problems.	I don't have a relationship with a member of my family that is as intimate as other people's relationships with family members.	I wish my family were much different.	TOTAL Out of 20
Crystal	1	0	1	1	1	0	1	1	1	18
Sharon	1	1	1	1	1	1	1	1	1	18
Stacy	1	1	1	1	1	0	1	1	1	18
Chantal	1	1	0	1	0	0	1	0	1	15
Lupita	1	1	1	1	1	1	1	0	1	19
Keyona	0	0	0	0	1	0	0	0	1	6
Michelle	1	1	1	1	1	1	1	0	1	19
Shanora	1	1	1	1	1	1	1	1	1	20
Tanya	0	0	0	0	0	0	0	0	0	0
Angela	0	1	1	0	1	0	1	0	0	13
Raven	0	1	1	1	1	0	0	1	1	15
									mean	14.636
									median	18

Perceived Social Support Scale Family Private Practice Centering Groups

Participant	My family gives me the moral support I need.	I get good ideas about how to do things or make things from my family.	Most other people are closer to their family than I am.	When I confide in the member of my family who are closest to me, I get the idea that it makes them uncomfortable.	My family enjoy hearing about what I think.	Members of my family share many of my interests.	Certain members of my family come to me when they have problems or need advice.	I rely on my family for emotional support.	There is a member of my family I could go to if I were just feeling down, without feeling funny about it later.	My family and I are very open about what we think about things.	My family is sensitive to my personal needs.
Jamilla*	1	1	0	0	1	1	0	1	1	1	0
Chloe	1	1	0	1	1	1	1	1	1	1	1
Monique	1	1	0	1	1	0	1	1	1	1	1
Ada	1	1	1	1	1	0	1	1	1	1	1
Kimberly	1	1	1	1	1	1	1	1	1	1	1
Emma	1	1	1	1	1	1	1	1	1	1	1
Christa	1	1	1	1	1	1	1	1	1	1	1
Jemma	1	1	1	1	1	1	1	1	1	1	1
Jennifer	1	1	1	1	1	1	1	1	1	1	1
Janice	1	1	1	1	1	1	1	1	1	1	1
Ann	1	1	1	1	1	1	1	1	1	1	1

*Jamilla is the only African American woman at the private practice.

Perceived Social Support Scale Family Private Practice Centering Groups Continued

Participant	Members of my family come to me for emotional support.	Member of my family are good at helping me solve problems.	I have a deep sharing relationship with a number of members of my family.	Members of my family get good ideas about how to do things or make things from me.	When I confide in members of my family, it makes me feel uncomfortable.	Members of my family seek me out for companionship.	I think that members of my family feel that I am good at helping them solve problems.	I don't have a relationship with a member of my family that is as intimate as other people's relationships with family members.	I wish my family were much different.	TOTAL out of 20
Jamilla*	1	1	1	1	1	1	1	0	1	15
Chloe	1	1	1	1	1	1	1	0	1	18
Monique	1	1	1		1	1	0	1	1	16
Ada	1	1	1	1	1	1	1	1	1	19
Kimberly	1	1	1	1	1	1	1	0	1	19
Emma	1	1	1	1	1	1	1	1	1	20
Christa	1	1	1	1	1	1	1	1	1	20
Jemma	0	1	1	1	1	1	1	1	1	19
Jennifer	1	1	1	1	1	1	1	1	1	20
Janice	1	1	1	1	1	1	1	1	1	20
Ann	1	1	1	1	1	1	1	1	1	20
									mean	19.1
									median	19.5

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Perceived Social Support Friends Scale Health Department Centering Groups

