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Examining Newcomer Women's Experiences with Perinatal Care in Ontario, Canada: An Application of Carspecken's Critical Ethnographic Method

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Abstract

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Keywords

critical ethnography, Carspecken, critical qualitative research, newcomer women, perinatal care, health insurance

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Examining Newcomer Women's Experiences with Perinatal Care in Ontario, Canada: An Application of Carspecken's Critical Ethnographic Method

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This article provides a practical description of Carspecken's (1996) five-stage critical ethnographic approach entitled "Critical Qualitative Research (CQR)." Situated epistemologically and ontologically in the critical paradigm, this article is an exploration of critical ethnography as an important methodology for shedding light on the discursive culture of perinatal care for newcomer women during the three-month health insurance waiting period in Ontario, Canada. We argue that Carspecken's approach to critical ethnography is especially instrumental in illuminating the social structures that contribute to health inequities.

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Introduction

Critical ethnography is a qualitative research method that emerged from a need to illuminate social structures embedded in culture such as racism and the patriarchy (Cook, 2008).

Critical theorists postulate that social culture reproduces disparities, especially when ideas and values related to social status are naturalized over time and accepted by society as reality (Carspecken, 1996; Gastaldo, 2017). As such, critical ethnographic research can be used to support changes that challenge systemic oppression. To do this, the subtleties of oppression must be uncovered, including clarifying how various groups are oppressed (Carspecken, 1996). The task of uncovering the subtleties of oppression is a difficult one since they are so pervasive and ensnared in everyday thinking and beliefs (Carspecken, 1996).

Carspecken's approach, which is not only concerned with the nature of social structure, but also social inequality that is reproduced through conventional practices (Carspecken, 1996), informed this study. Carspecken's (1996) critical ethnographic method is based on the belief that critical ethnography is a form of social activism, where "criticalists" (p. 3) engage in research that exposes existing systems of domination, hidden assumptions, and ideologies so that social situations and power distribution may be redefined. Critical ethnographic research can help create positive change by refining social theory through exposing systemic inequity, as opposed to simply describing social life (Carspecken, 1996; Kincheloe et al., 2018), thus helping to enhance human welfare and wellbeing.

Background

During my time as a labour and delivery nurse, I (the primary author) had many clients tell me that having a baby is like an “open door” experience, where your body and life are free for all to see. Many expressed that they had very little choice in the decisions made during the birthing process and felt as though they were at the mercy of a healthcare system where care providers “know all.” These experiences illuminated the disconnect between women’s strength and empowerment inherent in the very nature of the birthing process and the vulnerability that comes from being at the mercy of someone else during this time, resulting in feelings of objectification and humiliation.

As a labour and delivery nurse, I actively participated in a system of care that privileged English-speaking patients, as there were limited resources for those whose language was not English. As a nurse whose only language is English, I was especially struck by one seminal experience that left a lasting impression on me and served as the impetus for my Master of Nursing thesis research. I was caring for a newcomer woman who was in early labour and did not speak English. As her labour progressed, she was in a great deal of pain, and with the help of a translator, I talked her through the benefits and risks of having an epidural – a procedure where an analgesic agent is injected into the epidural space around the spinal cord, effectively numbing areas affected by labour and delivery (Mayo Clinic, 2020).

After waiting for some time, an anesthesiology resident walked into the room, read through the client’s chart, and learned that they were in the three-month waiting period to be covered by the Ontario Health Insurance Plan (OHIP), a basic health insurance plan for the Canadian province of Ontario, funded by the federal Canadian government (Government of Ontario, 2019). After learning this, the doctor excused himself and returned to the client’s room with a debit machine, asking for payment before starting the epidural procedure. Having been born and raised in a country that provides healthcare coverage for its residents, I felt so angry at the system for creating circumstances where equitable access to healthcare is not guaranteed. This experience illuminated the need to view clinical phenomena with a critical lens and attend to structures that shape healthcare delivery in Ontario. Therefore, I decided to pursue research on newcomer women’s perinatal experiences in the OHIP waiting period.

