

**A PROPOSAL TO THE OHIO UNIVERSITY RESEARCH COUNCIL**

TITLE OF PROJECT: The Impact of poverty & race on risk of infant mortality in Cleveland, OH  
 NAME OF APPLICANT: Sarah E Rubin

STATUS:  Asst. Prof.  Assoc. Prof.  Prof.  Administrator

DEPARTMENT: Social Medicine

CAMPUS ADDRESS: \_\_\_\_\_

E-MAIL ADDRESS: rubins@ohio.edu

RE-SUBMISSION:  YES (Original Submission Date Spring 2016)  
 NO

BUDGET: Total Request 67976 \$ 7988  
 (May not exceed \$8,000)

**IRB AND IACUC APPROVAL:**

To ensure that the University is in compliance with all federal regulations, complete the checklist below. Note: your proposal can be approved prior to IRB or IACUC approval, but funding will be withheld until notification of approval or exemption.

Yes	No	Office of Research Compliance	Policy #
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Human Subjects in Research (including surveys, interviews, educational interventions): Institutional Review Board (IRB) Approval #: <u>16-X-14</u> Expiration Date: <u>4/28/17</u>	19.052
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Animal Species: Institutional Animal Care & Use Committee (IACUC) Approval #: Expiration Date:	19.049

**SIGNATURES:**

Applicant's Signature		Chair/Director's Signature	
Signature	<u>[Signature]</u>	Signature	<u>[Signature]</u>
Name	<u>Sarah E Rubin</u>	Name	<u>David Descurner</u>
Dept/School	<u>Social Medicine</u>	Unit	<u>Social Medicine</u>
Date	<u>9/27/16</u>	Date	<u>9/27/16</u>
Dean's Signature			
Name	<u>ISAAC J. KIRSTEIN</u>	Signature	<u>[Signature]</u>
College	<u>HCOM - CCE</u>	Date	<u>9-27-2016</u>

**Optional:**

If selected for funding, I give permission to the Office of the Vice President for Research and Creative Activity to use my proposal as an example during training and workshop exercises.

Signature: [Signature] Date: 9/27/16

## Ohio University Research Council Proposal Checklist

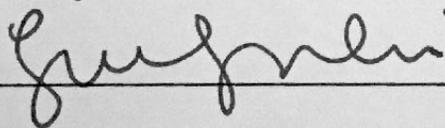
Applicants **must** complete and sign the checklist. The checklist should be included as the second page of the application (following the cover page).

<input checked="" type="checkbox"/> Cover Page	use OURC form
<input checked="" type="checkbox"/> Checklist	use OURC form
<input checked="" type="checkbox"/> Abstract*	1 double-spaced page
<input checked="" type="checkbox"/> Introduction ( <i>for resubmissions only</i> )*	1 double-spaced page
<input type="checkbox"/> New Project Description ( <i>for established applicants only</i> )*	1 double-spaced page
<input checked="" type="checkbox"/> Discussion	10 double-spaced pages
<input type="checkbox"/> Glossary/Definition of Terms* ( <i>not required</i> )	2 double-spaced pages
<input checked="" type="checkbox"/> Bibliography ( <i>not required</i> )	3 pages
<input checked="" type="checkbox"/> Biographical information ( <i>applicant(s) and key personnel</i> )	3 pages per person
<input checked="" type="checkbox"/> Other Support ( <i>applicant(s) and key personnel</i> )	1 page per person
<input checked="" type="checkbox"/> Budget and Justification	no limit specified
<input type="checkbox"/> Appended Materials	10 pages; no more than 10 minutes of footage
<input type="checkbox"/> Recommended Reviewers	5 required
<input checked="" type="checkbox"/> Electronic copy of proposal	Single Acrobat file, containing entire proposal and required signatures

\* These sections should be written in language understandable by an informed layperson to assist the committee in its review. Established applicants (†) are faculty members who have tenure **and** have been at the university at least three years or administrators who have been at the university at least five years.