Participant	My friends give me the moral support I need.	Most other people are closer to their friends than I am.	My friends enjoy hearing about what I think.	When I confide in my friends who are closest to me, I get the idea that it makes them uncomfortable.	I rely on my friends for emotional support.	If I felt that one or more of my friends were upset with me, I'd just keep it to myself.	I feel that I am on the fringe in my circle of friends	There is a friend I could go to if I were just feeling down, without feeling funny about it later.	My friends and I are very open about what we think about things.	My friends are sensitive to my personal needs.	My friends come to me for emotional support.
Crystal	1	0	1	1	0	1	1	1	1	1	1
Sharon	1	0	1	0	1	1	0	1	1	1	1
Stacy	1	1	1	1	1	1	1	1	1	0	1
Chantal	1	1	1	1	1	0	1	1	1	1	1
Lupita	1	1	1	1	1	1	1	1	1	1	1
Keyona	1	1	1	1	1	1	1	1	1	1	1
Michelle	1	1	1	1	1	1	1	0	1	1	1
Shanora	1	1	1	1	0	1	1	1	1	1	1
Tanya	1	0	1	0	1	1	0	0	1	0	0
Angela	1	1	1	1	1	1	1	1	1	1	1
Raven	1	0	1	1	1	1	1	1	1	1	1

Perceived Social Support Friends Scale Health Department Centering Groups Continued

Participant	My friends are good at helping me solve problems.	I have a deep sharing relationship with a number of friends.	My friends get good ideas about how to do things or make things from me.	When I confide in friends, it makes me feel uncomfortable.	My friends seek me out for companionship	I think that my friends feel that I am good at helping them solve problems.	I don't have a relationship with a friend that is as intimate as other people's relationship with friends.	I've recently gotten a good idea about how to do something from a friend.	I wish my friends were much different.	Total Out of 20
Crystal	1	1	1	1	1	1	0	1	1	17.85
Sharon	0	1	0	1	1	1	1	1	1	15
Stacy	1	1	0	1	0	1	1	1	1	17
Chantal	1	0	1	1	0	1	1	1	1	17
Lupita	1	1	1	1	1	1	1	1	1	19
Keyona	1	1	1	1	1	1	1	1	1	20
Michelle	1	1	1	1	1	1	0	1	1	18
Shanora	1	0	1	1	1	1	1	0	1	17
Tanya	1	0	0	0	0	0	0	1	0	7
Angela	1	1	1	1	1	1	1	1	1	20
Raven	1	0	1	1	1	1	1	1	1	18
									mean	16.895
									median	17

Perceived Social Support Friends Scale Private Practice Centering Groups

Participant	My friends give me the moral support I need.	Most other people are closer to their friends than I am.	My friends enjoy hearing about what I think.	When I confide in my friends who are closest to me, I get the idea that it makes them uncomfortable.	I rely on my friends for emotional support.	If I felt that one or more of my friends were upset with me, I'd just keep it to myself.	I feel that I am on the fringe in my circle of friends	There is a friend I could go to if I were just feeling down, without feeling funny about it later.	My friends and I are very open about what we think about things.	My friends are sensitive to my personal needs.	My friends come to me for emotional support.
Jamilla*	1	1	1	1	1	1	1	1	1	1	1
Chloe	1	0	1	1	1	1	1	1	1	1	1
Monique	1	0	1	1	0	1	0	0	1	1	1
Ada	1	1	1	1	1	1	1	1	1	1	1
Kimberly	1	0	1	1	0	1	1	1	1	1	0
Emma	1	1	1	1	1	1	1	1	1	1	1
Christa	1	1	1	1	1	1	1	1	1	1	1
Jemma	1	1	1	1	1	0	1	1	1	1	1
Jennifer	1	1	1	1	1	1	1	1	1	1	1
Janice	0	0	0	1	0	0	0	0	1	0	0
Ann	1	1	0	1	1	1	1	1	1	1	1

Perceived Social Support Friends Scale Private Practice Centering Groups Continued

	My friends get good ideas about how to do things or make things from me.	When I confide in friends, it makes me feel uncomfortable.	My friends seek me out for companionship	I think that my friends feel that I am good at helping them solve problems.	I don't have a relationship with a friend that is as intimate as other people's relationship with friends.	I've recently gotten a good idea about how to do something from a friend.	I wish my friends were much different.	Total
Jamilla*	1	1	1	1	1	1	1	20
Chloe	1	1	1	1	0	1	1	18
Monique	0	1	0	0	0	1	1	11
Ada	1	1	1	1	1	1	1	20
Kimberly	1	1	1	1	1	1	1	16
Emma	1	1	1	1	1	1	1	20
Christa	1	1	1	1	1	1	1	20
Jemma	1	1	1	1	1	1	1	19
Jennifer	1	1	1	1	1	1	1	20
Janice	1	1	0	1	0	0	0	5
Ann	1	1	1	0	1	1	1	18
							mean	17
							median	18.5