As I started my thesis work, I struggled to find an appropriate methodology to conduct this project. I wanted to move past the idea of gaining an understanding, as would be the case with narrative approaches (Denzin, 2015), and move towards adopting an emancipatory methodology to contribute to social change. After much searching, I, along with my thesis committee (co-authors of this paper), decided that a critical ethnographic methodology is particularly suited for this study because it allows for an examination of power as exerted through social, cultural, political, and economic structures that create social inequalities (Cook, 2008). The critical theory driving this methodology (Gastaldo, 2018) provides a unique lens with which to examine and uncover how systemic processes allow certain groups to hold more power over others (Gastaldo, 2017). Interrogation of these processes allows the researcher to act as a social activist by critiquing oppressive structures through their research and calling for transformation to promote social justice (Carspecken, 1996). The findings from critical ethnographic research can also support practice, policy, and education reform to fight systemic oppression (Kincheloe et al., 2018).

As one of the most influential scholars in the area of critical ethnography (Cook, 2008), Carspecken’s critical ethnographic approach (1996) was best suited for this study. This is because Carspecken’s work (1996) goes beyond description of the theoretical underpinnings for this methodology (Cook, 2008), and provides strategies for data collection and analysis that support the goals of critical ethnographic research. Carspecken’s approach was particularly helpful for uncovering the hidden culture of oppression that newcomer women face as their

various social identities intersect with economic, political, and social power systems in society. Carspecken's approach was also the most congruent with my values as a researcher in that I do not believe it is ethical for some groups to receive inequitable access to healthcare over others. The primary purpose of this study was to critically examine the factors that shape the experiences of perinatal care for newcomer women during the three-month OHIP waiting period. The research question was: what system relations shape the experiences of perinatal care for newcomer women during the three-month OHIP waiting period? "System relations" refers to the cultural, economic, and political structures that contribute to newcomer women's experiences with perinatal care (Carspecken, 1996). The theoretical perspective used to guide this study was intersectionality, which is a feminist sociological theory that originated in the work of African American feminist scholars such as Kimberlé Crenshaw (Hankivsky et al., 2010). Intersectionality is well suited for the topic of this study because it provides a multi-faceted approach for analyzing the individual and systemic factors that intersect to shape perinatal care for newcomer women during the three-month OHIP waiting period. It is also well suited for use with a critical ethnographic method because it focuses on uncovering social injustice and oppression at a structural level, challenging the current practices that perpetuate inequities among vulnerable populations. Additionally, this theoretical perspective provided an opportunity to explore how different intersecting social identities contribute to privilege and oppression, creating distinct perinatal care experiences for newcomer women. This is important because focusing on one particular social identity has been identified as a reductionist approach to understanding the multiple dimensions that produce healthcare experiences and health inequities (Hankivsky & Christoffersen, 2008).

While designing this study, I found myself uncomfortable with the non-prescriptive nature of critical ethnographic work. I also found that there are limited published resources discussing the use of critical ethnographic research in a health context, particularly using Carspecken's (1996) method. As a novice researcher, I felt that it would be helpful to have more resources that provide examples of how Carspecken's method could be applied to studies related to health. Therefore, the purpose of this article is to demonstrate how Carspecken's (1996) critical ethnographic method was utilized in this study and highlight the advantages of Carspecken's (1996) method in conducting research that illuminates how systemic oppression can result in social inequities.

Epistemology

Carspecken asserts that "the precise nature of oppression is an empirical question and not a given belief" (1996, p. 8). Therefore, a discussion related to the epistemological grounds upon which this study was based is necessary. Epistemology is a branch of philosophy that is concerned with issues central to the theory of knowledge, including the creation, breadth, and trustworthiness of knowledge claims (Carspecken, 1996). Carspecken's (1996) epistemological theory stands upon three central tenets and is informed by the work of Kincheloe and McLaren (1994). The first is that all thoughts, including those of researchers, are affected by the distribution of power in society (Carspecken, 1996). Therefore, the relationship between power and research claims, validity claims, and culture (thus power and thought) must be precisely explicated with critical epistemology. In this study, the first tenet was realized by making a conscious, reflexive effort to uncover and mitigate power imbalances between myself and the study participants. Power imbalances were mitigated by creating interview questions that helped to analyze the role that power plays in shaping perinatal care for newcomer women. It also involved a high level of reflexivity (as described in the section below) during participant interviews and an openness to new ideas and world views as presented by the participants.