**\*\*Please note: The committee has the right to return without review any proposals that do not conform to these format requirements.\*\***

Applicant signature: \_\_\_\_\_



Infant mortality is an urgent public health priority in Cleveland, Ohio due to higher than average infant mortality rates. There is a consensus among scholars that “poverty” and “race” contribute to elevated infant mortality rates, however the processes by which these factors influence infant mortality are still unclear. This pilot study aims to investigate how the experiences of race and poverty affect the wellbeing of pregnant mothers in Cleveland in order to better understand why the infant mortality rate (IMR) is higher among blacks than whites. We will use a qualitative, specifically ethnographic, approach to better understand participants’ everyday lives in order to elucidate the processes and factors by which poverty and race may increase risk for infant mortality. Over a 12 month period, we will interview each participant ten times spanning her pregnancy and postpartum year. These interviews will consist of open-ended interviews covering a variety of topics relating to stressors, wellbeing, perceptions of poverty and racism, and reproductive health. In addition to interviews, we will engage in direct and “participant” observation, the latter which entails observing while participating alongside participants in their daily tasks. All interviews will be transcribed and coded to elicit emergent themes, patterns, and models. This study has the potential to make significant contributions to both scientific scholarship and public health. This research puts pregnant women and their subjective experience of the world at the center of analysis, which gives poor women a voice and also creates an opportunity to reinterpret variables such as “poverty” and “race” in light of women’s own experiences, feelings, and priorities. This study will also help to shed light on how Cleveland-area pregnant women experience the world around them and may provide evidence-based insights that can guide local practices of care.

Reviewers will find the changes we have made *[in bold italics with brackets]* in the proposal text and budget. Here, we will discuss suggestions that we are unable to accommodate or require some explanation.

We were asked to provide more detail with regards to participant observation. Upon reflection, we realized that the researchers for this study are more likely to engage in direct observation than participant observation per se because they are unable to live in the communities they are studying. Length and number of observation “sessions” are difficult to specify. Direct observation will likely take place immediately before, after, and during the interviews and while spending unstructured time with participants, for example while helping them with rides to medical appointments or on other errands. Participant observation could occur if they engage in quotidian tasks alongside their participant like shopping, eating, childcare, attended a birthday party, etc. Participant observation will be encouraged but may be rare.

Since this study is currently oriented towards mentoring medical students in qualitative research methods, the interviewers will be medical students and the PI only; as the study is expanded, it would be useful to include lay/community health workers as suggested.

At this time, we are not able to match the participants to particular interviewers by demographic characteristics; we will employ “reflexivity” in data analysis to mitigate the potential biases of any demographic “mismatch.”

While we agree that 1.5-2 years is ideal for data analysis, the guidelines for the budget stipulate that the funds must be used within a year.

A. Specific Aims

This pilot study aims to investigate how the experiences of race and poverty affect the wellbeing of pregnant mothers in Cleveland in order to better understand why the infant mortality rate (IMR) is higher among blacks than whites. To date, epidemiological research has demonstrated that IMR is consistently higher for blacks than whites and that poverty and race are the most significant contributing factors for this difference. However, it is *not* well understood precisely *how and why* poverty and race affect IMR. The how and why remain elusive for several reasons: 1) how poverty is calculated (e.g. household income) is not necessarily an accurate depiction of how a pregnant mother and her future infant experience deprivation because of variations in household dynamics, her access to extra-household resources, and mitigating social factors such as resilience and support; 2) race is not a biological fact, but a social experience<sup>1, 1</sup>, thus identifying as black or African American is not what increases risk for infant mortality, but the structural ways that being *perceived by others as black* constrains life choices and access to resources, pre-determines one's neighborhood and educational level, exposes one to racism and informs one's ability to cope<sup>4,5</sup>; 3) the everyday experience of poverty and race are not necessarily negative--mutual need can lead to reciprocity and social support in a community, underemployment can prompt intergenerational households, and racial identity can create solidarity and social cohesion<sup>6,7</sup>; 4) even communities

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<sup>1</sup> Theories of epigenetics complicate this statement by demonstrating that social forces such as perceived racism can create chronic stress, which can cause heritable changes in the fetus that may predispose it to disease and a high risk of infant mortality in the next generation. e.g.

2. Collins JW, David RJ. Racial disparity in low birth weight and infant mortality. *Clin Perinatol*. 2009;36(1):63-73,

3. Sandman CA, Glynn L, Schetter CD, et al. Elevated maternal cortisol early in pregnancy predicts third trimester levels of placental corticotropin releasing hormone (CRH): priming the placental clock. *Peptides*. 2006;27(6):1457-1463.

of similar size and income levels can offer profoundly different experiences for residents based on history, past and present housing policies, surrounding communities, local culture, availability of resources, public transportation, etc; in other words, the material realities, history, and “feel” of the community all contribute to everyday experiences between poor communities<sup>4</sup>; and 5) although population-level data points clearly to a racial disparity in IMR, poor white and poor black women’s experiences are not often directly compared (and the experiences of poor white women are often overlooked completely with regards to infant mortality), which limits our understanding of what is uniquely deleterious about race when it comes to risk of infant mortality<sup>5</sup>.