APPENDIX 5

Abbreviated Data Matrices

Codebook Excerpt

Code Name	Code Definition	child code/sub codes	Code Example
Social support	receiving care or help from others	Centering	
Relationship between patient and provider	Interactions with healthcare providers and their perception	Positive; negative	

Display Matrix: Social Support and Relationship Between Patient and Provider

	CP group and Race	Social Support	Relationship Between Patient and Provider
Ada	Cora; white	"I think throughout pregnancy it was really helpful to know that other people existed who were in the same boat going through things at the same time. I wouldn't call them like my close social support but if I had a question or even watching through email seeing them asking questions was even helpful and kind of opened up people being able to ask questions of each other. What do you think about this? Has anybody else had that? Where would you go for this? I think just knowing that these are people you could go to if you had a question or needed something and potentially people can become really close friends out of it or it could be a really tight group depending. I'm not sure that's what I went into it thinking about"	" People putting their hands on me without asking permission is dis-empowering. People not having any thought or concern about my philosophy of being a parent. When he's screaming and a nurse is forcing him onto my physical body, I think it's both the physical aspect of that and just like the emotional peace. I just became a mom like six hours ago and now you're telling me that him screaming at the top of his lungs like this is normal? I feel that it is not."
Angela	Jill; African	"All you guys are very helpful in any questions that we had and	"I think Centering it opens your eyes a lot more about things that

	American	everything. It was just helpful knowing, so I just like that. That we had a lot of support too, because some people were there by themselves, no fathers for their baby or if they didn't, I'm not saying they didn't have them, but people that came to support even if no one came to support you at least you felt like you were supported with the people who were there."	happens during your pregnancy, your labor, because going to the doctor, they're pretty much going to tell you about your doctor visit but with Centering is they get more in-depth into those. I feel like with Jamaya, like I didn't have my older sister there at the time and a lot of questions I had and probably when I was having her I wouldn't have known certain things or something like that or what to expect basically, but with Centering you do get to feel out what you're going to go through or something like that. That then gets better than just going to sit in a doctor's office then they just tell you that you're going to get [type B 00:09:20], whatever, but Centering was fun, [inaudible 00:09:24] on the experience though."
Chantale	Abra; African American	"I feel like it's more diverse and you can learn more. People tell you about their experiences that they have, and you may think something's wrong with you, but you see everybody else having these problems so you're like, okay. It's more understanding, basically. You meet a lot of people, babies, everybody having their babies born, that was neat to me. Their little pictures and stuff like that. It's just something different."	"They were very helpful, they were helpful, and so sweet, making sure everybody was fine. Supportive also. I know if I ever had a problem I could call or text somebody, even if someone around me couldn't really help, I knew I could depend on you all. They were great support. Even Jessica came up to the room with me. It was a lot, but y'all were a big help. I know I had, when I thought my water had broke when I was sleeping, I actually called up there to see what was going on. She was like, you need to go to the hospital. I told her, I said, well, they sent me back home. She was like, no, you need to go back because if you're leaking, that can be dangerous, infections and stuff like that.