The second tenet claims that facts cannot be strictly isolated from values, in that facts can never be firmly objective because they are always affected by values (Carspecken, 1996). Therefore, critical researchers must have an understanding of how the two interact and make the distinction between facts and values very clear in their work. I attended to this tenet in the study through continual reflection on my values around the right to healthcare, or my (the researcher's) value orientation. These values include the belief that systemic structures should not result in inequitable access to healthcare for some groups in relation to others. The third tenet states that symbolically representing events (an important part of social research projects) is not simply a process of recording facts from an objective reality. Rather, critical epistemology acknowledges that events do not exist in a vacuum and takes into account the historical and socio-political context around the events recorded. As such, throughout the study, I strived to attend to the contextual structures that culminate into systemic power and oppression, such as the history behind contemporary healthcare and immigration policies. I also used the participants' shared experiences as well as actions observed as entry points into understanding the broader context.

Ontology

In terms of the nature of reality, including the conditions that should be in place when considering what is "truth," Carspecken (1996) draws on Jürgen Habermas' theory of communicative action (1985a, 1985b, 1987). Communicative action is meant to create action/change for the people, by the people – the idea is to create a forum to air grievances and raise consciousness – so that action is collective/shared. The integration of Habermas' theory of communicative action allowed me to consider realities that were specific to the lives of the participants and thereby see beyond an objective reality. My role was not to act as a removed researcher, but rather to engage with the participants and accept their spoken word and experiences as expert knowledge. Therefore, their claims were accepted as truth because they came from them (Habermas, 1985a; Habermas, 1985b; Habermas, 1987).

Carspecken used Habermas' theory to create three ontological categories related to "universal features of human communication" (Carspecken, 1996, p. 61). The three ontological categories were used in this study to make inferences about the data collected. These categories combine objective, subjective, and inter-subjective components to provide knowledge about what can be considered the "truth." The first ontological category is concerned with objectivity (Carspecken, 1996). Claims made through the objective realm follow the principle of multiple access, in that such a claim may be open to multiple observers who will agree on its existence. For example, if a participant stated that they had to make a deposit for obstetric care, the statement would fall under the objective realm. The second ontological category is concerned with subjectivity and concerns statements made that relate to things such as emotions, intentions, and beliefs (Carspecken, 1996). Claims made through the subjective realm follow the principle of privileged access in that one may not have access to another's subjective domain. In revealing a subjective statement, one must trust that the statement is honest in order to believe that the statement is true. For example, if a participant stated that they felt happy or sad with the perinatal care they received, this would fall under the subjective realm.

The third ontological category is "normative-evaluative" (Carspecken, 1996, p. 83) and refers to inter-subjective claims that are concerned with what is right, wrong, bad, or good. This category does not fall under the principle of multiple access or privileged access as it relates to values and follows its own distinct rules. These claims can be described as "should" claims (Carspecken, 1996, p. 83), as they refer to ways in which people should act or think and concern the "nature of our world" as opposed to "the world" or "my world" (Carspecken, 1996, p. 83). For example, if a participant stated that they felt the OHIP waiting period was unethical,

this would fall under the normative-evaluative realm. This statement is not just opinion and can be supported in multiple ways.

Participant Sample and Recruitment

In this study, the population of focus included both newcomer women and service providers. Specifically, the target population included newcomer immigrant women with permanent resident status who were pregnant within the three-month waiting period for provincial healthcare coverage at some point during the last ten years since arrival. Newcomer women were eligible if they met the following inclusion criteria: (a) 18 years of age or over, (b) able to speak, read, and understand English, (c) currently or previously received healthcare (perinatal care) during pregnancy, labour, delivery, or after the delivery of their baby during the three-month OHIP waiting period, and (d) received perinatal care within the last ten years. Service providers who were interested in participating in the study were eligible if they were: (a) 18 years of age or over, (b) currently able to speak, read, and understand English, (c) currently or previously provided healthcare (perinatal care) to newcomer women during pregnancy, labour, delivery, or after the delivery of their baby during the three-month OHIP waiting period, and (d) provided perinatal care within the last ten years.