These five complexities are obfuscated or rendered invisible by epidemiological research because they concern the nuances, variations, and contradictions of the *everyday lived experiences and perceptions* of pregnant and postpartum mothers at risk for infant mortality, a level of analysis not under the purview of epidemiology. Research, such as the proposed pilot study, that can examine poverty and race at the ground level, focus on pregnant women’s experiences of their everyday lives, and that can take different levels of experience and context--individual, interpersonal, household, community, city, nation--into account is needed to shed light on the *how and why* of this epidemiologically obvious, but otherwise mystifying, public health tragedy<sup>5,8</sup>.

To address these complexities and lacunae, this study aims to investigate how the experiences of race and poverty affect the wellbeing of pregnant mothers in Cleveland in order to better understand why the IMR is persistently higher among blacks than whites. To accomplish this aim, the study will focus on the following research objectives: 1) Identify

patterns in how participants understand, respond to, and cope with the everyday realities of being poor and being perceived as a certain race (e.g. perceived racism). 2) Discern any meaningful differences in perceptions of poverty and race between white and black participants. 3) Identify how participants perceive of their well-being and how poverty and race factor into that perception.

#### B. Background, Significance, and Dissemination Plan

**Background:** The infant mortality rate (IMR)--the number of infants dying before reaching one year of age, per 1,000 live births in a given year--is a globally recognized marker of poor health for a population and a sign of an inadequate public health system. The United States is ranked 167th among 224 countries<sup>9</sup> with its IMR of 5.86<sup>10</sup> even though it is the global leader in healthcare expenditures (16.9% of the GDP)<sup>11</sup>. Even more troubling is that the IMR rate in the United States is stratified by race, with the rate for blacks more than double that of whites and Hispanics: 5.06 for non-Hispanic whites, 5.00 for Hispanics, and 11.11 for non-Hispanic blacks<sup>10</sup>. There is broad consensus among scholars that the wide health disparity between black and white populations in particular is linked to socioeconomic disparities and experiences with racism. The City of Cleveland is a case in point.

Cleveland has an IMR of 12.9, which is nearly three times the country's; but the rate is highest among the black population at 15.73, compared to 11.84 for white and 10.87 Hispanic populations<sup>12</sup>. Furthermore, in Cleveland, race closely corresponds to income level in certain neighborhoods of the city<sup>4</sup>. A history of segregation and marginalization in Cleveland may be to blame<sup>4</sup>; there is also evidence that more recent shifts in poverty has a greater impact<sup>13</sup>. Sadly, because of its dramatically high, racially stratified IMR, Cleveland is an ideal place to study and

intervene in racial disparities in infant mortality; as the Cuyahoga County Health Commissioner has said, “there's nowhere to go but up<sup>14</sup>.”

And yet, although the consensus is that “poverty is the problem,” the processes by which “poverty” and “race” contribute to high infant mortality are not well understood. Poverty and race are vague and misleadingly categories: as previously discussed, poverty goes beyond income, and race goes beyond skin color. But, simply expanding or operationalizing the definitions without specificity of context is not the solution because of the importance--and variability--of social factors<sup>15</sup>. Longitudinal qualitative research gives us insight into the complexity of how poverty and race function “on the ground” by focusing on the perceptions and experiences of pregnant women themselves. Giurgescu and colleagues interviewed 22 black pregnant women from poor Chicago neighborhoods and used focus groups to investigate participants’ perceptions of what factors cause preterm birth, the greatest proximate risk factor for infant mortality<sup>8</sup>. Their findings indicate a mix of perceived risk factors some of which fall on the individual (health conditions, mothers’ worries, unhealthy behaviors), but most of which are in the social or structural realm representing the contexts the woman finds herself in and is usually unable to change or avoid (lack of social and financial support, society’s judgement of them, dangerous neighborhoods, and racism). It is not surprising then, that a majority of participants felt that preterm birth was inevitable and the few protective factors at their disposal (social support and positive coping/self-care) were inadequate to reduce their risk.

Although this and similar studies<sup>5</sup> persuasively argue for similarities between poor black populations, there are some evident differences in experiences. The differences in experience of racism between communities points to the importance of expanding qualitative research to

new populations at risk in order to build an empirical understanding of which risk factors are similar across populations and which are unique to certain contexts. This is especially crucial if we want qualitative research to be immediately useful to public health and policy makers that are working hard to effectively intervene in their respective communities.