			They were great help, yeah."
Stacy	Jill, African American	"with family or friends, just someone that you're able to go to and feel comfortable going to them. That would be pretty much it. I don't think it's one specific person. You could have more than one person that you're able to talk to or ask questions, get their feedback on something"	"She told me about it because I think one day I was actually having an experience with the front desk and she was walking past, and she was like, 'What's wrong? Why don't you come to Centering'"
Emma	Melissa; white	"I guess for me, just having people checking in and making sure, seeing how everything is going, around having a baby but just in general, having friends, family that supports you and always seeing how stuff is and checking in and all that. I've had a lot. My mom lives nearby, so she's always, she comes over almost every day, mainly to see her grandson, let's face it, but also to see how I'm doing and Theo's doing. That's helpful, it's been good"	"Obviously I was going to do whatever he needed if it was bad, but I felt ... I knew at the time, I knew he had been losing weight because he hadn't been eating, because at the hospital there was so much confusion and I kept asking the nurses, can you sit with me and try? It just wasn't, the couple nurses I had ... There was one that was very awful and there was one that was a little awful. They just weren't really supportive of it. The one kept telling me just to pump, but I kept wanting to try to put him to the breast and to see if he would do it, because I kept feeling like he would. Theo kept saying, just try it. Then I felt like we were trying to do it almost like, so the nurse wouldn't come in when we were doing it, because she had been telling us to pump. It was an awkward situation."
Chloe	Cora; white	"A strong network of community, people around you, to support you in life."	"The nurse came in and said I'm ready to put your I.V. port in. Even at centering, they said, that's pretty standard. You'll probably have to. I thought, why not, I'll just ask. Do I have to have it? No, so I didn't get it. Things like that were helpful."
Janice	Melissa; white	"For the most part, the thing that would probably affect me as far	"Oh yeah. I wanted to go to midwife [inaudible 00:02:49]

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		as society goes is the fact that right now my husband is Mexican and all my family. I'm really close to them. Lately in the news Donald Trump and everything, those attitudes, I know first-hand. A lot of my family's the same way, just have a very nativist, anything foreign is bad and really have a negative view on immigrants especially Hispanic immigrants. I feel as far as American society, that's the only aspect maybe where I don't feel too supported in as far as my family goes."	first. It was two months before I was due that my insurance finally kicked in. I could go to the OB. I just picked the first one off the list so I could get in there. It wasn't a bad experience with my first, but I did feel he wanted to pressure me more to get the pitocin. I never met the doctor. It was a big old practice. I don't know. He was like, "Well, we can wait and you'll probably advance on your own within a couple of days." His rhetoric made me really feel like he was trying to pressure me into doing what I didn't want to do, but the midwife was great."
Crystal	Abra; African American	"I liked it because you got to compare your experience with other people so [inaudible 00:16:37] like, oh my God, is it just me, am I just overreacting? Like right now, Marcus has a cousin here, his wife's pregnant. She calls me almost every day and is like, is this normal? Do you guys argue? Do you guys get into it [inaudible 00:16:55]. If she was in centering she would know that it's normal, even though she has two other kids she's still like, is it just me or, you know. That part about it, getting other people's experiences and their opinions, their insights [inaudible 00:17:14] it's just you or something's wrong with you. Or even, they don't know what they're talking about or whatever. Yeah, that's what I liked about it."	"The ob/gyn I had with my daughter was, the one who helped me give birth to my daughter, he was really straight forward. He was strictly business in that he wasn't really informative but he did do his job, he made sure that he did everything that he was supposed to do, but he didn't talk you through it and let you know, okay, at 28 weeks we do this test, not just I'm drawing your blood and bye. I actually knew what was going on at each point in my pregnancy. We went through the stages, first trimester this is going one, second trimester you guys, even though all of us were definitely, pretty much going through the same thing. Just the support and just feeling comfortable. I felt comfortable with my doctor cause I would've changed him but he, lie I said, he was just like strictly about his job. He wasn't trying to make friends or

			lollygag [inaudible 00:15:23]. I feel really comfortable in the centering group cause I probably opened up there more than I opened up to any doctor. The ob/gyn I had with my daughter was, the one who helped me give birth to my daughter, he was really straight forward. He was strictly business in that he wasn't really informative but he did do his job, he made sure that he did everything that he was supposed to do, but he didn't talk you through it and let you know, okay, at 28 weeks we do this test, not just I'm drawing your blood and bye. I actually knew what was going on at each point in my pregnancy. We went through the stages, first trimester this is going one, second trimester you guys, even though all of us were definitely, pretty much going through the same thing. Just the support and just feeling comfortable. I felt comfortable with my doctor cause I would've changed him but he, lie I said, he was just like strictly about his job. He wasn't trying to make friends or lollygag [inaudible 00:15:23]. I feel really comfortable in the centering group cause I probably opened up there more than I opened up to any doctor"

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