Both purposeful and snowball sampling (Sandelowski, 1995) were used to recruit participants. Recruitment posters were used intentionally to invite newcomer women or service providers who met the inclusion criteria. Permission was obtained to place the recruitment posters in twenty agencies across the Greater Toronto Area. Permission was obtained through both agency recruitment emails and agency recruitment phone calls using a script. These agencies were community health centers, community centers, midwifery clinics, and newcomer settlement agencies, and were chosen because they are places where newcomer women may go to receive perinatal care or information about perinatal care/services. An additional recruitment strategy was pursued by seeking permission to have a message posted about my research in the Midwifery Memo, the Association of Ontario Midwives' weekly news digest, during the recruitment process. Two messages related to the recruitment of newcomer women, and one geared towards recruiting midwives were posted using this strategy. During the recruitment process, I was also invited to present my research at a community centre that hosts prenatal classes for newcomer women.

The recruitment posters and Midwifery Memo post contained information relating to the purpose of the research and the expectations for participants. They also included a phone number and email contact that could be used to obtain more information about the study. Potential participants who inquired about the study using email were sent a study information letter and a time was set up for a phone call to determine eligibility. Potential participants who inquired about the study using the confidential phone line received the information from the study information letter verbally. A telephone script was then used to determine eligibility for all individuals who were interested in participating in the study. If deemed eligible, the individual was provided with potential interview dates/times from which to select.

Snowball sampling was a particularly relevant strategy, as not only was it intended to help find women who met the study criteria, but it addressed a potential challenge in accessing newcomer women as they may be hesitant to trust researchers and healthcare professionals after having negative experiences with the healthcare system. I had hoped that individuals might be more inclined to participate if they were referred by someone whom they trusted and who had already had a positive experience as a participant. To this end, each potential or consented participant was provided with extra study information letters to share with other women, whom they thought might be interested in participating.

Given the narrow aim of the study, very specific combination of participants, and my intent to engage in an in-depth exploration of participant experiences, my committee and I initially felt that 10-15 participants would provide sufficient saturation and richness of data to authentically describe the participant's experiences (Malterud et al., 2016). Study recruitment posed numerous challenges, and while 10-15 participants would have been ideal, I ended the participant recruitment process after seven interviews and ten months of active recruitment. The seven participants included four newcomer women and three service providers.

Each participant completed a demographic questionnaire followed by a different set of semi-structured interview questions for newcomer women and service providers.

Ethical Considerations

The key ethical considerations in this study were guided by the Tri-Council Policy Statement (TCPS 2) on ethical conduct with research involving humans (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2018). Before the recruitment process began, approval was obtained from the appropriate Institutional Research Ethics Board. Once a participant was successfully recruited to the study, I obtained informed consent through a verbal, in-person discussion relating to the purpose of the study, the research process (data collection, analysis and storing processes), the risks (such as negative feelings arising from the discussion of negative experiences) and benefits, confidentiality, voluntary participation, and the process for withdrawal from the study (at any time, without any consequences). In addition, I explicitly informed each participant of my duty to report any suspected child abuse or neglect, intention to inflict severe harm, either to self or others, and any professional misconduct to regulatory care bodies (for service provider participants). Following this discussion, each participant was given time to clarify any concerns and ask questions. Each participant was then given a consent form to read through and sign before starting the interview process.

Data Collection and Analysis

Data collection and analysis commenced by using Carspecken's preliminary processes of creating a list of broad comprehensive research questions to help identify issues that could be investigated through the study. This list was then used to create a second list that identified the information that would be needed to address these questions. I then engaged in a reflexive process, or "value orientation" (Carspecken, 1996, p. 6) to help explicate my biases and assumptions that could affect the research process. After engaging in these preliminary steps, I loosely followed Carspecken's method of collecting and analyzing the data through an iterative five stage process of compiling the primary record (stage one), developing a preliminary reconstructive analysis (stage two), engaging in dialogical data generation (stage three), describing system relations (stage four), and utilizing system relations as explanations of findings (stage five). These stages were loosely cyclical, and I moved back and forth between them as the project progressed (Carspecken, 1996).