### **Significance**

Firstly, this study will contribute nuanced empirical data on the lived experiences of pregnant and postpartum women living in poor neighborhoods of Cleveland, which, in conjunction with other qualitative community studies, will help draw a more complete picture of the similarities and differences across communities that have higher rates of infant mortality. Secondly, it will contribute much needed empirical data on how poverty is experienced by white pregnant and postpartum women, who, in Cleveland and other poor communities, are also at an increased risk for infant mortality, though it is lower than for blacks in the same communities. These data are important in their own right, but will also provide a crucial point of comparison to black populations and help shed light on what precisely it is about race that increases black women's risk. And lastly, it will contribute to theory-building, especially in my field of medical anthropology, on the myriad intersections between poverty, gender, culture, reproduction, and health. This study is also poised to contribute to public health initiatives in Cleveland, OH. At a January 2016 meeting of the Ohio Equity Initiative (OEI), representatives from infant mortality reduction projects from all over the county came together to discuss integration and collaboration. Although each public health measure is crucial to reducing infant mortality, OEI recognizes that we need research that crosscuts individual agencies to provide data that can help raise the tide and lift all boats to reduce IMR across the region.

## **Dissemination**

To contribute to medical and health scholarship, which is actively concerned with racial disparities in medicine, we will present at conferences such as the annual meeting of the American Osteopathic Association, and publish in journals such as *Social Science & Medicine*, *Preventative Medicine*, and the *American Journal of Health Promotion*. To contribute to social science theory, we will present at conferences such as the annual meeting of the American Anthropological Association and publish in journals such as the *American Anthropologist*, *Social Science & Medicine*, and *Medical Anthropology Quarterly*. To contribute to local public health interventions, we will write a research report and present it at an OEI meeting.

### **C. Preliminary Studies of Applicant**

I have substantial experience using ethnographic methods to study the lived experience of pregnant and postpartum mothers living in poverty. For twenty-two consecutive months, I conducted research in Cape Town, South Africa to investigate how women of the Xhosa culture experienced perinatal depression in the context of extreme poverty. Rather than focus on a diagnosis of depression per se, I conducted open-ended interviews over the course of their pregnancy and baby's first year to explore their experiences of pregnancy and motherhood and how they were impacted by poverty, emotional distress, resilience, social support, and other life experiences. I found that culture shaped women's expectations and their responses to hardship and emotional distress. For example, Xhosa women, especially those who were unmarried, felt intense anxiety during pregnancy because of the stigma of being pregnant out of wedlock, which seemed to imperil their chances of receiving social support in the postpartum. However, once the baby was born, new mothers revealed in how warmly their

infant was welcomed into the family and how their formerly disapproving parents were now at ease, even thrilled. For Xhosa mothers, pregnancy was linked to emotional distress, but rarely in the postpartum period.

#### D. Methods

**Rationale:** As previously discussed, this study builds off of a substantial body of epidemiological literature that correlates infant mortality rates with socioeconomic status and racial identity. However, although epidemiology is adept at establishing patterns in population health and correlations between risk factors and health outcomes, it is limited in elucidating the processes that underlie or explain these patterns and correlations<sup>18</sup>. Ethnographic research--a type of qualitative inquiry that uses interviewing, participation, and observation to understand subjects according to their own subjective experience of the world and in the contexts of their everyday lives--excels at illustrating the nuances of complex phenomena that epidemiologic methods can pinpoint, but not fully explain. Furthermore, because ethnographic studies are inductive, allowing insights to spontaneously emerge as data is collected, rather than collecting data to prove a hypothesis posed at the outset, ethnographic research often leads to findings that are unexpected and challenge firmly held scientific assumptions.

**Sample and Recruitment:** This pilot study will have a sample size of 25 participants, which is a number small enough to be feasible for longitudinal, in-depth interviewing and also adequate to provide thematic saturation. *Inclusion: Female, Aged 18 or older, Currently pregnant [(**<36 weeks**)], Self-reported primary resident [**of Wards 1-16 of Cleveland, OH<sup>2</sup>**], Self-identify as*

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<sup>2</sup> Wards 1-16 of Cleveland, OH have an infant mortality rate above the national average; being a resident of any ward of Cleveland except ward 17 can be used as a proxy for risk especially when combined with Medicaid eligibility.