Preliminary Steps

During the preliminary steps I created a list that broadly outlined the questions I had about the issues I wanted to explore in this study (see Appendix A). This list helped to conceptualize the areas I wanted to focus on and served as the basis for a second list (see Appendix B), where I determined what data, I would need to collect in order to answer the first list of questions, such as participant interviews and observations. Following the creation of

these lists, I explored my value orientations (Carspecken, 1996) through a journaling process before entering the field to collect any data. This is a reflexive strategy that helps identify potential researcher bias that may influence the research process. Making biases explicit thus supports rigour as it can ultimately help the research audience clearly understand the values that drove the research process and final research report (Carspecken, 1996). Following the preliminary steps, I again drew on Carspecken's (1996) work to engage in an iterative process of data collection and analysis.

Stage One

Compilation of the primary record from an etic, or outsider, perspective involves making passive observations in the field while recording notes for the primary record and the field journal (Carspecken, 1996). For example, a researcher who is looking to understand the culture of perinatal care for newcomer women may look to observe newcomer women in places where they seek or receive perinatal care, such as a midwifery clinic, without interacting with the participants. I collected primary participant observations through an intense set of field notes, that Carspecken (1996) calls the "primary record" (p. 45), where "thick descriptions" (p. 45) were recorded. Thick descriptions involve noting speech acts, body movements, and body postures (Carspecken, 1996). It also involves using a low inference vocabulary (such as "appears" and "it seems"), the recording of time frequently (such as noting the time every 15 minutes in the notes), adding speculations about the meaning of what is occurring in special brackets, and providing context information (such as location, number of people present, etc.). Thick description allowed me to compare my initial findings with what I then began to understand in subsequent stages of the analysis. The primary participant observations were recorded at the site of a recruitment presentation given to potential participants, at participant interview sites (before and after participant interviews), and during participant interviews. During the participant observation periods, I recorded observations through handwritten notes.

I collected secondary participant observations through a looser set of notes that Carspecken (1996) calls the "field journal" (p. 45). These notes were taken through observations in surrounding neighborhood areas of recruitment and interview sites (such as noting the number of surrounding stores and public resources in the area). Additionally, these notes included thoughts and feelings about observations and/or participant interviews for the day, such as feelings of anger when I learned that hospitals were often refusing OHIP cards for babies whose parents were not covered by OHIP. Parts of the journal were completed while I was still in the field (i.e., transcribed right away), while others were completed after returning home (e.g., if I remembered something that I observed and forgot to record, or if a new thought/feeling came to mind). The observations for the primary record and field journal were passive in nature, where I took on the role of an observer, describing what I saw from the perspective of an "uninvolved observer" (Carspecken, 1996, p. 42). Carspecken (1996) suggests that, at least initially, the researcher should maintain an unobtrusive stance, as this can then allow for a comparison between the data collected as a passive observer and a facilitator of data construction during participant interviews.

Throughout stage one, I visited the interview sites multiple times to obtain enough data for the primary record and field journal. To facilitate the type of thick description I wanted during participant interviews, I created an interview observation guide, in consultation with my thesis committee. I modified the interview observation guide to help frame additional participant observations. For the field journal, I observed surrounding neighbourhood areas as I walked through them or waited to meet with participants and took notes on casual conversations with informants to whom I spoke during the recruitment process, such as receptionists at some of the centres. These methods of observation were chosen because I

wanted to see how newcomer women are received by administrative staff (e.g., secretaries) or healthcare workers, interactions with healthcare providers, interactions with other people present in the setting, and anything else that might shape perinatal care experiences for newcomer women.

Stage Two

According to Carspecken (1996), preliminary reconstructive analysis is an initial effort to speculate about emerging patterns of iteration, power relations, and roles, in order to help tease out key issues and areas for further exploration in the next stages. To do this, I entered observational data from the primary record and field journals into a word document by transcribing my handwritten notes, which I then read over and over while “mentally noting possible underlying meanings” (Carspecken, 1996, p. 95). This led me to create a list of emergent codes and subcodes (distinctions within codes that have already been recorded) (Carspecken, 1996). In keeping with Carspecken’s approach, the emergent codes in the preliminary analysis were low-level codes that abstracted little and remained close to the objective features I had recorded, such as a conversation with a public health nurse who discussed how access to perinatal care is heavily dependent on self-navigation from newcomer women. This was a useful step as it helped me to reflect on possible patterns and identify events that might ultimately be useful in the broader analysis of data. For example, low-level codes related to strategies used to access perinatal care included: (a) personal networks, (b) phone calls to family practice clinics, (c) walk-in clinic visits, (d) emergency room visits, and (e) internet research. Subcodes that fell under code (a) included: (a) informal networks and (b) formal networks. When considering the multiple strategies that newcomer women had to use to access perinatal care in the OHIP waiting period, it sparked a thought about the hidden nature of Ontario’s healthcare system that conceals the perinatal resources that are available to individuals without health insurance.

Stage Three

Carspecken calls the stage of moving from an etic or outsider perspective to an insider or emic perspective “dialogical data generation” (Carspecken, 1996, p. 155). Dialogical data is generated through interview dialogue between the researcher and participant, in efforts to give each research participant an active voice in the research process. The dialogue allows participants to challenge the observational data collected by the researcher, and thereby initial patterns identified thus far. Data collection at this stage focuses on semi-structured interviews with research participants. A separate interview guide was developed for both newcomer women participants and service provider participants. Drawing on Carspecken’s (1996) approach, the interview guide was split into topic domains, leading questions, and sub-questions. Each interview guide had two over-arching topic domains: perinatal care experiences and institutional and political issues, which reflected the general research interests of the study. Each of these topic domains contained a range of two to eight leading questions, with additional sub-questions (or probes) to elicit a deeper level of information.

During stage three, I conducted seven one-on-one semi-structured participant interviews (n=7), each lasting between 30-90 minutes in length. The interviews were conducted in quiet, private locations chosen by the participant. These locations included either a private, booked room at a university, a local community centre, or a local community health centre. Keeping in line with Carspecken’s (1996) method, I acted as a facilitator in this stage, drawing out information through open-ended questions. Each interview was audio-recorded with the participant’s permission, and the audio recordings were transcribed verbatim. As described

above, I also recorded notes for the primary record during the interview process as a form of data. These notes provided valuable context for the interview transcriptions. For example, one of the service provider participants started crying while describing how they meet the cultural or religious needs of the newcomer women they care for. During this time, I stopped the audio recorder at the participant's request but was permitted to take handwritten notes until the audio recorder was turned back on. The participant explained how they identify as both a newcomer woman and a service provider, which allows for them to understand the unspoken cultural nuances that make a big difference in perinatal care experiences, such as modesty. After the participant interviews, I transcribed the audio-recorded data into a word document. At this point in the study, careful comparisons between the data collected in stage one and stage three were used to develop high-level codes that moved beyond description to a higher level of abstraction. For example, high-level codes related to barriers to accessing perinatal care included: (a) accessibility reliant on self-determination and (b) discrimination from individual actors within the system.

Stages Four and Five

Describing system relations (stage four) involves a system analysis to examine the relationships between the research group (or site) and other groups (Carspecken, 1996). I did this by comparing the findings (forthcoming in another publication) from the study with the existing literature. In particular, I examined journal articles, books, and grey literature that relate health inequities to oppression among newcomer individuals and other vulnerable groups, in a healthcare context. Conducting a system analysis links the social site of the study to other social sites, as similarities are discovered between the study findings and previous literature (Hardcastle, et al., 2006). Discovering similar findings across other studies assists with situating the findings of the study among the cultural, political, and economical structures that form the social world in which the study was conducted.

Utilizing system relations as explanations of findings (stage five) involves the use of a sociological theory to analyze and link the findings from the study (Carspecken, 1996). In this stage, sociological theory assists with finding a way to explain how sociopolitical structures contribute to the reproduction of study findings across settings, thus, how social phenomena is reproduced (Hardcastle et al., 2006). At this stage, I used intersectionality, the theoretical framework guiding this study, to explicate the study findings. In particular, I used an intersectional framework to explore how different social identities, such as race, gender, and socio-economic status, intersect with each other and the healthcare system to shape perinatal care experiences for newcomer women.

Reflexivity

Qualitative research requires the researcher to continually be reflexive – to be aware of how one's own positionality, history, experiences, and biases might influence the research process (Carspecken, 1996). This helps support rigour, as it makes decision-making more transparent. It also helps the researcher understand their own role in the analysis, be open to new ideas, and change their views on the world as new perspectives are discovered (Hardcastle et al., 2006). I made sure that I reflected on my own positionality at every stage of the research process. This required me to be aware of the deep-seated values and beliefs guiding my research journey and to consider how they played a role in the research decisions I was making. Reflexivity is especially important in a critical qualitative research context, as it helps differentiate the thoughts/feelings of the researcher from those of the participants and produces

a record of the research process (Carspecken, 1996; Cook, 2008). To support my own ongoing reflexivity, I consistently reflected on my social positioning in relation to the data. To do this, I recorded new reflections in a separate section of the field journal, and I made entries before, during, and after entering the field for participant observations and interviews.