*either black/African American or white/Caucasian, [eligible and receiving Medicaid (individual or household) Exclusion: Self-reported resident of Ward 17 of Cleveland, OH, >37 weeks.]*

To recruit participants who meet the inclusion criteria, we will use two non-randomized sampling methods, “opportunistic sampling” and “snowball sampling.” A randomized sample is not required for qualitative research, instead heterogeneity in the sample is useful for breadth and richness of data. ***[The researchers have begun recruiting at the following sites/events in Cleveland: WIC support groups, MomsFirst outreach events, community “baby showers” organized by public health groups or insurance companies for Medicaid-eligible pregnant women, and Ohio Equity Institute monthly meetings. If we are unable to recruit all of our participants, additional sites/events will be added and/or additional suburbs of Cleveland, OH that have a similarly high IMR.]***

**Data Collection:** The research method chosen for this study is ethnographic interviewing and observation<sup>19</sup>. We will conduct longitudinal, open-ended interviews and engage in observation (mostly direct with some participation, see Introduction section) with women over a 6-12 month period stretching from pregnancy to 1 year postpartum in order to understand the breadth of experiences that may contribute to risk of infant mortality. Although we have capped the maximum number of interviews at 10 (for the sake of clarity when asking participants to commit to the study and for logistical/budgetary reasons), it is not possible to stipulate the exact timeframe that each woman will participate in the study. Each women's timeframe will depend on her willingness and availability, and how early in their pregnancy she is recruited. This flexibility prioritizes the participant’s comfort and convenience while still allowing us to meet our main research objectives.

The interviews will be open-ended, which means that the interviewer has a list of topics that they wish to cover, but lets the interview be guided by the participant. ***[Baseline information gathered will include: demographics, how women cover food, clothing, shelter, health care, and how they manage financial insecurity.]*** Other topics include *emotions, stressors, well-being, coping, self-care, perceptions and experiences of poverty and racism (however the participant defines them), household characteristics and role, their own childhood, the pregnancy, significant relationships, reproductive history, any experiences with infant death, daily life with a new infant*. The topics are numerous and will take time to explore in-depth; this is one of the advantages of longitudinal interviewing.

**Data analysis:** Qualitative research uses a system of analysis called coding, which systematically labels and categorizes data to establish patterns (themes) and develop theories that emerge from the data. In this way, qualitative research lets the data drive theory rather than the other way around, which is common in hypothesis-driven quantitative research. All interviews will be audio recorded and researchers will write field notes of their observations. ***[Data input and analysis will begin early in the process so that subsequent interviews can be adjusted for emergent themes and new questions.]*** All audio recordings will be transcribed. Interview transcripts and field notes will be coded using axial coding<sup>20</sup> to create preliminary explanatory theories (i.e. models); these models will be further developed using memoing<sup>20</sup>, cross-case analysis<sup>21</sup> and the constant comparative method<sup>22</sup> to triangulate data, compare different types of participants, and clarify emerging patterns. Write-up will consist of preparing journal manuscripts for publication and reports to share with participants and local agencies.

### Research Timeline

month	1	2	3	4	5	6	7	8	9	10	11	12
recruitment	X	X	X	X								
interviewing		X	X	X	X	X	X	X	X			
direct/participant observation		X	X	X	X	X	X	X	X			
data analysis*						X	X	X	X	X	X	X
write up*											X	X

\*Analysis and write up will extend past the 12 month time period.

### E. Collaborations

This project was created with the explicit goal of mentoring OU-HCOM students in qualitative research methods to answer complex health-related research questions. ***[Three OMS-I were involved in planning, writing the IRB protocol, and writing CORE seed money proposals. An additional OMS-I joined after the planning period. Over the summer, the PI trained the students in ethnographic interview skills and they began recruitment. With additional support from OURC, the four students and the PI will each carry a “caseload” of 4-5 participants that they will interview and observe for the duration of the study. They will also begin data analysis and present preliminary findings in conference posters. In this way, students are integral to each aspect of the research process. The PI is also responsible for training, mentoring, and supervising the planning, recruitment, data collection, data analysis, and poster preparation. The PI will have a larger part in data analysis and preparing manuscripts because it will continue longer than the students are able to work on the project.]***

## Bibliography

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# Sarah E Rubin

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## **Biographic Information for OURC Grant**

### **EDUCATION**

- 2014 Ph.D., Medical Anthropology  
Case Western Reserve University, School of Graduate Studies, Cleveland, OH  
Dissertation: "Struggling and Coping With Life: Maternal Emotional Distress in a South African Township"  
Committee: Eileen Anderson-Fye, EdD (chair); Atwood Gaines, PhD; Vanessa Hildebrand, PhD
- 2006 M.Sc., African Studies  
University of Oxford, St. Cross College, Oxford, UK  
Thesis: "Reproducing Domesticity: Representations of Motherhood in Colonial-era Ethnographies of Southern African Societies, 1930-1960"  
Supervisor: Professor William Beinart, DPhil
- 2005 M.A., Medical Anthropology  
Case Western Reserve University, School of Graduate Studies, Cleveland, OH
- 2001 B.A., Philosophy  
University of California at Berkeley, College of Letters and Sciences, Berkeley, CA