My intersecting social identities put me in a unique position as both an “insider” (someone who shares membership in the same population) and an “outsider” at different points in the research process (Dwyer & Buckle, 2009). As a perinatal healthcare provider, I could be considered to be an “insider” in relation to the service provider participants. As members of a healthcare profession that provides perinatal care, we share some commonalities in terms of healthcare culture, language, and experiences. For example, the service provider participants often used language that is common among individuals providing perinatal care, such as “VBAC” (Vaginal Birth after C-Section), “Epis” (Episiotomy), and “AROM” (Artificial Rupture of Membranes). This language appeared to be used with an unspoken assumption that I would understand the meaning behind it, as a perinatal care provider. In qualitative research, being an “insider” facilitates openness in the interview process, and participants may be more willing to share information that would have otherwise been guarded against “outsiders” (Dwyer & Buckle, 2009). During my interviews with the service provider participants, I found that being a perinatal healthcare provider helped foster a sense of trust and rapport, which often promotes depth and richness of the data collected (Dwyer & Buckle, 2009).

At the same time, being a middle-class, English-speaking, non-racialized woman who was born and raised in Ontario with minimal (if any) barriers to accessing OHIP funded healthcare services, I could be considered an “outsider” in relation to the newcomer women participants. I may also be perceived as “representing” the system because I am a nurse within Ontario’s publicly funded healthcare system. As a result, I was concerned that some of the participants might feel uncomfortable sharing their experiences with me because I could not understand or relate to their experiences of migration and a lack of health insurance coverage. However, I found that the newcomer women participants were very open to sharing their perinatal care experiences, which were interwoven with institutional racism and classism. As a non-racialized woman of middle class, I have been afforded many economic and social privileges that made it difficult for me to grasp these experiences. Through reflections on participant interviews and observations, I became critical of my deep-seated assumptions and values. Although I was aware that racism and classism existed, I did not truly understand the extent to which Ontario’s healthcare system is structured to advantage individuals such as myself (i.e., non-racialized and middle-high class).

Rigour

In stage one, I drew on Carspecken’s notions of rigour to stay close to the data so that the roots of the later analysis were clear (Carspecken, 1996). I used a flexible observation schedule by recording observations, through handwritten notes, on different days, during both the morning and afternoon. I also shifted my attention from one person/aspect of the setting every five minutes (unless something significant was occurring), which Carspecken calls “the method of priority observation” (Carspecken, 1996, p. 48). Further, I spent as much time walking around interview sites as I could (before and after interviews). To get a deeper understanding of the participant experience, I returned to some interview sites multiple times. When recording my observations, I used language that did not abstract too soon, such as “it seems” and “as if,” before enough data was collected. I included all areas where I wanted to make comments referring to meaning in a separate field called “observer comments” (Carspecken, 1996, p. 47). In stage two, I used peer debriefing with my thesis committee to

check for what Carspecken (1996) calls “biases in attention and vocabulary” (p. 89) or gaps in the research analysis process due to the researcher’s values and assumptions.

In stage three, I used non-leading interview techniques, member checking, and encouraged participants to use and explain the terms they employ in naturalistic contexts (Carspecken, 1996). Non-leading interview techniques promote rigour by decreasing the possibility for researcher influence on the participants’ responses. I employed non-leading interview techniques by using one-word responses or facial expressions to acknowledge and respond to the participants. I also used low inference paraphrasing and non-leading questioning. Low inference paraphrasing involved restating or clarifying what the participant said without adding meaning to their words. Non-leading questioning involved asking questions, such as: “That is interesting. Tell me more about that,” without adding context to the questions.