### **FELLOWSHIPS and FUNDING – previous 5 years only**

- 2016 **Mentored Research funding** Office of the Associate Dean for Research and Innovation, Ohio University
- 2012 **Richard A. Zdanis Research Fellowship Award**. School of Graduate Studies, Case Western Reserve University. One award granted per year for demonstration of research creativity and potential to contribute to the field.
- 2012 **Arts and Sciences Dissertation Fellowship**. College of Arts and Sciences, Case Western Reserve University. Award and participation in a dissertation-writing seminar to facilitate progress on the final stages of the dissertation.
- 2010-2011 **National Science Foundation (NSF) Doctoral Dissertation Improvement Grant (DDIG)**. Cape Town, South Africa. To conduct dissertation data collection on study of motherhood, emotional distress, and poverty among Xhosa women in South Africa.
- 2010-2011 **Fulbright Hays Doctoral Dissertation Research Abroad Fellowship (DDRA)**. Cape Town, South Africa. To conduct dissertation data collection on study of motherhood, emotional distress, and poverty among Xhosa women in South Africa.

### **PUBLICATIONS – previous 5 years only**

(under review) **Rubin, SE** "The Inimba it Cuts: a Reconsideration of Mother Love in the Context of Poverty," Special Issue: Culture and Economic Adversity: Contemporary Psychocultural Engagements, *Ethos*.

(in progress) **Rubin, SE**, Burke, KB, and M Kohn "Devising Healthy Communities: an Innovative Community Arts Preclinical Curriculum."

Zrally, M, **Rubin, SE**, and D Mukamana (2013) "Motherhood and Resilience among Rwandan Genocide-Rape Survivors," *Ethos*. 41(4):411-439.

**Rubin, SE**. (2011) "Beware the 'anthropologist spoiler': identity, subjectivity and rapport in fieldwork," *Mentorship Column, Council on Anthropology and Reproduction Newsletter*. 18(1):4/6.

### **PRESENTATIONS—previous 5 years only**

Demott, J, **Rubin, SE**, Brown, B, and S Stagno. Poster: "Burnout and Empathy in the First Year of Residency—Using the Humanities to Develop the Interior Life" Emerging Diversities in Health Humanities Teaching Summer Seminar at Hiram College. Hiram, OH.

Updated January 2016

**Rubin, SE**, Skinner, D, and J Bianco. Poster: "Interdisciplinary Perspective, Creativity, and Case-Based Learning," Emerging Diversities in Health Humanities Teaching Summer Seminar at Hiram College. Hiram, OH.

**Rubin, SE**, Skinner, D, and J Bianco, "Using Medical Humanities to Improve Medical School Best Practices: Applying an Interdisciplinary Lens to Case-based Learning," Arts and Health Humanities Conference, Cleveland Clinic. Cleveland, OH.

**Rubin, SE.** (2015). *"Everyday Acts of Violence and Resistance: Motherhood and Childbirth in the South African Township Maternity Clinic,"* The Ontological Politics of Motherhood. Annual Meeting of the American Anthropological Association (AAA). Denver, CO.

**Rubin, SE.** (2015). *"'I'm sending my child so I can work for my child': Mother love in a South African township,"* Culture and Economic Adversity: Contemporary Psychocultural Engagements. Biannual Meeting of the Society for Psychological Anthropology (SPA). Boston, MA.

**Rubin, SE.** (2014). *"Maternal Emotion as an Opportunity for Mobility in a Context of Poverty: Exploring the Everyday Lives of Xhosa Mothers in a South African Township,"* Culture and Economic Adversity: Contemporary Psychocultural Engagements. Annual Meeting of the American Anthropological Association (AAA). Washington, DC.

**Rubin, SE.** (2013). *"Both here and there: meaning and modes of motherhood for Xhosa women in an urban South African township,"* Cultural Meaning and the Life Course in Urban Marginalized Zones. Annual Meeting of the American Anthropological Association (AAA). Chicago, IL.

**Rubin, SE.** (2013). *"Engaging with emotions: the methodological and cultural adaptation of quantitative diagnostic tools for perinatal depression,"* SMA/EASA/URV Medical Anthropology Conference. Tarragona, Spain.

**Rubin, SE.** (2012). *"Suffering transformed: the 'individual' and 'social' as modalities of suffering among poor Xhosa women in South Africa,"* Engaging With Borders Of Suffering: Re-Examining And Re-Conceptualizing Suffering Across Cultural Contexts (**Co-organizer and Presenter**). Annual Meeting of the American Anthropological Association (AAA). San Fran, CA.