Conducting member checks promotes the rigour of a study by mitigating power imbalances between the participant and the researcher (Carspecken, 1996). Philosophically, the data shared during the interview process is occurring at that moment in time and it is very possible for things to shift or oscillate after this time. Therefore, the data is represented cross-sectionally in this study and there was not a formal member checking process where participants made edits to what they had shared in a subsequent interview session. As recommended by Carspecken (1996), a modified method of member checking was performed during the interview process by asking participants to clarify the meaning of what they have shared during the interviews. Additionally, member checking was completed by summarizing my understanding of the interview results towards the end of the session and inviting participants to challenge the results I had summarized.

Participants sometimes try to please the researcher by using terms they believe that the researcher favours (Carspecken, 1996). Encouraging participants to use and explain the terms they employ in naturalistic contexts increases rigour by discouraging this behaviour, thereby reflecting the participants’ experiences as much as possible in the data collection phase. To do this, I tried to maintain reflexivity, be aware of when I was leading the questions, paraphrase and clarify what might be unclear, avoid writing from my own assumptions of what the person was saying, and summarize and invite challenges at the conclusion of the interview. In stages four and five, I examined my findings and those of other researchers to look for similarities. Finding similarities between my findings and those published by other researchers helps to uncover the relationships between the experiences of those in my study and those in other studies, thereby linking my findings to the cultural, economic, and political conditions (system relations) of society (Carspecken, 1996). I also used peer debriefing which involved discussing my findings with my thesis committee, ultimately deepening the analysis.

Implications and Conclusion

As will be reported in a subsequent paper, Carspecken’s method allowed me to identify how social identity, migration, and the healthcare system play a prominent role in shaping newcomer women’s experiences with perinatal care. In particular, an individual’s social location, as formed through intersections between gender, race, and socio-economic status, intersects with experiences of social isolation and exclusion, and systemic structures within the healthcare system to create perinatal care experiences. Carspecken’s (1996) critical ethnographic method was particularly helpful for examining the factors that shape the experiences of perinatal care for newcomer women during the three-month OHIP waiting period. In particular, it helped to illuminate the systemic structures (i.e., the healthcare system) that intersect with an individual’s social location to create a “hidden culture” of insurance coverage within Ontario, where perinatal resources and supports are not readily visible, and

thereby not readily accessible, to newcomer women. Additionally, it was useful for uncovering how this “hidden culture” of insurance coverage can create perinatal health inequities.

Adopting a critical approach to data collection and analysis can help uncover oppressive systemic structures that create health inequities for particular groups. Therefore, Carspecken’s (1996) method can also be applied to research looking at other populations. This method may be especially useful for research studies during the current COVID-19 pandemic, as many health- and social-related inequities have come to light; for example, individuals of low socio-economic status who are living in crowded shelter spaces and do not have health insurance (Bascaramurty et al., 2020; Ferreira, 2020). Carspecken’s (1996) method may also be helpful for novice researchers or individuals who are not familiar with qualitative research and are looking for a practical, logical approach to conduct critical qualitative research. Ultimately, a critical research approach helps to achieve social justice, which is concerned with equalizing the inequitable distribution of social resources in society (Hankivsky & Christoffersen, 2008) to improve the health of the overall population.

Appendix A

Preliminary List of Questions to Explore

1. How does the three-month OHIP waiting period affect newcomer women in the perinatal period?
2. What experiences do newcomer women have with receiving perinatal care?
3. What experiences do service providers have with providing perinatal care to newcomer women?
4. Is it easier for some newcomer women to access care than others? If so, what factors would affect access to care?
5. How do individual social identities affect newcomer women’s experiences with perinatal care?
6. What role do systemic policies play in creating newcomer women’s experiences with perinatal care?
7. What role does systemic culture play in creating newcomer women’s experiences with perinatal care?
8. What healthcare services are available for newcomer women in the perinatal period?
9. What community services might be helpful for newcomer women in the perinatal period?

Appendix B

Preliminary List of Data to Collect

1. Participant interviews with newcomer women who have received perinatal care during the OHIP waiting period.
2. Participant interviews with healthcare practitioners who have provided perinatal care to newcomer women during the OHIP waiting period.
3. Participant observation of places where newcomer women may receive perinatal care.
4. Participant observation of perinatal care appointments with newcomer women (e.g. postpartum midwife appointment).
5. Field journals to describe any secondary observation notes (e.g. things that I observed but may have forgotten to write down at the time) and any personal thoughts/feelings during the data collection process.

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