**Rubin, SE.** (2012). *"A community of suffering: experiences of emotional distress and strategies of coping for Xhosa women in a South African township."* International Congress of Psychology. 30<sup>th</sup> Annual Conference. Cape Town, South Africa.

**Rubin, SE.** (2011). *"Where Nurses Yell and Patients Lie: Care-Seeking and Care-Giving In Primary Maternity and Infant Care In a South African Township,"* Legacies of Care: Tracing difference, inequality and transformation in 21st century caregiving configurations. Annual Meeting of the Association of American Anthropologists (AAA). Montreal, QC.

#### **RESEARCH EXPERIENCE—previous 5 years only**

2010-2011      **Case Western Reserve University/  
University of Cape Town, Cape Town, South Africa**  
*Dissertation: Struggling and Coping With Life: Maternal Emotional Distress in a South African Township*

#### **MENTORING**

2016              Research and Scholarly Advancement Fellowship (RSAF) Mentor  
2016 Fellow: Morgan Craig OMS-I

2016              CORE Research Seed Funding Mentor  
2016 mentees: Morgan Craig, OMS-I, Genevoffa Morway OMS-I, Kathryn Clark OMS-I

#### **AWARDS - previous 5 years only**

2016              **Distinguished Osteopathic Commitment Award.** Outstanding Research Mentor, OU-HCOM  
**Distinguished Osteopathic Commitment Award.** Outstanding Behavioral Science Faculty, OU-HCOM

2014              **Graduate Dean's Instructional Excellence Award.** Winner, Case Western Reserve University

2013              **SAGES Excellence in Writing Instruction Award.** Finalist, Case Western Reserve University

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### **TEACHING EXPERIENCE**

- 2014-present      **Cleveland Clinic Lerner College of Medicine at Case Western Reserve University**  
**Qualitative Research Consultant and Lecturer**
- 2012, 2015        **Case Western Reserve University**  
**Department of Anthropology**  
**Adjunct Professor**  
"Person, Behavior and Culture: Psychological Anthropology;" upper level/graduate level
- 2014-present      **Case Western Reserve University**  
& 2012-2013      **Seminar Approach to General Education and Scholarship (SAGES)**  
& 2006-2009      **Lecturer in College Writing**
- 2013                **Cleveland State University**  
**School of Health Sciences**  
**Adjunct Professor, Online**  
"Culture and Health;" core course for all Health Sciences majors

### **INVITED LECTURES—previous 5 years only**

"Global Health and the "Problem" of Culture." *3rd Annual Workshops in Global Health*. Case Western Reserve University School of Medicine and the Cleveland Clinic Lerner College of Medicine. Cleveland, OH. January 2015.

"Doing Medical Anthropology Research in South Africa." Instructor, Dr. Eileen Anderson-Fye. Case Western Reserve University. Cleveland, OH. October 2014.

"Anthropological Approaches to Gender Violence: Rwanda and South Africa." Instructor, Dr. Ana Wetzl. Kent State University, Trumbull. Warren, OH. April 2014.

"Anthropological Theories of the Body." Instructor, Dr. Eileen Anderson-Fye. Case Western Reserve University, Cleveland, OH. April 2014.

"Anthropology of Emotions: Major Themes and Theories." Instructor, Dr. Eileen Anderson-Fye. Case Western Reserve University, Cleveland, OH. March 2014.

"Mental Illness/Witchcraft: a Xhosa example from Cape Town, South Africa." Instructor, Dr. Michele Hanks. Case Western Reserve University, Cleveland, OH. March 2013.

"Motherhood and emotional distress in Xhosa mothers in the township." Perinatal Mental Health Project program meeting. Department of Psychiatry, University of Cape Town, South Africa. September 2011.

"The Anthropology of Reproduction: Important Contributions and Themes." Instructor, Dr. Eileen Anderson-Fye. Case Western Reserve University, Cleveland, OH. November 2007-2014 (biannual).

### **LANGUAGE EXPERIENCE**

- 2010-2011        **Field language experience, isiXhosa**, Cape Town, South Africa.
- 2009                **Intermediate fluency in field language, isiXhosa.**  
Summer Cooperative African Languages Institute (SCALI), Michigan State University (MSU)

### **ACADEMIC LEADERSHIP & PARTICIPATION**

American Anthropological Association  
Society for Medical Anthropology  
Society for Psychological Anthropology  
Council on Anthropology of Reproduction

A. Previous University Funding

3/1/16            \$3000

Seed funding from CORE Research Committee, awarded to the original three student researchers (\$1000 each), for research expenses

- a) Participant compensation
- b) Recruitment supplies

5/9/16            \$8000

Special funds to support mentored student research from the Office of the Associate Dean for Research and Innovation

- a) Participant compensation
- b) Transcription costs
- c) small faculty stipend to support time spent mentoring students and analyzing data

These two funds were allocated to begin conducting research, including recruitment supplies, participant compensation, and transcription. An OURC grant is requested for non-duplicate funds:

- a) web-based qualitative data analysis program for data entry and analysis
- b) Additional participant compensation and transcription costs in order to increase personnel from 3 to 4 student researchers and allow the PI to also collect data (although the researchers are not paid "wages," each researcher recruits and interviews 4-5 participants incurring additional participant compensation and transcription costs)
- c) for travel expenses such as mileage and meals (as suggested by external reviewers)

B. External Funding

4/14/16            not funded

Applied for a MedTAPP grant entitled "Infant Mortality Research Partnership" (reviews and rankings were not made available)

OURC application 2016 - *Budget*

	Category	Item	Description	Cost
1A	Consumable supplies	Qualitative Data Analysis Program (www.dedoose.com)	1 year subscription to web-based qualitative data analysis program for data entry and analysis (\$21.90/mo for 12 months)	\$263
1B	Consumable supplies	Participant compensation	Each participant will receive compensation of a \$25 gift card for a local grocery store per interview; 5 participants, 10 interviews each	\$1250
1C	Travel	Occasional meals while traveling for interviews	Stipend to offset occasional meals with participants and/or researcher meals while traveling for interviews - \$170 per researcher x 5 (FY2017 M&IE = \$17 for lunch in Cleveland, OH <a href="http://www.gsa.gov/portal/content/101518">http://www.gsa.gov/portal/content/101518</a> )	\$850
1D	Travel	Ground transportation	Stipend to offset auto travel to and from interviews and recruitment sites - \$375 per researcher x 5 (FY2017 POV = .54/mi)	\$1875
	SUBTOTAL		SUBTOTAL NON-PERSONNEL	\$4238
2A	Personnel	Transcription services	Professional transcription service to transcribe interview data, \$1/min for approximately 3750 mins (50 interviews x 75 min each = 3750 mins)	\$3750
	SUBTOTAL		SUBTOTAL for PERSONNEL (<50%)	\$3750
	TOTAL			\$7988

Justification:

1A. To perform data analysis we need a reliable platform that can accommodate 2 users - one user is the PI and the other user will grant access to all the students. The students need to have their own user profile so that PI can monitor their contributions, i.e. adding and deleting documents, adding and deleting codes, etc. The PI has experience with the www.dedoose.com platform.

1B. Other funding sources (see Other Support) have funded the bulk of participant compensation. We request the OURC to fund the remaining in order to allow an additional student and the PI to also collect data.

1C. External reviewers suggested that we include in the budget money for incidentals such as coffee and meals with participants. We chose to pay for these costs through a stipend rather than individual reimbursements because submitting receipts for itemized reimbursement creates a large burden on my one administrative staff member. According to the GSA <http://www.gsa.gov/portal/content/101518> , the lunch allowance in Cleveland, OH is \$17 for FY2017. We feel that this is generous and two meals could be purchased for \$17. Each researcher will complete  $5 \times 10 = 50$  interviews. The stipend would enable the researcher to purchase a small meal for herself and her participant on ten occasions.

1D. External reviewers suggested that we include in the budget money for travel. We chose to pay for these costs through a stipend rather than individual reimbursements because submitting receipts for itemized reimbursement creates a large burden on my one administrative staff member. The only safe and reliable mode of transportation in these neighborhoods is by car so money for travel would consist of a stipend to offset mileage costs. According to the GSA, the POV mileage reimbursement for FY2017 is \$0.54/mile. From the Cleveland campus to interview locations is an average of 20 miles roundtrip per interview. Each researcher will complete  $5 \times 10 = 50$  interviews  $\times 20$  miles  $\times \$0.54/\text{mile} = \$540$ . We cannot afford to reimburse the whole amount with the OURC funding allowance, so we propose \$375 per researcher to offset travel costs.

2A. Transcription comprises a large proportion of any qualitative study's budget--even moreso because our study is narrative-focused and longitudinal. One other funding source (see Other Support) has funded the bulk the transcription costs. In addition, to offset costs, the researchers will transcribe 5 interviews each. For medical students to be able to participate in this research, we cannot make the research too time intensive during the school year. It is essential that their research time is spent doing the aspects of the research that a) provide the richest learning experience and b) cannot be outsourced. Interviewing and analysis provide the richest learning experience and only transcription can be outsourced. Therefore, we have requested as much of the OURC budget as allowed to pay for transcription costs.